

The wounded leader: the illness narratives of Boris Johnson and Donald Trump

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Jones, R. ORCID: <https://orcid.org/0000-0002-9426-727X>
(2021) The wounded leader: the illness narratives of Boris Johnson and Donald Trump. Discourse, Context & Media, 41. 100499. ISSN 2211-6958 doi: 10.1016/j.dcm.2021.100499
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To link to this article DOI: <http://dx.doi.org/10.1016/j.dcm.2021.100499>

Publisher: Elsevier

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To appear in: *Discourse, Context and Media*, Special issue: Covid-19 and discursive practices of political leaders across contexts, edited by Sylvia Jaworska and Camilia Vasquez

The wounded leader: The illness narratives of Boris Johnson and Donald Trump

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Abstract

This paper analyses the COVID-19 narratives of US President Donald Trump and UK Prime Minister Boris Johnson, combining principles from applied linguistic approaches to illness narratives and sociolinguistic approaches to language and gender. It focuses specifically on the ways Johnson and Trump structured their stories to portray themselves as certain kinds of ‘characters’, the ways they discursively constructed agency in their narratives, and the ways they engaged in various practices of stance-taking. The analysis reveals that, although Johnson and Trump seemed to have taken very different lessons from their illnesses, the subtext of both their narratives promoted a masculinist discourse designed to depict them as ‘strong leaders’ and to detract attention from discussions of their reckless personal behaviour leading up to their infections and the failures of their governments to formulate coherent plans to control the pandemic.

Keywords: affect, agency, illness narratives, masculinity, stance

‘one man can make all the difference.’

Boris Johnson, *The Churchill Factor*

Introduction

UK Prime Minister Boris Johnson was the first major world leader to contract the novel coronavirus, announcing his test result in a video message posted to Twitter on March 27, 2020. He was admitted to hospital on April 6 and moved to the intensive care unit the same day. On April 12, he was released from hospital, expressing his gratitude via video to NHS staff who had cared for him before travelling to his country residence to continue his convalescence. He returned to work on April 27.

US President Donald Trump tested positive for the virus on October 2, 2020. Like Johnson, Trump announced his positive test result on Twitter. That evening he was taken to Walter Reed Army Medical Center, where he received an experimental polyclonal antibody treatment. On leaving hospital on October 5, Mr. Trump tweeted, ‘Don’t be afraid of Covid. Don’t let it dominate your life.’ Shortly after his release from hospital he resumed appearances at large rallies, despite concerns from experts that he might still be contagious.

Both Johnson and Trump’s bouts with COVID-19 were imbued by the press and politicians with an almost literary significance. Commentators noted the ‘poetic justice’ of their misfortunes, Mr. Johnson’s illness being held up by reporters as a ‘symbol of his failed policy’ (Kahn & Dunn,

2020), and Donald Trump's diagnosis widely portrayed as 'an indictment of his approach to the coronavirus' (Lopez, 2020), with CNN anchor Jake Tapper bluntly announcing to the President: 'You have become a symbol of your own failure' (Tapper, 2020). Others, however, offered more generous interpretations. Guto Harri, an adviser to Mr. Johnson, for instance, suggested that being hospitalised with COVID-19 had not damaged his popularity, but rather, had turned him into 'a symbol of the nation' (Colchester and Isaac 2020), and the political editor of the *Sun on Sunday*, David Woodling (2020), wrote approvingly: '[H]is remarkable recovery in a few short weeks [...] inspire new life and hope. [...] with this PM's powers of revival you feel anything is possible.' Similarly, conservative commentators and politicians in the US hailed Trump as a hero for surviving the virus. Republican Representative Matt Gaetz, for instance, tweeted 'President Trump won't have to recover from COVID. COVID will have to recover from President Trump' ('GOP praises Trump...' 2020).

It is, of course, not unusual for people to search for symbolic meaning in the illnesses of their leaders or to draw parallels between the health of the leader and the health of the nation, a tendency that can be traced back to the medieval notion of the king's two bodies: the natural body and the body politic (Kantorowicz, 1957). Furthermore, narratives of the illnesses of leaders are often carefully performed in a way designed to inspire such readings. The coronavirus pandemic, perhaps, highlighted the rhetorical connection between the health of leaders and the health of nations more strongly than ever before in recent history. As leaders across the world became infected with the virus, the stories they told about their illnesses came under intense scrutiny for what they revealed about both their personal conduct and their public

policy in relation to the pandemic. Such stories also inevitably affected how the public thought and behaved in response to the virus.

This paper analyses the COVID-19 narratives of UK Prime Minister Boris Johnson and US President Donald Trump. It explores how they used the storylines of their diseases to frame public perceptions of the crisis and their handling of it, to construct for themselves identities as strong leaders, and to enlist their audiences in public rituals of patriotism. Trump and Johnson have often been compared as leaders, both known for their populist rhetorical styles, and intentional ‘political incorrectness’. Their ‘masculine brand of clarity’ (McIntosh, 2020:17) and unapologetic rudeness has been seen by scholars as an intentional effort to contrast themselves with ‘feminized’ elitists and conventional politicians and to ingratiate themselves with the working-class men who constitute their core of political support (Johnson, 2017; Sunderland, 2020).

Some have suggested that the hyper-masculine discourse of the two leaders also had an impact on their response to the pandemic, leading, for example, to Johnson’s early suggestions that the UK ‘take it on the chin’ (McKenna, 2020), and to Trump’s refusal to model preventative measures and his undermining of the efforts of (particularly female) state governors to control the pandemic (Kurtzleben, 2020). A number of scholars have also noted how ‘toxic masculinity’ more generally contributed to the spread of the virus (Palmer & Peterson 2020) as well as to the spread of disinformation about it (Harsin, 2020).

Masculinity was a central theme in the illness narratives of the two leaders, with each endeavouring to portray themselves as strong, resilient leaders whose illnesses made them even more qualified to lead. Although the two leaders had rather different experiences with the illness and derived very different lessons from those experiences, the illness narratives of both men were characterized by masculinist discourses of ‘strength’ and ‘swagger’ which, in the end, rendered these narratives counterproductive as a public health message.

Illness narratives as public performances

Ever since the 1995 publication of Arthur Frank’s *The Wounded Storyteller*, illness narratives have served as important sources of insight into the way people make sense of disease. Frank focused particularly on the narrative structures of illness narratives, which, he argued, can be classified based on their underlying ‘storylines’ of ‘chaos’, ‘restitution’, and ‘quest’. In ‘chaos’ narratives, narrators’ experience with disease seems to have no meaning beyond the present moment of suffering. In ‘restitution’ narratives, narrators focus on their recovery from the disease, and ‘quest’ narratives involve narrators reflecting on the deeper meaning of their illness.

