Personality disorders as a predictor of counterproductive knowledge behavior: the application of the Millon Clinical Multiaxial Inventory-IV

Alexander Serenko

Abstract

Purpose – *This study investigates the role of personality disorders in the context of counterproductive knowledge behavior.*

Design/methodology/approach – *Data were collected through a survey administered to 120 full-time employees recruited from Amazon's Mechanical Turk. Personality disorders were measured by means of the Millon Clinical Multiaxial Inventory-IV.*

Findings – *Personality disorders play an important role in the context of counterproductive knowledge behavior: employees suffering from various personality disorders are likely to hide knowledge from their fellow coworkers and engage in knowledge sabotage. Of particular importance are dependent, narcissistic and sadistic personality disorders as well as schizophrenic and delusional severe clinical syndromes. There is a need for a paradigm shift in terms of how the research community should portray those who engage in counterproductive knowledge behavior, reconsidering the underlying assumption that all of them act deliberately, consciously and rationally. Unexpectedly, most personality disorders do not facilitate knowledge hoarding.*

Practical implications – *Organizations should provide insurance coverage for the treatment of personality disorders, assist those seeking treatment, inform employees about the existence of personality disorders in the workplace and their impact on interemployee relationships, facilitate a stress-free work environment, remove social stigma that may be associated with personality disorders and, as a last resort, reassign workers suffering from extreme forms of personality disorders to tasks that require less interemployee interaction (instead of terminating them).*

Originality/value – *To the best of the authors' knowledge, this work represents one of the first attempts to empirically investigate the notion of personality disorders in the context of knowledge management.*

Keywords *Personality disorder, Mental disorder, Knowledge sharing, Knowledge hoarding, Knowledge hiding, Knowledge sabotage, Counterproductive work behavior*

Paper type *Research paper*

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1. Introduction [1]

Some time ago, on a cold December afternoon, I was working in my office on the gorgeous St. George Campus of the University of Toronto. Time flew by fast as the reviewers' comments seemed to take me on a never-ending journey, but, suddenly, the creative process was interrupted by my stomach: it stubbornly refused to "let me address just another comment" until I got a proper meal. It was the holiday season: all nearby restaurants were closed, and the famous University of Toronto's food trucks had magically disappeared until January. Luckily, my inner voice reminded me that my best (and only) option was to visit the hot-table section at a local grocery store and get a whole grilled chicken to satisfy my need for protein after my morning gym workout.

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So, this is where I headed. The grilled chickens were sold out – I guess there were quite a few hungry professors and students stuck in downtown Toronto – but Priya, an employee who presumably oversaw the grilling process, happily informed me that a new batch "will be ready in exactly eighteen minutes" and quickly disappeared into an adjacent room. I leaned on a nearby counter and anxiously watched the slowly rotating chickens while guessing which one was going to end up on my plate. Strangely, the chickens gradually started to change color from golden brown to black, and the smell of smoke disrupted the peaceful Christmas ambiance. Obviously, the gilling process was not going as planned. To my surprise, Mary, another hot-table section employee, showed no reaction and casually continued chopping sandwiches, pretending that everything was under control. At some point, as I realized that, under no circumstances, would I eat these pieces of charcoal, Priya returned to the hot-table section and screamed, "Oh, no! Not again!" She rushed to the grill, turned it off, did something inside and stepped toward me. One may assume that Priya was supposed to look guilty, apologetic and remorseful for ruining my prospective meal. Instead, her eyes were angry. She did not even apologize! She simply pointed at Mary and said, "She always does that to me. She has always worked here and knows it all but did not teach me even when I asked. She often tells me wrong: that's why the timer was off. Why is she doing this to me? What's wrong with her?" Then, she followed up with a lengthy tirade about her various problems in work and life, confusing me with an old friend rather than a hungry customer eager for delicious chicken. All this time, Mary calmly continued working on her sandwiches, but I noticed a glimpse of a snide smile on her face. It was obvious that she enjoyed the scene. With no hot-table options left, I ended up getting some frozen food. Fortunately, the faculty lounge has a microwave [2]!

After taking notes about the unexpected encounter above, returning to my office and having a meal, I decided to analyze my observations from the perspective of counterproductive knowledge behavior, which has recently become one of the leading topics in knowledge management research. First, it was obvious that Mary was a seasoned employee who possessed a great deal of knowledge ("she has always worked here and knows it all"), yet she never volunteered to share it with Priya ("but did not teach me"), which represented a classic example of knowledge hoarding, defined as a deliberate strategy to accumulate knowledge yet never voluntarily share it with others (Evans *et al.*, 2015). Second, this incident also described knowledge hiding – an intentional attempt to conceal knowledge after someone unambiguously requested it (Connelly *et al.*, 2012) – because Mary did not share knowledge with Priya "even when I asked." Third, this encounter also depicted an instance of active knowledge sabotage – when one worker intentionally provides wrong knowledge to another while being fully cognizant of the negative impact of the application of the incorrect knowledge (Serenko, 2019) – because "she often tells me wrong: that's why the timer was off." The key questions, however, that hitherto remained unanswered are, "Why is she [Mary] doing this to me?" and "What's wrong with her?"

Since the birth of knowledge management as a scientific discipline, scholars have made numerous attempts to understand the nature and underlying causes of counterproductive knowledge behavior in the workplace (Di Vaio *et al.*, 2021; Bernatović *et al.*, 2022). One important stream of research points to the role of employees' personality-related issues (Afshar-Jalili *et al.*, 2021; Issac *et al.*, 2021a; Anand *et al.*, 2022). Recently, Issac *et al.* (2021b) took this a step further by arguing and empirically demonstrating that counterproductive knowledge behavior may be often executed by workers who exhibit certain mental disorders. Specifically, by relying on a case study approach, they highlighted the pernicious role of major depressive disorder and mood disorders such as mania and showed how these disorders may reinforce employees' knowledge hiding. Kmieciak (2022) also empirically demonstrated that alexithymia – defined as difficulty identifying and describing one's feelings – and social inhibition predict knowledge hiding. In a similar vein, Santoro *et al.* (2021) emphasized that employees' mental health is also a sign of resilience which, in turn, boosts their productive behaviors. This suggests that it behooves organizations to monitor not only the physical (Papa *et al.*, 2020) but also the mental health (Ettner, 2011) of their workers.

To continue the line of research pioneered by Issac *et al.* (2021b) and Kmieciak (2022), this study explores the role of personality disorders in the context of counterproductive knowledge behavior. Personality disorders are a specific group of mental disorders (Millon, 2011a) which include people's pervasive and inflexible inner experiences and behaviors which substantially deviate from the expectations of their culture: these experiences and behaviors are generally stable and cause distress and impairment (APA, 2013). A growing body of research in psychology, psychiatry and management reveals a likely relationship between personality disorders and employees' counterproductive knowledge behavior: personality disorders cause a variety of social problems (Newton-Howes *et al.*, 2008), including deception, vengeance, manipulation, insensitivity and cruelty (Ettner, 2011) and negatively impact employees' interactions with their coworkers (Sansone and Sansone, 2010; Els *et al.*, 2011). This study theorizes that employees with personality disorders exhibit distorted cognitive, affective, behavioral and biological processes which, in turn, trigger their maladaptive behavioral responses thereby influencing their knowledge hoarding, hiding and sabotage. As such, it is likely that employees exhibiting personality disorders may hoard knowledge, hide knowledge and even engage in knowledge sabotage against their fellow colleagues. Regrettably, despite its importance, research that focuses on personality disorders in the workplace has been underrepresented in the knowledge management literature. As argued by Issac *et al.* (2021b), it is imperative to dig deeper into employees' mental conditions because doing so may shed some light on the reason behind Mary's knowledge hoarding, knowledge hiding and knowledge sabotage behavior. This may further help to enrich the nomological network explicating the antecedents of counterproductive knowledge behavior and contribute to not only knowledge management but also other scientific domains such as human resource management and psychology. In a similar vein, Connelly *et al.* (2019) emphasize that it is vital to learn more about the personal characteristics of the perpetrators of counterproductive knowledge behavior. Therefore, this study attempts to understand the role of personality disorders in the context of counterproductive knowledge behavior.

Based on the extant literature, this study hypothesizes that employees' personality disorders are positively associated with their counterproductive knowledge behavior, namely, knowledge hoarding, knowledge hiding and knowledge sabotage. In line with the Millon Clinical Multiaxial Inventory-IV (Millon *et al.*, 2015), four types of personality disorders were investigated in the context of counterproductive knowledge behavior: clinical personality patterns, severe personality pathologies, clinical syndromes and severe clinical syndromes. By analyzing survey responses provided by 120 full-time employees, it was concluded that personality disorders play an important role in the context of counterproductive knowledge behavior: employees suffering from various personality disorders are likely to hide knowledge from their fellow coworkers and engage in knowledge sabotage. Particularly salient are dependent, narcissistic and sadistic personality disorders as well as schizophrenic and delusional severe clinical syndromes. In addition to several practical recommendations, this study contributes to the literature by emphasizing the critical role of reference disciplines such as psychology in knowledge management research, questioning the paradigm of considering knowledge hiders and saboteurs as villains and clarifying the reason for previously inconsistent findings on the impact of personality traits on knowledge behavior.

The rest of this article is structured as follows. Section 2 defines mental and personality disorders, explains the role of personality disorders in the workplace, offers the classification of personality disorders, discusses three types of counterproductive knowledge behavior explored in this study and presents this study's hypothesis. Section 3 outlines the research methods, Section 4 documents the results and Section 5 discusses the findings. Section 6 describes this study's limitations and future research directions, and Section 7 concludes the paper.

