

## Definition and Description (Traits and Skills) of Narcissistic Leaders

**Abstract** After describing the different clusters of personality disorders and their associated traits and behaviors, Germain details the differences between healthy and unhealthy narcissism, as well as clarifying the concepts of covert vs. overt narcissism. “Definition and Description of Narcissistic Leaders” then examines the role of racial and gender differences in narcissistic individuals. After presenting interpersonal challenges associated with pathological narcissism, Germain concludes by placing NPD in the workplace context. She does so by discussing how certain corporate leaders may present observable signs of NPD in the workplace, and how these signs may affect employees and organizations as a whole.

**Keywords** Traits and behaviors of NPD · Healthy vs. unhealthy narcissism · Covert vs. overt narcissism · Interpersonal challenges · Pathological narcissism · NPD in the workplace

### BACKGROUND ON PERSONALITY DISORDERS

The Diagnostic and Statistical Manual of Mental Disorders (DSM) offers specific diagnostic criteria to better define two broad classes of psychiatric disorders: Axis I (clinical disorders such as depression, anxiety, schizophrenia, or bipolar disorder) and Axis II (personality disorders [APA 2000]).

To be diagnosed with a personality disorder (PD), an individual must display “an enduring pattern of inner experience and behavior that

deviates markedly from the expectations of the individual's culture" (APA 2000). Furthermore, the behavior patterns of the individual must be evident in at least two of the following mental activities:

1. Cognition (the way in which one perceives or interprets oneself, other people, and/or events)
2. Affectivity (the range, intensity, liability, and appropriateness of one's emotional responses)
3. Interpersonal functioning
4. Impulse control

The pattern of behavior must also meet the following standards:

- Be rigid and prevalent across a wide range of personal and/or social situations
- Be stable and enduring, with the onset attributable to adolescence or, at the very least, early adulthood; cannot be a consequence of substance abuse, a medical condition, or another mental disorder
- Results in clinically significant malaise or impairment regarding social, occupational, or other vital areas of functioning

PDs are grouped in three clusters, identified as A, B, and C:

- **Cluster A** includes a cognitive dimension (Paris 2003) and incorporates paranoid, schizoid, and schizotypal personality disorders. Often, people with Cluster A disorders are regarded as being weird or eccentric, speaking or behaving in abnormal ways, exhibiting peculiar cognitions and ideas, and potentially struggling to relate to others (APA 2000).
- **Cluster B** disorders, correlating to externalizing dimensions (Paris 2003), encompass antisocial, histrionic, borderline, and narcissistic personality disorders. In general, people who suffer from Cluster B disorders may demonstrate behavior that is overly emotional, dramatic, or erratic, and they will often act out with little regard for social norms. They struggle with impulsive behavior and are commonly hostile toward other people as well as engaging in self-abuse (APA 2000).
- **Cluster C** disorders, correlating to internalizing dimensions (Paris 2003), include PDs that are avoidant, dependent, and obsessive-compulsive. Those who suffer from Cluster C disorders are likely to experience feelings of anxiety, extreme fear of social interactions, and generalized loss of control (APA 2000).

At some point over the course of his or her life, every individual is likely to display several of these traits; however, it is truly the severity and stability of a particular set of personality traits that define a diagnosable personality disorder.

When it comes to the role that genetics and the early childhood environment play in the development of PDs, a multitude of conflicting theories and opinions exist. However, much of literature suggests that it is truly a convergence of “nature and nurture” (APA 2000; Yudofsky 2005). Basically, a child may be born with certain genetic predispositions to developing a PD; however, the child’s experiences and environment could ultimately determine whether and how that disorder plays out.

For instance, children who possess specific temperaments that coincide with Cluster B disorders are more likely to develop a PD if their environment includes elements of abuse, neglect, or abandonment by their caregiver, deeming these children incapable of forming solid attachments with a parental figure (Karen 1998).

