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Leadership and Mental Illness

Realities and New Directions

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Much is known about how leaders influence the mental health and well-being of their employees at work (see Chapter 9), but at the same time precious little is known about how leaders' own mental health or illness affects their own leadership. Indeed, there are probably few other topics in organizational psychology or behaviour about which so little is known.

The absence of research on how leaders' own mental health affects their leadership behaviour could be based on several assumptions: (1) that leaders do not experience mental illness and so no research is needed in this area, (2) that leaders do experience mental illness, but their mental illness does not affect their leadership, i.e. it has no negative consequences for their employees, or their organizations, and (3) that even if leaders did experience mental health issues, there is nothing that could be done. All these assumptions are unsatisfactory as there is research that suggests that employees with personality disorders are likely to find themselves in leadership roles (e.g., Hogan, 2007) and that mental illness negatively affects their leadership behaviours (e.g., Westerlaken & Woods, 2013).

'Mental illness' refers to a wide range of conditions and disorders that affect individual mood, thinking and behaviour and are associated with significant distress and impaired functioning over an extended period of time (Health Canada, 2002; Mayo Foundation for Medical Education and Research, 2015b). The economic burden of mental illness is immense. This includes health care costs, lost productivity, and reductions in health-related quality of life (Lim, Sanderson & Andrews, 2000; Smetanin, Stiff, Briante et al., 2011).

The goal of this chapter is to outline what is known about mental illness and its relationship to leadership through the examination of personality disorders (specifically, narcissism and psychopathy), depression and anxiety. We also consider three factors (stress, alcohol use, sleep) that could cause or exacerbate any effects of mental illness on leadership.

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Why Should Organizational Behaviour Researchers Care about Mental Illness?

There are many good reasons for organizations to be concerned with mental illness, such as social and financial considerations (Knapp, 2003; Stuart, 2006). In this chapter we focus our concern on the implications of mental health issues for leaders in the organization, and specifically on what is known about mental health and leadership. This is important as, before any interventions can be effective, we need to understand how mental illness affects all employees, including leaders.

Personality Disorders

Personality disorders cause enduring patterns of inner experience and behaviour that deviate from the expectations of society, are pervasive, intractable and stable over time, and lead to distress or impairment (Health Canada, 2002). Some deviations may be quite mild and interfere very little with home or work life; others may cause great disruption to family and work. In general, individuals with personality disorders find it difficult to get along with others and may be irritable, demanding, hostile, fearful or manipulative (Mayo Foundation for Medical Education and Research, 2014). Estimates of the prevalence of personality disorders in the US range from 6 to 9 per cent (Lenzenweger, Lane, Loranger & Kessler, 2007). While there are many types of personality disorders, we will focus specifically on psychopathy and neuroticism and what they mean for leaders' own behaviours.

Psychopathy

Psychopathy is a 'socially devastating disorder defined by a constellation of affective, interpersonal, and behavioural characteristics, including egocentricity; impulsivity; irresponsibility; shallow emotions; lack of empathy, guilt, or remorse; pathological lying; manipulativeness; and the persistent violation of social norms and expectations' (Hare, 1996, p. 25). Estimates from the US suggest that as many as three million employees and employers could be classified as fully expressing psychopathy (Babiak & Hare, 2006; Babiak, Neumann & Hare, 2010). Psychopathy in the workplace is of importance: irrespective of whether it was the leader or the follower who scored highly on psychopathy, meta-analytic findings show it is associated with lower levels of employees' job performance and a higher level of counterproductive workplace behaviours (O'Boyle, Forsyth, Banks & McDaniel, 2012).

Media portrayals suggest a disproportionately higher rate of psychopathy among those holding leadership positions (e.g., Babiak & Hare, 2006). However, with few exceptions, research on psychopathy in the corporate world remains limited (Babiak, 1995, 2000; Babiak & Hare, 2006). In one exception, Babiak and Hare's (2006) extensive analysis of psychopathology in the workplace suggested that 3.5 per cent of top executives score very highly on standard measures of psychopathy, significantly higher than the typical range (.5–3.0%) in the general population.

To understand why leaders score higher on measures of psychopathy than the general population, researchers have recently turned to the adaptive side of psychopathy to understand where psychopathy may be advantageous. As one example, Furnham (2010) details cases where high levels of psychopathy, when combined with other factors such as intelligence and physical attractiveness, can help individuals acquire leadership positions.

