The role of power-addiction and maladaptive denial in the US federal COVID-19 response

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Abstract
Purpose – Given the substantial resources of the United States, the failure of the American federal response to coronavirus disease 2019 (COVID-19) has been both tragic and avoidable. The authors frame this response as an artifact of power-addiction among administration officials and examine the US federal response to the COVID-19 pandemic through the lens of maladaptive denial by government officials, including President Trump.
Design/methodology/approach – The authors use qualitative research methods for this study by analyzing key events, public statements by administration officials from multiple credible media reports and US federal government websites. The authors analyzed these data using Weidner and Purohit’s (2009) model describing maladaptive denial in organizations and power-addiction among leaders.
Findings – The authors’ analysis identifies maladaptive denial – and the concomitant power-addiction – as significantly contributing to the Trump administration’s failed response to COVID-19. Maladaptive denial and power-addiction characterized Trump as a candidate and for the three years of his presidency preceding the COVID-19 crisis. Whatever normative “guardrails” or checks and balances existed in the American system to restrict the administration’s behavior before the crisis were ill-equipped to significantly prevent or alter the failed federal response to the pandemic.
Originality/value – The article applies the model of maladaptive denial in organizations (Weidner and Purohit, 2009) to the public sector, and explores the lengths to which power-addicted leaders and regimes can violate the public’s trust in institutions in a crisis, even in the US, a liberal democracy characterized by freedom of political expression. While organizations and change initiatives may fail for a variety of reasons, this case revealed the extent to which maladaptive denial can permeate a government – or any organization – and its response to a crisis.
Keywords Leadership, Public health, American COVID-19 response, Crisis response failure, Maladaptive denial and power addiction, Organizational defenses
Paper type Viewpoint

Given the substantial resources of the United States, the failure of the American federal response to coronavirus disease 2019 (COVID-19) has been both tragic and avoidable. In this paper, we argue that this failure is rooted in President Trump’s addiction to power which has also governed the behavior of several senior administration officials. Addiction is accompanied and fueled by denial (Kearney, 1996), specifically maladaptive denial (Weidner and Purohit, 2009), which in turn defends the underlying power-addiction with an array of protective mechanisms. Public leaders who are power-addicted have a corrosive effect on agencies and governments, impairing routine functioning and preventing effective response to crises (Kets de Vries, 2001, 2004).

This paper is organized as follows: first, we summarize the American federal government’s preparedness for infectious disease crises prior to the onset of the COVID-19 pandemic. We then provide a general timeline of the COVID-19 pandemic, focusing on
developments in the US and comparing the other countries’ successful initial national responses to that of the United States. Next, building on previous work by Weidner and Purohit (2009) used to analyze corporate executive behavior, we present a framework for maladaptive denial that is applicable to both public and private sector organizations. We then use that framework to interrogate indicators of maladaptive denial by President Trump and senior administration officials. The paper concludes with a discussion of implications for research and practice.

The US federal response to COVID-19

US health crisis response capabilities

The United States has tremendous resources with which to respond to an epidemic or pandemic. Following the Reagan/Bush administration’s failure to assess and rapidly respond to the HIV/AIDS crisis in the 1980s (Chang, 2018; see Fayyad, 2019), successive American administrations incorporated the lessons learned and developed a robust health crisis response infrastructure (Fauci and Folkers, 2012) for domestic deployment as well as providing critical expertise and resources to other countries in need.

Recent US administrations appear to have dealt with highly communicable diseases more effectively. In 2003, President George W. Bush created the President’s Emergency Plan for AIDS Relief, which provided over $80bn for HIV/AIDS prevention and research and is credited with saving millions of lives (Donnelly, 2012). The same year, President Bush responded quickly to severe acute respiratory syndrome (SARS) by ordering involuntarily quarantine of potentially exposed individuals (Fauci, 2017); only eight cases of SARS occurred in the United States. President Barack Obama’s administration successfully addressed successive outbreaks. In 2009–2010, H1N1 swine flu was declared an emergency six weeks before it was declared a pandemic, and fewer than 13,000 Americans died (see Fineberg, 2014). Ebola caused over 11,000 deaths in West Africa in 2014–2016, while the US experienced only 11 cases with no fatalities among the cases contracted in the US (see Firger, 2014). The National Security Council (NSC) Directorate for Global Health Security and Biodefense was established in 2014 during the Obama administration after the global Ebola crisis (Cameron, 2020, para. 1).