The development of emotional empathy (and related neural capacities) is often determined by factors such as temperament and attachment styles. Prior to developing language, infants read and generate facial expressions as a means of communication (Leppänen and Nelson 2009). These emotional components rely on perceptual processing and emotion-based neural circuits and are often evident at birth. These components are crucial in preparing infants to connect empathetically and participate in effective interactions with others later in life. Fostering healthy and secure emotional attachments is a crucial aspect of infant development and depends largely on the primary caregiver’s empathetic abilities since the majority of an infant’s interactions involve the primary caregiver. Children who can develop secure attachment qualities tend to develop in ways that allow them to respond well to the needs of others (Mikulincer et al. 2003). Ronningstam (1998) deepens this understanding by stating, “The combination of a doting but emotionally depriving parent who delivers the message of specialness along with unrealistic expectations and a second non-doting parent who is absent, critical, entitled, cold, disengaging, or rejecting sets the stage for narcissistic personality disorder” (p. 247).

Children who have been abandoned or suffer from abandonment issues are highly likely to develop a personality disorder; they are reported to be one of the most common groups of people who will develop narcissistic personality disorder (NPD) (Kernberg 1970; Rinsley 1967). Furthermore, children who were raised by abusive parents who

lacked parental warmth and struggled with perspective taking skills reported low levels of self-confidence and high frequency of narcissistic traits (Wiehe 2003).

Abundant research and literature support the conclusion that individuals who develop personality disorders find it incredibly difficult to change and are inherently challenging to treat, mostly because they develop such disorders early in life and experience “lasting patterns of perceiving, relating to, and thinking about oneself and the environment.” These enduring patterns of inner experiences and behavior can lead to clinically significant distress or impairment in social, occupational, or other areas of functioning (APA 2000). Whereas Axis I disorders (such as depression and anxiety) are typically confined to a specific time period, personality disorders (Axis II) are generally expected to maintain a lifelong diagnosis. Although events occurring in an individual’s life may exacerbate behaviors typical of a personality disorder (e.g., divorce might trigger suicidal thoughts in a person plagued with borderline personality disorder), the characteristics of the disorder are inherently enduring.

Individuals diagnosed with personality disorders are frequently linked to low levels of emotional and social functioning, with little improvement shown in the areas of psychosocial functioning, even over time (Skodol et al. 2005). While less concrete evidence exists to support the effect that personality disorders have on labor market performance, it is fairly easy to make a direct connection between the two.

### DEFINITION OF NARCISSISTIC PERSONALITY DISORDER (NPD)

Narcissistic Personality Disorder (NPD), a Cluster B personality disorder, is highly regarded as one of the most difficult personality disorders to identify (Pies 2011).

Thanks to great efforts made by psychoanalysts and psychoanalytical psychotherapists, the development of NPD as a diagnostic category offers a cluster for patients who did not previously fit into an established personality disorder category. These difficult-to-define patients generally do not exhibit signs of psychosis or neurosis and are often unresponsive to conventional psychotherapeutic treatment, making it very challenging to categorize them (Gildersleeve 2012).

NPD commonly coexists with other psychiatric disorders, often resulting in patients who exhibit signs of anxiety or depression in addition to their narcissistic traits.

A fair number of patients who display characteristics of NPD when seeking psychiatric counsel also express traits associated with various other disorders and issues. A multitude of comorbid disorders are known to exist with NPD, the most prevalent being major depressive disorder, which is apparent in about 45–50% of NPD patients (Ronningstam and Weinberg 2013; Payson 2002). Bipolar disorder appears in approximately 5–11% of NPD patients (Ronningstam and Weinberg 2013). Obsessive-compulsive behaviors are frequently associated with NPD (Payson 2002). However, substance abuse is the most commonly seen comorbidity. Approximately 24–64.2% of NPD patients experience some form of a substance abuse disorder (Ronningstam and Weinberg 2013). Attention-Deficit Hyperactivity Disorder (ADHD) has also been connected to NPD (Payson 2002). Existing alongside NPD, these additional afflictions tend to aggravate and often cloak the disorder; however, when properly diagnosed and treated, these issues may potentially soften the traits of NPD. It is of the utmost importance to accurately identify and treat comorbid disorders to provide the best opportunity for change to occur.