Others have taken similar structural approaches to illness narratives. Hydèn (1997), for example, also offers a typology of three different types of illness narrative: ‘illness *as* narrative’, in which the narrative is used as a way of coping with illness; ‘narrative *about* illness’ in which the main purpose of the narrative is to convey knowledge or ideas about illness; and ‘narrative *as* illness’, in which narrative actually leads to or constitutes illness. Bury (2001) offers a different typology

consisting of ‘contingent narratives’, which focus on the proximate causes of the illness and its effects on everyday life; ‘moral narratives’, which account for how the disease has brought about changes in the teller’s moral standing; and ‘core narratives’, in which tellers draw connections between their experiences and deeper levels of cultural meaning associated with illness. Such approaches to illness narratives highlight the importance of narrative in helping people who suffer illness articulate their experiences in culturally recognisable patterns through appropriating a range of conventional genres and cultural storylines (Kelly and Dickinson, 1997).

Although applied linguists and discourse analysts are also interested in narrative as a means through which people transform stretches of experience into coherent and culturally recognisable artefacts, they are also concerned with the ways stories are socially and culturally *situated* and *occasioned*. From this perspective, illness narratives are seen as *performances* through which narrators enact social identities and engage in interactional projects (see e.g., Jones, 2013; Riessman, 2003). Approaching illness narratives as performances opens up analytic possibilities that are missed with more structural approaches, taking into account the ways such narratives are often co-constructed between speakers and listeners, focusing attention on the ways they are used to create different kinds of alignments with and stances towards different people, institutions or ideas about illness, and reminding us that the purpose of telling stories about illness is never just to talk about illness, but also to accomplish social actions, including managing relationships of intimacy and power with others.

Nowhere is the performative nature of illness narrative more evident than in the mediatized narratives of the illnesses of celebrities and politicians. One reason for this is that famous people

often have more at stake in protecting or repairing a public identity that may have been ‘spoiled’ by news of their illness (Goffman, 1963). But another reason is the tendency for media commentators and the public to ‘read into’ their illnesses meanings about their character or behaviour, or to assign to them the role of ‘representative patients’, whose experience comes to effect how the illness is understood more generally (Lerner, 2009). Consequently, the stories famous people tell of their experiences with an illness, and the insights they claim from those experiences, can be extremely influential in affecting people’s health behaviours as well as the way they treat other people with the same illness. While celebrity narratives have often been credited with encouraging healthy behaviours, they have also been blamed for spreading misinformation and encouraging harmful practices (Hoffman & Tan, 2013). Finally, the illness narratives of famous people are often sites at which society’s deeper cultural understandings of not just of diseases but also of politics and economics are played out. Franssen (2020:93), for instance, argues that, in Western capitalist countries, the illness narratives of celebrities often serve to reproduce neoliberal ideologies of individuality, particularly ‘the traditional “myth of success” and ideology of meritocracy.’

Because of their mediatized nature, however, celebrity narratives of illness are often more complicated to produce. Celebrities have to exert more discursive effort to make sure their story gets told the way they want it to be told, sometimes in the face of powerful counter-narratives from media commentators. In his work on ‘AIDS celebrities’, Jones (1998) observes how the illness narratives of public figures arise from a complex negotiation among multiple ‘authors’, including the media, the medical establishment, the public, and the patient, each bringing their own agendas to the process.

This negotiation, of course, is even more consequential in the case of powerful politicians such as Johnson and Trump, whose illnesses may raise questions about their fitness to lead or the stability of their governments. It is for this reason that, historically, the illness stories of presidents and prime ministers have been tightly controlled, if they are told at all. The illness of President Woodrow Wilson, for instance, who was incapacitated for much of his second term, was kept secret from the public, and FDR, who had been disabled by polio, never allowed himself to be photographed in his wheelchair. More recently however, there has been more transparency around the health of leaders, with leaders of many countries regularly releasing their health records, and the health of candidates becoming a central issue in political campaigns. The way politicians talk about their own health, and the way others talk about it has become a highly scripted part of the symbolic performance of power in Western democracies, contributing both to the ‘biographical aura’ of leaders (Lempert and Silverstein, 2012) and to the way the public evaluate their leadership, their policies, and the health of the nation itself.

Illness and masculinity

It is perhaps not surprising that much of the work on illness narratives as performances has touched upon the performance of gender and its relationship to illness. Riesman (2003), for instance, explores how men with multiple sclerosis use narratives to position themselves as retaining their masculinity in relation to their roles as husbands, fathers and workers, and Edley (2002) examines the way men construct illness narratives in ways that help them resist disease designation and position themselves as retaining agency and choice. These examinations of

men's narratives of illness are part of a wider body of work in the social sciences that has shown how illness is often regarded as a challenge to men's sense of masculinity, making it hard for them to accept becoming ill and to express their fears and needs (Moynihan, 1998). Ideas about masculinity can also make men more willing to engage in risky behaviour, less likely to comply with treatments and, may even affect the way they conceptualise disease and the body in the first place. Emslie and her colleagues (2001:212), for instance, observe how men often bring to their experiences of illness a highly mechanistic understanding of the body in which damaged organs can be 'repaired or replaced', allowing 'masculine' attributes to return after the body has been 'fixed'. Taken together, these studies show how males 'use health beliefs and behaviours to demonstrate dominant and hegemonic masculine ideals that clearly establish them as men' (Courtenay, 2000:1388).

Insights into the links between the way men talk about illness and the way they perform masculinity resonates with work on language and gender conducted by sociolinguists and discourse analysts (see e.g., Johnson & Meinhoff, 1997; Milani, 2015), which explores how masculinity is performed through the exploitation of indexical links between certain kinds of speech and larger cultural discourses of gender. Scholars in this field have pointed out a range of resources men use for such performances such as particular speech styles, discourse patterns, interactional rituals, stances, and bodily displays. An important point to make is that the way these resources are used and the kinds of masculinities that they index is contingent on the social contexts in which they are used. Seal and Charteris-Black (2008) for example, have found that men of different socio-economic classes in the UK use different kinds of linguistic resources when talking about illness, particularly in the way they express affect.

As noted above, the employment of masculinist discourses in talk about health can have consequences for the well-being of individuals, sometimes, for example, making it more difficult for them to access the support that they need. Such discourses, when they become part of the way politicians frame their approach to health-related issues, can also have an impact on health policies and public perceptions of illnesses. Hansen (2018), for instance, discusses how US President Nixon's masculinist 'war on cancer' rhetoric had a significant impact on the collective consciousness of the disease, affecting how cancer was talked about in the media and in clinical settings for years afterwards. The way men like Johnson and Trump use their illness narratives to perform identities, including gender identities, does not just have to do with how these performances might affect them as individuals, but also how they might relate to their leadership styles, influence their policies, and affect their constituents' health beliefs and behaviour.

