

OCCASIONAL PAPER**Hubris syndrome: An acquired personality disorder? A study of US Presidents and UK Prime Ministers over the last 100 years**David Owen¹ and Jonathan Davidson²

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'The history of madness is the history of power. Because it imagines power, madness is both impotence and omnipotence. It requires power to control it. Threatening the normal structures of authority, insanity is engaged in an endless dialogue—a monomaniacal monologue sometimes—about power'.

Roy Porter

A Social History of Madness: Stories of the Insane, Weidenfeld & Nicolson, 1987 p. 39

Introduction

Charisma, charm, the ability to inspire, persuasiveness, breadth of vision, willingness to take risks, grandiose aspirations and bold self-confidence—these qualities are often associated with successful leadership. Yet there is another side to this profile, for these very same qualities can be marked by impetuosity, a refusal to listen to or take advice and a particular form of incompetence when impulsivity, recklessness and frequent inattention to detail predominate. This can result in disastrous leadership and cause damage on a large scale. The attendant loss of capacity to make rational decisions is perceived by the general public to be more than 'just making a mistake'. While they may use discarded medical or colloquial terms, such as 'madness' or 'he's lost it', to describe such behaviour, they instinctively sense a change

of behaviour although their words do not adequately capture its essence.

A common thread tying these elements together is hubris, or exaggerated pride, overwhelming self-confidence and contempt for others (Owen, 2006). How may we usefully think about a leader who hubristically abuses power, damaging the lives of others? Some see it as nothing more than the extreme manifestation of normal behaviour along a spectrum of narcissism. Others simply dismiss hubris as an occupational hazard of powerful leaders, politicians or leaders in business, the military and academia; an unattractive but understandable aspect of those who crave power.

But the matter can be formulated differently so that it becomes appropriate to think of hubris in medical terms. It then becomes necessary first to rule out conditions such as bipolar (manic-depressive) disorder, in which grandiosity may be a prominent feature. From the medical perspective, a number of questions other than the practicalities of treatment can be raised. For example can physicians and psychiatrists help in identifying features of hubris and contribute to designing legislation, codes of practice and democratic processes to constrain some of its features? Can neuroscientists go further and discover through brain imaging and other techniques more about the presentations of abnormal personality? (Goodman *et al.*, 2007).

We see the relevance of hubris by virtue of it being a trait or a propensity towards certain attitudes and behaviours. A certain level of hubris can indicate a shift in the behavioural pattern

of a leader who then becomes no longer fully functional in terms of the powerful office held. First, several characteristics of hubris are easily thought of as adaptive behaviours either in a modified context or when present with slightly less intensity. The most illustrative such example is impulsivity, which can be adaptive in certain contexts. More detailed study of powerful leaders is needed to see whether it is mere impulsivity that leads to haphazard decision making, or whether some become impulsive because they inhabit a more emotional grandiose and isolated culture of decision making.

We believe that extreme hubristic behaviour is a syndrome, constituting a cluster of features ('symptoms') evoked by a specific trigger (power), and usually remitting when power fades. 'Hubris syndrome' is seen as an acquired condition, and therefore different from most personality disorders which are traditionally seen as persistent throughout adulthood. The key concept is that hubris syndrome is a disorder of the possession of power, particularly power which has been associated with overwhelming success, held for a period of years and with minimal constraint on the leader.

The ability to make swift decisions, sometimes based on little evidence, is of particular importance—arguably necessary—in a leader. Similarly, a thin-skinned person will not be able to stand the process of public scrutiny, attacks by opponents and back-stabbings from within, without some form of self-exultation and grand belief about their own mission and importance. Powerful leaders are a highly selected sample and many criteria of any syndrome based on hubris are those behaviours by which they are probably selected—they make up the pores of the filter through which such individuals must pass to achieve high office.

Hubris is associated in Greek mythology with Nemesis. The syndrome, however, develops irrespective of whether the individual's leadership is judged a success or failure; and it is not dependent on bad outcomes. For the purpose of clarity, given that these are retrospective judgements, we have determined that the syndrome is best confined to those who have no history of a major depressive illness that could conceivably be a manifestation of bipolar disorder.

Hubris is acquired, therefore, over a period. The full blown hubris, associated with holding considerable power in high office, may or may not be transient. There is a moving scale of hubris and no absolute cut-off in definition or the distinction from fully functional leadership. External events can influence the variation both in intensity and time of onset.

Dictators are particularly prone to hubris because there are few, if any, constraints on their behaviour. Here, this complex area is not covered but one of us has considered the matter elsewhere (Owen, 2008). Hitler's biographer, Ian Kershaw (1998, 2000), entitled his first volume *1889–1936 Hubris* and the second *1936–1945 Nemesis*. Stalin's hubris was not as marked or as progressive as Hitler's. As for Mussolini and Mao both had hubris but probably each also had bipolar disorder. Khrushchev was diagnosed as having hypomania and there is some evidence that Saddam Hussein had bipolar disease (Owen, 2008).

Being elected to high office for a democratic leader is a significant event. Subsequent election victories appear to increase the likelihood of hubristic behaviour becoming hubris syndrome. Facing a crisis situation such as a looming or actual war or facing potential financial disaster may further increase hubris. But only the more developed cases of hubris deserve classification as a syndrome exposed as an occupational hazard in those made vulnerable by circumstance.

Hubris syndrome and its characteristics

Unlike most personality disorders, which appear by early adulthood, we view hubris syndrome as developing only after power has been held for a period of time, and therefore manifesting at any age. In this regard, it follows a tradition which acknowledges the existence of pathological personality change, such as the four types in ICD-10: enduring personality change after trauma, psychiatric illness, chronic pain or unspecified type (ICD-10, 1994)—although ICD-10 implies that these four diagnoses are unlikely to improve.