Although the public generally pays more attention to clinical disorders (such as depression and schizophrenia) rather than more obscure personality disorders, the latter may offer a deeper level of understanding regarding labor market outcomes.

Although personality disorders often vary from atypical (e.g., antisocial PD, in severe cases sometimes referred to as “sociopathy”) to the less pathological (e.g., obsessive-compulsive disorder), all have the inherent potential to cause significant issues in interpersonal relationships, including those with supervisors, co-workers, and employees.

While there is a plethora of characteristics that serve to define NPD, some of the most notable characteristics are lack of empathy, grandiosity, and seeking superfluous admiration (Ronningstam and Weinberg 2013). One of the true defining qualities of an individual with NPD is a blatant lack of empathy, a signifier of the disorder highlighted in both the clinician’s and general public’s understanding of those with NPD.

Lack of empathy often has negative impacts on an individual’s interpersonal relationships and quality of life. While NPD individuals may exude an impression of self-control, dismissal of others, and an overall condescending attitude, they are likely battling extraordinary low self-esteem and feelings of inadequacy internally.

Typically, NPD individuals attain many personal and professional goals throughout their lives, though their achievements are generally tarnished

due to the negative effects that NPD has on personal and professional relationships. Largely, this is due to the individual with NPD being incapable of handling criticism in any form, while exhibiting little to no empathy or respect for the people in his or her life.

### *Healthy vs. Unhealthy Narcissism*

Rather than regarding narcissism in all or nothing terms, Malkin (2015) suggests imagining a continuum (spectrum) from 0 to 10 that reflects given criteria for diagnosing NPD, as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA 2011). For example, the desire to "feel special" ranges from abstinence (1) to addiction (10).

Living in constant extremes is generally viewed as being unhealthy, but finding a happy medium is often difficult for NPD individuals. For instance, individuals living at an extreme such as 0–1, likely will never feel special. They may turn down sympathy or assistance even when they need it the most due to believing they do not deserve any attention or help. While some degree of selflessness is considered admirable, unrelenting selflessness can be detrimental to one's health.

The opposite end of the spectrum features individuals living at a 10—those who wish to live in the spotlight consistently, no matter the cost. These individuals live with the mindset that if others are not acknowledging their importance, then they simply cease to exist. Essentially, people at this end of the spectrum are addicted to any kind of attention and will go to great lengths to satisfy their addiction (Malkin 2015).

Consider someone living at a 9 on the spectrum; this level is still considered dark narcissism. While these individuals may not need to elbow their way into the spotlight to feel whole, they certainly would if given the opportunity.

People living at a 1 tend to suffer just as much as those at a 9 or 10, though in quite opposite ways. Any minute amount of attention that they are given, say for instance on a birthday or special occasion, is simply more than they can tolerate. At the 2, 3, 7, and 8 marks, people's feelings are generally more flexible and open to change. Presumably, the healthiest range is in the center, between 4 and 6. Although those who exist in this healthy range certainly experience intense ambition or occasional arrogance, feeling special or receiving attention is neither compulsive nor uncomfortable. For instance, a 6 would be considered healthy

narcissism where one oscillates between self-absorption and attentiveness. Individuals who live in the 5 range tend to be equally comfortable and modest about their need to be in the spotlight. While they undeniably enjoy success, their life does not revolve around constant achievement.

