

Psychiatry and politicians: the 'hubris syndrome'[†]

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Summary Lord Owen has alerted us to the dangers of ill health in heads of government, especially if they strive to keep their illnesses secret. The description of the hubris syndrome is still at an early stage but Owen has provided psychiatrists and other physicians with useful guidance on how to recognise its appearance in persons who hold positions of power. He has also provided advice to doctors caring for such persons.

Declaration of interest None.

Lord Owen presented his ideas on the psychiatry of politicians at the 2009 General Meeting of the Royal College of Psychiatrists to a packed audience. Hitherto his work has been published in books and in general medical journals.^{1–3} This review is intended to make it available more directly to psychiatrists.

David Owen has had a rich and varied career. He moved rapidly from medicine (including a significant psychiatric input) to the higher echelons of politics (parliamentarian, foreign secretary, Social Democratic Party leader and peace envoy to the former Yugoslavia). He became an influential, albeit controversial, political thinker. In writing on the medical aspects of prominent politicians' behaviour during the past 100 years he has approached his subject from a unique vantage point, combining the mindsets of clinician and politician. Four main themes can be discerned in his writings. First, he describes the crucial importance of ill health in heads of government, whose decisions may gravely affect the interests of people they represent. Second, his case histories reveal the common tendency for heads of state to keep their illnesses secret thereby avoiding the best medical advice and treatment. Third, he has identified the 'hubris syndrome', a condition also likely to impair the behaviour and decision-making of politicians. Finally, he has proposed remedial measures to minimise the impact of ill health on the politicians' ability to deal with affairs of state.

The hubris syndrome has great appeal to psychiatrists, partly because it is a new concept, but also because we find it difficult to resist the conundrums of the psychiatric classification industry. David Owen's general contributions to the psychiatry of politicians should not be eclipsed by the novelty of the hubris syndrome. Although his work mainly focuses on politicians, it also has relevance for psychiatrists and physicians who care for patients who hold other powerful professional positions.

Historical accounts of ill health in heads of government

Owen has closely examined the numerous ways in which physical or mental illness may impair the quality of

decisions made by heads of governments. He has covered the past 100 years through the presentation of clinical vignettes of statesmen, ranging from Theodore Roosevelt and Woodrow Wilson in the early 1900s to Ronald Reagan and Boris Yeltsin in more recent times.¹

Further depth has been added through a detailed historical analysis of four leaders whose illnesses had a profound effect on world events, Anthony Eden, John F. Kennedy, the Shah of Iran and François Mitterrand. In order to maintain a psychiatric emphasis in this article, only the first two will be further discussed, but a third person will be added in whom frank mental illness was evident. These accounts are necessarily brief and run the risk of not doing justice to Owen's scholarly researches especially into the available medical records. However, an interplay will be demonstrated between fluctuations in the three men's health and their political skills.

Anthony Eden

Anthony Eden's career came to an end following the Suez crisis (October–December 1956). He had decided to take military action in Egypt, in alliance with the French and the Israelis, following President Nasser of Egypt's seizure of the Suez Canal. The operation was a military success but a political disaster, especially in terms of relations between the USA and the UK, President Eisenhower not having been consulted. Eden's judgement was considered to be seriously impaired with regard to crucial decisions. There was no doubt he had been seriously ill as a result of a bile duct injury due to a failed surgical operation, leading to recurrent episodes of cholangitis and high fever. Another factor was the injudicious prescribing of drinamyl tablets ('purple hearts', combined amphetamine and barbiturate). Eventually, Eden came to suffer from severe exhaustion. His physician, Horace Evans, was adamant he should resign on health grounds, and he did so on 10 January 1957.

John F. Kennedy

Owen describes well how President Kennedy's political astuteness (or lack of it) was dependent on his state of

[†]See commentaries, pp. 145–150, this issue.

health, and especially the quality of the treatment he received.

At 43, John F. Kennedy was the youngest US president ever elected (November 1960). Despite his youth his health was already compromised. He had Addison's disease, a fact he kept secret in spite of a definite diagnosis in 1947. He was also prone to severe back pain due to injury sustained when the small torpedo boat he commanded was sunk by a Japanese destroyer in 1943. He required an operation in 1954 when a metal plate was used to stabilise his lumbar spine, but the site became infected and the plate had to be removed a few months later.