Initially 14 symptoms constituting the hubristic syndrome were proposed (Owen, 2006). Now, we have shortened and tabulated these descriptions and mapped their broad affinities with the DSM IV criteria for narcissistic personality disorder, antisocial personality disorder and histrionic personality disorder. These three personality disorders also appear in ICD-10, although narcissistic personality disorder is presented in an appendix as a provisional condition, whose clinical or scientific status is regarded as uncertain. ICD-10 considers narcissistic personality disorder to be sufficiently important to warrant more study, but that it is not yet ready for international acceptance. In practice, the correlations are less precise than the table suggests and the syndrome better described by the broader patterns and descriptions that the individual criteria encapsulate.

Establishing the diagnostic features of hubris syndrome

The nosology of psychiatric illness depends on traditional criteria for placing diagnoses in a biomedical framework (Robins and Guze, 1970). There are, however, other underpinnings—psychological or sociological—that can be applied. Validity for a psychiatric illness involves assessing five phases: (i) clinical description; (ii) laboratory studies; (iii) defining boundaries *vis-a-vis* other disorders; (iv) follow-up study; and (v) family study. While these phases are worth analysing, it has to be recognized that there are severe limitations in rigidly applying such criteria to hubris syndrome given that so few people exercise real power in any society and the frequency amongst those 'at-risk' is low. The potential importance of the syndrome derives, however, from the extensive damage that can be done by the small number of people who are affected. As an investigative strategy, it may be that studies such as neuroimaging, family

studies, or careful personality assessments in more accessible subjects with hubristic qualities or narcissistic personality disorder from other vulnerable groups might inform the validation process.

Proposed clinical features

Hubris syndrome was formulated as a pattern of behaviour in a person who: (i) sees the world as a place for self-glorification through the use of power; (ii) has a tendency to take action primarily to enhance personal image; (iii) shows disproportionate concern for image and presentation; (iv) exhibits messianic zeal and exaltation in speech; (v) conflates self with nation or organization; (vi) uses the royal 'we' in conversation; (vii) shows excessive self-confidence; (viii) manifestly has contempt for others; (ix) shows accountability only to a higher court (history or God); (x) displays unshakeable belief that they will be vindicated in that court; (xi) loses contact with reality; (xii) resorts to restlessness, recklessness and impulsive actions; (xiii) allows moral rectitude to obviate consideration of practicality, cost or outcome; and (xiv) displays incompetence with disregard for nuts and bolts of policy making.

In defining the clinical features of any disorder, more is required than simply listing the symptoms. In the case of hubris syndrome, a context of substantial power is necessary, as well as a certain period of time in power—although the length has not been specified, varying in the cases described from 1 to 9 years. The condition may have predisposing personality characteristics but it is acquired, that is its appearance post-dates the acquisition of power.

Establishment of the clinical features should include the demonstration of criterion reliability, exploration of a preferred threshold for the minimum number of features that must be present, and the measurement of symptoms (e.g. their presence or absence, and a severity scale). This endeavour may also include a decision as to whether the 14 criteria suggested might usefully be revised.

To determine whether hubris syndrome can be characterized biologically will be very difficult. It is the nature of leaders who have the syndrome that they are resistant to the very idea that they can be ill, for this is a sign of weakness. Rather, they tend to cover up illness and so would be most unlikely to submit voluntarily to any testing, e.g. the completion of scales measuring anxiety, neuroticism and impulsivity. Also the numbers of people with the syndrome is likely to be so small preventing the realistic application of statistical analyses. It also needs to be remembered that leaders are prone to using performance-enhancing drugs fashionable at the time. Two heads of government, Eden and Kennedy, were on amphetamines in the 1950s and 1960s. In the 21st century hubristic leaders are likely to be amongst the first to use the new category of so-called cognition enhancers. Many neuroscientists believe that such drugs properly used can be taken without harm. The problem is a leader who takes these without medical supervision and in combination with other substances or in dosages substantially above those that are recommended. In 2008, *Nature* carried out an informal survey of its mainly scientific readers and found that one in five of 1400 responders were taking stimulants and wake-promoting agents such as methylphenidate and modafinil, or β -blockers for non-medical reasons (Maher, 2008).

In defining the boundaries, one of the more important questions may be to understand whether hubris syndrome is essentially the same as narcissistic personality disorder (NPD), a subtype of NPD or a separate entity. As shown in Table 1, 7 of the 14 possible defining symptoms are also among the criteria for NPD in DSM-IV, and two correspond to those for antisocial personality and histrionic personality disorders (APD and HPD, respectively) (American Psychiatric Association, 2000). The five remaining symptoms are unique, in the sense they have not been classified elsewhere: (v) conflation of self with the nation or organization; (vi) use of the royal 'we'; (x) an unshakable belief that a higher court (history or God) will provide vindication; (xii) restlessness,

Table 1 The symptoms of hubris syndrome

Proposed criteria for hubris syndrome, and their correspondence to features of cluster B personality disorders in DSM-IV
1. A narcissistic propensity to see their world primarily as an arena in which to exercise power and seek glory; NPD.6
2. A predisposition to take actions which seem likely to cast the individual in a good light—i.e. in order to enhance image; NPD.1
3. A disproportionate concern with image and presentation; NPD.3
4. A messianic manner of talking about current activities and a tendency to exaltation; NPD.2
5. An identification with the nation, or organization to the extent that the individual regards his/her outlook and interests as identical; (unique)
6. A tendency to speak in the third person or use the royal 'we'; (unique)
7. Excessive confidence in the individual's own judgement and contempt for the advice or criticism of others; NPD.9
8. Exaggerated self-belief, bordering on a sense of omnipotence, in what they personally can achieve; NPD.1 and 2 combined
9. A belief that rather than being accountable to the mundane court of colleagues or public opinion, the court to which they answer is: History or God; NPD.3
10. An unshakable belief that in that court they will be vindicated; (unique)
11. Loss of contact with reality; often associated with progressive isolation; APD 3 and 5
12. Restlessness, recklessness and impulsiveness; (unique)
13. A tendency to allow their 'broad vision', about the moral rectitude of a proposed course, to obviate the need to consider practicality, cost or outcomes; (unique)
14. Hubristic incompetence, where things go wrong because too much self-confidence has led the leader not to worry about the nuts and bolts of policy; HPD.5

recklessness and impulsiveness; and (xiii) moral rectitude that overrides practicalities, cost and outcome.