As Malkin (2015) postulates, most models of human behavior consider flexibility to be the hallmark of mental health. Healthy humans have the innate ability to adapt behaviors and feelings based on their current circumstances. Conversely, in narcissism, one lives in a constant state of extremes, generally fixed at one end of the spectrum with an inability to fluctuate. However, life events tend to affect the position of an NPD individual (up or down) on the spectrum by a few points, with an unusual circumstance pushing them to reach one extreme or the other. Divorce and illness may increase narcissistic tendencies as individuals attempt to salvage their self-worth. Teenagers, who often display a know-it-all attitude, have a propensity for behaving more narcissistically, as they are generally more prone to despair, anguish, and humiliation than adults. The teenage years are considered an essential part of identity development and the exhibited behaviors are not typically permanent; they dissipate during young adulthood as individuals become more attuned to the people around them.

### *Overt or Covert NPD*

While some researchers make a clear distinction between overt and covert narcissism, Pincus (2013) suggests that overt expressions of narcissism are often incorrectly associated with grandiosity while covert expressions of narcissism are associated with vulnerability. Essentially, pathological narcissism is demonstrated by both grandiosity and vulnerability, each having an overt and a covert manifestation (Fig. 2.1).

Pincus claims that this notion regarding overt and covert narcissism is largely inaccurate in that the phenotypes are not wholly distinct. NPD criteria along with self-reported items and interviews include a mix of overt expressions (behaviors, emotions, expressed attitudes) and covert expressions (private feelings, cognitions, needs, or motives) (McGlashan et al. 2005; Pincus 2013). No factual evidence exists justifying the actuality of overt and covert narcissism, with distinguishing between overt and covert expressions of narcissism coming secondary

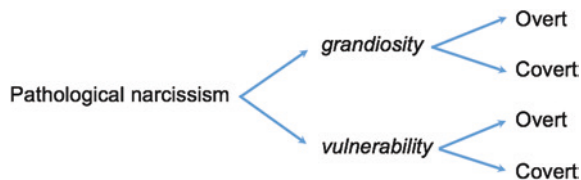


Fig. 2.1 The hierarchical structure of pathological narcissism

to phenotypic variations seen via grandeur and culpability (Pincus and Lukowitsky 2010).

An overt NPD leader is someone whose identity allows for a more open expression of narcissistic needs such as power, admiration, or control (Payson 2002). The overt NPD leader may be a power broker, using developed skills to advance in public endeavors, such as in an executive position or as a politician. In the public arena, the overt NPD leader gains attention by exuding charm, executing intimidation tactics, or expressing grandiosity by other means such as showcasing acquired money. The overt NPD leader uses a strong persona to steal the spotlight and demand the public's attention, admiration, awe, respect, or fear. Socially, these NPD leaders believe their audience enjoys their personality and is impressed with their power, money, and physical or intellectual prowess. While often initially drawn to an NPD leader's charisma, an audience will soon develop a better understanding of the dynamic that they have entered. The NPD leader will demand constant admiration and support and, while appearing to have friends, are likely surrounding themselves only with people who offer admiration and are willing to play a supporting role—often for their own personal gain. Friendships such as these are generally superficial and require minimal emotional investment from the NPD leader.

By comparison, the covert NPD leader gains power, admiration, status, and control by indirect means. These individuals are generally more self-contained or may even be viewed as aloof. They will disguise their grandiose needs by taking on the role of a helper, doctor, pastor, humanitarian, do-gooder, expert professional, hermit, or even a misunderstood artist (Payson 2002). This assumed persona allows the covert NPD leader to gain attention, status, and power through deeds or connections, rather than taking on a solo role in the spotlight. In fact, he



or she may shy away from the spotlight, for example, talking at length about connections to important people and promising introductions to others. The covert NPD leader's feeling of pride and self-importance generally has little to do with a genuine ability to empathize with the feelings and needs of others and is gained more from his or her self-imposed humanitarian status.

Similar to the overt NPD leader, the covert NPD leader has an inability to empathize but disguises a narcissistic need for attention with a demeanor of worry, fretting, and overprotection. Also like the overt NPD, the covert NPD leader's hidden traits will eventually surface as relationships with others deepen.