The first example of Kennedy's lack of political skill was the failed attempt to destabilise Fidel Castro in Cuba. The American policy was to lend support to 1500 Castro opponents as they landed in the Bay of Pigs in Cuba in April 1961. Kennedy sensed that open military support was politically risky, but he was indecisive in overseeing the concealed US military adventures. In the event of failure there was an agreed plan for the American evacuation of the opponents of Castro, but this too was unsuccessful.

Kennedy's political failure can be attributed to his medical condition and the poor coordination of treatments, because he selected his own doctors rather than accepting advice from others to appoint recognised specialists. For his back pain one doctor used muscular infiltrations of procaine. Another prescribed amphetamine by mouth or intramuscular injections, at times supplemented with steroid drugs in doses above the usual replacement therapy.

In contrast, Kennedy displayed consummate political skill in the way he handled the Cuban Missile Crisis of October 1962. The Soviet Union leader, Khrushchev had previously decided to install nuclear missiles in Cuba, a move to support Communism in Cuba and in Latin America. Over the course of 2 weeks, Kennedy's demeanour and concentration were vastly improved compared with his approach to the events in the Bay of Pigs. He had set up a special executive committee whose advice he followed. He veered away from using air strikes in favour of naval blockade, a more effective method. He gave Khrushchev the opportunity to say 'I saved Cuba: I stopped an invasion'.¹ Through private diplomacy with Khrushchev, Kennedy offered as a *quid pro quo* the removal of US missiles from bases in Turkey.

Kennedy's vastly improved political skills were thought to be due to a marked improvement in his health. By then he had appointed a recognised specialist, Dr Hans Kraus, who demanded total control of the medical treatment, relying more on structured physical therapy and reducing the harmful combination of amphetamine and steroids.

Lyndon Johnson

When John F. Kennedy was assassinated in 1963, he was succeeded by his vice president, Lyndon Johnson. Johnson's health was already in doubt as he had suffered a serious heart attack in 1955, at the age of 46. Although mood swings with clear-cut depressive episodes had been part of his character, he developed a deep depression following the heart attack. At present little is known about what, if any, drug treatment for depression was given to Johnson then and during the years he was president.

In 1965 Johnson had a cholecystectomy for the removal of gallstones. He experienced postoperative depression bad enough to contemplate his resignation from the presidency, but was dissuaded from doing so. In 1965, close observers noted his increasingly irrational behaviour, his inner resistance having been undermined by external events – the Vietnam War – and crumbling public support.

Johnson was a suspicious character and did his best to hide information about his medical condition. There is little doubt about the fact that he had deep depression throughout his life; some psychiatrists have interpreted his coarse and volatile behaviour as due to hypomania. In 2006, the review of biographical sources of American presidents considered that during his presidency Johnson exhibited the features of bipolar I disorder. He went through long periods of stress through 1965–1967 and anguish over Vietnam. In late 1967 his physicians warned Johnson's wife, Lady Bird, of concern over her husband's health, but already he had confided in her that he would resign before the 1968 presidential election. He announced on television that he would not stand again.

Clark Clifford (advisor to presidents Truman, Kennedy, Johnson and Carter) is quoted as saying that 'had it not been for Vietnam, Johnson would have been one of the most illustrious presidents'.¹ His early time in the White House was outstanding in terms of legislative social reforms, particularly on civil rights. However, he became haunted by the war in Vietnam, which, in combination with his declining health, led him to resign.

The hubris syndrome

In explaining his term 'the hubris syndrome', Owen states that his aim is to establish 'the causal link between holding power and aberrant behaviour that has the whiff of mental instability about it'.² He carefully avoids explicit terms such as madness or psychosis. In fact, he relies on the language of Bertrand Russell, who describes what may happen when 'the necessary element of humility' is missing: 'When this check upon pride is removed, a further step is taken on the road towards a certain kind of madness – the intoxication of power'.⁴

The word 'hubris' comes from the Greek meaning 'inviting disaster' as well as 'arrogance'. Much of the evidence used by Owen to develop his thesis on the hubris syndrome is derived from observations on the US President George W. Bush and the British Prime Minister Tony Blair. He focuses his critical comments on their decision to go to war in Iraq without apparently planning adequately for the aftermath of the conflict. He says there is a mass of knowledge about the genesis of these events and mentions his personal contacts with Blair during the period 1998–2003. Owen does acknowledge that his case histories on Bush and Blair do not have 'the perspective of a greater distance from the period of history they describe'.¹ In my own commentary I shall bypass these views on Bush and Blair for the very reason that a fuller historical perspective is wanting. Instead, I shall examine two examples of heads of government whose histories have been carefully described and more prudently argued as illustrating the hubris syndrome. They are David Lloyd George and Richard Nixon.