A separate line of research has focused on the link between leaders' psychopathy and their success or failure. In one study, psychopathy was positively associated with ratings of charisma but negatively associated with ratings of responsibility and individual and team performance (Babiak et al., 2010). Lilienfeld et al. (2012) examined the 43 US presidents up to and including George W. Bush using estimates of psychopathy derived from personality data completed by historical experts on each president, and objective indicators of presidential performance. Fearless Dominance, which reflects the boldness inherent in psychopathy, was associated with more positive presidential characteristics, namely leadership, persuasiveness and crisis management, and with being viewed as a world figure. In contrast, the Impulsive Antisociality component of psychopathy was not associated with rated presidential performance, but did predict negative presidential outcomes such as congressional impeachment resolutions and tolerating unethical behaviour in subordinates.

While there is research on psychopathy in famous leaders, less is known about how psychopathy affects everyday leadership behaviours. An exception to this is a study focusing on 115 student leaders (Westerlaken & Woods, 2013). Psychopathic traits among these student leaders was associated with lower levels of transformational leadership, and higher levels of passive leadership behaviours (Westerlaken & Woods, 2013). Research has also shown that leaders' psychopathy is associated with followers' job dissatisfaction, involvement in counterproductive workplace behaviours, and higher levels of work–family conflict (Mathieu, Neumann, Hare & Babiak, 2014). Meta-analytic results (O'Boyle et al., 2012) demonstrate that, in general, the dark triad traits (psychopathy, narcissism and Machiavellianism) are negatively related to job performance and positively related to counterproductive work (CWB) behaviours across 186 articles.

To conclude this discussion, the charismatic interpersonal skills associated with psychopathy help these individuals get hired and possibly even promoted to leadership positions, irrespective of their actual performance (Babiak, 1995; Babiak & Hare, 2006; Babiak et al., 2010). Organizations need to do what they can to avoid falling into this trap, as some of the traits associated with psychopathy (e.g., impulsive antisociality) negatively affect the quality of leadership behaviours and employee outcomes.

Narcissism

Like psychopathy, narcissism is a clinical personality disorder (American Psychiatric Association, 2013, p. 717) reflected in 'a grandiose sense of self-importance', needing 'excessive admiration', 'a sense of entitlement', 'a lack of empathy', and a tendency towards being 'exploitative, manipulative, and arrogant'. Not surprisingly, narcissists elicit negative responses from those with whom they interact (e.g., Leary, Bednarski, Hammon & Duncan, 1997).

An important point that must be made, however, is that organizational researchers focus on subclinical levels of narcissism.

Narcissism in the workplace has been linked to a variety of important outcomes, including unsatisfactory task performance (Judge, LePine & Rich, 2006). This might be important for our focus, as leadership behaviours can be seen as one specific form of task performance.

Narcissism has often been viewed as a key ingredient of leadership emergence and success (Grijalva, Harms, Newman, Gaddis & Fraley, 2015), perhaps because narcissists engage in more self-promotion (De Vries & Miller, 1986), impression management (Vohs, Baumeister & Ciarocco, 2005) and organizational politicking (Vredenburgh & Shea-VanFossen, 2010), which ultimately enables them to get noticed by, and gain favour with, their superiors. Multiple studies support this phenomenon (e.g., Galvin, Waldman & Balthazard, 2010; Harms, Spain & Hannah, 2011; Judge, LePine & Rich, 2006). As well, in a longitudinal study of military school cadets, narcissism positively predicted leadership development and performance (Harms et al., 2011). However, caution needs to be exercised in interpreting these findings: Judge et al. (2006) showed that narcissism was positively related only to self-ratings of transformational leadership (even after controlling for the Big Five personality traits). Narcissism is positively related to charismatic leadership as rated by subordinates, through the visionary boldness component of charisma – the component representing the tendency to take risks and be inspirational and exciting (Galvin et al., 2010). Nonetheless, the meaning of these findings is cast into question, because Judge et al. (2006) also showed that leaders' narcissism was negatively associated with subordinates' ratings of transformational leadership.