Whether overt or covert, the internal traits that NPD leaders display are largely the same: only the public, outer persona varies. The intensity of narcissism can vary from mild to extreme, but in almost all cases, the NPD leader puts his or her employees in a "giving" position. The first indication that NPD exists may become evident when an employee either becomes assertive or declines a request made by the NPD leader. Because the NPD leader has already established power and control within the relationship, the employee will likely feel impotent.

### *Gender and Race Breakdown*

For reasons largely unknown, NPD tends to be more prominent among males than females. A 2008 epidemiologic survey of over 34,000 US adults, found that the overall prevalence of lifetime NPD was 6.2%, with rates greater for men (7.7%) than for women (4.8%) (Stinson et al. 2008; Farnsworth and Ella 2015).

With only a handful of clinical or epidemiologic studies having been performed to explore the relationship between race-ethnicity and NPD, there is a glaring absence of pertinent data (Chavara et al. 2003), considering the fundamental degree to which culture and personality are entwined (Stinson et al. 2008). For instance, in a study done by Black et al. (1993), NPD was decidedly more ubiquitous among black men and women, younger adults, Hispanic women, and those widowed/divorced/separated or who had never been married. Studies such as this pay tribute to the potential codependence that exists between ethnicity and personality.

## PERSONALITY DISORDERS IN THE WORKPLACE

By definition, leaders are expected to exhibit characteristics that exceed those of other employees. After all, not everyone is elected Vice-President or CEO of a Fortune 500 company. A true leader must demonstrate unique qualities to reach such powerful levels—qualities that go beyond general experience, problem-solving skills, knowledge, or simply being an expert within a particular domain (Germain 2008). Leadership is not only about demonstrating powerful qualities but also, as Northouse (2007, p. 12) suggests, “leadership is an influence process that assists groups of individuals towards goal attainment.”

Popular in the 1940s, the leadership trait theory included physical and social skills as well as unique personality traits and abilities. These are reflected in Germain’s (2006) self-enhancement items of perceived expertise. Similar to experts, leaders are a “special kind of people” who often possess the gift to accomplish extraordinary things. The true difference between leaders and non-leaders lies in the special traits that leaders inherently maintain.

According to Jung, successful leaders must reflect an archetypal image (Schwartz-Salant 2015). In Western culture, leaders are expected to project energy and confidence, with an occasional display of toughness. Some degree of healthy narcissistic traits can be advantageous in organizational leaders, though only when these traits are inwardly identified rather than reflective of pathological narcissism.

As defined earlier, narcissism as a personality disorder is characterized by high self-regard and an innate desire for personal aggrandizement (Pinto and Patanakul 2015). Based on this, a psychiatrist is likely to witness as much psychopathology at office parties, conferences, and within organizations as in their own office.

Family members, friends, business partners, and co-workers of individuals with personality disorders often experience great levels of distress and frustration (Jackson and Burgess 2000; Miller et al. 2007). While each personality disorder is specifically defined by different symptoms and behaviors, personality disorders in general all feature some form of maladaptive coping mechanisms that tend to negatively affect interpersonal and work relationships (The Merck Manuals Online Medical Library 2007).

For example, while most people tend to project unpleasant emotions or thoughts onto others, those suffering from NPD often project with

greater intensity. Disordered individuals may engage in externalization of blame in which others are faulted for problems that the disordered individual caused (Campbell et al. 2005). They are capable of distorting facts to their advantage and may also struggle when it comes to offering praise to subordinates, often resorting to controlling or manipulative behavior, becoming deceptive and vengeful, and ultimately leading to interpersonal problems both on and off the job. Because of their excessively competitive nature and willingness to exploit co-workers, narcissistic leaders might achieve great professional success, but it is almost always at the expense of others.

The breadth of impairment that leaders with personality disorders may cause in the workplace is significant and often results in not only the decline of labor market success for the disordered individual but also in the diminishment of the productivity of co-workers.