Data and methodology

The data for this study consist of a collection of public statements made by Prime Minister Boris Johnson and President Donald Trump about their experiences contracting, being treated for and recovering from COVID-19 in the form of public statements, social media posts, and media interviews. In the case of Mr Johnson, this includes all references to his illness he made in public addresses and on Twitter from the day of his diagnosis on March 27 until his return to work on April 27. It also includes comments he made in an interview with the *Sun of Sunday* on May 2, the only interview he granted in the months after his hospitalisation. In the case of Mr. Trump this includes references he made to his illness on Twitter from the day of his diagnosis on October 2 until November 2, the day before the US election. It also includes three media interviews he gave

shortly after his release from hospital as well as transcripts from three of his many campaign rallies, one held at the White House on October 10, the other held on October 12 in Opalocka, Florida— his first major rally after his return from hospital—and the other held on October 21 in Manchester, New Hampshire. Also included are statements made about the two leaders’ health conditions by their designated spokespeople, in the case of Boris Johnson, Dominic Raab, First Secretary of State and the cabinet minister whom Johnson designated to deputise for him during his illness, and, in the case of Donald Trump, White House physician Sean Conley, who held regular press briefings during Mr Trump’s hospitalisation. A list of the texts considered appears in Table 1.

Table 1: Data

Johnson	Trump
<p>Social media:</p> <p>Tweets from 27/3/20 – 27/4/20 (totalling 26, 16 of which were about COVID-19 in general and 8 of which mentioned his own illness), including 2 videoed speeches posted to Twitter:</p> <p>March 27 (Announcement of positive test) (BJ/Vid/27-3)</p> <p>April 12 (Remarks on release from hospital) (BJ/Vid/12-4)</p> <p>Public remarks:</p>	<p>Social media:</p> <p>Tweets (totalling 1424 of which 83 were about COVID-19 in general and 27 of which mentioned his own illness), including 5 videoed speeches posted to Twitter:</p> <p>October 2 (Announcement from the White House of hospitalisation) (DT/Vid/2-10)</p> <p>October 3 (Speech from Walter Reed Hospital) (DT/Vid/3-10)</p> <p>October 4 (Speech from Walter Reed Hospital) (DT/Vid/ 4-10)</p>

<p>April 30 (Remarks at the Government Coronavirus Briefing) (BJ/Briefing/30-4)</p> <p>Media Interviews:</p> <p>May 2 (Interview with David Woodling of the <i>Sun on Sunday</i>) (BJ/Int/2-5)</p> <p>Remarks from official Spokespeople:</p> <p>April 6 (Remarks by Dominic Raab at the Government Coronavirus Briefing on the day of Johnson's hospitalisation) (DR/Briefing/4-6)</p> <p>April 7 (Remarks by Dominic Raab at the Government Coronavirus Briefing on the day Johnson entered ICU) (DR/Briefing/7-4)</p>	<p>October 5 (Speech from Walter Reed Hospital) (DT/Vid/5-10)</p> <p>October 7 (Speech from White House on release from hospital) (DT/Vid/7-10)</p> <p>Public remarks:</p> <p>October 10 (Campaign rally, White House) (DT/Rally/10-10)</p> <p>October 12 (Campaign rally, Florida) (DT/Rally/12-10)</p> <p>October 21 (Campaign rally, New Hampshire) (DT/Rally/21-10)</p> <p>Media interviews:</p> <p>October 8 (Interview with Sean Hannity of <i>Fox News</i>) (DT/Int/8-10)</p> <p>October 9 (Interview with Rush Limbaugh of <i>Premiere Radio</i>) (DT/Int/9-10a)</p> <p>October 9 (Interview with Tucker Carlson/Dr Marc Siegel of <i>Fox News</i>) (DT/Int/9-10b)</p> <p>Remarks from official spokespeople:</p> <p>October 3 (Press conference with Trump's medical team) (DTsp/PC/3-10)</p> <p>October 5 (Press conference with Trump's medical team) (DTsp/PC/5-10)</p>
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The rather dramatic imbalance between the amount of material related to Mr Johnson and to Mr Trump already constitutes an important finding: the fact that Mr Trump talked about his illness much more than Mr Johnson. Part of this has to do with more general differences in the communicative styles of the two leaders (see below), with Trump known for loquaciousness, and Johnson often criticised for the lack of access he gave to the media, a criticism that was particularly pronounced during the coronavirus crisis, with one commentator wondering whether he was practicing ‘social distancing’ with respect to reporters and the public (Tomkins, 2020). (At the same time, it’s important to note that, of the over 1000 tweets Trump sent during the month under consideration, fewer than 100 were about the pandemic that was killing thousands of US citizens a day during that time).

Another important difference has to do with the circumstance under which the narratives were produced: unlike Mr Johnson, Mr Trump was engaged in an election campaign in which his ability to explain his illness was particularly consequential to his candidacy. This also meant that Mr Trump had occasion to talk about his illness in contexts that Mr Johnson did not, specifically, campaign rallies. Finally, the differences in the amount of data from the two figures belies some important differences in the political cultures of the two nations concerned. In the US the public expects to be provided with intimate details about the President’s health, preferably directly from his doctors. In the UK, updates about Mr Johnson’s condition came solely from Downing St. and his political representatives and tended to be of a more general nature.

Given the interactional nature of illness narratives, one would expect different perspectives to be offered and different stances to be performed in narratives told *by* the leaders themselves and those told *for* them by their spokespeople, as well in as those delivered in different interactional contexts, specifically the more monologic context of political speeches and social media posts and the dialogic context of media interviews. In this data, however, there was a high degree of consistency across these different interaction orders: Both Johnson and Trump's spokespeople loyally ventriloquised the stories told by their bosses, sometimes (as was clearly the case with Trump's doctors), in ways that compromised their own 'professional voices'. As for the media interviews, since both Trump and Johnson only allowed themselves to be interviewed by 'friendly' journalist from supportive news outlets, there was little about these interviews that was genuinely dialogic, the questions asked seemingly designed to allow the leaders to articulate or re-articulate their own stories on their own terms with no challenges and little probing. In other words, spokespeople and interviewers served mainly as 'props' for the leaders' performances. Counter-narratives came chiefly from opposition politicians and more antagonistic media outlets, and these counter-narratives, mostly about personal recklessness, administrative ineptitude, and loss of control, did play a role in shaping these narratives which, as I will show below, were carefully crafted to depict leaders who were responsible, in command, and largely successful in their policies.

The data were analysed using the principles developed in work on illness narratives and language and gender discussed above. In particular, attention was paid to:

- 1) The overall *structure* of the narratives: the kinds of ‘storylines’ they reproduced, and the kinds of ‘characters’ these storylines allowed Johnson and Trump to portray themselves as.
- 2) The ways Johnson and Trump discursively constructed *agency* in their narratives.
- 3) The practices of *stance-taking* the two leaders exhibited in their narratives.