In making the diagnosis of hubris syndrome we suggest that ≥ 3 of the 14 defining symptoms should be present of which at least one must be amongst the five components identified as unique.

Heads of Government in the US and UK over the last 100 years

Both of us have written elsewhere in detail about the health of heads of government (Owen, 2006, 2008a, b; Davidson *et al.*, 2006). Partly as a consequence, the examples of hubris we describe are drawn from the US Presidents and UK Prime Ministers in office over the last 100 years; but also it is because there are far more extensive biographical sources for Heads of Government than for other categories of leaders. We emphasize that hubris syndrome can affect anyone endowed with power, and examples have been quoted by others amongst business leaders (Schwartz, 1991; Maccoby, 2000) artists and religious gurus (Storr, 1997). The world has recently seen that in the

financial collapse of 2008 some leading international bankers also displayed marked signs of hubris.

A review of biographical sources of mental illness in US Presidents between 1776 and 1974 (Davidson *et al.*, 2006) showed that 18 (49%) Presidents met criteria suggesting psychiatric disorder: depression (24%), anxiety (8%), bipolar disorder (8%) and alcohol abuse/dependence (8%) were the most common. In 10 instances (27%) a disorder was evident during presidential office, which in most cases probably impaired job performance. The overall (49%) rate of psychiatric disorder was in tune with US population rates of mental illness, but the rate of depression was greater than expected in males, which has been reported as 13% in the US population (Kessler *et al.*, 1994).

It can be argued that Heads of Government might be expected to have a lower incidence of mental illness than the general population, reflecting the robust personality of people who are prepared to run for the highest political office in the two countries and therefore whether depression is a consequence of holding office. Also many Heads of Government display hubristic traits which are difficult to quantify but do not, in our view, add up to the full hubris syndrome. We list those US Presidents and UK Prime Ministers whose hubristic traits were the most obvious (Table 2 and 3). We ascribe hubris syndrome definitively only to a few of these leaders, in part because we are wary of making

Table 2 Hubris syndrome amongst the 18 US Presidents in office since 1908

Presidents	Related illnesses to hubris	Impairment evident to others or sought treatment	Hubristic traits	Hubris syndrome
Theodore Roosevelt 1901–09	Bipolar disorder	Yes	Yes	No
Woodrow Wilson 1913–21	Anxiety disorder Major depressive disorder Personality change due to stroke	Yes	Yes	?
Franklin D. Roosevelt 1933–45	None	No	Yes	No
John F. Kennedy 1961–63	Addison's disease Amphetamine abuse	Yes	Yes	No
Lyndon B. Johnson 1963–69	Bipolar 1 disorder	Yes	Yes	No
Richard Nixon 1969–74	Alcoholic abuse	Yes	Yes	?
George W. Bush 2001–09	History of alcohol-related problems	Yes	Yes	Yes

? uncertain - probable.

Table 3 Hubris syndrome amongst the 26 UK Prime Ministers in office since 1908

Prime Ministers	Related illnesses to hubris	Impairment evident to others Treatment sought	Hubristic traits	Hubris syndrome
Herbert Asquith 1908–16	Alcohol abuse	Yes	Yes	No
David Lloyd George 1916–22	None	Yes	Yes	Yes
Neville Chamberlain 1937–40	None	Yes	Yes	Yes
Winston Churchill 1940–45, 1951–55	Major depressive disorder: cyclothymic features	Yes	Yes	No
Anthony Eden 1955–57	Amphetamine abuse	Yes	Yes	No
Margaret Thatcher 1979–90	None	Yes	Yes	Yes
Tony Blair 1997–2007	None	Yes	Yes	Yes

the diagnosis of hubris syndrome where there is evidence of bipolar disorder, as for example with Theodore Roosevelt and Lyndon Johnson. Where there are other illnesses, which could complicate the diagnosis, such as Woodrow Wilson's cerebrovascular deterioration and Richard Nixon's alcoholic abuse, we signify a probable hubris syndrome with question marks in the table.

There is little evidence of progression in Theodore Roosevelt's hubristic traits during his time as President, although they were ever present throughout his life. It is relevant in determining that he did not develop hubris syndrome that he kept his promise to the electors not to stand for a second term. However, the fact that he took the controversial step of running on a third party ticket in 1912, thereby splitting the Republican vote and handing the presidency to Woodrow Wilson is a sign that he was still hubristic out of office and indeed to the end of his life. In their book, *Manic-depressive Illness*, Goodwin and Jamison wrote 'the hypomanic lifestyle of Roosevelt has been detailed by biographer Pringle (1931). As President of the US and as adventurer, Roosevelt lived at an extraordinarily high level of energy and was frequently grandiose, elated, restless, overtalkative and inordinately enthusiastic. He functioned with very few hours of sleep and wrote, administered or explored ceaselessly. It is estimated that Roosevelt wrote more than 150 000 letters in his lifetime, and a phenomenal number of books. Although he, on occasion, became mildly depressed, he could best be described as chronically hypomanic' (Goodwin and Jamison, 1990). Another revealing comment on Roosevelt claims that the cavalry regiment which he commanded in the Spanish–American War sustained 'incredibly high' casualties as compared to the other five regiments taking part, putting this down to his 'reckless inefficiency' (Fieve, 1997). The most recent assessment judges that Theodore Roosevelt suffered from bipolar 1 disorder (Davidson *et al.*, 2006).