Before COVID-19: Lowering the guard. In May 2018 the Trump administration disbanded the NSC Directorate for Global Health Security and Biodefense (Sun, 2018) “at a time when many experts say the country [was] already underprepared for the increasing risks of a pandemic or bioterrorism attack” (para. 2). According to Beth Cameron (2020), vice president for global biological policy at the Nuclear Threat Initiative and the former leader of the Directorate, “The job of a White House pandemics office would have been to get ahead: to accelerate the response, empower experts, anticipate failures, and act quickly and transparently to solve problems” (para. 4).

Disputing the claim that the pandemic response efforts were eliminated, Tim Morrison (2020), the Trump administration’s former NSC senior director for counterproliferation and biodefense, has contended that “. . . [T]he bloat that occurred under the previous administration clearly needed a correction” (para. 5). The remedy was a “reorganization that critics have misconstrued or intentionally misrepresented” (para. 6). Cameron, however, is unequivocal: “[I]t is clear that eliminating the office has contributed to the federal government’s sluggish domestic response. What’s especially concerning about the absence of this office today is that it was originally set up because a previous epidemic made the need for it quite clear” (para. 5).

COVID-19: crisis, response and impacts

The Trump administration’s response to the COVID-19 pandemic has been widely, roundly and rightfully criticized by both domestic and global stakeholders. By any objective measure, the US federal response to COVID-19 has fallen woefully short of both public expectations and the advice of public health experts. Successive surges of the virus have resulted in an
avoidable and significant loss of life. In this section, we provide a general timeline of the pandemic crisis, the US federal response and the impacts on the country.


Bremmer (2020) summarized a comparative analysis in June 2020 of national governments’ responses to COVID-19, identifying the countries that had been most effective in terms of healthcare response, political response and financial policy response (Argentina, Australia, Canada, Germany, Greece, Iceland, New Zealand, Singapore, South Korea, Taiwan and the United Arab Emirates). Common elements of those countries’ successes included:

1. Taking the threat seriously from the virus’s initial emergence, following the advice of communicable disease experts and quickly mounting a well-resourced public health response that was communicated clearly and credibly to the populace;
2. Keeping partisan politics separate from the pandemic response and
3. Providing generous financial relief to prevent major economic disruption (up to 20% of GDP).

Effective public health responses by these countries entailed thorough travel/entry restrictions, enforcement of quarantine upon entry, abundant testing and rapid contact tracing. These steps were accompanied by adequate ICU capacity and supplies of personal protective equipment, ventilators and other medical equipment. Government officials in each of the above countries coordinated their responses and resources between national, regional and local levels of government – an effort especially important in larger countries. Countries that framed the pandemic as a national threat rather than a political issue experienced greater national solidarity, which contributed to making rapid financial commitments substantial enough to mitigate economic hardships caused by restrictions on normal consumer and business activity. Citizens largely complied with lockdowns intended to reduce spread of the virus and the attendant strain on ICU capacity and front-line healthcare providers (For a summary of lessons learned from South Korea’s response, see You, 2020; Jamieson, 2020, provides a summary of lessons from New Zealand’s response).

After the initial spikes of COVID-19 cases in China and Italy, the United States quickly became the worldwide epicenter for the virus, surpassing both countries with over 83,000 cases by 26 March, and over 210,000 cases by 1 April (Johns Hopkins University, 2020). The US federal response differed in almost every dimension from the steps taken in the countries listed above:

1. **Taking the threat seriously.** In January–early February 2020 the Trump administration dismissed the virus, comparing it to the flu (Dilanian et al., 2020; Watson, 2020). The administration subsequently claimed that the government had a plan for COVID-19, the virus was under control and the risk to Americans remained very low (Dilanian et al., 2020; Watson, 2020).

2. **Thorough travel/entry restrictions and quarantine enforcement.** A “travel ban” implemented for travelers from China was porous and did not restrict the virus from reaching the US from other countries (Dilanian et al., 2020).
Following the advice of public health experts. Public health officials were marginalized in White House Coronavirus Task Force discussions or were publicly undermined by federal officials, including President Trump (Dilanian et al., 2020; see also Hauck et al., 2020; see also Watson, 2020; see also White House Press Brief, as cited by United States Department of Defense, 2020).

Testing and contact tracing. Insufficient testing capacity was often too slow and beset with “persistent problems” (Cathey, 2020) that prevented useful results. The CDC developed initially useless tests instead of using formulas for available and effective tests elsewhere (e.g. Germany) (Leonhardt, 2020b). The virus spread to the point where contact tracing in some areas became difficult or impossible (Layne, 2020).