2. Theoretical background

2.1 What are mental and personality disorders?

A mental disorder is a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" and that is "associated with significant distress or disability in social, occupational, or other important activities" (APA, 2013, p. 20). To be classified as a mental disorder, a mental condition must negatively affect one's cognitive, emotional, biological or behavioral functioning (Wakefield and Conrad, 2020). Presently, there is a variety of formally recognized mental disorders – for example, obsessive-compulsive disorder, impulse-control disorder, as well as eating, sleeping and substance-related disorders. In addition, personality disorders have attracted the attention of not only the medical/psychiatric professions but also the management research community because they are frequently associated with various counterproductive work behaviors (Clarke, 2005; Babiak and Hare, 2006; Michalak and Ashkanasy, 2020).

Personality is "best understood as a system characterizing the individual's typical motivating factors, inner world and defenses, affective proclivities, interpersonal life, reflections of self, thought processes and so on" (Millon *et al.*, 2015, p. 42). Personality forms in people's childhood or early adulthood; uniquely influences their cognition, motivations, learning, habits, socialization tendencies, relationship maintenance and behaviors in various situations; and is relatively stable (Caspi *et al.*, 2005; Ryckman, 2008). People possess various personality traits which positively contribute to their routine functioning and overall well-being (Allport, 1937; Cattell, 1946; Matthews *et al.*, 2003).

However, under the influence of intrinsic biological processes, unique developmental experiences, environmental pressures and sociocultural influences, some individuals develop personality disorders which represent a distinct category of mental disorders (Millon, 2011a) – a category defined as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has on onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (APA, 2013, p. 645). A key feature of the definition above is that people whose cognition, emotions and behavior merely deviate from the cultural or social norms cannot be automatically diagnosed with a personality disorder unless their personality is so maladaptive that it creates a significant dysfunction. This dysfunction, in turn, must negatively affect these individuals and their environment (APA, 2013). Moreover, personality disorders are pervasive across a wide range of individual and social settings and are manifested in home and workplace environment. Presently, personality disorders represent perhaps the most common form of mental disorders (Tyrer, 2014). One of their key characteristics is that people are generally unaware of their personality disorders and their corresponding behavioral impacts (Brüne, 2016). Within this context, it is possible that, by approaching the situation from the personality disorder perspective, it may be possible to answer Priya's heartbreaking questions, "Why is she [Mary] doing this to me?" and "What's wrong with her?"

2.2 Personality disorders in the workplace

Recent years have witnessed an upsurge of interest in the role of the dark side of personality at work because of its negative impact on many aspects of organizational life (Cullen and Sackett, 2003; Clarke, 2005; Babiak and Hare, 2006; Goldman, 2006; Michalak and Ashkanasy, 2020). Previous research on this topic has progressed in two general directions. The first line of inquiry employs a number of subclinical personality traits as determinants of employee perceptions, attitudes and behaviors (Harms *et al.*, 2011; Spain *et al.*, 2014). Subclinical personality traits do not meet the formal criteria of mental disorders

specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) or the International Classification of Diseases for Mortality and Morbidity Statistics (ICD-11) (WHO, 2018) and are, therefore, considered nonpathological. Nevertheless, they may severely hamper one's functioning within the professional environment. For this line of study, researchers rely on the dimensional models of personality disorders (Eaton *et al.*, 2011; Haslam *et al.*, 2012) and mostly employ the Dark Triad traits (narcissism, Machiavellianism and psychopathy) (Paulhus and Williams, 2002), the Hogan Development Survey (Hogan and Hogan, 2001; Hogan and Hogan, 2009) and the Big Five/Seven (Almagor *et al.*, 1995; Costa and McCrae, 1995; Saulsman and Page, 2004). The key contribution of these studies is that they have established a strong, empirically supported link between employees' negative personality traits and their counterproductive work behavior (Burch and Anderson, 2008; Spain *et al.*, 2014) such as subordinate abuse (Kiazad *et al.*, 2010), absenteeism (Schaumberg and Flynn, 2017), poor citizenship (Becker and O'Hair, 2007), bullying (Boddy, 2011), conflict (Boddy, 2014), interpersonal deviance (Berry *et al.*, 2007), lower performance motivation (Judge and Ilies, 2002) and harassment (Krings and Facchin, 2009). As argued by Cohen (2016), deviant personality traits are the main factor driving counterproductive work behavior.

On the one hand, the contribution of the line of research above is unarguable. On the other hand, its focus on subclinical personality traits limits our understanding of the role of personality disorders in the workplace because these studies rely on instruments and assessment approaches that cannot diagnose someone with a particular mental disorder (Burch and Foo, 2010). For example, the Hogan Development Survey (Hogan and Hogan, 2009) merely "provides information on the likelihood that certain dysfunctional patterns of behavior will emerge in work setting" (p. 99) and "higher scores [on a particular dimension] indicate a greater likelihood that the behavior will emerge under stressful conditions" (p. 101), but it does not indicate the presence of a mental disorder. However, evidence suggests that the extreme forms of counterproductive work behavior are specifically exhibited by individuals diagnosed with formal mental disorders (Issac *et al.*, 2021b). Thus, the second line of research on the dark side of personality in the workplace addresses the limitation above by focusing on the clinical personality disorders and employing diagnostic approaches that allow researchers to diagnose the presence of a particular personality disorder.

Previous research has made three key conclusions that inform our understanding of this very important phenomenon in the context of counterproductive knowledge behavior. First, the prevalence rate of workplace personality disorders is extremely high: in the USA, 22.5% of working age (25–64 years old) adults may be diagnosed with at least one personality disorder (Ettner, 2011). Employees who exhibit personality disorders occupy various positions, including senior-level ones. For instance, Board and Fritzon (2005) report that many senior business managers possess various significant elements of personality disorders. Second, people exhibiting personality disorders may experience social and emotional problems (Newton-Howes *et al.*, 2008) which impair their workplace functioning (Hengartner *et al.*, 2014a), especially their interaction with other employees (Sansone and Sansone, 2010), including supervisors, subordinates and coworkers (Els *et al.*, 2011). As a result of interactional problems, workers with personality disorders are frequently fired or laid-off, remain chronically unemployed (Ettner *et al.*, 2011), quit their jobs (Sansone and Wiederman, 2013), underperform (Juurlink *et al.*, 2020), engage in workplace conflict (Hengartner *et al.*, 2014b) and rarely receive support from their coworkers (Juurlink *et al.*, 2018). Third, employees with personality disorders may be very cruel, insensitive, deceptive, vengeful and manipulative (Ettner, 2011). When necessary, they may show great charm and appear to be helpful and even altruistic whereas they are merely waiting for others to lower their guard to unexpectedly hurt them. This leads to workplace divisiveness, an atmosphere of mutual mistrust and lack of cooperation.

2.3 Classification of personality disorders

Personality disorders may be diagnosed according to two approaches: categorical and dimensional (Haslam *et al.*, 2012). The categorical approach, which is employed in DSM-5 as a main assessment method, assumes that personality disorders are qualitatively distinct clinical entities such that a person is classified as either having or not having a particular personality disorder (Eaton *et al.*, 2011; APA, 2013). To be diagnosed with a personality disorder in this approach, an individual must meet a certain threshold expressed in a minimum number of criteria – for example, display at least four out of six symptoms listed in the manual. In contrast, the dimensional perspective does not rely on a simple present-or-not present approach. Instead, it assumes that "personality disorders represent maladaptive variants of personality traits" (APA, 2013, p. 646) which are continuous rather than discrete and which range from normality to abnormality (Eaton *et al.*, 2011; Haslam *et al.*, 2012). For this, researchers measure a number of personality traits along a continuous scale, and a resulting personality disorder is determined based on the constellation of traits rather than on the presence of categorical states (Krueger *et al.*, 2011; Wright *et al.*, 2012; Skodol, 2014).

Each of these diagnostic perspectives has its strengths and limitations. For example, the categorical perspective often fails to distinguish between the cooccurrence of multiple personality disorders, provides a limited number of diagnoses, exhibits unstable boundaries with normal psychological functioning and lacks a strong scientific base (Widiger and Trull, 2007). At the same time, this approach is valued by practicing clinicians who need to diagnose someone with the presence or absence of a particular mental disorder. In contrast, the dimensional approach addresses most of the shortcomings of the categorical perspective, and it appeals to academics and researchers because of its conceptual richness and flexibility (Widiger and Trull, 2007; Choca and Grossman, 2015). The dimensional approach also fits well within the domain of counterproductive work behavior (MacLane and Walmsley, 2010). As a result, a growing body of empirical evidence attests that it is particularly beneficial to synthesize the categorical and dimensional approaches to form a robust and comprehensive view of personality disorders (Krueger *et al.*, 2007).

The Millon Clinical Multiaxial Inventory-IV (Millon *et al.*, 2015) represents a synthesis of the categorical and dimensional perspectives. It is a scientific system to explain "normal and abnormal personality functioning and to identify different types of personality styles and disorders based on deductive reasoning" (Grossman, 2015, p. 436). Its key advantage is that it relies on an evidence-based dimensional model of personality disorders (Millon, 2011a; Millon, 2011b), in which people's personality traits are scored along a number of dimensions which are then combined into distinct categories of unique personality disorders. Most importantly, based on the preestablished cutoff points, the severity of personality disorders may be classified into several groups (Millon *et al.*, 2015). Thus, this study employs the Millon Clinical Multiaxial Inventory-IV to understand the causes of counterproductive knowledge behavior.

The Millon Clinical Multiaxial Inventory-IV employs four types of scales to measure:

1. 12 clinical personality patterns;
2. three severe personality pathologies;
3. seven clinical syndromes; and
4. three severe clinical syndromes.

Clinical personality patterns (Appendix 1, Table A1) reflect pervasive and deeply etched characteristics of functioning which may perpetuate and aggravate everyday difficulties. They are maladaptive and are so embedded in people's emotional, cognitive and

behavioral processes that they become automatic and function beyond people's conscious awareness. As a result, individuals are completely unaware of the destructive potential of their clinical personality patterns when these are activated (Millon, 2011b; Millon *et al.*, 2015).