Woodrow Wilson had such a complicated medical history that it is hard to disentangle. He had pre-existing chronic anxiety and depressive problems from early adulthood, then developed neurological episodes, probably vascular in origin, from 1889 onwards. Hypertension increased but these multiple health problems did not initially interfere with his competency in office, and his first years as President are widely judged to have been successful. He took the US into the First World War in 1917 with less difficulty than Roosevelt encountered in 1940. Yet by the Paris Peace Conference, he was described by Park as being secretive, defensive, indiscreet in his criticism of others, petulant, acerbic and paranoid (Park, 1986) and by Weinstein as being 'increasingly egocentric, suspicious and secretive and less discreet in references to people' (Weinstein, 1988). Additionally, by late 1918, his memory was failing. To the French Prime Minister, a medical doctor, Georges Clemenceau, Wilson was mentally afflicted and suffered from 'religious neurosis' and in Europe it was felt that Wilson talked to the conference like Jesus Christ. By this stage, he was showing features of dementia which may have intensified his hubristic traits. Yet, there seemed to be a progression in his hubris which leads us to question whether he had hubris syndrome. Park noted that by early 1917, Wilson was becoming stubbornly self-righteous, extremely certain in his

views and rigid in his thinking (Park, 1986). His vehemently autocratic ways gave rise to much concern in members of both parties and by 1918, Wilson was acting 'to enhance his authority and to exercise it without any restrictions' (George and George, 1965). All of this occurred before his severe hemiplegia developed in September 1919 accompanied by neglect, but still within the context of growing dementia.

In 1937, Franklin Roosevelt came close to being taken over by hubris when he fought and lost a battle with Congress over the Judicial Branch Reorganization Plan, affecting the nomination of Justices to the Supreme Court. Raymond Moley, in describing Roosevelt, whom he knew well, said, 'He [Roosevelt] developed a very special method of reassuring himself of his own preconceptions... . Ultimately, of course, a man closed off by one means or another from free opinion and advice suffers a kind of mental intoxication' (Moley, 1986). Fortunately, he had a sense of humour and a certain cynicism which meant that he never lost his firm moorings in the democratic system (Owen, 2008).

Kennedy displayed occasional hubris, particularly during the Bay of Pigs fiasco in 1961. One of Kennedy's advisers on Latin America, Richard Goodwin, described the atmosphere at these meetings on whether to invade Cuba: 'Beneath the uninformed acquiescence, there was also arrogance—the unacknowledged, unspoken belief that we could understand, even predict, the elusive, often surprising, always conjectural course of historical change' (Goodwin, 1988). Kennedy's hubris was in part related to his use of recreational drugs, amphetamine and bizarre levels of cortisone, which in a properly prescribed dose he had to take for his Addison's disease. Kennedy was almost certainly given an intravenous injection of amphetamine, perhaps with additional cortisone, just prior to a meeting with the Russian leader, Khrushchev, in Vienna in June 1961 and this very likely explains his poor performance at the meeting. Fortunately, by the Cuban Missile Crisis in October 1962 his medication was under far better control and he showed a steadiness that made a significant contribution to defusing a potential nuclear confrontation (Owen, 2008).

Lyndon Johnson is an example of a leader who had severe depression and a family history suggestive of bipolar disorder. His megalomania is thought to have been bipolar, but it could have been hubristic or both (Davidson *et al.*, 2006; Owen, 2008).

Richard Nixon began to behave evermore hubristically in the run up to the election over the summer and autumn of 1972 when it became very likely that he would win a second term. Nixon in fact won 49 of the 50 states. But he soon revealed hubris and paranoia. Newly released recordings by the national archives reveal Nixon telling Henry Kissinger, on 14 December 1972, 'Never forget, the press is the enemy. The establishment is the enemy. The professors are the enemy' (Nixon Library, run by the National Archives, on 2 December 2008 released tape recordings and 90 000 pages of documents.). Depression, drink and hubris all played their part in his illegal involvement in the cover up of the burglary of the Democratic HQ in Washington, the so-called Watergate scandal. In the play by Peter Morgan, *Frost/Nixon*, the author has one of his characters describe Nixon: 'Aeschylus and his Greek contemporaries believed that

the gods begrudged human success and would send a curse of “hubris” on a person at the height of their powers, a loss of sanity that would eventually bring about their downfall. Nowadays we give the Gods less credit. We prefer to call it self destruction’ (Peter Morgan, 2006).

George W. Bush developed hubris syndrome after only a little more than 2 years in office. He was, however, operating in the very exceptional political climate set by the 9/11 terrorist attack on the Twin Towers in New York. After Afghanistan he decided to invade Iraq. His appearance in flying gear on the aircraft carrier, *Abraham Lincoln*, cruising off the coast of California, on 1 May 2003, and then speaking on television with the slogan ‘Mission Accomplished’ emblazoned on the ship control tower behind him, marked the highest point in his scale of hubris. This episode is particularly interesting when one considers that the so-called success in Baghdad was only 10 days later described in a memo to Prime Minister Blair by the then British Ambassador to Iraq, John Sawers, as involving a complete absence of any serious planning for the aftermath of the taking of Baghdad: ‘No leadership, no strategy, no coordination, no structure and inaccessible to ordinary Iraqis’ (Owen, 2008).