In general, narcissists do not handle criticism well, often lashing out, engaging in heated arguments, or invoking chilling detachment strategies. Narcissists are often quick to offer judgment, ridicule, criticism, and blame while at the same time refusing to reach any kind of solution to problematic situations. Corporate leaders who exhibit these particular behaviors often instigate a multitude of issues within the workplace, from risky decision-making to troublesome relationships with colleagues (Tables 2.1, 2.2 and 2.3).

As will be developed in upcoming chapters, the NPD leader's ego is fragile and great lengths will be taken to boost it. Essentially, NPD leaders are predominantly self-serving individuals who deceive others into making unreasonable sacrifices. These behaviors are not only self-destructive, but also serve to destroy the NPD leader's home, work environments, and relationships. As Paramhansa Yogananda (2003) suggests, "Some people try to be tall by cutting off the heads of others" (p. 132).

Personality disorders of any domain are challenging to understand, even to the seasoned psychotherapist (Payson 2002). NPD individuals are an elusive and complex breed, skilled at projecting charm and creating the illusion of control and competence, especially in the public eye. Only the people closest to NPD individuals, who are likely unaware of their own deep-seated issues, will be able to see the disturbing and volatile traits of this disorder that lay beneath the surface.

**Table 2.1** Brief description of axis II personality disorders—Cluster B personality disorders

---

Narcissistic	<ul style="list-style-type: none"> <li>• Demonstrates grandiosity, immodesty, and unrealistic self-perception</li> <li>• Requires constant approval/admiration; overly concerned with success and hypersensitive to criticism</li> <li>• Displays utter lack of empathy, incapable of seeing others' point of view</li> <li>• Extreme sense of entitlement and envious nature</li> <li>• Propensity to be exploitative (with a lesser degree of deliberate intent often seen in those with antisocial personality disorder)</li> </ul>
Borderline	<ul style="list-style-type: none"> <li>• Experiences profound emotional and interpersonal instability; exhibits rapid mood swings, including displays of inappropriate and intense anger</li> <li>• Possesses deep fear of abandonment, strong reaction to separations</li> <li>• Involved in troubled relationships with frequent verbal outbursts; rapid switching between idealizing and devaluing others</li> <li>• Shaky self-image and lack of self-identity, both resulting in rapid and frequent changes in opinions or plans about career, sexual identity, values, and friends</li> <li>• Perpetually inconsistent and impulsive, lacks clear goals or direction, performs poorly in work/school situations without proper structure</li> <li>• Can be self-destructive by undermining themselves, often when goals are soon to be met</li> </ul>
Antisocial	<ul style="list-style-type: none"> <li>• Lacks a superego or conscience, unable to follow societal rules</li> <li>• No regard for moral or legal standards, willingness to lie, potentially violent, commonly has a criminal record</li> <li>• Acts carelessly, irresponsibly, or impetuously</li> <li>• Ability to feign charm though realistically struggles to get along with others</li> <li>• Displays aggressive behavior, shows no remorse, takes pleasure in humiliating others</li> </ul>
Histrionic	<ul style="list-style-type: none"> <li>• Exhibits exaggerated emotional reactions in everyday situations</li> <li>• Overly dramatic, constantly seeks attention, showcases vanity</li> <li>• Engages in demanding and manipulative behaviors, frequently throws tantrums, requires constant stimulation</li> <li>• Sexually provocative, wishes to be the center of attention</li> </ul>

---

**Table 2.2** Behaviors of Narcissistic Leaders

<i>Behaviors</i>	<i>Description</i>
Abuse of power	Serve personal goals, to reinforce self image, conceal inadequacies, enhance perception of performance (Benson and Hogan 2008)
Inflicts damage on others	Bullying, coercion, damage of psychological well-being of others, inconsistent treatment of subordinates (Asland et al. 2008)
Controls to meet personal needs	Perfectionism, limit subordinate initiatives (Benson and Hogan 2008)
Breaks rules to serve herself	Engage in corrupt, unethical and sometimes illegal behaviors (Lipman-Blumen 2005)
Self-admiration, self-aggrandizement, and see others as an extension of herself	