Severe personality pathologies (Appendix 1, Table A2) represent more advanced stages of personality pathology and reflect a gradual deterioration of the personality structure. They differ from clinical personality patterns because of cognitive deficits in social competence, frequent psychotic episodes and ineffective coping mechanisms which are particularly vulnerable to the strains of life (Millon, 2011b; Millon *et al.*, 2015).

Clinical syndromes (Appendix 1, Table A3) represent mental disorders that are embedded within the context of the clinical personality patterns and severe personality pathologies. Clinical syndromes are best conceptualized as the behavioral (e.g. aggressive actions), cognitive (e.g. delusional beliefs), affective (e.g. depression) and biological (e.g. loss of appetite) extensions of personality distortions. Identifying clinical syndromes and treating them as the outgrowths of personality disorders allow researchers to better comprehend the nature of people's personality vulnerabilities and their reaction to life's stressors. In contrast to the clinical personality patterns and severe personality pathologies which are generally stable over one's lifetime, clinical syndromes represent transient states which wax and wane depending on a person's exposure to the stressful environment. In times of distress, clinical syndromes particularly accentuate the most prosaic features of personality disorders. Thus, measuring clinical syndromes helps researchers better understand an overt expression of personality disorders (Millon and Grossman, 2007; Millon, 2011b).

Severe clinical syndromes (Appendix 1, Table A4) represent an extreme form of mental disorders that are entrenched in the context of clinical personality patterns and severe personality pathologies. As such, they are a more pathologically advanced form of clinical syndromes because they embed more psychotic content and are full of psychotic features (Millon, 2011b; Millon *et al.*, 2015).

2.4 Counterproductive knowledge behavior

Counterproductive work behavior generally refers to "volitional acts that harm or intend to harm organizations and their stakeholders" (Spector and Fox, 2005, p. 151): these may be directed toward individuals (e.g. subordinates, managers, coworkers, customers) and/or the entire organization itself (Crino, 1994; Robinson and Bennett, 1995; Spector and Fox, 2010). Counterproductive knowledge behavior represents a form of counterproductive work behavior and is defined as employee behavior that "potentially or actually impedes the constructive flow of knowledge within the organization and hampers opportunities to transform knowledge into productive action" (Afshar-Jalili *et al.*, 2021, p. 1364). As a result, seven distinct forms of counterproductive knowledge behavior have been identified, ranging from the least to the most extreme in terms of their negative impact on an organization and its stakeholders. These are as follows: disengagement from knowledge sharing (Ford *et al.*, 2015), knowledge sharing ignorance (Israilidis *et al.*, 2015), partial knowledge sharing (Ford and Staples, 2008; Ford and Staples, 2010), bad counter-knowledge sharing (Bolisani and Cegarra-Navarro, 2021), knowledge hoarding (Hislop, 2003; Evans *et al.*, 2015), knowledge hiding (Connelly *et al.*, 2012; Connelly and Zweig, 2015; Hernaus *et al.*, 2019) and knowledge sabotage (Serenko, 2019; Ferraris and Perotti, 2020; Serenko, 2020; Serenko and Choo, 2020; Perotti *et al.*, 2022). While all types of the counterproductive knowledge behavior above are inimical to organizational effectiveness and efficiency (Afshar-Jalili *et al.*, 2021), this study focuses on three more extreme categories – knowledge hoarding, knowledge hiding and knowledge sabotage – because these are likely to be driven by employees' personality disorders.

Knowledge hoarding is "an individual's deliberate and strategic concealment of knowledge and information or the fact that they may possess relevant knowledge or information" (Evans *et al.*, 2015, p. 495). There are several characteristics of knowledge hoarding that make it conceptually distinct from the other forms of counterproductive knowledge behavior in the workplace (Oliveira *et al.*, 2021). First, knowledge hoarders do not always realize the value of the knowledge that they possess. Second, they have no malicious intentions against their colleagues or the entire organization. Third, the fact of knowledge possession remains clandestine: other employees are not aware that someone may have a specific knowledge, and they simply do not know who to approach and what questions to ask (de Garcia *et al.*, 2022). Fourth, knowledge hoarding is not directed toward a particular employee because the hoarder does not engage in preferential treatment – it affects all organizational members equally because all of them are deprived of potentially useful knowledge (Holten *et al.*, 2016).

Knowledge hiding occurs when employees intentionally conceal their knowledge when it is requested by their fellow coworkers (Connelly *et al.*, 2012; Connelly and Zweig, 2015; Serenko and Bontis, 2016; Hernaus *et al.*, 2019). It differs from knowledge hoarding in two key features: intentionality (i.e. the perpetrator acts deliberately by realizing a coworker's need for knowledge) and request (i.e. a coworker unambiguously requested knowledge). The concept of knowledge hiding has traditionally attracted the attention of both academics and practitioners, which is evident in the growing volume of publications on this topic (Di Vaio *et al.*, 2021; Bernatović *et al.*, 2022). Based on its negative impact on organizations and their stakeholders, knowledge hiding is considered a more damaging type of counterproductive knowledge behavior than knowledge hoarding. It is, however, not the most extreme one.

Knowledge sabotage represents the most destructive category of counterproductive knowledge behavior (Serenko, 2019; Ferraris and Perotti, 2020; Serenko, 2020; Serenko and Abubakar, 2022). It occurs "when an employee intentionally provides incorrect knowledge to another or conceals knowledge from another while being fully aware that the knowledge in question is needed by and extremely important to the other party" (Serenko and Choo, 2020, p. 2299). Saboteurs clearly realize the devastating consequences of their behavior when their fellow coworkers use the wrong knowledge or fail to apply the critically needed knowledge, but they act intentionally and rationally with a clear, destructive goal in mind. Knowledge sabotage is a widespread workplace phenomenon: at least 40% of employees admit engaging in this pernicious behavior and 50% describe themselves as its victims (Serenko, 2019; Serenko, 2020).

Overall, all three types of counterproductive knowledge behavior – knowledge hoarding, knowledge hiding and knowledge sabotage – have a detrimental effect on the knowledge-intensive contemporary organization. For this reason, many previous investigations tried to understand their antecedents to propose proactive prevention measures.

2.5 Personality disorders and counterproductive knowledge behavior

Knowledge management researchers have made multiple attempts to uncover the role of personality traits in the context of productive and counterproductive knowledge behavior (Cabrera *et al.*, 2006; Harari *et al.*, 2014; Afshar-Jalili *et al.*, 2021; Issac *et al.*, 2021a; Obrenovic *et al.*, 2022). However, the findings on the role of personality traits are highly inconclusive. For instance, Matzler *et al.* (2011), Lotfi *et al.* (2016) and Wang and Yang (2007) found that individuals possessing high conscientiousness (one of the Big Five personality traits) are more likely to document and share their knowledge with others, while Agyemang *et al.* (2016), Rahman *et al.* (2018) and Wang *et al.* (2014) refuted this claim. Mixed verdicts were also reached on the role of personality traits in counterproductive knowledge behavior: some studies supported the efficacy of certain personality traits in the

context of knowledge hiding, while others did not (Demirkasimoglu, 2016; Pan *et al.*, 2016; Anaza and Nowlin, 2017; Arshad and Ismail, 2018; Pan and Zhang, 2018; Banagou *et al.*, 2021; He *et al.*, 2021a).

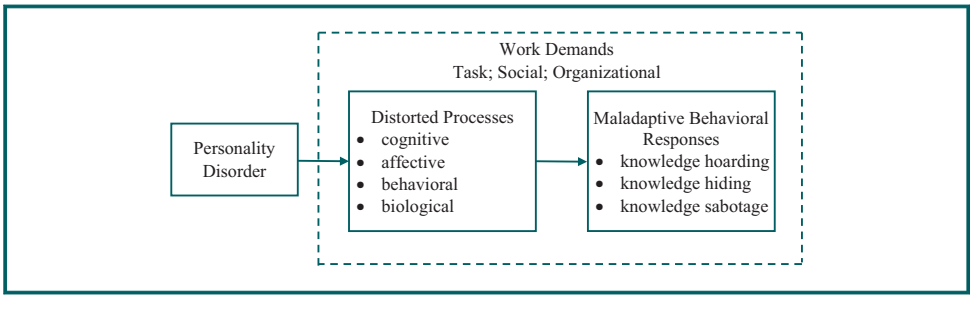
On the one hand, previous studies confirm that employees' personality traits are important in the context of productive and counterproductive knowledge behaviors. On the other hand, they imply that researchers should look beyond the personality traits commonly explored in the knowledge management literature. Specifically, in the context of counterproductive knowledge behavior, it is likely that personality disorders play a more important role than personality traits.

Figure 1 presents a general framework explicating the impact of personality disorders on counterproductive knowledge behavior. It posits that mental disorders are manifested in the workplace as responses to three types of situational cues associated with stressful work demands: task (i.e. individual), social (i.e. group) and organizational (i.e. the broad organizational context) demands (Tett and Burnett, 2003). Of these, social work demands are particularly important because counterproductive knowledge behavior is generally conducted in the social environment when employees interact with their fellow coworkers. Employees who possess personality disorders exhibit psychological and social deficiencies that determine their knowledge-related decisions (Kmieciak, 2022). In particular, when they are exposed to situational clues which are associated with workplace stress, their personality disorders are manifested in such a way that they distort these workers' cognitive, affective, behavioral and biological processes (Lee *et al.*, 2005; Gray *et al.*, 2011) which, in turn, trigger maladaptive behavioral responses (Kovacs and Beck, 1978; Liau *et al.*, 1998) in the workplace.