The data were first analysed with attention to the way they unfolded structurally over time, using concepts borrowed from the typologies of Frank (1995), Hyden (1997), and Bury (2001) (see above), with a focus on the differences between the way aspects of the tellers experiences were foregrounded and background in the stories they told while they were ill and in the retrospective narratives they offered up after they had recovered. Then the focus turned to understanding how agency was constructed in the narratives, particularly through aspects of transitivity – the configurations of participants, processes and moments of transformation in the stories (see Jones, 2018). Finally, concepts drawn from sociolinguistic perspectives on stance (Jaffee, 2009; Kiesling, 2018) were applied to the data, with particular attention to how the leaders signalled their attitudes towards the disease, their caregivers, and the audiences of their narratives, and how they produced particular kinds of gendered affective performances through these acts of stance-taking.

Storylines

The form illness narratives take depends on the point in the progression of the illness at which they are told. Patients who recover from an acute illness always tell at least two kinds of stories: the stories they tell while they are ill, which Bury (2001) calls ‘contingent narratives’, and the

stories they tell once they have recovered, which relate the ‘journey’ (Frank, 1995) from illness to recovery. Both of these kinds of narratives were contained in the public statements of Johnson and Trump, and, in both cases, these two kinds of narratives took rather different forms and served different purposes.

Contingent narratives

Not surprisingly, when leaders become ill, the stories that are told to the public about their illnesses as they unfold tend to be highly controlled, approached as a kind of ‘crisis communication’ in which, as information about the illness is released, efforts are often made to undermine this information by showing the leader functioning normally. This normality is sometimes created through language that downplays the importance of the news, as in Johnson’s announcement of his positive test result on Twitter on March 27:

Hi folks, I want to bring you up to speed with something that’s happening today, which is that I’ve developed mild symptoms of the coronavirus, that’s to say a temperature and a persistent cough. On the advice of the Chief Medical Officer, I’ve taken a test, that has come out positive. So, I am working from home. (BJ/Vid/27-3)

This excerpt displays a range of strategies typically used for minimising bad news (Maynard, 2003), including a *preannouncement*, which softens the news by framing it as a matter of routine information giving (bringing the public ‘up to speed’), the subordination of the information about symptoms and the test result into relative clauses, and the foregrounding of the consequence (‘working from home’) over the cause. After divulging his positive status, Johnson quickly redirected his focus away from himself and towards ‘everybody who’s working to keep our

country going through this epidemic,’ reassuring listeners that ‘we will get through it.’ In this way he subsumed his own situation into the more general situation of the nation.

Trump similarly announced his positive test result on Twitter. Although his announcement was more direct than Johnson’s, containing no pre-announcement or grammatical backgrounding of the news, Trump’s plain and direct style also gave the sense of ‘business as usual’. Like Johnson, Trump ended on an optimistic note, also reframing his individual challenge as a collective one: ‘We will get through this TOGETHER!’ (Fig.1).

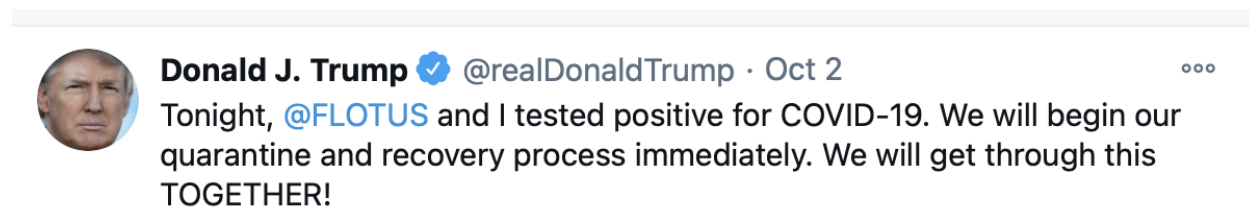


Figure 1: October 2 Tweet from Trump

As with many viral infections, with COVID-19 there is a difference between testing positive for the virus and actually having the disease, and the way this dividing line between being ‘positive’ and being ‘ill’ was managed by the two leaders and their spokespeople was designed to delay as long as possible (if not to avoid altogether) the designation of illness. Typically hospitalisation would be considered an indicator of illness, but, in both the case of Johnson and Trump, considerable discursive work was performed to counteract this assumption. Johnson, who had been ‘working from home’ for over a week after his test result, announced his hospitalisation with a tweet, explaining it as a matter of ‘routine tests’, and emphasising that he would continue to work and ‘keep in touch with [his] team’ (Fig. 2).



Figure 2: April 6 Tweet from Johnson

Unlike Johnson, Trump was hospitalised less than 24 hours after his test result was announced. Before he left, he posted a video on Twitter containing a short, fifty-word statement announcing that he was going to Walter Reed Hospital, adding: 'I think I'm doing very well. But we're going to make sure things work out' (DT/Vid/2-10).

Even after both leaders were hospitalised, assessments of their condition given to the public were almost universally positive. In the case of Johnson, an official statement from Downing St. described the Prime Minister as 'stable and in good spirits,' and receiving 'standard oxygen treatment,' and in response to reporters' questions during the Government Coronavirus Briefing the day Johnson was hospitalised, Dominic Raab claimed that the Prime Minister had been 'admitted to hospital for tests as a precaution only'. When pressed about the apparent contradiction that 'the Prime Minister is sick enough to take up a valuable hospital bed, but well enough to still be running the country,' Raab evaded the question, saying 'I'm not going to comment on security matters' (DR/Briefing/4-6).

In the case of Trump, most of the statements about his condition came directly from him in the form of tweets or videos posted on Twitter, and these assessments were not just universally positive, but increased in positivity with each day. Trump described himself as ‘doing well’ (DT/Vid/3-10), as ‘getting great reports from the doctors,’ (DT/Vid/4-10), as feeling ‘better than I have in a long time’ (DT/Vid/5-10), and as feeling ‘like perfect’ (DT/Vid/7-10). Meanwhile, the President’s physician, Dr Sean Conley, held regular briefings in which he also emphasised that the President was ‘doing very well’ and was ‘in exceptionally good spirits’ (DTsp/PC/3-10). During these briefings, Conley regularly evaded questions from reporters as to whether or not the President had been administered supplemental oxygen (which he had):

Reporter: And he has not received any supplemental oxygen?

Dr. Conley: He’s not on oxygen right now. That’s right.

Reporter: He has not received any at all?