David Lloyd George

Lloyd George achieved prominence during the First World War when he manoeuvred himself into leading the coalition government of Liberals and Conservatives. His power over the War Cabinet 'was due to force of talent and personality rather than to the inherent strength of his position... He set much store by conciliation'.¹ He initiated several significant interventions during the war. When it ended in November 1918, Lloyd George was acclaimed as 'the man who won the war'.¹

The coalition obtained renewed support after the election in December 1919 and Lloyd George remained prime minister. There was agreement that he was a genius as prime minister. He obtained a reputation as a successful peacemaker. He also achieved important social reforms such as the Unemployment Insurance and creating a new Ministry of Health. However, by 1921–1922 there was a reversal of fortunes, as observed by Beaverbrook (1963): 'Then his virtues turned to failings. He committed the crime of arrogance. His structure of self-confidence and success came tumbling down'.¹ His reputation as a successful peacemaker was damaged following the failure of the League of Nations. It is concluded that Lloyd George's downfall was due to mistakes 'borne out of hubristic actions'.³ He was fascinated by the world stage and developed the 'conference habit'. He also began a presidential style of government, interfering with the responsibilities of other senior ministers.

Richard Nixon

Nixon was extremely successful in his early political career and was selected US vice president during the presidency of Dwight Eisenhower. He ran for the presidency in 1960 but was narrowly defeated by John F. Kennedy. However, when he ran again in 1968, he was successfully elected and re-elected for a second term by a landslide victory in November 1972. He had been consistently ahead of his democratic rival in opinion polls, so that it was puzzling why the 1972 committee to re-elect the president engineered the break-in at the Democratic National Committee headquarters at Watergate, Washington DC. President Nixon's staff conspired in a cover-up and eventually it was revealed that he himself had been implicated. When he faced near-certain impeachment, he resigned on 9 August 1974. On 8 September 1974 his successor, President Gerald Ford, granted him an absolute pardon. Biographers have found it difficult to assess Nixon's achievements during his presidency. There is much on the positive side, including ending the war in Vietnam and achieving an improved era of relations between the USA and China. Owen, however, is uncompromising, stating that Nixon's abuse of power should never be forgotten.

There were clear disturbances in Nixon's mental state during his presidency and strong evidence indicative of the hubris syndrome, especially after winning re-election.¹ His personality is described as that of a loner, showing a paranoid temperament with anxiety, depression and alcohol misuse. At one time, there was so much concern about his mental stability that James Schlesinger, defence secretary, told the joint chiefs of staff not to carry out any decisions of the President involving military matters without consulting

him. Nixon's mental state deteriorated further during his last 18 months in office with the growing threat of his impeachment.

By early 1975, Nixon's health was improving. He regained respect as an elder statesman in the area of foreign affairs. He had a severe stroke on 18 April 1994 and died a few days later.

Clinical features of the hubris syndrome

A long list of behaviours considered typical of the hubris syndrome has been compiled.⁵

Criteria

The behaviour is seen in a person who:

- 1 sees the world as a place for self-glorification through the use of power
- 2 has a tendency to take action primarily to enhance personal image
- 3 shows disproportionate concern for image and presentation
- 4 exhibits messianic zeal and exaltation in speech
- 5 conflates self with nation or organisation
- 6 uses the royal 'we' in conversations
- 7 shows excessive self-confidence
- 8 manifestly has contempt for others
- 9 shows accountability only to a higher court (history or God)
- 10 displays the unshakable belief that he will be vindicated in that court
- 11 loses contact with reality
- 12 resorts to restlessness and impulsive actions
- 13 allows moral rectitude to obviate consideration of practicality, cost or outcome, and
- 14 displays incompetence with disregard for the nuts and bolts of policy-making.