First, it is hypothesized that employees exhibiting personality disorders tend to hoard their knowledge. The common characteristics of general hoarding behavior include avoidance, procrastination, indecisiveness and perfectionism (APA, 2013), which may be exacerbated in employees exhibiting certain personality disorders such as avoidant, antisocial and narcissistic clinical personality patterns. It is likely that workers who exhibit the symptoms of avoidant and antisocial personality may accumulate a great deal of knowledge but never share it with others because of reclusive working styles and lack of coworker interaction. Those who have a narcissistic personality may try to acquire as much knowledge as possible to satisfy their unrealistic feelings of superiority and arrogant self-assurance. This suggests that some personality disorders may lead to knowledge hoarding.

Second, it is proposed that distorted personality processes may also trigger knowledge hiding behavior. For instance, employees with a severe paranoid personality pathology may be proactively defensive against anticipated criticism for making incorrect suggestions. As a result, they may hide their knowledge even when asked for it to avoid possible public confrontation if the recommendation does not work. In addition, every time someone asks

Figure 1 Impact of personality disorders in the workplace



paranoid individuals to share knowledge, they may assume that the requester has some ulterior motive and is trying to trick or frame them. As a result, they may engage in a defensive mode and deny the request. In a similar vein, employees with an avoidance personality disorder tend to be detached and keep interpersonal distance from others. After receiving a knowledge request, these workers may never respond simply because they want to avoid additional interaction with their fellow coworkers. The line of reasoning above has already received empirical support: Kmieciak (2022) showed that social inhibition, defined as "the tendency to inhibit the expression of emotions/behaviors in social interactions to avoid disapproval by others" (Denollet, 2005, p. 89), promotes knowledge hiding.

Third, it is argued that personality disorders may lead to knowledge sabotage. Knowledge sabotage is mostly directed at other coworkers rather than an entire organization and is often driven by a need for retaliation (Serenko and Abubakar, 2022). Workplace conflict is an unavoidable part of routine organizational processes. Conflict may arise because of disagreement on the allocation of scarce resources (e.g. time, tasks, rewards, budgets), values (e.g. political views, religious preferences, ethics, morality), interemployee interactions (e.g. communication styles) and worldviews (e.g. facts), and it occasionally leads to positive organizational outcomes (De Dreu, 2008). However, employees with negativistic and sadistic clinical personality patterns may dramatically overreact to a trivial difference of opinion or an innocent remark. They may view conflict very negatively and derive pleasure from hurting a presumed offender by means of knowledge sabotage. Moreover, those suffering a delusional clinical syndrome may completely fail to realize the consequences of their actions or completely misinterpret them.

Based on the arguments above, the following overarching hypothesis is proposed:

> Employees' personality disorders are positively associated with their counterproductive knowledge behavior, namely knowledge hoarding, knowledge hiding, and knowledge sabotage.

3. Methods

3.1 Instrument

The measurement items were adapted from the following sources: knowledge sabotage from Serenko and Choo (2020); evasive knowledge hiding, playing dumb knowledge hiding, rationalized knowledge hiding, knowledge hoarding and knowledge sharing from Connelly *et al.* (2012); general knowledge hiding from Peng (2013) (with modifications); and bullying knowledge hiding from Yuan *et al.* (2021). Knowledge sharing was measured to better understand the role of personality disorders in not only promoting counterproductive knowledge behaviors but also suppressing productive ones.

To enable their knowledge hiding behavior, perpetrators may employ four key strategies: being evasive, playing dumb, rationalizing and bullying (Webster *et al.*, 2008; Connelly *et al.*, 2012; Hernaus *et al.*, 2019; Yuan *et al.*, 2021). Employees who use an evasive knowledge hiding approach dodge the request, stall as much as they can and do not follow up on their initial promise to help, hoping that the requester will eventually stop insisting. Those who play dumb pretend that they possess no expertise or knowledge in this particular area and, therefore, cannot assist the requester. The rationalized knowledge hiding strategy involves a justification as to why requestees may not share the knowledge. For instance, they may refer to nonexistent company policies, rules established by their managers and/or confidentiality clauses. Employees who take advantage of the bullying approach directly attack, pressure and humiliate knowledge requesters, hoping that their damaged egos, reduced self-confidence and hurt feelings will make them abandon their present and future knowledge solicitation

attempts. While evasive, playing dumb and rationalized knowledge hiding approaches are well-established in the literature, the bullying knowledge hiding strategy is relatively new. This construct was added because, first, bullying is (unfortunately) present in the contemporary workplace environment and, second, it undermines various knowledge-based organizational processes (Yao *et al.*, 2020; Bari *et al.*, 2022). To better understand the role of personality disorders in the context of knowledge hiding, all four knowledge hiding strategies were measured. All items were measured on a seven-point Likert-type scale (Appendix 2).

The original Millon Clinical Multiaxial Inventory-IV (Millon *et al.*, 2015) was used to measure personality patterns, personality pathologies, clinical syndromes, and severe clinical syndromes.

The instrument consists of 195 self-reported true/false questions, conforms to major DSM-5 criteria and is highly suitable for diagnosing personality disorders and psychopathology. Initially, it was designed for clinical use, but it was later demonstrated that it works well with nonclinical samples for research purposes (Dyce *et al.*, 1997; Rosen *et al.*, 2013). The instrument also included basic demographic questions.

3.2 Participants and study design

In total, 121 participants were recruited from the Amazon's Mechanical Turk (MTurk) which is an online marketplace where individuals perform human intelligence tasks, including participating in research studies, for a fee. Statistical power analysis by means of G*Power 3 (Faul *et al.*, 2007) was done to confirm the sample size with the following settings: one-tailed test (because the direction of association was established in the hypothesis), medium effect size of 0.3, alpha error probability of 0.05, beta error probability of 0.80 [which is a reasonable level commonly used in such estimations (e.g. see Zheng *et al.*, 2017; Kang, 2021)], the number of groups = 3 (for ANOVA, as explained later) and H_0 correlation = 0 (for correlation). The required minimum sample sizes were 111 for ANOVA and 67 for correlation.

MTurk was selected for six main reasons. First, many MTurk participants represent knowledge workers who, as demonstrated in previous studies (Serenko, 2019; Serenko, 2020; Serenko and Choo, 2020), may engage in various forms of counterproductive knowledge behavior. Thus, the selection of MTurk as a recruitment platform may enrich the findings and lead to theory building (Eisenhardt, 2021). Second, MTurk ensures the anonymity of study participants because investigators may access their MTurk Worker ID but not their name and contact information. Mental disorders and counterproductive knowledge behavior represent extremely sensitive, private and controversial topics. Thus, it is vital to preserve respondents' anonymity (Yin, 2018) to minimize social desirability bias (Crowne and Marlowe, 1960). Third, as described below, MTurk allows researchers to prescreen prospective participants. Fourth, MTurk offers researchers access to a geographically diverse pool of highly motivated participants who may be randomly distributed within a particular country, which further improves data quality and results generalizability (Buhrmester *et al.*, 2011). Fifth, findings obtained by relying on MTurk participants are comparable to those reported in prior research (Berinsky *et al.*, 2012; Goodman *et al.*, 2012; Kees *et al.*, 2017). Last, MTurk and other similar data collection platforms have been employed in various empirical investigations documented in major knowledge management journals (Jardim *et al.*, 2021), including the *Journal of Knowledge Management* (Peralta and Saldanha, 2014; Duan *et al.*, 2022).

A set of best-practice recommendations by Aguinis *et al.* (2021) was followed. To qualify for the study, a prospective participant was required to:

- be currently employed full-time for at least two years in an organization that had ten or more employees;
- be located in the USA;
- have human intelligence task (HIT) approval rate of 98%; and
- have at least 5,000 previous HITs approved.

For a full, accurate and honest completion of an online survey, the respondents were offered US$6 which exceeded the US minimum wage (the survey took around 25 min to complete). All decisions to approve compensation for completed responses were done within 1 h. To minimize social desirability bias, the study was described in general terms as a knowledge sharing investigation. The respondents were informed about built-in attention check questions. A detailed consent form also stated an estimated study completion time. No cues that might motivate individuals to misrepresent themselves were mentioned. As data collection progressed, two MTurk communities (Turkopticon and TurkerView) were constantly monitored to identify potential issues with the study from the perspective of respondents (none were observed). The study was reviewed and approved by the author's institutional Research Ethics Board.

4. Results

4.1 Overview

Personality disorder scores were calculated by following the procedure outlined in the Millon Clinical Multiaxial Inventory-IV Manual (Millon *et al.*, 2015). As recommended, the raw scores were converted to the base rate scores, and all recommended adjustments were made. The conversion and analysis of personality disorder scores include rigorous reliability and validity assessments which are documented in detail in Millon *et al.* (2015). Specifically, to identify unreliable records, the questionnaire included a number of items that are usually answered similarity, and, to spot invalid entries, it had three questions that were unlikely to be endorsed (i.e. should be answered as "false"). As a result, one entry was flagged and excluded, resulting in a sample size of 120 valid records. This sample size is sufficient, given a well-established reliability and validity of the Millon Clinical Multiaxial Inventory. For example, many studies employing this inventory in a nonclinical setting relied on sample sizes between 70 and 140 (Strack, 1991; White *et al.*, 2001; Stredny *et al.*, 2006; Lenny and Dear, 2009; Aguerrevere *et al.*, 2011; Dozier *et al.*, 2020).

On average, respondents in the sample were 37 years old, ranging from 22 to 67 years old. In terms of the highest level of education, 14% finished high school or less; 25%, an associate degree (two-year degree) or some college; 51%, an undergraduate degree; 9%, a master's degree; and 1%, a doctoral degree. 59% of them were women. About 76% and 24% worked in private and public organizations, respectively. On average, they had 15 years of full-time work experience in total (ranging from 2 to 43 years) and 7 years of work experience at their current organization (ranging from 2 to 22 years). About 37% worked in small organizations (fewer than 100 employees); 41%, in medium-sized organizations (100–999 employees); and the rest worked in large organizations (1,000 and more employees). All data were visually analyzed in SPSS, and no outliers were spotted.