Of the 18 US Presidents during this 100 year period, some personalities were widely judged to be non-hubristic and without substantial pathology, in particular Harry Truman, Dwight Eisenhower, Gerald Ford and Ronald Reagan. Reagan’s Alzheimer’s was not evident when he was examined in the Mayo Clinic in the summer of 1990, a year after he left office (Owen, 2008).

Among British Prime Ministers, Asquith had hubristic traits but not hubris syndrome and these traits were overlaid by his alcoholic intake. In April 1911, his doctor warned him to substantially reduce his alcohol intake and some claim that henceforward he did so (Owen, 2008). But in October 1911, after having lunch with Asquith, Constance Battersea, an old friend, wrote to her sister ‘the PM kind, extremely cordial, but how he is changed! Red and bloated – quite different from what he used to be. He gave me a shock. They all talk of his overeating and drinking too much. I am afraid there is no doubt about it’ (Clifford, 2003). He was warned to reduce his drinking by his doctor and this he did, but not completely. In September 1916, Field Marshal Sir Douglas Haig wrote to his wife after Asquith had visited his HQ in France: ‘The PM seemed to like our old brandy. He had a couple of glasses (big sherry glass size!) before I left the table at 9.30 and apparently he had several more before I saw him again. By that time his legs were unsteady, but his head was quite clear and he was able to read the map and discuss the situation with me’.

David Lloyd George ran an effective War Cabinet on becoming Prime Minister in 1916 and showed exceptional leadership. He was the only Liberal in that War Cabinet and he worked with three Conservative politicians and one Labour MP in a consensual leadership. He was helped in curbing his hubristic tendencies by his close relationship with the skeptical Conservative MP, Bonar Law, who was Chancellor of the Exchequer and the two discussed difficult issues most days with the Prime Minister going across from No. 10 to No. 11 Downing Street.

Lloyd George was less constrained after winning the 1918 election and began to develop hubris syndrome. He pulled more and more power into No. 10 and, in 1920, Winston Churchill wrote that he was virtually running the Foreign Office. Lord Beaverbrook, who strongly supported Lloyd George as a war leader, wrote a devastating account of his presidential style in 1921–22, ‘The Greeks told us of a man in high position, self confident, so successful as to be overpowering to others. Then his virtues turned to failings. He committed the crime of arrogance. His structure of self-confidence and success came tumbling down’ (Beaverbrook, 1963).

Lloyd George who, by common consent, earned the accolade as ‘The Man who won the War’ ended his period in office with Lord Morgan, an admirer, writing in his book covering the years 1921–22 of ‘the dangers of Caesarism... intuitive, erratic diplomacy and confused, ill-prepared encounters’, how he seemed ‘a desperate man’ and that this underlined his ‘temporary physical breakdown’ (Morgan, 1979).

Neville Chamberlain developed hubris syndrome in the summer of 1938 only a year after taking office, although he had been covering for the Prime Minister Stanley Baldwin, who was depressed, since the summer of 1936 (Self, 2006). Over Munich, the first of the so-called summit meetings of heads of government in September 1938, Chamberlain’s conduct has been heavily criticized ‘More dangerous still was the idealism (and hubris) of a politician who believed he could bring peace to Europe’. After Munich, Chamberlain admitted to his sister that he had come nearer to a nervous breakdown ‘than I have ever been in my life’ (Reynolds, 2007). His mood on arrival back in England was exultant, even triumphalist. He had personalized power into No. 10 acting with only a small group of Cabinet Ministers who agreed with him and marginalizing the rest.

Some psychiatrists believe that Winston Churchill had bipolar disorder. On balance what some see as manic behaviour, or crazy exultation, we see as hubristic traits and perhaps hypomania and we are content to apply no diagnosis beyond that of his undoubted periodic depressions. The older he became the more he was affected by vascular dementia and excessive alcohol but there was no progression to hubris syndrome.

Anthony Eden’s undoubted use of dextro-amphetamine combined in the same tablet with amylobarbitone (in those days called Drinamyl) explains some of his hubristic traits in the run up to the Suez Crisis. During the crisis he was variously described as being in a state of what you might call ‘exaltation’ or ‘like a prophet inspired’ or ‘very jumpy, very nervy, very wrought’ (Owen, 2008). Quite coincidentally his cholangitis, the result of the accidental cutting of his bile duct during a routine cholecystectomy in 1953, flared up and in October 1956 he developed a temperature of 106°F, 9 days prior to the crucial decision to collude with Israel and France over the invasion of the Suez Canal.

Margaret Thatcher, we judge, did not develop hubris syndrome until 1988, 9 years after becoming Prime Minister. But some believe she was hubristic throughout her period in office. Yet for her first two terms she relied on the wise counsel of Willie Whitelaw and this probably helped contain her hubristic traits as had Bonar Law’s relationship during the war years with

Lloyd George. The evidence is that she was cautious and controlled during the Falklands War of 1982, despite saying to the press 'Rejoice, rejoice' after the taking back of South Georgia Island. Over this it can be argued she was entitled to feel relieved after what could have been a disaster. Also she prudently did not use her new trade union legislation during the 1984–85 miners strike. After her third General Election victory in 1987, she tried to impose the unpopular poll tax. She saw German reunification in 1989 in cataclysmic terms as a potential Fourth Reich and told George Bush Sr 'if we are not careful the Germans will get in peace what Hitler couldn't get in the war' (Bush and Scowcroft, 1998). She also began to refer to herself in the third person 'We have become a grandmother'. By 1990 her own party's MPs forced her to resign after displaying raw hubris in her handling of the European Union and bawling in the House of Commons, 'No, no, no' (Young, 1998).