Among the 14 behaviours, 5 are called 'unique' (5, 6, 10, 12 and 13) in the sense that they do not appear among the criteria of personality disorders in DSM-IV.⁶ Owen & Davidson state⁵ that at least 3 of the 14 defining behaviours should be present, of which at least 1 should be among the 5 unique components, to satisfy the diagnostic criteria of the hubris syndrome.

Context

Key to the diagnosis is that the person is in a position of substantial power and has been in this position for a certain period of time, as a precursor of developing some of the above behaviours. The behaviours are likely to abate once power is lost.

Predisposing personality characteristics

The very personality traits which enable a person to acquire a position of power are those which, when exaggerated, contribute to the hubris syndrome.⁵ When distorted these personality characteristics become abnormal behaviours which would also qualify the person for a diagnosis of a personality disorder as defined in DSM-IV. Three such disorders have been identified:⁵

- 1 narcissistic personality disorder
- 2 antisocial personality disorder
- 3 histrionic personality disorder.

Moreover, 7 of the 14 defining behaviours are also among the criteria for the narcissistic personality disorder.

Use of performance-enhancing drugs and/or misuse of alcohol may accentuate the features of the hubris syndrome. The diagnosis should be confined to those who have no history of a major depressive illness,⁵ an excluding criterion to separate the syndrome from bipolar affective disorder.

Classification and pathogenesis

In choosing the term 'the hubris syndrome', Owen has reached a cautious compromise allowing the identification of abnormal behaviours for purposes of diagnosis without necessarily ascribing a frankly pathological status thereto. In other words, he avoids the concept of disease and even that of illness. Both DSM-IV and ICD-10 evade the difficult task of defining the nature of the entities that are being classified and instead adopt the term 'disorder' as the currency unit in psychiatric classification.⁶⁻⁸ Some of the problems with the term disorder can be avoided by referring to unitary syndromes, which are merely collections of symptoms that tend to cluster together.

Owen has reached a compromise, but he has also edged his bets: 'Whether [the hubris syndrome could be validated] as a separate psychiatric diagnosis, or whether it could emerge as a sub-type of narcissistic personality disorder does not really matter'.

An acquired subtype for narcissistic personality disorder (Axis II) has been favoured, which post-dates the acquisition of power and remits after power is lost. Owen & Davidson suggest alternatively that the hubris syndrome may be an Axis I disorder with an environmental onset akin to a stressful experience, thus resembling an adjustment disorder as defined in DSM-IV and ICD-10.⁵ They appear to have been deterred by the title of the article on the adjustment disorders as a 'fault line in the psychiatric glossary'.⁹ Nevertheless, the marginalisation of adjustment disorder (at least in epidemiological studies) has been regretted as a result of an over-elastic concept of depression and the rigid criteria of ICD-10 and DSM-IV.⁹

Recast diagnostic criteria of the hubris syndrome

Owen's concept of the hubris syndrome has the merit of caution, but his long list of abnormal behaviours suffers from being 'operationalised', with none of them being a necessary criterion for the diagnosis. It is therefore desirable to recast the framework of the hubris syndrome, which may also render it more palatable to future judges of DSM editions.

Context

The context is all-important in that the person developing the disorder should be in a position of power.

Disturbances of behaviour

Rather than list a wide range of behaviours, a judgement should be made whether the person affected is behaving in a dysfunctional manner resulting in unwise and risk-laden decisions to the detriment of the people he or she represents. This is difficult because only those in close contact with the decision-making process are likely to pick up changes in behaviour.² Moreover, this judgement must remain detached from the content of the political process itself.

Politician's excessive reactions to stressful political events

The individual's deterioration can be seen to be an excessive reaction to personal and political life events, understandable as a coping mechanism in the face of serious threats (e.g. impending war or a catastrophe such as that of 11 September 2001). The stresses are often compounded by politicians being pilloried by hostile media.