Tables 1 offers descriptive statistics and reliability assessment, and Table 2 presents construct correlations. They indicate that all constructs meet the minimum reliability and validity thresholds, and that further analysis may proceed. The square root of the average variance extracted of bullying knowledge hiding exceeds all respective interconstruct correlations (as per Table 2). Therefore, it is concluded that bullying knowledge hiding, which is a new construct in knowledge management research, represents a distinct dimension that is independent of evasive knowledge hiding, playing dumb knowledge hiding and rationalized knowledge hiding.

Table 1 Descriptive statistics and reliability assessment

Item	Mean	SD	ITC	Loading	Alpha	AVE	CR
KSA1	1.62	1.27	0.92	0.957	0.97	0.911	0.976
KSA2	1.56	1.18	0.90	0.941			
KSA3	1.59	1.27	0.94	0.966			
KSA4	1.58	1.19	0.92	0.953			
KHG1	1.90	1.30	0.75	0.881	0.89	0.826	0.830
KHG2	1.83	1.20	0.86	0.946			
KHG3	1.80	1.07	0.77	0.898			
EKH1	2.07	1.38	0.78	0.877	0.91	0.780	0.934
EKH2	1.75	1.44	0.82	0.900			
EKH3	2.05	1.41	0.76	0.867			
EKH4	1.73	1.23	0.80	0.889			
PDKH1	1.74	1.09	0.74	0.866	0.87	0.718	0.910
PDKH2	1.88	1.20	0.76	0.887			
PDKH3	1.79	1.29	0.76	0.873			
PDKH4	2.43	1.33	0.60	0.756			
RKH1	1.83	1.27	0.72	0.849	0.84	0.678	0.893
RKH2	2.00	1.40	0.81	0.903			
RKH3	1.76	1.15	0.73	0.858			
RKH4	1.43	1.80	0.49	0.662			
BKH1	1.60	1.16	0.66	0.841	0.84	0.761	0.799
BKH2	1.69	1.22	0.73	0.884			
BKH3	1.47	1.14	0.74	0.891			
KHO1	3.95	1.80	0.64	0.799	0.85	0.697	0.901
KHO2	4.94	1.64	0.80	0.904			
KHO3	4.78	1.67	0.81	0.911			
KHO4	4.99	1.68	0.54	0.709			
KS1	5.56	1.17	0.75	0.854	0.85	0.562	0.904
KS2	5.55	1.13	0.71	0.822			
KS3	5.78	0.99	0.69	0.809			
KS4	5.57	1.26	0.76	0.866			
KS5	5.25	0.95	0.47	0.616			

Notes: SD = standard deviation; ITC = corrected item-to-total correlation; Alpha = Cronbach's Alpha; AVE = average variance extracted; CR = composite reliability. Loadings represent the result of confirmatory factor analysis. KSA = knowledge sabotage; KHG = general knowledge hiding; EKH = evasive knowledge hiding; PDKH = playing dumb knowledge hiding; RKH = rationalized knowledge hiding; BKH = bullying knowledge hiding; KHO = knowledge hoarding; KS = knowledge sharing

Table 2 Construct correlations

Construct	KSA	KHG	EKH	PDKH	RHK	BKH	KHO	KS
KSA	*0.954*							
KHG	0.743	*0.909*						
EKH	0.763	0.755	*0.883*					
PDKH	0.604	0.704	0.665	*0.847*				
RKH	0.663	0.658	0.694	0.615	*0.823*			
BKH	0.776	0.744	0.735	0.584	0.714	*0.872*		
KHO	−0.006	0.560	0.026	0.055	0.065	0.100	*0.835*	
KS	−0.172	−0.293	−0.271	−0.352	−0.177	−0.111	0.306	*0.750*

Note: The diagonal elements are the square root of the AVE of a respective construct

4.2 Analysis

Based on the base scores on the Millon Clinical Multiaxial Inventory-IV (Millon *et al.*, 2015), each respondent was classified into one of three groups on each of 25 personality disorders (as per Appendix 1):

- Group 1: Functional personality – when employees' mental condition does not impede their workplace behavior (i.e. there is no sign of the presence of personality disorder, base rate scores below 60).
- Group 2: Potentially dysfunctional personality – when employees' mental condition may impede their workplace behavior in some circumstances (i.e. generally adaptive personality with moderate or occasional difficulties in some areas, base rate scores between 60 and 74, inclusive).
- Group 3: Dysfunctional personality – when employees' mental condition impedes their workplace behavior (i.e. clinically significant personality disorder or pathology, base rate scores 75 and over) [3].

As described in Appendix 1, the Millon Clinical Multiaxial Inventory-IV includes four categories of scales to measure:

1. 12 clinical personality patterns;
2. three severe personality pathologies;
3. seven clinical syndromes; and
4. three severe clinical syndromes – 25 disorders in total.

For all of them, three types of analysis were done. First, for each disorder, eight ANOVA tests were done to compare mean differences in base rate scores for knowledge sabotage, general knowledge hiding, evasive knowledge hiding, playing dumb knowledge hiding, rationalized knowledge hiding, bullying knowledge hiding, knowledge hoarding and knowledge sharing. Tables 3 and 4 present sample results for schizoid and avoidant clinical personality patterns, respectively. The other 23 tables are available from the author upon request.

Second, to aggregate the findings from the 25 tables generated in the previous step, average differences for seven scales measuring counterproductive knowledge behavior were calculated between the pairs of Groups 1–3 (Table 5). For this, the scores on the knowledge sabotage, general knowledge hiding, evasive knowledge hiding, playing dumb knowledge hiding, rationalized knowledge hiding, bullying knowledge hiding and knowledge hoarding scales were combined and averaged, and all nonsignificant values were replaced with zeros. Third, correlations were calculated between base rate scores and the eight knowledge behavior scales (Table 6).

The analysis above resulted in six key conclusions. First, large differences on knowledge hoarding, knowledge hiding and knowledge sabotage scores were observed for Group 3 (dysfunctional personality) vs. Group 1 (functional personality) and for Group 3 vs Group 2 (potentially dysfunctional personality), while the differences between Group 2 and Group 1

Table 3 Mean differences – clinical personality patterns – schizoid

	ANOVA		Group 3-Group 1		Group 2-Group 1		Group 3-Group 2	
Construct	*F*(2,117)	*p*-value	Mean Diff.	Sig. Level	Mean Diff.	Sig. Level	Mean Diff.	Sig. Level
KSA	4.154	0.05	0.85	0.05	0.28	ns	0.57	ns
KHG	4.778	0.01	0.76	0.05	0.49	0.1	0.27	ns
EKH	3.624	0.05	0.73	0.1	0.49	0.1	0.73	0.1
PDKH	4.434	0.05	0.76	0.05	0.37	ns	0.39	ns
RHK	4.193	0.05	0.51	0.1	0.49	0.05	0.01	ns
BKH	7.943	0.001	0.98	0.001	0.43	0.1	0.54	0.1
KHO	0.698	ns	n/a	n/a	n/a	n/a	n/a	n/a
KS	2.536	0.1	−0.51	0.1	−0.14	ns	−0.36	ns

Table 4 Mean differences – clinical personality patterns – avoidant

	ANOVA		Group 3-Group 1		Group 2-Group 1		Group 3-Group 2	
Construct	*F*(2,117)	*p*-value	Mean Diff.	Sig. Level	Mean Diff.	Sig. Level	Mean Diff.	Sig. Level
KSA	3.434	0.05	0.47	0.1	0.68	0.1	−0.20	ns
KHG	6.878	0.001	0.74	0.005	0.58	ns	0.15	ns
EKH	5.782	0.005	0.69	0.05	0.80	0.05	−0.11	ns
PDKH	6.686	0.005	0.73	0.001	0.35	ns	0.37	ns
RHK	1.244	ns	n/a	n/a	n/a	n/a	n/a	n/a
BKH	3.732	0.05	0.48	0.05	0.54	ns	−0.06	ns
KHO	1.387	ns	n/a	n/a	n/a	n/a	n/a	n/a
KS	4.956	0.01	−0.54	0.01	−0.23	ns	−0.31	ns

Table 5 Mean differences between the groups on the average of KSA, KHG, EKH, PDKH, RHK, BKH and KHO scores

Disorder	Group 3-Group 1	Group 2-Group 1	Group 3-Group 2
Clinical personality patterns			
Schizoid	0.66	0.27	0.18
Avoidant	0.44	0.21	0.00
Melancholic	0.62	0.00	0.29
Dependent	0.88	0.54	0.29
Histrionic	0.18	0.03	0.15
Turbulent	0.43	0.15	0.08
Narcissistic	1.28	0.10	0.46
Antisocial	0.84	0.00	0.61
Sadistic	2.10	0.00	1.90
Compulsive	0.20	0.09	0.09
Negativistic	0.72	0.22	0.00
Masochistic	0.69	0.68	0.00
Severe personality pathology			
Schizotypal	1.00	0.07	0.67
Borderline	0.52	0.95	−0.26
Paranoid	0.94	0.17	0.62
Clinical syndromes			
Generalized anxiety	0.57	0.00	0.42
Somatic symptom	0.13	0.24	−0.12
Bipolar spectrum	1.20	0.00	1.20
Persistent depression	0.52	0.09	0.00
Alcohol use	0.73	0.00	0.75
Drug use	0.42	−0.0.09	0.19
Posttraumatic stress	0.70	0.19	0.00
Severe clinical syndromes			
Schizophrenic spectrum	2.22	0.47	1.75
Major depression	0.62	0.00	0.14
Delusional	2.71	0.11	2.53

were small and frequently absent. This suggests that employees with clinically significant personality disorders or pathologies who comprise Group 3 are responsible for most instances of counterproductive knowledge behavior. Second, a vast majority of personality disorders facilitate knowledge sabotage and knowledge hiding. At the same time, only a few of them drive knowledge hoarding. Third, as theoretically expected, many personality disorders suppress knowledge sharing. Unexpectedly, three of them – histrionic, turbulent and compulsive personality disorders – facilitate knowledge sharing.