Tony Blair's hubris syndrome started to develop over NATO's bombing of Kosovo in 1999, 2 years after coming into office. At one stage President Clinton angrily told Blair to 'pull himself together' and halt 'domestic grandstanding'. He was starting to display excessive pride in his own judgements. One of Clinton's aides mocked Blair's 'Churchillian tone' and one of his officials, who frequently saw Blair said of him, 'Tony is doing too much, he's overdoing it and he's overplaying his hand'. Another of Clinton's staff accused Blair of 'sprinkling too much adrenalin on his cornflakes' (Owen, 2008) and it is noticeable how often this hormone, called epinephrine in the US, and secreted by the adrenal gland is referred to when lay people discuss manic or hubristic behaviour. After the dramatic collapse of the Twin Towers in New York on 11 September 2001, Blair responded with hyperactive travel and hyperbolic speeches. The historian, Lord Morgan, described him speaking to the Labour Party Conference: 'He seemed a political Colossus, half Caesar, half Messiah'. Bush and Blair's religious fervour coincided over Iraq. In 2006 on television, Blair said over Iraq: 'If you have faith about these things then you realize that judgement is made by other people. If you believe in God, it's made by God as well'. The historian, David Reynolds, brought the issue of hubris to the fore when he wrote about Chamberlain and compared him to Blair: 'A well intentioned leader convinced of his own rightness, whose confidence in his powers of persuasion bordered on hubris. Who squeezed out critical professional advice controlling policy and information from an inner circle'. He went on to say, 'For all their differences, Tony Blair's approach to summitry had a good deal in common with that of Neville Chamberlain' (Reynolds, 2007).

Blair was accused of being 'disingenuous', a word that just avoids the parliamentary ban on calling someone a liar, over his handling of the intelligence on Iraq by the former Cabinet Secretary, Lord Butler, in the House of Lords on 22 February 2007. This was some time after the publication of the Report of the Committee Lord Butler had chaired. Blair, he said, had been told by the intelligence community in August 2002 'we know little about Iraq's chemical and biological weapons work since late 1988'. Yet just over a month later, he was claiming to Parliament that the picture painted by the intelligence services was 'extensive, detailed and authoritative'.

It is too early to make a judgement on whether Gordon Brown will develop hubris syndrome as Prime Minister. It is worth recalling however, that on 20 June 2007, 7 days before becoming Prime Minister, he talked of 'the beginning of a new golden age for the City of London'. Having boasted for some time of ending 'boom and bust' in this speech he claimed that out of the first decade of the 21st Century, 'the greatest restructuring of the global economy, perhaps even greater than the industrial revolution, a new world order was created'. Within months banks were being nationalized or bailed out and the world faced its worst economic crisis for more than 70 years.

Of the 26 British Prime Ministers in the last 100 years, a number showed little tendency to hubris or excessive narcissism—in particular—Campbell-Bannerman, Clement Attlee, Harold Macmillan, Alec Douglas-Home, James Callaghan and John Major—although less confidence can be placed on the judgement of some others, including Stanley Baldwin.

General conclusions drawn from such a small sample of Heads of Government in the US and UK have to be treated with caution. It is worth noting, however, that hubris seems to manifest itself most in areas of policy where the leader feels they have their greatest expertise. Also that non-hubristic decision making does not seem confined to those leaders who had, in relative terms, a quiet time in office; for example Truman and Attlee took highly influential and controversial decisions at home and abroad while being amongst the least hubristic of leaders.

Finally, while there is some patchy evidence of pre-morbid personalities, it must be remembered that all these leaders held high, if not always the highest, office after winning elections within the democratic process and were judged by those electorates as being fit to hold that office.

Relationship between hubris syndrome and narcissistic personality disorder

We do not know the exact relationship between hubris syndrome and narcissistic personality disorder, which itself has been somewhat neglected. However, a number of recent studies shed light on narcissistic personality disorder in ways that are relevant. One study (Ronningstam *et al.*, 1995) found that narcissistic personality disorder itself is surprisingly transient, with only 46–50% of cases retaining the diagnosis at 3 year follow-up. Pertinent to our notion of hubris syndrome as an acquired disorder, Ronningstam and colleagues found that 4 of 20 patients failed to meet operational criteria for narcissistic personality disorder at baseline, but acquired this diagnosis at follow-up. The authors conclude that serious questions remain about the construct validity of narcissistic personality disorder as a diagnostic category.

A large epidemiological study has reached several interesting conclusions (Stinson *et al.*, 2008). The study observed a 6.2% lifetime prevalence of narcissistic personality disorder, which was higher in men (7.7%) than women (4.8%). Elevated rates of bipolar disorder among those with narcissistic personality

disorder suggest that an important part of assessing narcissistic personality disorder is the identification of features, which distinguish the two conditions, as well as recognizing their possible co-occurrence. The authors also comment on the transience of this supposedly enduring condition and its potential influence by value systems and cultural factors. They speak to the possibility of a context-dependent form of narcissistic personality disorder and urge further long term, epidemiological, clinical and genetic studies to identify unique and common factors for narcissistic personality disorder relative to neighbouring disorders. From a similar approach, we might learn whether hubris syndrome is one (acquired) form of narcissistic personality disorder.

A principal components analysis has shown that narcissistic personality disorder can be distinguished from other closely related cluster B personality disorders by its association with 'disorderliness', which we see as comparable to the lack of attention to detail criterion in hubris syndrome. Also, those with narcissistic personality disorder are most likely to express aggression when their low frustration tolerance causes irritability (Fossati *et al.*, 2007). Three subtypes of narcissistic personality disorder have been labelled: grandiose/malignant, fragile and high functioning/exhibitionistic (Russ *et al.*, 2008).

Neurobiology of hubris syndrome

Neuroimaging studies of cluster B personality disorders have mostly been limited to borderline and sociopathic types (Goodman, 2007). To the extent that they provide information about cortical and amygdala dysregulation in this particular personality cluster, they might be of some relevance to narcissistic personality disorder, but what is needed are imaging studies specifically of narcissistic personality.