Previous personality traits and pathoplasticity

These traits comprise attributes which suited a person well to develop powers of leadership and rise to the top. But they may also exert a pathoplastic influence. Pathoplasticity is a term introduced by Birnbaum,¹⁰ who applied it to causal factors contributing to the structure of an illness. It may also apply to personality features and the social context influencing the 'colouring' and the form of a neurotic disorder, as well as its psychological content.¹¹ Accordingly, the person may appear to switch from a personality disorder to a frank mental illness. Here the concept of an adjustment disorder has much merit.

Reaction so far to the concept of the hubris syndrome

I have a fellow feeling with anyone who tries to scale the ramparts of DSM and ICD in order to raise awareness of a new syndrome. When I described bulimia nervosa in 1979,¹² I merely had to contend with a punctilious editor who wanted me to specify whether I considered it a 'separate syndrome'. I committed myself to the extent that it was indeed a separate syndrome with diagnostic usefulness but without any implications regarding its causation. I was also fortunate that this was a time when the DSM system was about to undergo a major conversion with the publication of DSM-III, adopting an 'a-theoretical' approach.¹³ By then ICD-10 had not yet appeared, but when it did in 1992, it adopted my description of bulimia nervosa without demur.

The planning committees of DSM are generally viewed as following a conservative approach. For them to embrace the hubris syndrome in its fifth edition in 2013 would be surprising. The protagonists of new syndromes are also likely to encounter opposition because of the prevailing zeitgeist. A BBC news health report issued in July 2010 had the following heading: 'Mental health: are we all sick now?'¹⁴ Concern was expressed that DSM-5 would result in almost everyone being diagnosed with a mental condition.

The risk of overdiagnosis has been presented by professionals in a more balanced way.¹⁵ Yet they questioned whether making a diagnosis was really a helpful guide to treatment. They regretted what they predicted to be a slippage from a multidimensional approach to classification as originally promised for DSM-5. Diagnostic labelling must surely be developed, partly as a guide to treatment but mainly to develop a language used by professionals and all who endeavour to understand mental aberrations.

There have been a few specific commentaries on Owen's wish to accord the hubris syndrome some status within classificatory systems. MacSuihbne¹⁶ has written a wide-ranging and thoughtful essay on the conceptualisation of illness, especially mental illness, in which he draws on philosophical approaches: Thomas Szasz at one extreme as

well as other less radical and more subtle philosophers of medicine, Georges Canguilhem and K.W. Fulford. Set against definitions of illness the hubris syndrome is found wanting: 'the problem of leaders growing out of control is a political one. The case of the concept of disease... is simply an error'.¹⁶

In response, Owen would probably argue that his concept of the hubris syndrome is not simply depending on that of mental illness. Moreover, the article by Pincus *et al*¹³ is a salutary corrective for people who believe that it is only justified to reach a psychiatric diagnosis in severely ill patients with organic or psychotic disorders, discarding milder or atypical behaviour as 'merely a social problem', or 'only a personality disorder', or 'simply a political problem'. In their a-theoretical approach, DSM and ICD avoid exclusion hierarchies in the hope that all clinically relevant information would be captured. This has led to a wide range of narrowly defined psychiatric diagnoses, each with operationalised diagnostic criteria. Usually there are no assumptions made about causality which must be based empirically.

Wessely is another author who commented directly on Owen's work.¹⁷ He was lukewarm about the psychiatry of hubris. He pointed out the dangers of using pejorative terms to describe people who exhibit behaviours that are difficult, dangerous or different from others. This is a fair warning, given that in the past technical diagnostic terms have come to be used in a derogatory way, especially when they seep from the medical literature to the lay press. This theme is also echoed by those who fear that DSM-5 is likely to lead to medicalisation of patterns of behaviour and increased stigmatisation.¹⁵ It has always been the case that diagnostic terms, with even a whiff of mental dysfunction, carry the risk of stigmatisation. This was well expressed by Roy Porter when he said dryly: 'The true solution of course to the problem of psychiatric stigmatisation would be the public acceptance, without shame, of mental disorder. But that would be crying for the moon'.¹⁸ Wessely also poses the question of which David Owen has the most telling insights, Owen the doctor or Owen the politician.¹⁷ Owen the politician and historian has certainly illuminated the subject, but his medical contribution to understanding behavioural disturbances in politicians merits further scrutiny. He should also be respected for helping to identify at an early stage those politicians whose health gives rise to concern, when a hubris syndrome may lead to dangerous decisions arising from an inability to foresee undesirable outcomes with the danger of great harm to countless numbers of people.¹

Treatment and prevention

Frank mental illness

Owen lists seven US presidents judged to have had mental illness while in office between 1906 and 2006. He has also identified the common practice among politicians of concealing their illnesses. This is usually because the politicians judge that they will not be elected if such disclosures are made. The secrecy continues while in office

because the politicians dread that their opinions and decisions will be considered unreliable.