Table 6 Correlations between personality disorders (i.e. base rate scores) and the eight knowledge behavior scales

Disorder	KSA	KHG	EKH	PDKH	RHK	BKH	KHO	KS
Clinical personality patterns								
Schizoid	0.25**	0.27**	0.23*	0.25**	0.20*	0.32**	−0.06	−0.23*
Avoidant	0.13	0.24**	0.22*	0.25**	0.12	0.18	−0.11	−0.32**
Melancholic	0.27**	0.30**	0.27**	0.29**	0.24**	0.29**	−0.09	−0.26**
Dependent	0.40**	0.44**	0.44**	0.35**	0.37**	0.44**	−0.19*	−0.24**
Histrionic	0.11	0.05	0.04	−0.02	0.13	0.13	0.34**	0.33**
Turbulent	0.17	0.05	0.05	−0.02	0.23*	0.19*	0.37**	0.36**
Narcissistic	0.42**	0.44**	0.40**	0.28**	0.46**	0.57**	0.43**	0.11
Antisocial	0.32**	0.35**	0.28**	0.27**	0.29**	0.38**	0.17	−0.12
Sadistic	0.36**	0.43**	0.32**	0.35**	0.35**	0.38**	0.14	−0.09
Compulsive	0.06	0.04	0.11	0.07	0.18	0.13	0.24**	0.29**
Negativistic	0.27**	0.38**	0.35**	0.30**	0.29**	0.37**	0.12	−0.18*
Masochistic	0.28**	0.36**	0.32**	0.32**	0.26**	0.33**	−0.11	−0.32**
Severe personality pathology								
Schizotypal	0.32**	0.39**	0.33**	0.32**	0.30**	0.42**	0.02	−0.25**
Borderline	0.37**	0.42**	0.36**	0.35**	0.33**	0.40**	−0.07	−0.22*
Paranoid	0.38**	0.46**	0.40**	0.35**	0.40**	0.51**	0.22*	−0.11
Clinical syndromes								
Generalized anxiety	0.31**	0.40**	0.40**	0.36**	0.33**	0.37**	0.04	−0.15
Somatic symptom	0.24**	0.27**	0.25**	0.22*	0.18*	0.26**	−0.01	−0.15
Bipolar spectrum	0.49**	0.45**	0.42**	0.33**	0.39**	0.49**	0.26**	0.09
Persistent depression	0.25**	0.27**	0.25**	0.26**	0.22*	0.27**	−0.07	−0.211*
Alcohol use	0.50**	0.47**	0.41**	0.40**	0.43**	0.53**	0.07	−0.07
Drug use	0.23*	0.21*	0.15	0.19*	0.21*	0.25**	0.09	−0.01
Posttraumatic stress	0.27**	0.35**	0.31**	0.35**	0.028**	0.33**	0.05	−0.15
Severe clinical syndromes								
Schizophrenic spectrum	0.43**	0.50**	0.44**	0.42**	0.42**	0.50**	0.13	−0.20*
Major depression	0.29**	0.34**	0.29**	0.35**	0.29**	0.31**	−0.10	−0.24**
Delusional	0.62**	0.60**	0.55**	0.45**	0.56**	0.68**	0.20*	0.00

Notes: *$p < 0.05$; **$p < 0.01$

Fourth, out of all predictors, two clinical syndromes (bipolar spectrum and alcohol use) and two severe clinical syndromes (schizophrenic spectrum and delusional disorder) exert the strongest impact on knowledge sabotage and knowledge hiding. In particular, schizophrenic spectrum and delusional disorder exhibit an astonishingly high difference in scores between Groups 3 and 1. Fifth, histrionic and compulsive personality disorders do not facilitate knowledge sabotage and knowledge hiding. However, both of them, as well as turbulent personality disorder, trigger knowledge hoarding and knowledge sharing – a totally serendipitous finding (Balzano, 2022). All other clinical personality patterns, especially dependent, narcissistic and sadistic personality disorders, facilitate knowledge sabotage and knowledge hiding, at least to some extent. Last, the impact of personality disorders on four knowledge hiding strategies – evasive knowledge hiding, playing dumb knowledge hiding, rationalized knowledge hiding and bullying knowledge hiding – was very consistent.

5. Discussion

Inspired by the unexpected encounter described in Section 1 of this paper, the purpose of this study was to understand the relationship between employees' personality disorders and their counterproductive knowledge behavior (namely knowledge hoarding, knowledge hiding and knowledge sabotage) to answer Priya's perplexing questions, "Why is she

[Mary] doing this to me?" and "What's wrong with her?" Based on the findings, several theoretical and practical implication emerged, as discussed below.

5.1 Theoretical implications

First, this study emphasizes the importance of relying on the body of knowledge documented in the reference disciplines – especially, in psychology – when studying the antecedents of counterproductive knowledge behavior. Knowledge management is the youngest management field that has progressed well toward maturity and recognition (Kör *et al.*, 2022). The interdisciplinary nature of the knowledge management domain (Serenko, 2021) calls for the application of concepts and empirical research techniques from various reference disciplines which are well-established, respected fields of science that provide conceptual and methodological foundations for other disciplines (Nambisan, 2003). For interdisciplinary fields such as knowledge management, it is vital to rely on reference disciplines because "pathbreaking ideas within any specialty usually come from cross-referencing ideas from other specialties or disciplines rather than from research that is narrowly focused within the specialty" (Turner, 1990, p. 672). Psychology represents one of the leading reference disciplines that has been infusing its knowledge into other domains for over a century. At the same time, the knowledge management discipline has not been able to fully benefit from this body of knowledge: evidence shows that only one percent of all works cited by knowledge management scholars appear in peer-reviewed psychology journals (Serenko and Bontis, 2013). This study inspires future knowledge management scholars to rely on the concepts and methods documented in the psychology discipline. In addition, knowledge documented in the human resource management domain may further enrich the theoretical and methodological aspects of knowledge management studies.

Second, knowledge management research has traditionally embraced an underlying paradigm that portrays workers engaging in knowledge hoarding, knowledge hiding and knowledge sabotage as wrongdoers who consciously pursue their personal goals at the expense of the overall organizational success. This assumption was a natural conclusion based on the offenders' observed behavior and its negative consequences (Černe *et al.*, 2014), and the author of this paper must admit that he is "not without sin" on this point. Yet, this study revealed that it is possible that Mary's counterproductive knowledge behavior was driven by her personality disorder, not explicit personal goals. The key problem, however, is that most individuals are completely unaware of the fact that they possess a personality disorder and that it affects their workplace functioning (Millon, 2011b; Millon *et al.*, 2015; Brüne, 2016). In particular, Mary likely could not possibly comprehend the social and organizational consequences of her counterproductive knowledge behavior or attribute its causes to her personality disorder (David, 1990). In fact, it is possible that Mary did not consider her maladaptive behavior and mistreatment of her fellow coworker as abnormal and saw nothing wrong with it. It is quite feasible that Mary had the best intentions in mind and truly wanted to be a productive, well-respected organizational member who enjoys a healthy relationship with her coworkers. Moreover, it is possible that she even perceived herself this way because, due to the presence of a personality disorder, her brain had no ability to recognize her actions as abnormal. In this case, it is erroneous to consider Mary a villain who deliberately hoards knowledge, hides knowledge and uses wrong knowledge to sabotage the performance of other employees. As such, this study points to a possible paradigm shift in terms of how the research community should depict those who engage in counterproductive knowledge behavior and suggests a reconsideration of the underlying assumption that all of them act deliberately and consciously.

Third, this study clarifies the reason for previous inconsistent findings on the role of personality traits in the context of knowledge behavior. While some studies confirmed the impact of personality traits such as the Big Five (Borges *et al.*, 2019), allocentrism,

idiocentrism (Eaves, 2014), prosocial orientation (Matzler and Mueller, 2011; Jadin *et al.*, 2013), cooperativeness (Zhang *et al.*, 2022) and propensity to trust (Mooradian *et al.*, 2006) on knowledge sharing, others failed to reach similar conclusions (Cho *et al.*, 2007; Arabshahi *et al.*, 2013; Peralta and Saldanha, 2014). Considering the likely possibility of the file – drawer problem – when scientists are more likely to publish the findings that confirm the presence of an effect as opposed to conclusions where the hypothesized relationship was not observed (Rosenthal, 1979; Rotton *et al.*, 1995) – it can be reasonably assumed that the relationship between personality traits and knowledge sharing was not supported in a large number of investigations. This study shows that researchers should look beyond the personality traits and focus on personality disorders because the latter suppress productive knowledge behavior and reinforce counterproductive one.

Fourth, as the severity of personality disorders increases so does their impact on knowledge hiding and knowledge sabotage. While all four categories of personality disorders – clinical personality patterns, severe personality pathologies, clinical syndromes and severe clinical syndromes – play an important role in the context of knowledge hiding and knowledge sabotage, severe clinical syndromes have the strongest predictive power with respect to knowledge hiding and knowledge sabotage (i.e. the salience of personality disorders increases from clinical personality patterns to severe clinical syndromes). Severe clinical syndromes represent the most extreme behavioral, cognitive, affective and biological extensions of personality disorders. Each of these syndromes is embedded in a cluster of personality disorders. As a result, their impact is the strongest. Thus, it may be sufficient to measure employees' clinical syndromes as a proxy for their personality disorders because assessing the entire spectrum of their personality pathology is a very time-consuming process.