Chatterjee and Hambrick's (2007) research may be most persuasive as they used unobtrusive measures of the narcissism of 111 CEOs in the computer hardware and software industries, creatively avoiding the need for self-ratings of narcissism. They showed that, as expected, CEOs' narcissism was positively related to strategic dynamism and grandiosity. However, higher levels of narcissism were also linked to a greater number and size of acquisitions, and engendered extreme and fluctuating organizational performance. In general, their findings suggest that narcissistic CEOs favour bold actions that attract attention to themselves (for example, the media would be most interested in higher-value mergers and acquisitions), resulting in big wins or big losses. At the same time, the performance of firms with narcissistic CEOs is neither better nor worse than that of firms with non-narcissistic CEOs.

Along with the research showing positive effects of leader narcissism, several studies point to potential negative effects of narcissism on leaders' behaviours and effectiveness. In one study, narcissism was negatively and indirectly related to charismatic leadership, with narcissism being associated with lower levels of altruism, which it turn were linked with lower levels of charisma (Galvin et al., 2010). A separate study focused on CEOs of Major League Baseball (Resick, Whitman, Weingarden & Hiller, 2009), and showed that CEO narcissism was negatively related to the contingent reward component of transformational leadership, and indirectly associated with higher levels of managerial turnover. Last, having a narcissistic leader is associated with reduced group-level information

exchange, which is detrimental to team performance (Nevicka, Ten Velden, De Hoogh & Van Vianen, 2011).

Thus, findings concerning narcissistic leaders seem to be inconsistent. One possible reason for this is that narcissism affects different aspects or phases of leadership. For example, research shows that, like psychopaths, narcissists generally make a positive first impression, as others initially perceive them to be charming and self-confident (Grijalva et al., 2015), and thus it is no surprise that narcissistic leaders have an advantage regarding leadership emergence. Over time, however, more negative behaviours associated with narcissism become apparent (e.g., arrogance, exploitativeness, self-centredness) which are associated with diminished effectiveness (Back, Schmukle & Egloff, 2010; Paulhus, 1998; Robins & Beer, 2001). This is confirmed in a recent meta-analysis (Grijalva et al., 2015) showing that narcissists are more likely to emerge as leaders, which was explained by the overlap of narcissism with extraversion. At the same time narcissistic leaders were no more or less likely to be effective (Grijalva et al., 2015). Grijalva et al. (2015) then extended their analyses, and isolated a curvilinear relationship between narcissism and leadership effectiveness which showed that moderate levels of narcissism predicted leadership effectiveness, beyond which narcissism becomes detrimental to leadership effectiveness.

Thus, both narcissists and psychopaths possess traits that tend to help them to emerge as leaders. These two personality disorders then diverge in terms of their effects on leadership behaviours and employee outcomes, with psychopathy seemingly having worse effects. It remains for research, however, to investigate whether leader psychopathy is also associated in a curvilinear fashion with follower outcomes. In any case, leader personality disorders tend to be problematic for employees and the organization. Moving away from personality disorders, we will now examine a mood disorder (depression) and anxiety disorders.

Mood Disorders

Individuals with mood disorders suffer significant distress and impairment in all areas of life, including social, occupational and educational. Mood disorders include major depression, bipolar disorder (combining episodes of mania and depression) and dysthymia (Health Canada, 2002). In this chapter, we focusing on the most common mood disorder, depression.

Depression

Depression is the leading cause of years lived with disability in adults (Gilmour & Patten, 2007). In North America, approximately 11–13 per cent of adults will experience major depression at some time in their lives, and 6.6 per cent of adults in the USA have experienced a major depressive disorder in the last 12-month period (Pearson, Janz & Ali, 2013). Individuals with diagnosed depression suffer significant distress and impairment with symptoms that include problems with sleep, feelings of sadness, loss of interest in activities, difficulty making decisions, trouble thinking or concentrating, feelings of worthlessness, and having a pessimistic outlook about the future (Mayo Foundation for Medical Education and Research, 2015a). As well, individuals with depressive symptoms report significantly

more health service usage (e.g., Johnson, Weissman & Klerman, 1992), need for social assistance (e.g., Judd, Akiskal & Paulus, 1997), and higher levels of household and financial strain (e.g., Judd, Paulus, Wells & Rapaport, 1996). Depressive symptoms have also been linked with job-related problems such as poorer job performance (Judd, Paulus et al., 1996). Indeed, the impact of depression on job performance is estimated to be greater than that of chronic conditions such as arthritis, hypertension, back problems and diabetes (Goetzel et al., 2004).