Next to nothing is known about the neurobiology of hubris *per se*, and it is beyond the scope of this report to give a comprehensive neurobiological review, but to the extent that hubris syndrome shares common elements with narcissistic and sociopathic disorders, e.g. impaired decision-making, poor impulse control, poor modulation of aggression, lack of appropriate empathy, the findings of altered dopaminergic, noradrenergic and serotonergic function in these conditions could all be relevant. For example Cools (2008) has identified frontostriatal and limbic-striatal dopaminergic pathways as important regulators of impulsive and/or rigid behaviours, which may reflect deficient motivational or cognitive control. Interpretation of the findings, however, can be complicated. For example a dopamine agonist (bromocriptine) has varying effects on cognitive processing which are determined by baseline impulsivity, brain region and the type of cognitive function (updating versus distraction) being examined (Cools *et al.*, 2007). The role of other neurotransmitters, such as norepinephrine and serotonin, also bears further examination. Pathological gambling shares some of the features of hubris syndrome, such as impairment in risk appraisal and consequent decision making. Neurobiologically, pathological gambling is characterized by abnormal behavioural and neuroendocrine

responses following challenge by meta-chlorophenylpiperazine (m-CPP), a partial serotonin agonist (Pallanti *et al.*, 2006); and, at least in males, is associated with a variant in the promoter region of the serotonin transporter gene and the monoamine oxidase A gene (Perez de Castro *et al.*, 1999; 2002). In a study by Comings *et al.* (2001), significant associations were found between pathological gambling and genes for the D₂ and D₄, dopamine transporter, tryptophan hydroxylase and the α_{2c} adrenergic receptors, with the dopamine, serotonin and norepinephrine genes each accounting for <2% of the variance. Serotonin is also involved in the regulation of decision making and processing punishment-related information (Blair *et al.*, 2008), deficiencies of which could be relevant to hubris syndrome. As the authors put it, the 5HT transporter may be more integral to 'choosing the lesser of two evils' than to 'choosing the better of two goods'. As hubris syndrome becomes more widely recognized, and its biology better understood, it may be that psychiatrists and neuroscientists will discover a way of treating some of its more damaging features.

Recent work has directed attention to the importance of ventromedial prefrontal (vmPFC) and insular cortical regions in underpinning accurate risk appraisal and decision making and, for the insular cortex, proper awareness of aversive consequences (Paulus and Stein, 2006; Clark *et al.*, 2008). Subjects with lesions of these areas were prone to more risky decision making; there was misplaced confidence in the correctness of their decisions (Clark *et al.*, 2008). Interestingly, the administration of 40 mg methylphenidate normalized decision-making in a small sample ($n=8$) of patients with the frontal variant of fronto-temporal dementia, who become less risk-taking in their behaviour (Rahman *et al.*, 2006). These findings would seem relevant to the neurobiology of Hubris Syndrome as a condition in which undue confidence leads to (i) impaired risk appraisal; (ii) inability to foresee undesirable outcomes; and (iii) dangerous decision-making and much harm to others.

Comorbidity and classification

The comorbidity of narcissistic personality disorder, and perhaps hubris syndrome, with other personality disorders such as histrionic, borderline and sociopathic disorders presents a real problem. In the DSM-IV field trials, for example it proved extremely difficult to find patients who had narcissistic personality disorder without other personality disorders (Gunderson *et al.*, 1996). Our knowledge of narcissistic personality disorder lags considerably behind other personality disorders. In the emerging literature and the debate about narcissistic personality disorder it is clear that there may be more forms of the disorder and hubris syndrome may be but one of them. We have defined the disorder as likely to remit once power has been lost, although outcome seems to be related to the length of time in power. Ideally, follow up should assess naturalistic outcome as well as outcome after interventions of different kinds but once again small sample size will present difficulties. The studies referred to above already suggest that forms of narcissistic personality disorder can remit, as well as arise *de novo* in adult life. It is not far-fetched, therefore,

to postulate that hubris syndrome is both acquired and likely to abate once the context of power has changed, but that is hard to prove since we often know little about the lives of leaders once they cease to hold office. We can for the moment only assume that hubris syndrome shares the qualities of transience and influence by value systems that have been identified in reports on narcissistic personality disorder. Ideally longitudinal study could also examine the degree to which hubristic traits appear in subjects who, before achieving success, did not manifest any such features. For example might someone with obsessive personality traits but few narcissistic, histrionic or sociopathic features develop hubris syndrome?

If hubris syndrome, or traits of hubris, run in families, this would tend to support the existence of the syndrome, or point to possible comorbidity associations. Genetic linkage studies, however, either use twins or depend on fairly large numbers, and either strategy is offset by the small sample available for study.

Robins and Guze's five phase process is intended to be ongoing and subject to self-rectification. Whether such an approach would ultimately validate hubris syndrome as a separate psychiatric diagnosis, or whether it could emerge as a subtype of narcissistic personality disorder does not really matter. If the former, then it will give an important insight into the nature of power; if the latter, then the mapping of hubris syndrome would be a significant contribution to a fuller understanding of pathological narcissism. Either way recognition of the syndrome will help in that the general public will be alerted to the danger of hubris. Yet another possibility is that hubris syndrome may represent the manifestation of a bipolar diathesis, in which the disorder appears later in life perhaps in those with hyperthymic temperament and precipitated by the peculiar conditions of power, great success and stress, and carrying lower genetic risk than early onset bipolar disorder. It is not always easy to sort out whether megalomaniacal behaviour takes its origins in hubris or in bipolar disorder.