Dr. Conley: He’s not needed any this morning today at all. That’s right. (DTsp/PC/3-10)

One important purpose of contingent narratives, says Bury (2001), is to account for how the patient is negotiating the illness’s impact on their ability to perform their social roles. For both Johnson and Trump, this meant producing regular displays of ‘working’ and remaining ‘in charge’, in line with traditional concepts of masculinity in which men’s social worth is defined by work (Moynihan, 1998). After his test result, for instance, Johnson reminded people that he was able to continue working thanks to ‘the wizardry of modern technology,’ which allowed him to continue ‘to lead the national fightback against coronavirus’ (BJ/Vid/27-3), and on March 31 he tweeted a screenshot of him conducting a Zoom meeting with his cabinet (Fig. 3).



Figure 3: March 31 Tweet from Johnson

Similarly, Trump and his spokespeople emphasised that he continued to work throughout his illness, releasing as evidence two photos of the President wearing different outfits and sitting at different desks surrounded by documents and files (which, it later emerged, were taken ten minutes apart). One of these photos appeared in a tweet from his daughter, accompanied by the words: ‘Nothing can stop him working for the American people’ (Fig. 4).



Figure 4: October 4 Tweet from Ivanka Trump

One feature that regularly appears in contingent narratives — the discussion of the possible *cause* of the narrator’s disease — is conspicuously downplayed in the stories of the two leaders, though this is an issue that preoccupied the media, given the reckless behaviour of the two men prior to their diagnoses (i.e. Trump’s refusal to wear a mask and Johnson’s bragging about shaking hands with COVID-19 patients). In the case of Johnson, no mention at all was made by either himself or his spokespeople about the possible connection between his behaviour and his condition. Trump, on the other hand, starting from his admission to hospital on October 3, began developing a storyline in which his infection was the inevitable result of his responsibilities of office: ‘I had no choice,’ he said in his October 3 speech from Walter Reed, ‘because I just didn’t want to stay in the White House. I was given that alternative. [...] I can’t do that. I had to be out front [...] As a leader, you have to confront problems’ (DT/Vid/3-10).

The contingency narratives of both leaders ended with their recovery and ‘heroic return’ to the positions of leadership which they all along insisted they had never left. For Johnson, this was a more low-key affair, characterised mostly by expressions of gratitude to the doctors and nurses that had cared for him. In a statement from Downing St. on the 27th of April, Johnson began by apologising for having ‘been away from [his] desk for much longer than he would have liked,’ and then went on to use his own ‘fight’ against COVID as an analogy for the nation’s efforts against the disease (see below) (BJ/Vid/12-4). Trump’s return was much more carefully staged, involving the President arriving at the White House by helicopter on October 5, ascending to the balcony outside of his residence, and dramatically removing his mask as if to show that he had conquered the disease and was no longer bound by any protocols of hygiene (as if he had ever been).

Retrospective narratives

One problem with the heroic returns that marked the end of Johnson and Trump’s contingent narratives was that the downplaying of the severity of the illness that led up to them threatened to make their returns seem less heroic. This problem was swiftly addressed in the retrospective narratives they told in which, for both leaders, the progression of their illness took an entirely different shape. Retrospective illness narratives are almost invariably narratives of transformation, which, according to Hawkins (1990), contrast the ‘crisis’ introduced by the illness and the ‘regeneration’ brought about by its resolution. In such narratives, the strength of the ‘regeneration’ is often linked to the severity of the ‘crisis’.

Revisions to Johnson’s narrative began when he was released from the ICU on April 10 and his father told the BBC that the Prime Minister had ‘almost taken one for the team’ (‘Boris is not out

of the woods...’, 2020), a metaphor which both indexed the younger Johnson’s masculinity and framed his illness as a sacrifice he had undergone for the nation. When he finally returned to work on April 27, Johnson himself highlighted the severity of his condition in his effusive displays of gratitude towards the medical workers who, as he put it, ‘took some crucial decisions [...] which I will be grateful for the rest of my life.’

A few days later, in an interview with the *Sun on Sunday* (BJ/Int/2-5), Johnson elaborated on his crisis using much more colourful language. ‘I was aware there were contingency plans in place [...] for what to do if things went badly wrong,’ a situation that Johnson described as a ‘death of Stalin-type scenario.’ ‘The bloody indicators kept going in the wrong direction,’ he added, ‘and I thought, ‘There’s no medicine for this thing and there’s no cure [...] That was the stage when I was thinking, “How am I going to get out of this?”’ While this revised version of Johnson’s disease progression had an important informational function, revealing to the public facts that had previously been hidden from them, it also had an important rhetorical function, transforming Johnson’s illness narrative into a story of the heroic deeds of the doctors and nurses who cared for him and of the bravery and resilience of Johnson himself.

Trump’s portrayal of his struggle with the disease also changed after his return to the White House. In an October 9 interview with the radio host Rush Limbaugh, he said he had asked his doctors, ‘How bad was I?’:

They said, ‘You could have been very bad. You were going into a very bad phase.’ And so it wasn’t like it was just going to, like with the kids where they get it and it get sniffles

and they're better two days later, right? This looks like it was going to be a big deal. And you know what that means, right? That means bad. (DT/Int/9-10a)

As with Johnson's revision, Trump's newfound focus on the severity of his illness helped to enhance his status as one who had overcome it. At the same time, neither Trump nor Johnson depicted the crises they faced in terms of physical suffering or fear. Indeed, it was almost as if their realisations of how bad things were depended on the doctors or, in Johnson's case, the 'indicators', telling them, hinting at a 'masculine' dis-attention to the physical danger they were in.

Agency

An important aspect of retrospective narratives of disease is how narrators portray the agents of their restitution — who or what they 'give credit to' for their recovery, — and how they portray their own role in it (Arduser, 2014; Jones, 2018). According to Frank (1995), 'quest' narratives often depict illnesses as initiating a crisis of agency when the narrator becomes a 'patient', and a key element of their restitution is a restoration of independence and control. Ascriptions of agency have been found to be particularly complex in the way men talk about their health, 'control' often being seen as a defining feature of masculinity (Courtney, 2000).

For Trump and Johnson, ascriptions of agency in their retrospective narratives presented a dilemma -- the need to balance two competing codes of masculinity when talking about health (Farrimond, 2012), one in which 'real men' are meant to resist the care of doctors, and the other in which 'real men' are seen as 'problem solvers' who cooperate with doctors and assume of the

role of ‘expert patients’. The two leaders negotiated this dilemma by simultaneously praising the care they received as exemplary and talking about how they resisted it. In his interview with the *Sun on Sunday*, for instance, Johnson spoke of how he was initially ‘in denial’ about the seriousness of his condition. ‘I really didn’t want to go into hospital,’ he said. ‘It didn’t seem to me to be a good move, but they were pretty adamant. Looking back, they were right to force me to go’ (BJ/Int/2-5). In this statement, Johnson combines both the persona of the ‘self-reliant man’ who resists the ‘drama’ of hospitalisation, and of the ‘good patient’, who, albeit grudgingly, admits that his doctors were right.