Fifth, in contrast to expectations, most personality disorders do not facilitate knowledge hoarding. Because knowledge hiding and knowledge sabotage are considered more extreme than knowledge hoarding, it is likely that personality disorders lead to more severe forms of counterproductive knowledge behavior. At the same time, personality disorders do not generally lead to the mere accumulation of knowledge. Instead, they facilitate a more negative and damaging behavior. Sixth, histrionic, turbulent and compulsive personality disorders play a unique role in the context of knowledge behavior. Unexpectedly, they do not lead to knowledge hiding and knowledge sabotage; instead, they facilitate both knowledge hoarding and knowledge sharing. While the mechanism behind this phenomenon is not yet understood, it is possible that histrionic employees tend to engage in social behavior to maximize attention and favors from their coworkers. For this, they accumulate a great degree of knowledge to increase their status, but they eventually have to share some of this knowledge with others to establish and maintain reciprocal relationships to continuously receive attention.

Last, this study confirms that it is important to look beyond subclinical personality traits as determinants of counterproductive knowledge behavior and focus on employees' personality disorders. Subclinical personality traits, which are frequently positioned as antecedents of knowledge hoarding and hiding, have a limited predictive power in the context of counterproductive knowledge behavior because they do not meet the formal criteria of mental disorders and are, therefore, less pathological. In contrast, personality disorders may better tap into the dark side of workers' inner states and explain their various pernicious actions. As concluded by He *et al.* (2021b), it is important to explore innovative research designs and concepts to better understand the mechanisms driving workers' counterproductive knowledge behavior.

5.2 Practical recommendations

To a casual observer, Priya's excruciating questions, "Why is she [Mary] doing this to me?" and "What's wrong with her?" appear to be logical and fully reflect her workplace

experience. From an overall organizational perspective, however, the more appropriate questions would be, "What can be done to identify the root causes of Mary's maladaptive behavior?" and "How can we help to correct it?" An obvious decision would be to terminate Mary and free Priya from suffering. However, no one voluntarily chooses to be afflicted by a personality disorder, and it is likely that Mary is fully unaware of the destructive nature of her action (Amador, 2010). Thus, terminating her because of the presence of an uncontrolled mental condition is not only unethical but also discriminatory and illegal in some jurisdictions (e.g., see Ontario Human Rights Commission, 2022). Because all organizational members have the right to enjoy a safe, collegial and enjoyable work environment (Siegel, 1994), management should explore all options to address the issue at its root cause (Tyrer, 2014) instead of trying to merely fix the consequences of counterproductive knowledge behavior. For this, several approaches may be explored.

First, organizations should introduce or increase insurance coverage for the treatment of personality disorders (Mulvale and Hurley, 2008) and assist those seeking help. It is possible that Mary would use such an opportunity to receive professional treatment which would help her control and correct her interactions with others. Second, management should inform employees about the existence of personality disorders in the workplace and their impact on interemployee relationships. For instance, if Priya were aware that Mary's behavior was driven by her personality disorder, it is possible that she would have adjusted her reaction to Mary's actions or asked for help other coworkers. Third, stress often exacerbates and triggers maladaptive behavior in individuals with mental disorders (Chopra, 2009). It is possible that stressful workplace events, such as poor relationships with a manager, unreasonable performance expectations and a demanding work schedule sparked the manifestation of Mary's personality disorder (Melchior *et al.*, 2007) in the form of knowledge hiding and knowledge sabotage. Therefore, organizations should facilitate a stress-free work environment. Fourth, organizations should focus on removing the social stigma that may be (unfortunately) associated with personality disorders and so prevent employees from seeking professional help (Hinshaw and Cicchetti, 2000). It is quite possible that Mary simply did not want anyone to realize her mental struggle and, instead, directed her maladaptive behavior onto others. Last, if all the approaches above fail, management may try reassigning Mary to tasks that require minimal interaction with other workers. Doing so would minimize Mary's knowledge hiding and knowledge sabotage behavior and would be better than her termination.

6. Limitations and future research directions

To the best knowledge of the author, this work is only the third study that empirically investigated the role of personality disorders in the context of counterproductive knowledge behavior (Issac *et al.*, 2021b; Kmieciak, 2022). At the same time, despite its novelty and potential contribution, it has several limitations. First, the components making up one's personality often overlap and are often difficult to precisely identify. As a result, individuals may be often diagnosed with several mental disorders and exhibit covarying clinical syndromes. Some people possess such as a strong mental pathology that it becomes too difficult to clearly identify and categorize it in one single pattern. Thus, future researchers should look beyond a single mental diagnosis. Second, this study collected data from individuals located in the USA. However, the US-based findings may not always generalize to other countries and regions of the world (Palvia *et al.*, 2017). Thus, future scholars are recommended to replicate this study in the contexts of other countries. Third, even though the quality of data collected on Amazon's MTurk is comparable to that obtained by other means (Berinsky *et al.*, 2012; Goodman *et al.*, 2012; Kees *et al.*, 2017), future investigators are advised to gather data directly from employees of multiple organizations in different

geographical regions to ensure the generalizability of their findings. Fourth, while this study achieved its purpose by demonstrating the role of personality disorders in the context of counterproductive knowledge behavior, it only briefly touched upon a variety of personality disorders instead of exploring a single personality disorder in depth. As such, it has formed a foundation for future empirical work in this domain.

Fifth, this investigation employed the Millon Clinical Multiaxial Inventory-IV (Millon *et al.*, 2015). However, there are other instruments to diagnose personality disorders. For instance, future researchers may employ the measurement approaches provided in DSM-5 (APA, 2013) or rely on the Minnesota Multiphasic Personality Inventory (Ben-Porath and Tellegen, 2008). Sixth, the role of personality disorders in the context of knowledge hoarding remains unclear and requires further conceptualization and empirical research. Seventh, future researchers are advised to develop and test a causal model explicating the impact of personality disorders on various forms of knowledge behavior and test it by means of structural equation modelling techniques (Cepeda-Carrion *et al.*, 2019). In particular, as recommended by Cohen (2016), it may be beneficial to explore factors mediating the relationship between personality disorders and counterproductive knowledge behavior. Eighth, knowledge hiding was operationalized with four dimensions – evasive knowledge hiding, playing dumb knowledge hiding, rationalized knowledge hiding and bullying knowledge hiding – which were very consistently influenced by personality disorders. Future researchers may also employ the counter-questioning knowledge hiding strategy (Jha and Varkkey, 2018) and its recent operationalization by Zhai *et al.* (2021), which was not available when this study was designed. Last, it would be interesting to explore how the recent Great Resignation trend (Serenko, 2022) exposes knowledge workers to additional stress which may exacerbate their personality disorders and trigger counterproductive knowledge behavior.

7. Conclusion

It has been well-established that mental disorders drive various forms of counterproductive work behavior and often impede interemployee interactions (Sansone and Sansone, 2010; Els *et al.*, 2011; Hengartner *et al.*, 2014b). The magnitude of the issue is truly staggering because every fifth worker may be diagnosed with at least one type of mental disorder at any given time (Ettner, 2011). Personality disorders represent a major group of mental disorders (Millon, 2011a). They pervasively and persistently distort employees' cognitive, affective, behavioral and biological processes and lead to maladaptive and counterproductive knowledge behavior which markedly deviates from the expectations of organizational culture. This study shows that organizational knowledge exchange processes are not immune to the personality disorder problem. Regrettably, the knowledge management research community has paid little attention to this sensitive yet critical research topic.

The topic of personality disorders is highly delicate and is frequently surrounded by stigma and misunderstanding. Yet, as this study shows, personality disorders play an important role in the context of counterproductive knowledge behavior. In particular, employees suffering from personality disorders are likely to hide knowledge from their fellow coworkers and engage in knowledge sabotage. Previously, the knowledge management research community has remained somewhat ignorant of this critical issue. As such, this study has made one of the first strides toward bringing scholars' attention to the notion of personality disorders in the knowledge management discipline and so has formed the foundation for further empirical work. Thus, this study urges knowledge management scholars to continue this important line of research by relying on concepts and empirical methods documented in the psychology discipline and beyond.

Notes

1. The unorthodox narrative style employed in this paper is a response to a recent critique of management publications by Tourish (2020) who states that "it is time to write about management and organizations with less obscure theorizing, with more variety, and with a little more humor, curiosity, and passion" (p. 108). Tourish, D. (2020), "The triumph of nonsense in management studies", *Academy of Management Learning & Education*, Vol. 19 No. 1, pp. 99–109.
2. Employees' names have been changed to preserve anonymity. All events and Priya's speech were preserved as accurately as possible to the best of the author's ability and his notes.
3. Groups with the scores of 75–84 and 85+ (as described in the Millon Clinical Multiaxial Inventory-IV) were merged to simplify the analysis and results interpretation.