A slightly more radical idea is that hubris syndrome is not an Axis II disorder (of personality) but an Axis I disorder, in that it has an environmental onset, akin to a stressful experience, and that it ultimately disappears in response to environmental change. In this sense, it resembles an adjustment disorder, albeit one which is malignant in its effects on others. However, adjustment disorder has become something of a waste-bin, or, as described by Casey and colleagues as a 'fault line in the psychiatric glossary' (Casey *et al.*, 2001); and, as far as the research community is concerned, it generates little interest. Rightly or wrongly, adjustment disorder is almost always pre-empted by other diagnoses, in part because of the ways in which DSM and ICD define these other conditions.

Is hubris syndrome treatable?

Even if the existence of hubris syndrome is established and it receives strong diagnostic support, it cannot be assumed that this of itself will lead to effective treatments. It is unlikely that hubristic individuals will seek psychological or biomedical treatment for their hubris, although they may accept help for complications such as depression, alcohol-related problems or related

family difficulties. However, as the evidence grows for effective psychological treatment of personality disorders, it is conceivable that individuals with hubris syndrome, narcissistic personality disorder or other related conditions, might be more willing to receive help, knowing that they could receive greater and more sympathetic benefit than in the past.

The more likely dividend from improved societal awareness of hubris is that, as expectations change, leaders in all walks of life may feel a much greater obligation to accept and not resist society's prescribed course of democratic constraint, accept statutory term constraints such as the 8 years on a US President and, when alerted to their behaviour, step down voluntarily from office or not seek re-election and reappointment as leader. In some ways the non-executive members of Boards monitor the Presidents or Chief Executives of large companies better than Cabinets monitor Heads of Government. If faced by early signs of hubris the independent directors can insist on discussing the issue and even introduce a mentoring process. Strategies for managing hubris among corporate executives have been outlined (Maccoby, 2000). In the case of military leaders there is often a forum for monitoring the Chiefs of the Defence Staff and political accountability. President Truman's firing of General Douglas MacArthur for insubordination is a good example of a military chief being cut down to size for hubris. The prison sentences for some of the leaders of Enron appear to be in part an example for others. We have yet to see what, if any, penalties will be imposed on the hubristic behaviour of financial leaders after the crisis of 2008.

Because a political leader intoxicated by power can have devastating effects on many people, there is a particular need to create a climate of opinion that political leaders should be held more accountable for their actions. The most important constraint on a Head of Government is fear of not being able to win re-election. Another is fixed-term limits, such as the two 4-year terms for US Presidents. Cabinets, which are appointed by the Head of Government, have not been very successful in constraining hubris syndrome, in part because they owe their appointment to the Head of Government, also because they find it difficult to detect the development of hubris. Single resignations of members of the Cabinet have often been important triggers for alerting people to what is going on behind closed doors. In the US, a threat of impeachment is a constraint and in the UK a withdrawal of support by Members of Parliament has been a crucial element in forcing all the four Prime Ministers, Lloyd George, Chamberlain, Thatcher and Blair—diagnosed here as having hubris syndrome—to resign. Parliamentary revolts would not have happened if Thatcher and Blair had only stayed 8 years in office.

Hubris syndrome in politicians is a greater threat than conventional illness to the quality of their leadership and the proper government of our world. Strategies for identifying and constraining hubris have been suggested (Storr, 1997; Hillman, 1999; Owen, 2008). Qualities protective against disproportionate hubris, like humour and cynicism are worth mentioning. But nothing can replace the need for self-control, the preservation of modesty while in power, the ability to be laughed at, and the ability to listen to those who are in a position to advise. Another important safeguard comes from the practice of devoted concern to the

needs of individuals and not simply to the greater cause (Storr, 1997; Hillman, 1999). Efforts at rehabilitation may be successful to the extent they are able to inculcate some of these qualities.

Neustadt (1964) has argued that a governed people's view of a leader's effectiveness is typically determined by what is happening to them during the leader's term of office. Park goes on to say that there is something missing in this assessment: it is equally necessary that public perception of a leader should also include an awareness of what is happening to *him* (Park, 1986). We would include hubris syndrome as one of the possible pitfalls.

Caveats and limitations

Since DSM-I was published in 1952, with a listing of 106 mental disorders, the number has climbed remorselessly to 182 in DSM-II (1968), to 265 in DSM-III (1980), to 292 in DSM-III-R (1987), to 297 in DSM-IV (1994). Is there room for another?

Psychiatry trespasses into the world of politics and big business at its peril. Some of the pitfalls have been described by Beveridge (2003) and Wessely (2003), who draw attention to a number of problems, including the potential misappropriation and pejorative use of the 'powerful weapons' of psychiatric terminology. Wessely notes correctly that psychiatric attempts to understand the minds of famous people have often come to grief and hardly left a good impression. There is always the risk of unprovable speculation, as for example in the portrait of Woodrow Wilson by Freud and Bullitt (1999). Psychiatry is on firmer ground in such matters if it remains focused on observable facts from reliable sources, instead of speculating on reasons for behaviour of the famous, most of whom have never been seen by those expressing their opinions. This leads to another consideration since full medical diagnosis traditionally relies upon an encounter between doctor and patient. It draws on information from the interview as well as collateral information. Thus any attempt to identify disorder at a distance must be treated with caution. Premature, uncritical, dissemination of labels should be avoided. Therefore, we stress that, while the recognition of hubris syndrome is important today, it will need further careful evaluation well into the future.

Finally, it should never be forgotten that in a letter, written on 5 April 1887 to Mandell Creighton, the author of 'History of the Papacy during the period of Reformation', Lord Acton wrote something very profound which preceded his famous dictum: 'I cannot accept your canon that we are to judge Pope and King unlike other men, with a favourable presumption that they did no wrong. If there is any presumption it is the other way against the holders of power'. He followed this with 'Power tends to corrupt, and absolute power corrupts absolutely'.

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