**Table 2.3** Interpersonal challenges associated with pathological narcissism

<i>Trait</i>	<i>Specific behavior</i>
Grandiosity	Dominance, Superiority, Arrogance, Authority, Vindictive, Intrusive, (I like to be the center of attention; I am better than others)
Vulnerability	Coldness, Social avoidance, Exploitative, Entitlement (I demand respect), Intolerant of criticism, Unwilling to compromise, Lack of empathy, Poor listener

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental health disorders* (4th ed.). Washington, DC: American Psychiatric Association. Text Revision (DSM-IV-TR).

American Psychiatric Association. (2011). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: American Psychiatric Association. Text Revision (DSM-V-TR).

Aasland, M. S., Skogstad, A., & Einarsen, S. (2008). The dark side: Defining destructive leadership behavior. *Organisations and People*, 15(3), 19–26.

Benson, M. J., & Hogan, R. S. (2008). How dark side leadership personality destroys trust and degrades organisational effectiveness. *Organisations and People*, 15(3), 10–18.

Black, D. W., Noyes, R., Jr., Pfohl, B., Goldstein, R. B., & Blum, N. (1993). Personality disorder in obsessive-compulsive volunteers, well comparison

- subjects, and their first-degree relatives. *American Journal of Psychiatry*, 150(8), 1226–1232.
- Campbell, W. K., Bush, C. P., Brunell, A. B., & Shelton, J. (2005). Understanding the social costs of narcissism: The case of the tragedy of the commons. *Personality and Social Psychology Bulletin*, 31(10), 1358–1368.
- Chavira, D. A., Grilo, C. M., Shea, M. T., Yen, S., Gunderson, J. G., Morey, L. C., ..., McGlashan, T. H. (2003). Ethnicity and four personality disorders. *Comprehensive Psychiatry*, 44(6), 483–491.
- Farnsworth, & Ella (2015). *The Legal Consequences of Hiring Narcissists*. Retrieved from <https://www.shrm.org/hr-today/news/hr-magazine/pages/0515-narcissistic-personality-disorder.aspx>.
- Germain, M. L. (2006). *Development and preliminary validation of a psychometric measure of expertise: The Generalized Expertise Measure (GEM)* (Unpublished dissertation). Barry University, Miami, FL.
- Germain, M. L. (2008). Traits and skills theories as the Nexus between leadership and expertise: Reality or fallacy? In *Academy of Human Resource Development Proceedings*.
- Gildersleeve, M. (2012). Demystifying paradoxical characteristics of narcissistic personality disorder. *Indian Journal of Psychological Medicine*, 34(4), 403–404. Retrieved from <http://www.ijpm.info/article.asp?issn=0253-7176;year=2012;volume=34;issue=4;page=403;page=404;aulast=Gildersleeve>.
- Jackson, H. J., & Burgess, P. M. (2000). Personality disorders in the community: A report from the Australian National Survey of Mental Health and Wellbeing. *Social Psychiatry and Psychiatric Epidemiology*, 35(12), 531–538.
- Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. New York, NY: Oxford University Press.
- Kernberg, O. F. (1970). Factors in the treatment of narcissistic personality disorder. *Journal of American Psychoanalytical Association*, 18, 51–58.
- Leppänen, J. M., & Nelson, C. A. (2009). Tuning the developing brain to social signals of emotions. *Nature Reviews Neuroscience*, 10(1), 37–47.
- Lipman-Blumen, J. (2005). Toxic leadership: When grand illusions masquerade as noble visions. *Leader to Leader*, 2005(36), 29–36.
- McGlashan, T. H., Grilo, C. M., Sanislow, C. A., Ralevski, E., Morey, L. C., Gunderson, J. G., ..., Stout, R. L. (2005). Two-year prevalence and stability of individual DSM-IV criteria for schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders: Toward a hybrid model of axis II disorders. *American Journal of Psychiatry*, 162(5), 883–889.
- Malkin, C. (2015). Rethinking narcissism. In *The bad- and surprisingly good-about feeling special*. New York, NY: Harper Collins.
- Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion*, 27(2), 77–102.