Adequate capacity and supplies. The pandemic illuminated taut supply chains of needed equipment and the inadequacy of the Strategic National Stockpile. A shortage of personal protective equipment (PPE) resulted in single-use surgical masks being reused by front-line hospital staff members and first responders (Centers for Disease Control and Prevention, 2020a). President Trump invoked, but did not fully employ, the Defense Production Act to compel companies to manufacture PPE, ventilators or tests (Kanno-Youngs and Swanson, 2020), prolonging existing delays.

Coordinating national, state and local efforts. The Trump administration told state governors they were on their own to procure ventilators, which initially resulted in higher prices as states bid against each other for the scarce equipment (Sherman, 2020a). In response to the lack of federal coordination, states worked with both neighboring and distant states to share ventilators and share other critical supplies as the virus emerged in new locations and waned in others (KOMO News Staff, 2020).

Avoiding politicizing of the pandemic. The public health response – notably, mask wearing to protect others from risk of transmission – has been politicized (Hauck et al., 2020; Leonhardt, 2020b; Taylor, 2020). Trump has blamed Democrats and criticized political opponents, accusing them and the media of undermining his efforts.

Providing financial relief. In part due to the politicization of the pandemic, temporary economic relief approved by Congress and the President in the spring (Dilanian et al., 2020; see also White House Press release, as cited by United States Department of Defense, 2020) was not followed by longer term and more substantial relief.

Impacts. According to the CDC (2020b) and Johns Hopkins University (2020), the US leads the world in lives lost to COVID-19 through August 2020 (over 180,000, a rate of over 550 deaths per million). By contrast, Johns Hopkins reported that the death rate in Canada (247 deaths per million) is less than half that of the US, and the death rate of Japan (10 deaths per million) is less than 2% of morbidity in the US.

The economic damage to the American economy was immediate. “In just a few weeks, the pandemic put nearly 10 million Americans out of work, including a staggering 6.6 million people who applied for unemployment benefits in the last week of March. The speed and scale of the job losses was without precedent: Until March, the worst week for unemployment filings was 695,000 in 1982” (Taylor, 2020; see also United States Department of Defense, 2020).

After eight months, American public confidence in the federal response was relatively low, even within Trump’s own party. Approximately half (52%) of Americans surveyed by the American Trends Panel (Pew Research Center, 2020) “say that the US has done only a fair or poor job in dealing with the coronavirus outbreak” (p. 11), with South Korea and Germany identified as exemplar nations. Political divides among Americans were evident in opinions
regarding COVID-19 crisis response; “47% of adults say the United States has done a good or
excellent job of handling the outbreak, but just 27% of Democrats and Democratic-leaning
independents hold that view, compared with 71% of Republicans and Republican-leaning
independents” (p. 4).

Outside the US, the ineffectiveness of the American COVID-19 response has compelled
other countries to protect their own citizens by banning travelers from the US. By the end of
July 2020, at least 33 nations had banned entry to travelers from the US (Sternlicht, 2020).
Since August 2020, some countries have periodically reviewed restrictions to US travelers,
incrementally lifting bans but imposing strict conditions and protocols for approved entry
(e.g. a negative PCR – polymerase chain reaction – test, in-country 14-day quarantine, medical
clearance, medical travel insurance, approved health visas) (United States Department of
State, 2020a). As of the end of October 2020, only nine nations had permitted unrestricted
entry from US travelers (CNN, 2020). Countries sharing borders with the US have enacted
vastly different policies; Mexico is unrestricted to US travelers, while Canada’s ban on
nonessential travel from the US was extended through November 21, 2020 (United States
Department of State, 2020b).

The US federal response has been criticized by health experts both within the US and
abroad. Peter J. Hotez, a global health expert and Dean of Baylor College of Medicine, stated
“The Trump administration is responsible for the single worst public health failure in the past
100 years” According to Devi Sridhar, a professor of global public health at the University of
Edinburgh, “The biggest obstacle to an effective COVID-19 response is President Donald
Trump” (Kristof, 2020, p. A26). These failings are evidenced by lives lost, economic hardship,
loss of public confidence and steps taken by other countries to protect their own citizens
against visitors from the US.