A similar ambivalence towards treatment was present in Trump’s narrative, with the President, also portraying himself as entering hospital reluctantly. In his October 7 speech on his return to the White House he said:

I could’ve stayed at the White House, but the doctors said, ‘Because you’re president, let’s do it.’ I said, ‘Fine. You tell me what to do, and I’m going to listen.’ These are great professionals. They’ve done a fantastic job. (DT/Vid/7-10)

In this statement Trump managed to perform masculinity by simultaneously undermining the advice of his doctors (‘I could have stayed...’) and by relinquishing his agency (‘Fine, you tell me what to do...’) in a way that highlighted that he was still in charge. Later, in his interview on the *Tucker Carlson Show*, Trump talked about ‘negotiating’ with his doctors, again highlighting that ‘generally, maybe [he] wouldn’t’ listen’ to doctors, but had decided in this case to do so based on their experience with treating soldiers:

Trump: I did negotiate, but ultimately, I have a lot of respect for these doctors. They're really the best doctors, I think in the world and Walter Reed, I've seen the work they do in the military and people coming in so badly injured like you've never seen before. I have a lot of respect, so I really tended to listen, but generally, maybe I wouldn't, but I did tend to listen to this group. (DJ/Int/9-10b)

Even as he talked of giving in to the doctors' orders, however, Trump consistently depicted himself as an active participant in his treatment, even taking credit for deciding what drugs should be administered:

I heard about this drug. I said, 'Let me take it.' It was my suggestion. I said, 'Let me take it,' and it was incredible the way it worked. Incredible. (DT/Vid/7-10)

Another dilemma of agency the two men faced, was how much to claim credit for their recovery themselves and how much to ascribe credit to external forces. Interestingly, although both Trump and Johnson had moments where they highlighted their own agency, Johnson, for example, referring in his interview with the *Sun* to how his 'terrible buoyancy' helped him pull through (BJ/Int/2-5), and Trump bragging at rallies after his recovery of his 'youth' and 'good health' (DJ/Rally/12-10), most references to the leaders' 'strength' and 'fighting spirit' were left to their supporters and spokespeople. Instead, Johnson and Trump primarily ascribed the cause of their recovery to external factors, Johnson to the 'courage', 'devotion', and 'love' of the 'brilliant' doctors and nurses that cared for him (BJ/Vid/12-4), and Trump to the 'miraculous' drugs prescribed to him (DT/Int/9-10b) by his 'AMAZING' doctors (DT/tweet/3-10). In both cases, however, their alignment to the qualities of 'courage' and 'innovation' exemplified by these

external agents allowed them to co-opt these ascriptions of agency into their own performances of masculinity.

An example of this can be seen in Johnson's April 12th speech on his release from hospital in which he highlighted the courage and 'risk taking' of the NHS staff:

I've seen the personal courage, not just of the doctors and nurses, but of everyone, the cleaners, the cooks, the healthcare workers of every description. [...] who kept coming to work, kept putting themselves in harm's way, kept risking this deadly virus. It is thanks to that courage, that devotion, that duty and that love that our NHS has been unbeatable.
(BJ/Vid/12-4)

It is significant that Johnson did not just express gratitude to the NHS staff in general, but referred to them by name, prefacing his list with the modest disclaimer; 'I'm going to forget some names so please forgive me.' He named 'Po Ling and Shannon and Emily and Angel and Connie and Becky and Rachel and Nikki and Anne,' singled out two nurses, 'Jenny from New Zealand' and 'Luis from Portugal,' as well as referring to the 'utterly brilliant doctors [...] several of them for some reason called Nick.' With this move, Johnson was able to simultaneously index graciousness and power by exercising the leader's prerogative to 'single out' and 'recognise' the deeds of others. Moreover, he was further able to position himself as a leader by folding these expressions of personal gratitude into a larger story of national heroism centred on the NHS and the support his Government was (supposedly) giving it.

Finally, Johnson was able to indirectly index his own heroic 'fight' against the disease in his assessment of the nation's fight. 'If this virus were a physical assailant, an unexpected and

invisible mugger,’ he said in his April 27 speech, ‘which I can tell you from personal experience it is, then this is the moment when we have begun together to wrestle it to the floor’ (BJ/Vid/27-3), the implication being that his own recovery had been, at least partially, a matter of him ‘wrestling the virus to the floor’.

Like Johnson, Trump also gave credit for his recovery to the people who cared for him, but he focused less on their compassion and dedication and more on their credentials, and, while Johnson indexed his power by praising the effectiveness of public services, Trump did so by highlighting the access he had to elite services. In his October 9 interview with Limbaugh, for instance, he said, ‘It’s always the good thing about when you’re president, 11 doctors show up and they’re all the head of Johns Hopkins and this and that’ (DT/Int/9-10a) Interestingly, Trump’s boasts about his access to exceptional medical care featured most prominently in his rallies where he was addressing middle or lower income supporters, some of whom had extremely limited healthcare options. ‘I had doctors from the best schools, the best hospitals in the world,’ he said at an October 25 rally, ‘because you’re president, right?’ (DT/Rally/25-10).

Emphasising the elite nature of his care might seem like a risky move for a politician presiding over a public health crisis which had, under his watch, caused unprecedented death and misery. But Trump’s strategy was consistent with the other ostentatious displays of wealth and privilege that marked his political career, displays that many voters welcomed as evidence of his ‘power’ and leadership abilities. This show of privilege also opened up an opportunity for Trump to produce a show of largess by promising to make the same treatment he had received available for free to everybody (a promise which, of course, he never kept). ‘I’m going to have it delivered to

every hospital we have sick people with the COVID, or the China Virus as we call it,' he told Hannity on October 8, 'and we're going to make people better' (DT/Int/8-10).

Even more than the doctors who cared for him, Trump credited his recovery to the drugs he was given (drugs which were also unavailable to most Americans). He focused especially on the experimental cocktail of monoclonal antibodies produced by Regeneron Pharmaceuticals, saying:

[...] I went in and I wasn't feeling so hot, and within a very short period of time, they gave me Regeneron. It's called Regeneron, and other things too. But I think this was the key, but they gave me Regeneron, and it was like, unbelievable. I felt good immediately. I felt as good three days ago as I do now [...] I view these, I know they call them therapeutic, but to me it wasn't therapeutic, it just made me better. I call that a cure.
(DT/Vid/7-10)

This focus on a pharmaceutical 'magic bullet', of course, resonates with Trump's rhetoric on the pandemic long before he became infected, in which he repeatedly touted treatments such as hydroxychloroquine as miraculous solutions. By characterizing the Regeneron treatment at a 'cure', he was able to effectively declare an 'end' the pandemic which threatened his presidency, and was also able to position himself as, if not as the agent of his own recovery, the agent of the development and approval of the drug that saved him. In his interview with Limbaugh, he said: 'I'm just saying that we have something that will cure this now [...] And without us, without the Trump administration, this would never have happened' (DT/Int/9-10a).