- Miller J. D., Campbell, K. W., & Pilkonis, P. A. (2007). Narcissistic personality disorder: Relations with distress and functional impairment. *Comprehensive Psychiatry*, 48(2), 170–177.
- Northouse, P. G. (2007). *Leadership: theory and practice* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Paris, J. (2003). Personality disorders over time: Precursors, course, and outcome. *Journal of Personality Disorders*, 17(6), 479–488.
- Payson, E. D. (2002). *The Wizard of Oz and other narcissists: Coping with the one-way relationship in work, love, and family*. Julian Day Publications.
- Pies, R. (2011, February). How to eliminate narcissism overnight. *Innovations in Clinical Neuroscience*, 8(2), 23–27. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071092/>.
- Pincus, A. L. (2013). The pathological narcissism inventory. In J.S. Ogrodniczuk, (Ed.), *Understanding and treating pathological narcissism*. American Psychological Association.
- Pincus, A. L., & Lukowitsky, M. R. (2010). Pathological narcissism and narcissistic personality disorder. *Annual Review of Clinical Psychology*, 6, 421–446.
- Pinto, J. K., & Patanakul, P. (2015). When narcissism drives project champions: A review and research agenda. *International Journal of Project Management*, 33(5), 1180–1190.
- Rinsley, D. B. (1967). The adolescent in residential treatment. Some critical reflections. *Adolescence*, 2(5), 83.
- Ronningstam, E. F. (1998). *Disorders of narcissism: Diagnostic, clinical, and empirical implications* (pp. 29–51). Washington, DC: American Psychiatric Press.
- Ronningstam, E. F., & Weinberg, I. (2013, Spring). Narcissistic personality disorder: Progress in recognition and treatment. *The Journal of Lifelong Learning in Psychiatry*, XI(2), 167–177. Retrieved from <http://focus.psychiatryonline.org/data/Journals/FOCUS/926935/167.pdf>.
- Schwartz-Salant, N. (2015). Healthy presidential narcissism. Is that possible? In S. Buser & L. Cruz (Eds.), *A clear and present danger: Narcissism in the era of Donald Trump*. Asheville, NC: Chiron Publications.
- Skodol, A. E., Pagano, M. E., Bender, D. S., Shea, M. T., Gunderson, J. G., Yen, S., ..., Zanarini, M. C. (2005). Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder over two years. *Psychological Medicine*, 35(3), 443–451.
- Stinson, F. S., Dawson, D. A., Goldstein, R. B., Chou, S. P., Huang, B., Smith, S. M., ..., Grant, B. F. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV narcissistic personality disorder: Results from the wave 2 national epidemiologic survey on alcohol and related conditions. *The Journal of Clinical Psychiatry*, 69(7), 1033.
- The Merck Manuals Online Medical Library Personality Disorders. (2007). Last full review/revision September 2007 by John G. Gunderson, MD. Retrieved from <http://www.merck.com/mmpe/sec15/ch201/ch201a.html>.

- Wiehe, V. R. (2003). Empathy and narcissism in a sample of child abuse perpetrators and a comparison sample of foster parents. *Child Abuse and Neglect*, 27(5), 541–555.
- Yogananda, P. (2003). *Autobiography of a yogi*. Sterling.
- Yudofsky, S. C. (2005). *Fatal flaws: Navigating destructive relationships with people with disorders of personality and character*. Washington, DC: American Psychiatric.



Narcissism at Work

Personality Disorders of Corporate Leaders

Germain, M.-L.

2018, XIII, 177 p. 1 illus., Hardcover

ISBN: 978-3-319-60329-2