One report found that 79 per cent of workers who had experienced depression stated that the symptoms had interfered with their ability to work (Gilmour & Patten, 2007). On average, depressed workers reported 32 days in the past year during which the symptoms had resulted in their being totally unable to work or carry out normal activities (Gilmour & Patten, 2007). The marked degree to which depression interfered with functioning at work is not surprising, as a number of crucial elements of job performance are particularly vulnerable to these symptoms, such as time management, concentration and teamwork (Burton, Pransky, Conti, Chen & Edington, 2004).

However, while much is known about how depression impacts work generally, there is virtually no research on whether and how depression affects leaders and their leadership behaviours specifically. This is important, as there are no conceptual reasons why leaders would be immune from either suffering from depression or its adverse effects. Supporting this, there have been numerous accounts of famous leaders throughout history, both in public life (e.g., Eleanor Roosevelt) and in the private sector (e.g., media mogul Ted Turner), who have suffered from depression.

Outside of the organizational behaviour area, the book *A First-Rate Madness* (Ghaemi, 2011) examined the link between mental illness and leadership using retrospective analyses of major leaders. Ghaemi, a professor of psychiatry, examined the connections between mood disorders and leadership in some of history's greatest leaders. He posited that many leaders did suffer from mood disorders, and that the very symptoms of either depression or bipolar disorder are what made these leaders great in times of crisis.

For example, one key finding from psychology is that in contrast to mentally healthy individuals, who use optimism to make themselves happier but by doing so cloud their ability to make realistic judgements, depressed individuals make more realistic assessments of the control that they have over their environment (Alloy & Abramson, 1979). This 'depressive realism', Ghaemi (2011) suggests, enables leaders to make better decisions during a crisis. He cites Winston Churchill as an example of a leader who had a more realistic view of the Nazi threat than others in power in England (Ghaemi, 2011), which contributed to his emergence and success as a leader.

Empathy is also an outcome of depression (O'Connor, Berry, Weiss & Gilbert, 2002), and Ghaemi (2011) posits that this too could help depressed individuals' leadership behaviour. Ghaemi cites Gandhi as an example of a leader whose radical empathy enhanced his leadership behaviours in his goal of preserving a united India.

One exception to the lack of empirical studies in this area is a study by Byrne et al. (2014) that examined how leaders' mental health affected leadership

behaviour. These authors showed that leaders' depressive symptoms predicted lower transformational leadership behaviours and higher abusive supervision across 172 leader–subordinate dyads. Importantly, Byrne et al.'s findings run counter to Ghaemi's (2011) assertion that mental illness is productive for leadership, clearly indicating the need for more research on this important topic.

In conclusion Ghaemi (2011) argues that during crises, mental illness enhances leadership behaviours and effectiveness. This is a bold claim based on a restricted group of historical leaders that awaits empirical replication on a broad range of leaders. As shown, the relationship between depression and leadership is sorely lacking research and this area is ripe with research opportunity.

Anxiety Disorders

Another common mental illness among the general population is anxiety disorders. There are a number of types or forms of anxiety disorders, including generalized anxiety disorder, post-traumatic stress disorder, social anxiety, panic disorder and obsessive compulsive disorder. Pooled one-year and lifetime prevalence rates in the general population for anxiety disorders are estimated to be 10.6 per cent (Somers, Goldner, Waraich & Hsu, 2006), with anxiety being less common among adults than depression (Pearson et al., 2013). A common feature of anxiety disorders, however, is its comorbidity with other mental illnesses such as depression. For example, 80 per cent of individuals with lifetime generalized anxiety disorder also experienced a comorbid mood disorder during their lifetime (Judd et al., 1998).

Individuals with anxiety disorders experience severe anxiety on a chronic basis, that is, it lasts at least six months, and although each anxiety disorder has different symptoms, all the symptoms cluster around excessive and irrational fear and dread (National Institute of Mental Health, 2016). Left untreated, anxiety can worsen (American Psychiatric Association, 2013). Everyone feels anxious in response to specific events, but individuals with an anxiety disorder have excessive and unrealistic feelings that interfere with their lives, including their relationships, school and work performance, social activities and recreation (Health Canada, 2002). Anxiety disorders also have major economic and personal costs (Hollifield, Katon, Skipper et al., 1997; Kessler, Chiu, Demler & Walters, 2005), and contribute to lowered work performance (Waghorn, Chant, White & Whiteford, 2005) and lost productivity due to time away from work (Katerndahl & Realini, 1997). As well, anxiety disorders are associated with high unemployment and low health-related quality of life (Ettigi, Meyerhoff, Chirban, Jacobs & Wilson, 1997; Hollifield et al., 1997; Katerndahl & Realini, 1997).