Finally, a key function of retrospective illness narratives is to articulate not just a transformation of the body, but a spiritual or moral transformation of the patient, involving new insights or a new perspective on life. In the case of Johnson and Trump, this transformation constituted what might be described as the ‘core narrative’ of their illness stories, a narrative that sought to position them as *better* leaders for having gotten the disease. The key archetype invoked in this core narrative is that of the ‘wounded healer’ (Jackson, 2001), a character whose roots can be traced to the Greek myth of Chiron the Centaur, who, after being wounded by a poisoned arrow from the bow of Heracles, relinquished his claim to immortality and used his experience of suffering to benefit others. The image of the wounded healer, of course, also has Biblical implications, with Christ portrayed in the passion narratives as a servant who suffers for the salvation of others.

Johnson’s invocation of this figure came in the form of his references to his personal experience with the illness in his warnings to the public to comply with government restrictions, as well as the more general philosophical bearing he performed in relation to his illness. Colchester and Isaac (2020) remark, for example, on how often Johnson quoted Cicero during his illness, explaining why he wanted to continue working by citing the advice Cicero was given by his brother Quintus about the importance of remaining in Rome and staying visible to show his care for the people, and declaring in a video meeting with his cabinet after his release from hospital: ‘*Salus populi suprema lex esto*’ (‘Let the health of the people be the highest law’). More explicit links between Johnson’s experience with the illness and his leadership abilities came from his supporters such as his long-time ally David Woodling (2020), political editor of the *Sun*, who

claimed: ‘Who better to revive the country than someone who has himself bounced back from the brink?’

Trump’s claims to having gained special insight into the pandemic from his illness experience were more overt and, in many ways more damaging since the main lesson he brought to the public based on them was ‘Don’t let it dominate your lives. Get out there’ (DT/Vid/5-10). In his claims to enhanced leadership abilities arising from his illness, Trump pitted his own ‘real-life’, embodied knowledge against the abstract knowledge of experts, in line with the more general denigration of ‘intellectuals’ that characterized his administration’ ‘I learned a lot about COVID,’ he said in his October 4 video. ‘I learned it by really going to school. This is the real school. This isn’t the lets-read-the-books-school, and I get it, I understand it’ (DT/Vid/4-10). In fact, this unique understanding the President had gained was even used as a selling point against his opponent in the campaign. On October 5, White House spokesperson Erin Perrine, noted that Trump ‘has experience now fighting the coronavirus as an individual... first-hand experiences... that Joe Biden doesn’t have’ (Zoellner 2020).

Stance and Affect

In the last two sections I focused on the way the two leaders performed masculinity by constructing certain kinds of storylines through which they portrayed themselves as particular kinds of characters such as ‘returning heroes’ and ‘generous leaders’ and by constructing themselves as agents in their recoveries. In this section I will focus more on the stylistic elements of their stories and how they constructed particular *stances* and performed particular kinds of *affect*.

Stance refers to the way speakers use language to signal their attitude towards what they are talking about, whom they are talking to, or the talk itself. It can fulfil a variety of functions from producing evaluations of people or situations to claiming or imputing certain kinds of social identities (Jaffe, 2009). In her analysis of stance-taking in online illness narratives, for example, Zhang (2019) shows how patients use stance to position themselves in relation to their illnesses and legitimise their complaints about healthcare services and personnel. Stance has also been an important consideration in work on language and gender, going back to Ochs's (1992) seminal essay, 'Indexing Gender', in which she points out that often it is not so much a particular linguistic behaviour that indexes gender as much as it is the *stance* performed by that behaviour, which is ideologically linked to particular gender categories.

Kiesling (2018) has further developed the notion of stance in studies of language and masculinity, linking certain performances of stance (such as the 'cool solidarity' expressed with the word 'dude') not just to ideologies of hegemonic masculinity, but also to the production of a particular *affect*, which he calls 'masculine ease'. The integration of insights from affect studies (see e.g., Clough & Halley, 2007) with sociolinguistic perspectives on stance allows Kiesling to consider not just the identities and ideologies indexed by different stances, but also the effects/affects stance-taking can produce in speakers, audiences, and on the overall 'tone' of situations. This is especially relevant to understanding how Johnson and Trump's illness narratives might have influenced the feelings and behaviour of their constituents in relation to the pandemic.

The stance that was most prominently performed in these narratives one of 'masculine swagger' or 'manly insouciance', which distanced the leaders from the consequences of their illnesses.

This stance, however, was performed differently by Johnson and by Trump, and resulted in the production of rather different affects.

For Johnson it took the form of the kind hedging and understatement that has long been associated with 20th century British bourgeoisie masculinity (Francis, 2002), seen in the use of diminishers such as ‘pretty’ and ‘not particularly’ in conjunction with phrases such as ‘I won’t deny it’, or ‘to be honest’, as in these lines from the *Sun* interview:

I was really feeling pretty groggy, to be totally honest with you.

It was a tough old moment, I won’t deny it.

I was not in particularly brilliant shape. (BJ/Int/2-5)

This rhetorical technique gives to Johnson’s descriptions of even his darkest moments of illness a tone of a self-deprecating, good-humoured courage, his overall stance creating a backdrop against which genuine expressions of emotion end up indexing masculinity by virtue of the fact that they seem so marked, as in this description of Johnson talking in the same interview about the care he received. Notably, it is not fear that produces affect in Johnson, but gratitude for a ‘job well done’:

‘It was thanks to some wonderful, wonderful nursing that I made it. They really did it and they made a huge difference. I can’t explain how it happened. I don’t know . . . it was just wonderful to see the . . .’ His voice falters while his eyes redden and he pauses to take a

deep breath. He continues: ‘I get emotional about it . . . but it was an extraordinary thing.’
(BJ/Int/2-5)

Trump’s performance of ‘masculine ease’ is also occasionally manifested through understatement in expressions like ‘I wasn’t feeling so hot’ (DT/Vid/7-10) and ‘I was not in the greatest of shape’ (DT/Int/9-10b), but more often Trump performed his ‘swagger’ through *overstatement* rather than understatement, repeatedly, for example, assessing his condition as ‘perfect’, the doctors and the facilities at Walter Reed Hospital as ‘incredible’ and ‘amazing’, and the drugs he took as ‘miraculous’. An example of this, complete with typographical boosters such as capital letters and the liberal use of exclamation points, can be seen in Figure 5.

