diagnosis lies in the quality of love relationships, we suggest that a careful examination of modes of relatedness is crucial. As Kohut stressed, some patients who are narcissistically organized tend to idealize others so that they can bask in the reflected glory of an idealized object. They may insist on the most famous psychotherapist or pick a romantic partner purely on his/her looks so that others will be impressed.

Denial of the romantic partner’s autonomy may be a central strategy for some narcissists. They are wounded if their love object acts or thinks independently. The fantasy of control serves to defend against ongoing anxiety of losing the one they love. However, it also represents a common problem with narcissistic individuals — namely, they cannot mentalize the internal experience of the other. Hence, they are unable to empathize with the partner’s need for agency, autonomy, and freedom from control. Another common mode of relatedness is to deny all pain or conflict in the love relationship, thus turning away from reality.

Narcissistic patients are desperately attempting to manage their vulnerability. Hence denial of dependency, sometimes referred to as “pseudo-self-sufficiency”, is another strategy in their repertoire. If they do not need anyone, then they cannot be hurt by losing someone. Another way that narcissistic individuals will relate to love objects is to see the other as completing the self. It is as though there is a “hole” in their sense of self that requires another person to perform missing functions for them. A common form of this occurs in patients who cannot soothe themselves and need their romantic partner to comfort them, tell them they are wonderful, and provide empathy for their pain. The relationship may end when the partner is not consistently providing the admiration or praise the patient requires.

Narcissism is pervasive in its normal and pathological variants. While some presentations are quickly apparent in treatment, as in the oblivious subtype, others may take longer to manifest in the clinical relationship. A person with the high functioning variant, who presents with energy, gregariousness and self-importance, may be initially charming to the psychiatrist and hence it takes longer to detect clinically significant narcissism. Only over time does the lack of relatedness and low self-esteem become clear.

Narcissistic patients may feel understood if the clinician focuses on self-esteem struggles and vulnerability beneath the grandiose surface. Some patients may not be able to tolerate any confrontation at first, and may need long periods of empathic validation in order to preserve a therapeutic alliance. A subset of these hypervigilant patients may never be able to tolerate confrontation or rupture, and may instead use the treatment over months and years to shore up a shaky sense of self-esteem and build validation. Timing is everything in making an impact through interventions, and it is advisable to wait for openings in which the patient lets the therapist know that he or she is hurting and yearning for help.

The psychiatrist must be attentive to countertransference issues. Kernberg described that the therapist can feel consigned to a “satellite existence”, which can lead to boredom and distance impacting the therapy. In addition, therapists must be alert to contempt and enactments of judgment and criticism. Finally, patients with narcissistic problems can require some of the longest treatments in a therapist’s caseload. Consultation is recommended in conflicted or difficult cases.

**Time for a global commission on mental health institutions**

Concerns about institutional care of people with mental disorders are no longer as prominent as they once were. This is understandable in light of deinstitutionalization and the closure of many psychiatric hospitals in much of the Western world. However, this neglect of old concerns is not excusable. Custodial mental hospitals which are, either directly or indirectly, the legacy of colonial psychiatry remain in many low- and middle-income countries the dominant, if not the only, component of national mental health systems. It is puzzling therefore that, despite the increasing attention to global mental health and the increasing familiarity with the unsatisfactory circumstances of people with mental disorders in such institutions, there is currently little interest in what is happening in those hospitals and other facilities in which people with severe and persistent mental disorders are treated and sometimes confined.

To a great extent, the field of global mental health has relegated the exposure of abuses in mental hospitals and other institutions to news media, non-governmental organizations, and human rights commissions. Hospitals and other institutions are not mentioned in any of the top 25 Grand Challenges in Global Mental Health, although that paper includes a photo of women in a psychiatric hospital in Ukraine.
Moreover, hospitals are not the only sites in which the human rights of people with mental disorders may be violated. For example, in Nigeria, prisons are often where families abandon members who are mentally ill. In Indonesia, the conditions for long-term residents in some social shelters are horrendous and deadly for those mentally ill people who have no other place to live. A report about mental health facilities in Ghana included scathing accounts of abuses in psychiatric hospitals and prayer camps run by spiritual healers. To this list one can add the rapidly growing number of private nursing homes that warehouse patients who have been discharged from mental hospitals.

Unfortunately, it does not seem that reform of these institutions is a priority for global mental health. Instead, development of community and primary care mental health services is overwhelmingly emphasized, with the implicit assumption that such services can meet all requirements of those who need care and treatment for a mental disorder. This is an ill-advised strategy that runs counter to the fact that long-term care options are necessary components of balanced and comprehensive mental health systems. Thus, it is imperative that attention is again directed to the task of transforming existing mental hospitals and other residential care institutions that are plagued by poor physical infrastructure, problematic staff attitudes and practices, the widely prevalent custodial ethos of care, and lack of appropriate discharge options and outreach services. These problems translate into formidable impediments to the creation of comprehensive mental health systems that have at their heart protection of the human rights of persons with mental disorder and disability.

Despite this generally bleak picture, there are examples of mental hospitals that have been transformed into institutions of excellence and repute. Although there is little published evidence of how this is to be done, there is a wealth of accumulated experience of how major changes can be achieved. Just as there is a compelling case to be made for reducing the gap between the number of people in need of care and the number receiving effective treatments, a case must be made for closing the “knowledge and transformation gap” that exists in relation to those institutions that are responsible for the care of persons with mental disorders. Addressing this gap through a combination of internal changes along with the development of integrated community services, in collaboration with service users and local partners from multiple sectors, should become a priority of global mental health.

We propose the establishment of a global commission on mental health institutions. This commission, which would be comprised of mental health professionals, social scientists, representatives of advocacy groups, and legal experts, would develop and carry out a programme of work that would include the following: a) establishing a working definition of “mental health institution”; b) comprehensively mapping mental health institutions in Europe, Asia, the Americas and Africa; c) documenting and understanding the determinants of poor conditions in mental institutions, using instruments such as the Quality Rights Toolkit of the World Health Organization; d) identifying the determinants of long-term stay in such institutions; and e) compiling a comprehensive report on successful strategies for bringing about institutional changes, such as those that have been applied at the National Institute of Mental Health and Neurosciences in Bengaluru, India; Angoda Hospital in Colombo, Sri Lanka; and Yuli Veterans Hospital in Taiwan.

The vision of the United Nations 2030 Agenda for Sustainable Development, adopted by the General Assembly in September 2015, includes “a world with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social wellbeing are assured” and where “all human beings can fulfill their potential in dignity and equality and in a healthy environment.” The conditions in mental hospitals and other institutions for persons experiencing mental illness are an affront to such aspirations. This is the moment to embark on an ambitious program of work to address this problem.

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1. BBC News. Mentally ill patients in Indonesia held in chains. www.bbc.co.uk.

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