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Appendix 1. Millon Clinical Multiaxial Inventory-IV

Table A1 Millon Clinical Multiaxial Inventory-IV – clinical personality patterns

Pattern	Cause	Overt characteristics
Schizoid	A lack of desire and incapacity to experience deep pleasure or pain	Passively detached from others, indifferent to social relationships, apathetic, distant, listless, antisocial, limited emotions, affectionless, and unable to form and detached from human relationships
Avoidant	A diminished ability to experience pleasure and possessing an unusual sensitivity and responsiveness to pain which they actively seek to avoid	Actively detached from others, always on guard, fear and mistrust of others, constantly vigilant and keeping interpersonal distance despite desires to relate to others
Melancholic	Experiencing pain as a permanent state where pleasure is no longer considered possible	Pessimistic, defenseless, disheartened outlook and permanent hopeless orientation to significant loss
Dependent	Internalization that the feelings associated with pleasure (i.e. feeling good, secure, confident) and the avoidance of pain require a passive reliance on the goodwill of others	Lack of initiative and autonomy, turning to others for nurturance, security, affection and guidance, always waiting for others' leadership, passiveness in relationships and submitting to the wishes of others to keep their affection
Histrionic	An active pursuit of pleasure derived from getting attention from others	A facile and enterprising manipulation of events and artful social behavior to maximize the attention and favors from others. The (fake) appearance of self-assurance and self-confidence to disguise a fear of genuine autonomy, a need for repeated signs of acceptance and a need for constant approval
Turbulent	Solely centered on an active pursuit of pleasure by any means	Buoyant, animated, cheerful, irritating, intrusive and mercurial. Despite looking passionate and enterprising, is quickly bored, inconsistent and unable to complete goals. Left uncontrolled, the behavior may become unpredictable, extreme, dangerous and erratic, frequently followed by depressive exhaustion, momentary anger and fearful anxiety
Narcissistic	Internalization that maximizing pleasure and minimizing pain is achieved by diminishing others and elevating the self	Egotistic self-involvement, experiencing pleasure through self-focusing, unrealistic feelings of superiority, arrogant self-assurance, snobbish, sublime confidence, pretentious and taking advantage of others. Little or no incentive to form genuinely reciprocal relationships
Antisocial	An inner inclination to turn to themselves as the primary source for needs fulfillment and for aggrandizing themselves to achieve superiority	Skepticism of others, assuming that others are unreliable and disloyal, a desire for autonomy, irresponsible, impulsive, driven by a wish for revenge for what they consider past injustices, engagement in duplicitous or illegal behavior for self-gain, insensitive and ruthless
Sadistic	A sense of unresolved hopelessness, futility and frustration in life that is resolved by the mistreatment of others	Seeking personal pleasure and satisfaction from hurting and humiliating others, hostile, pervasively combative and indifferent or pleased by the destructive outcomes of their contentious, brutal and abusive behavior
Compulsive	Experiencing a conflict between hostility toward others and a fear of social disapproval which is resolved through rigid obedience and the repression of oppositional urges toward autonomy and independence	Prudent, controlled, conscientious, perfectionistic, self-disciplined and highly demanding of themselves and others
Negativistic	An inability to either submerge or resolve conflict between gaining the rewards offered by others and the ones they desire themselves	Erratic patterns of explosive anger or stubbornness intermingled with periods of shame and guilt. Indecisive, fluctuating attitudes, oppositional behaviors, emotionally unstable, erratic and unpredictable
Masochistic	A reversal of the pleasure-pain polarity	Self-abasing, abject, inverted, servile and self-denigrating

Table A2 Millon clinical multiaxial Inventory-IV – severe personality pathologies

Pathology	Cause	Overt characteristics
Schizotypal	Deficient orientation in the pleasure-pain polarity schema and experiencing minimal pleasure accompanied by notable difficulties in the cognitive realm	Social isolation, emotional dyscontrols, minimal personal attachments and obligations, cognitive disorganization, self-absorption, rumination, extreme behavioral eccentricities, severe behavioral abnormalities and diminished reality awareness
Borderline	Emotionally dysfunctional and maladaptively ambivalent/fluctuating orientation toward the three evolutionary polarities: pleasure-pain, active-passive and self-other	Unstable and labile affect, intense endogenous moods followed by the recurring periods of apathy, anger, anxiety and euphoria. A lack of clear sense of identity, suicidal and self-mutilating thoughts and conflicting feelings of love, rage and guilt toward others
Paranoid	A high sensitivity to pain (rejection humiliation) and a strong orientation to the self-polarity	A vigilant mistrust of others, an edgy defensiveness against anticipated criticism and deception, touchy irritability, a need for assertiveness in the inner world of self-determined beliefs and extremely immutable and inflexible thoughts and feelings

Table A3 Millon Clinical Multiaxial Inventory-IV – clinical syndromes

Syndrome	Description
Generalized anxiety	A generalized state of physical or emotional tension which is manifested by excessive edginess, apprehension, alertness, fidgety movements, muscular aches, excessive perspiration, inability to relax and a readiness to react
Somatic symptom	Ungrounded complaints about and preoccupation with unspecified pains and physical health problems which are typically employed to solicit attention, nurture, and reassurance of care from others as a way of discharging psychic tension. Misinterpretation and exaggeration of minor physical discomfort and ailment as serious health issues
Bipolar spectrum	Periods of an abnormally elevated euphoric or hostile mood resulting in buoyant hyperactivity or uncontrollable rages, respectively. Manic episodes are accompanied by disorganized thoughts, scattered ideas, aimless behaviors, inflated self-esteem, a sense of grandiosity, pressured speech, psychomotor agitation, preference for high-risk pleasurable activities, lack of judgment and limited impulse control
Persistent depression	Psychomotor deceleration, dragged-out speech, fatigue, exhaustion, feelings of profound dejection, apathy, social withdrawal, lack of motivation or initiative, weight loss/gain as a result of poor appetite/overeating, concentration problems, oppressive thoughts, the anticipation of an impending disaster and a pessimistic outlook toward the future
Alcohol use	Having a recurrent or recent history of alcoholism and trying to overcome it with minimal success which leads to considerable personal, family and work problems
Drug use	Having a recurrent or recent history of drug abuse and an inability to restrain the drug-related impulses, accompanied by the inability to control the personal consequences of the drug consumption behavior
Posttraumatic stress	Experiencing or witnessing an event involving actual or potential physical harm that triggered intense fear, horror or helplessness and then repeatedly experiencing the same traumatic event through dreams, flashbacks, or nightmares which causes significant anxiety and distress

Table A4 Millon Clinical Multiaxial Inventory-IV – severe clinical syndromes

Syndrome	Description
Schizophrenic spectrum	Disorganized, incongruous, withdrawn, reclusive, secretive, confused, disoriented or regressive behavior, fragmented or bizarre thinking, blunted feelings and a sense of being isolated from and misunderstood by others
Major depression	Incapable of functioning in a normal environment, marked psychomotor impairment or agitation, insomnia, fatigue and weight change. Suicidal ideation, fearfulness, a pessimistic view of the future and a constant sense of hopelessness
Delusional	Acutely paranoid and periodically belligerent, signs of disturbed thinking, overarching suspiciousness, raising interconnected and irrational issues of grandiose, persecutory and jealous nature

Appendix 2. Questionnaire

You must be currently employed full-time for at least for two years in an organization that has ten or more employees.

Screening questions

For how many years have you worked in your current organization?

How many employees does your current organization have?

Your current organization is (private/public/other – please specify)

Instructions: Please answer all questions below in the context of the organization in which you are currently employed full-time.

Knowledge sabotage (seven-point agree/disagree scale)

Please read the following definition:

Knowledge sabotage is an incident when an employee (i.e., the saboteur) *intentionally* provides *wrong* knowledge (information, advice, a document, or a recommendation) to another employee (i.e., the target) or *intentionally* conceals knowledge from another employee when the saboteur:

- *possesses* the required knowledge;
- knows that this knowledge is *very important* to the target;
- is fully *aware* of the target's critical need for this knowledge; and
- knows that the target would be able to productively *apply* the required knowledge to work-related tasks.

In my current workplace,

KSA1. I may sabotage the performance of my co-worker by deliberately supplying him/her with the wrong information, advice, document or recommendation when he/she asks for help.

KSA2. I may sabotage the professional success of my co-worker by deliberately supplying him/her with the wrong information, advice, document or recommendation when I realize that he/she needs it.

KSA3. I may sabotage the performance of my co-worker by deliberately withholding the critical information, advice, document or recommendation when he/she asks for help.

KSA4. I may sabotage the professional success of my co-worker by deliberately withholding the critical information, advice, document or recommendation when I realize that he/she needs it.

In my current organization, when my fellow co-workers ask me to share my knowledge (e.g. they request information, advice, a document or a recommendation), I (seven-point never/always scale).

General knowledge hiding

KHG1. Withhold the knowledge that I possess from others.

KHG2. Try to hide what I know.

KHG3. Do not share my knowledge with them.

Knowledge sharing

KS1. Explain everything very thoroughly.

KS2. Go out of my way to ensure that I understand the request before responding.

KS3. Tell my coworkers exactly what they need to know.

KS4. Look into the request to make sure my answers are accurate.

KS5. Answer all their questions immediately.

Evasive knowledge hiding

EKH1. Agree to help them but never really intend to.

EKH2. Agree to help them but instead give them information different from what they want.

EKH3. Tell them that I would help them out later but stall as much as possible.

EKH4. Offer them some other information instead of what they really want.

AT. Say that I quit my job at this organization twenty years ago. (Attention check)

Playing dumb knowledge hiding

PDKH1. Pretend that I do not know the information.

PDKH2. Say that I do not know, even though I do.

PDKH3. Pretend that I do not know what they are talking about.

PDKH4. Say that I am not very knowledgeable about the topic.

Rationalized knowledge hiding

RKH1. Explain that I would like to tell them, but are not supposed to.

RKH2. Explain that the information is confidential and only available to people on a particular project.

RKH3. Tell them that my boss would not let anyone share this knowledge.

RKH4. Say that I would not answer their questions.

Bullying knowledge hiding

BKH1. Say "this is so simple" and "think about it yourself!"

BKH2. Say "do you not know that our organization has relevant regulations about that?"

BKH3. Ask "as a professional, do you really have to ask that kind of question?", and tell them to "think about it!"

Knowledge hoarding (seven-point agree/disagree scale)

When working in my current organization,

KHO1. I am a "pack rat" when it comes to knowledge.

KHO2. I tend to accumulate and store knowledge.

KHO3. I like to stockpile knowledge just in case I might need it.

KHO4. I never throw away any knowledge that I think might be useful in the future.

Demographics

How many years of full-time work experience do you have?

What is your age?

What is your gender?

What is your highest level of education? (High School or less; Associate degree (two year degree) or some college; Bachelor's degree; Master's degree; PhD)

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