Research on the effects of anxiety on work performance has a relatively long history (e.g. Cherry, 1978; Doby & Caplan 1995). One study showed that individuals who reported higher anxiety also reported greater work impairment (Erickson et al., 2009). Kessler and Frank (1997) used the US National Comorbidity Survey data, and showed that, compared with persons without anxiety, individuals with anxiety disorders experienced significantly higher rates of work impairment, with panic disorders causing the greatest number of days in which productivity was reduced (mean = 4.87 days per month). In addition, the effects

of anxiety go beyond work performance. Frone (2000) showed that along with being related to work performance and productivity, anxiety is related to work–family conflict. This study found that individuals who experience more work–family conflict were 2.46 times more likely to have an anxiety disorder than those who report never experiencing work–family conflict.

Thus, while research has examined anxiety disorders and work, much less is known about the impact of anxiety disorders on leaders and leadership behaviours. Some reports in the popular press suggest that anxiety might be good for leadership (Porter, 2014), as, without anxiety, little would be accomplished. Similarly, Robert Rosen (2008) suggests in his book *Just Enough Anxiety: The Hidden Driver of Business Success* that anxiety helps leaders to concentrate, learn, relate to people, think more creatively, and deliver better results. Empirical research, however, refutes these notions. Byrne et al. (2014) showed that leaders' anxiety was associated with lower levels of transformational leadership behaviours, and higher levels of abusive supervisory behaviours. As was the case with leaders' depression, there is a disconnect between speculation about and findings from empirical research on leaders' anxiety; and clearly, more research is warranted.

Thus, it would be premature to think that we have an adequate understanding of the effects of mental illness on leaders, or on their leadership behaviours. This is an important omission for organizations, made more complex by the social stigma and discrimination experienced by those suffering from mental illness. Nonetheless, under supportive conditions and with proper treatment and support, mental illness in no way precludes people from appropriate work performance, whether as leaders or employees. Work is often a very positive experience for individuals recovering from mental illness. The development of social networks and a sense of purpose and accomplishment make employment a key part of many people's recovery (Gilmour & Patten, 2007). The challenge is to develop a more complete understanding of the links between mental illness and leadership, so that organizations and mental health providers can create the conditions under which all people can thrive in the workplace.

Mental Health Challenges

Aside from the formal mental illness issues experienced by some leaders, all leaders face daily problems of living that, while not formally classifiable as mental illness, challenge their mental health. In this section, we deal with three such issues, namely work stress, alcohol use and sleep problems.

Work Stress

Work stressors are pervasive, and when they exceed individual resources and ability to cope they can threaten mental health (Partnership for Workplace Mental Health, 2016). Indeed, it is not uncommon to find that diverse work stressors are associated with mental health problems such as anxiety and depression. For example, one study found that employees who considered most of their

days to be 'quite a bit' or 'extremely' stressful were more than three times as likely to suffer a major depressive episode than those who reported low levels of general stress (Szeto & Dobson, 2013). A separate study of 3,707 employees found that high psychological job demands increased the risk of both subsequent anxiety and depression (Andrea, Bültmann, van Amelsvoort & Kant, 2009). Moreover, work stress can exacerbate an already present mental illness (Partnership for Workplace Mental Health, 2016).

Considerable research has been devoted to *employee* stress and health, including how leadership behaviours affect employee stress and well-being (e.g., Kelloway, Turner, Barling & Loughlin, 2012). The time has come for work stress research to focus on the stress and well-being of leaders, who are not immune from experiencing work stress or its negative effects. A report by the Center for Creative Leadership examined 240 upper-middle-management or executive-level leaders' work stress (Campbell, Baltes, Martin & Meddings, 2007). Fully 88 per cent of the leaders examined reported that work was their primary source of stress, and that having a leadership role increased the level of stress they were under. Moreover, 60 per cent of these leaders also believed that their organizations failed to provide them with the tools to manage stress, and more than two-thirds reported that their stress had been increasing across the last five years. Intriguingly, what stressed the leaders most was a lack of resources and time (Campbell et al., 2007), the same stressors often reported by employees. All this might become worse, as Roche, Haar and Luthans (2014) suggest that leaders are under ever-increasing pressure because of the competitiveness and complexity of the global economy.