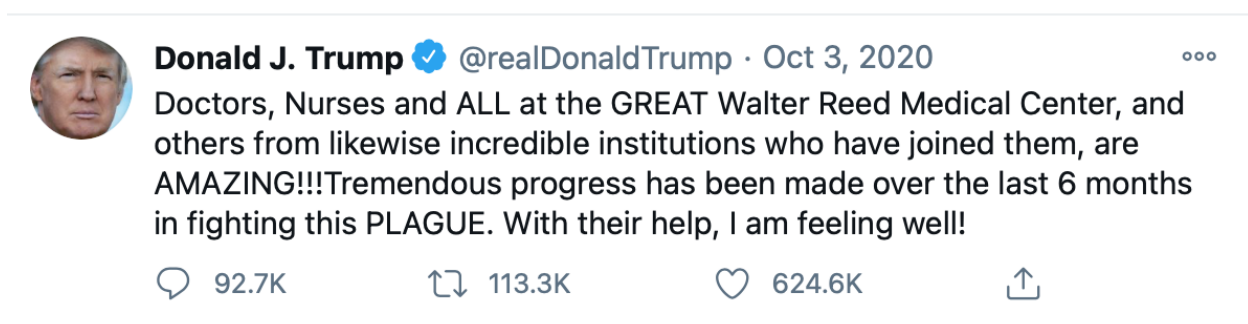


Figure 5: October 3 Tweet from Trump

Moreover, whereas Johnson’s narrative was characterised by relative reticence, Trump’s was characterised by conspicuous *exposure*. This included not just discursive exposure (exemplified by the 193 tweets he sent during the 5 days he was in hospital), but also *physical* exposure, symbolised most potently by his public removal of his mask on his return to the White House. Unlike Johnson, who continued his self-quarantine for 15 days after his release from hospital, Trump took every opportunity to expose himself to others. While he was in hospital, he invited

staffers and photographers into his hospital room, and he ordered the Secret Service to drive him past supporters outside. Just three days after his return, he held a rally on the White House Lawn, and two days later he was back on the campaign trail, even promising (threatening) to attend the October 15 presidential debate, despite concerns about his continued infectiousness.

For Trump, exposing himself to others, both discursively and bodily, has long been his signature way of performing masculinity, a kind of rhetorical ‘manspreading’ (Kiesling, 2018). But this penchant for self-exposure took on particular significance during the coronavirus pandemic, during which he endeavoured to contrast himself with the ‘feminine’ Biden, whom he accused of ‘hiding in his basement’ (DT/Int/9-10b, DT/Rally/12-10. DT/Rally/21-10). Exposure was for Trump was a ‘double-barrelled’ way of indexing masculinity, first by displaying ‘strength’ through risk-taking, and second by exercising his power over others by forcing them to take risks along with him. At his first rally outside of the White House after his return from hospital he bragged:

I feel so powerful. I will walk into that audience. I’ll walk in there, I’ll kiss everyone in that audience. I’ll kiss the guys and the beautiful women, and everybody. I’ll just give you a big, fat kiss. (DT/Rally/10-10)

Such rhetoric highlights an important aspect Trump’s stance that was often ignored or misunderstood by his outraged and incredulous critics, the way he used it to establish an *affective* relationship with his supporters, making them feel that, by putting them at risk, he was actually empowering them. Responses from the audiences at his rallies, for instance, demonstrate how infectious Trump’s displays of invincibility could be:

Trump: I took something called Regeneron. The following morning, I felt so good. I felt like Superman. I wanted to get back. I didn't want to cancel anything.

Crowd: Super Trump. Super Trump. Super Trump. Super Trump. Super Trump. Super Trump.

Trump: Now we didn't want to be cancelling. We didn't want to be cancelling a lot of things, right? Like Biden. I mean, I don't know what the hell's wrong with him. He never goes anywhere. (DT/Rally/25-10)

It is in scenes like this where Kiesling's (2018) focus on the relationship between stance and affect seems particularly relevant. The important thing about performances of masculinity, he argues, is the feedback loop they create in which men desire the sense of ease and power they perform and in turn create the same desire in other men (see also Wetherell, 2012). In this way, hegemonic masculinity becomes, in a sense, contagious. A similar dynamic can be seen in Trump's performance of 'swagger', in this case with serious implications for health behaviour. It is likely that many of the (mostly) men who mimicked Trump's high-risk behaviour during the pandemic did so not because they really believed the pandemic to be a hoax or they thought public health measures like mask-wearing seriously impinged on their 'personal freedom', but because by adopting the masculine swagger of their leader, they could generate the same feelings of power and invincibility in themselves.

Conclusion

In this paper I have analysed the way Boris Johnson and Donald Trump constructed narratives of their experiences of contracting COVID-19, paying particular attention to how they deployed these narratives as performances of masculinity designed to depict themselves as ‘strong leaders’ and to detract attention from discussions of their reckless personal behaviour leading up to their infections and the failures of their governments to formulate coherent plans to control the pandemic.

Although the ‘lessons’ that the two leaders ostensibly took from their illnesses were very different, Johnson using his experience to urge the British public to take the disease more seriously, and Trump using his to urge the American people to take it less seriously -- not to let it ‘dominate’ their lives—the subtext of both of their narratives was essentially the same: that ‘defeating’ the virus was a matter of ‘strength’, ‘courage’, and technological innovation (in the form of ‘miracle drugs’) rather than of sensible public health measures or evidence-based government policies. Central to the masculinist discourse of both leaders was the invocation of nationalistic exceptionalism: ‘British’ bravery and perseverance and ‘American’ strength and entrepreneurial spirit, and even though both leaders praised institutions such as the NHS, in Johnson’s case, and, in the case of Trump, the Walter Reed Army Medical Center, their focus was almost always on the actions of exceptional individuals.

There are a range of ways such masculinist framings of disease can negatively impact public health, the penchant for Trump supporters to imitate the President’s risk-taking behaviour being only one. A focus on the role of ‘strength’ and ‘courage’ – whether on the part of patients or medical workers – in ‘fighting’ the disease not only implies that those who do not survive lack

fortitude, but also ignores the importance of adequately supporting the institutions where these ‘strong’ and ‘courageous’ individuals work with adequate funding. Finally, such performances of masculinity by leaders experiencing health crises have serious implications for governance, making it more difficult for them to relinquish their power at times of incapacitation.

This paper has demonstrated the potential for combining insights from applied linguistics and sociolinguistics in understanding illness narratives as performances of social identity, and more specifically, has highlighted the importance for those interested in illness narratives to attend the narrative performances of illness by public figures as along with the narratives of ‘ordinary’ people. What is missing from this analysis and should be taken up in future research is a fuller account of how the emergence, development and sedimentation of these public stories played out as they were taken up and reworked by politicians, journalists, and networked audiences on social media, and the ways different ‘publics’ performed alignment or dis-alignment to the stances and affect projected by these leaders.

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