Owen discusses with sensitivity the difficult role played by personal physicians to heads of state. They will want to respect totally the confidentiality of their patient, but they may experience serious conflicts. He expresses his views forcefully: 'Doctors must be ready to contemplate that they have a responsibility to their own country that goes beyond their responsibility to their patients. The Hippocratic oath is not an absolute. Very rarely there have to be exceptions' (p.209).¹ In theory this may be the case. In practice, however, a personal physician will feel he owes his primary loyalty to his patient.

There has been recent publicity regarding Mo Mowlam when she was Secretary of State for Northern Ireland and allegedly lied regarding the benign or malignant nature of her brain tumour. Her doctor thought that this tumour could contribute to her behavioural disturbance and poor judgement: 'But there was nothing I could do. I was her doctor. I was responsible for her care, even if she would not let me keep records in a proper place or write to her GP. I told her to tell [the British Prime Minister Tony] Blair but she didn't, she lied... I was trapped... She was also my patient and I owed her confidentiality'.¹⁹ On this issue there is frank opposition to Owen's concept of the doctors' responsibility to their own country.²⁰

Owen has suggested a part-solution to the dilemma. This is that the role of a personal doctor as the advisor to the patient should be upheld and the practice stopped of the personal doctor also being the voice of the patient in public. It seems good advice to separate the responsibilities of a personal physician and a second doctor, officially appointed, who would issue reports for public consumption.

The hubris syndrome

The nature of this disorder leaves the person with impaired insight so that it is difficult for the personal physician to impose treatment even if treatment were effective. The examples of solutions proposed by Owen are partly of a political nature, for example setting fixed-term limits of office, such as the two 4-year terms for US presidents. But there should be room for general management such as mobilising help from close relatives and friends. Individuals with hubristic syndrome may accept help for complications such as depression, alcohol-related problems, or related family difficulties. Owen is hopeful that psychological treatment of personality disorders is becoming more effective and the individual might be more willing to seek help if he knew that he would receive greater benefits and more sympathetic treatment than in the past.

Conclusions

Owen has made important contributions to the psychiatry of politicians and others in positions of power, which should be warmly welcomed. The description of the hubris syndrome may require further refinement before entry into the recognised psychiatric classifications. With this in mind Owen's original diagnostic criteria have been recast and simplified. His advice of doctors caring for persons in

positions of power will give rise to controversy among professionals and those who believe that private lives should not belong to the public. Nevertheless, he has begun a useful discussion on this subject, including a proposal for the division of responsibility between the patient's personal doctor and a second doctor who would interpret the person's illness for the benefit of the public.

About the author

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Psychiatry and politicians – afterword

Commentary on... Psychiatry and politicians[†]

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Summary Contempt is one of the more important signs of hubris syndrome. Lying to Parliament or the courts is often a sign of someone in thrall to hubris. In business and banking, collective or corporate hubris is not uncommon as is hubris syndrome among its most powerful leaders. BP, RBS and HBOS need to be the subject of serious case studies for hubris, 'group think', tunnel vision, closed minds or silo thinking. There are indications of a neurobiological explanation for the intoxication of power in hubris syndrome.

Declaration of interest None.

It is not for me to comment on Gerald Russell's assessment of what I have called hubris syndrome.¹ I am impressed, however, at both the precision and the selection of what he has written. His suggestion for recasting the diagnostic

criteria is exactly the sort of informed criticism that is needed for I am all too conscious that I have insufficient psychiatric experience and knowledge. I think I can best write an afterword to Russell's analysis by examining the interconnections between the psychological states of the leaders of business in which for the past 15 years I have made my living, and my earlier exposure to political leaders.

[†]See special article, pp. 140–145, and commentary, pp. 148–150, this issue.