Alcohol Use

While there is a very substantial body of knowledge on alcohol use and abuse, a separate line of research has focused on workplace alcohol consumption. Many of the predictors of context-free alcohol consumption also predict workplace alcohol consumption, such as (job) stress, negative affectivity and impulsivity (Cooper, Frone, Russell & Mudar, 1995; Frone, 2003). Workplace alcohol use is of unique importance to an understanding of leaders' mental health for several reasons. First, a survey using a nationally representative sample of 2,805 employed adults in the US showed significantly higher levels of alcohol consumption at work among organizational managers and leaders than among those lower in the organizational hierarchy (Frone, 2006). Second, there is some evidence that workplace alcohol use impacts leader and managerial performance. An earlier study (Streufert, Pogash, Roache et al., 1994) that explored alcohol use among managers found that strategy and planning were negatively affected in a management simulation task at both.05 and .10 blood alcohol levels. Third, and more recently, a survey showed that even moderate levels of workplace alcohol consumption by leaders were associated with lower levels of transformational leadership and higher levels of abusive supervision (Byrne et al., 2014). This same study showed that leaders' depressive symptoms mostly hurt their transformational leadership behaviours when workplace alcohol consumption was medium or high. Taken together, these two studies (Byrne et al., 2014; Streufert et al., 1994)

point to the negative effects of leaders' workplace alcohol consumption; and the former study also suggests that leaders' alcohol consumption interacts with other indicators of mental illness. Clearly, more research is needed on leaders' workplace alcohol consumption, and its effects on the quality of leadership behaviours. For example, it is not far-fetched to posit that higher levels of workplace alcohol consumption may predispose leaders to engage in more passive leadership behaviours.

Sleep

Researchers have recently turned their attention to the workplace antecedents and consequences of sleep problems (Barling, Barnes, Carleton & Wagner, 2016), and we now know that poor sleep affects a variety of work-related outcomes (e.g., Åkerstedt, Fredlund, Gillberg & Jansson, 2002; Barnes, Wagner & Ghumman, 2012). For example, problems with sleep quantity and quality lead to poor task performance (Kessler et al., 2011) and concentration at work (Wagner, Barnes, Lim & Ferris, 2012), as well as workplace deviance (Christian & Ellis, 2011). By depleting individuals' psychological resources, sleep problems can even result in unethical behaviour (Barnes, Schaubroeck, Huth & Ghumman, 2011).

There are now good reasons to believe that sleep problems might also affect the quality of leadership behaviours. In general, lack of sleep results in poorer interpersonal functioning, including reduced empathy towards others and diminished interpersonal relationships, poorer stress management skills (reduced impulse control and difficulty with delay of gratification), and poorer coping (Killgore, Kahn-Greene, Lipizzi et al., 2008). In addition, sleep problems reduce an individual's willingness to behave in ways that facilitate effective social interaction (Kahn-Greene, Lipizzi, Conrad, Kamimori & Killgore, 2006), and increases the propensity to make risky choices (e.g., Killgore, Kamimori & Balkin, 2011).

One study examining sleep and leadership supported this general notion. Barnes, Lucianetti, Bhave and Christian (2014) demonstrated that daily sleep quality indirectly affected daily abusive supervisory behaviours; moreover, their findings also showed that ego depletion mediated this link: specifically, sleep problems predicted lower levels of ego depletion, which in turn were associated with higher levels of abusive supervision. Underscoring the need for research on the effects of sleep on leadership behaviours, Barnes et al. also showed that leaders' sleep problems had a distal and negative effect on their teams' work unit engagement, and this effect was mediated by abusive supervision.

Moving Forward

Neither leadership nor mental health can be construed as new issues in the workplace; instead, there is a very vibrant body of research on each of these two areas, enabling separate but substantial bodies of knowledge on leadership (Barling, 2014) and mental health (Harder, Wagner & Rash, 2014) in the workplace. Leaders' mental health can no longer be taken for granted, and probably has substantial and complex effects on the quality of their leadership behaviours,

and, in turn, on their employees' performance and well-being. While there is a long tradition of speculating about the mental health of our political and military leaders (e.g., L'Etang, 1969; Owen, 2008), the time has come to replace speculation with knowledge.

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