Behind the failed response: power, addiction and denial
The failed US federal response was not an isolated event or a series of cascading disaster of
tightly-coupled systems (see Perrow, 2008, 2011) but a thorough failure, collectively
attributable to President Trump’s leadership and the culture (see Schein, 1990) among senior
administration officials. We posit that the initial federal response is an artifact of President
Trump’s addiction to power and the effects of that power-addiction on Trump and senior
Trump administration officials. Trump’s conduct in office and, specifically with regard to
COVID-19, all too closely resemble Kets de Vries’ (1991) discussion of the potential addictive
effects of power on leaders:

[Power shows remarkable similarities in the course taken by those who are addicted... Some] power-holders show a radical change in functioning after attaining a position of leadership. Displays of erratic and impulsive behavior, suspiciousness, and inappropriate expression of aggressive feelings can regularly be observed. What is most noticeable is the extreme dependency of leaders on power. Their desperation in hanging on to power, often against all odds, may be symptomatic of their realization – conscious or unconscious – that with its loss painful withdrawal symptoms may follow. (p. 341)

The effects of power-addiction do not end with the leader but have organizational
consequences. Kets de Vries (1991) continues:

Unfortunately, not all leaders possess a sufficient degree of self-criticism and distance from
themselves to realize that they are in reality not as wonderful as others think they are. Some may
eventually start to imagine that these reactions are their due and that they really deserve this kind of
attention. Consequently, they may get stuck in a vicious circle of self-delusions about their own
importance and capabilities... The craving for applause becomes an addiction. If that is the case,
continuous confirmation is needed to “nourish” such leaders’ vulnerable grandiose self. Hence
sycophantic behavior on the part of followers is encouraged. Those who don’t oblige will be removed.
The leader will overestimate his or her capabilities, living in a hall of mirrors and doing anything to maintain the illusion. Letting go of power and thereby losing this “fix” becomes a very unattractive proposition. (p. 343, and pp. 343–344, respectively).

The actions and statements of President Trump and senior administration officials throughout the initial pandemic response frequently exhibited the behaviors described by Kets de Vries. The addiction literature suggests that addiction is accompanied by denial, which protects the individual and defends the addiction (Kearney, 1996). Denial is conceptually consistent with organizational defenses that prevent organizational learning (Argyris, 1990), and Finkelstein’s (2003) observations about how and why executives fail through avoidance of reality.

A framework for maladaptive denial and power-addiction
In this section, we explain the framework of maladaptive denial and power-addiction in organizational settings used in this paper. First, we establish boundaries for a framework of denial in organizational settings (Bacharach, 1989) by distinguishing between normal, or adaptive, denial and maladaptive denial. Kearney (1996) describes how denial interferes with addiction recovery through an array of enduring and shifting defenses. Weidner and Purohit (2009) adapted Kearney’s model to leaders and organizations, exploring how maladaptive denial reflected power-addiction and undermined organizational and executive effectiveness. This framework of maladaptive denial is then used in the analysis that follows.

Denial
Adaptive denial. Adaptive denial is a normal psychological response that people use to cope with overwhelming psychological threat (Freud, 1992; Kearney, 1996). Kearney (1996) observed that denial is “as normal as flinching” (p. 2). Normally functioning, adaptive denial allows individuals to compartmentalize potential threats, and block out everyday risks.

Denial is also a normal stage in the grieving process as part of a person’s recovery process following a significant psychological loss (Kübler-Ross and Kessler, 2014). Adaptive denial is relatively transitory; when an individual has difficulty accepting a loss (of a loved one, or one’s livelihood), denial allows individuals to delay facing that loss until they are better prepared to do so (see Dzhurova, 2020, for an application of Kübler-Ross’s, 1969 model of grieving to describe the US COVID-19 response).

Addiction and maladaptive denial. While adaptive denial helps one temporarily cope with overwhelming psychological stress, we characterize more rigid and chronic denial as maladaptive denial because instead of being a temporary coping mechanism, it operates as a defensive mechanism of relative permanence, especially in cases of addiction. Maladaptive denial is prominent in the literature on clinical psychology and other forms of treatment and therapy and is particularly central to the literature on – and our understanding of – treatment of individuals suffering from addiction (see Kearney, 1996). The distinction we are drawing between adaptive denial and maladaptive denial is not unlike the distinction between eustress, the “good stress” that fosters challenge and motivation and distress, and stress that causes anxiety and impedes functioning (Selye, 1975).

Addiction arises from dependence that has power over the individual, resulting in the loss of an individual’s autonomy or free will to the object of addiction. Addiction is powerful and changes the actions and motivations of the individual in its grip. Across the addiction recovery literature, recognition of this powerlessness is identified as one of the first steps to recovery (see Kurtz, 1979), and overcoming denial in order to make recovery possible. Kearney (1996) observed that denial and addiction are mutually enabling, reinforcing processes: addiction fuels denial, and denial defends the addiction.
Maladaptive denial takes a variety of forms, all in service of the same aim: to deflect responsibility from the individual and “protect” the individual from threats. Kearney (1996) explains that someone suffering from addictions uses four concentric layers or “walls” of denial that protect the individual from accepting the existence of their addiction and accompanying powerlessness. From the outside working inward, these layers of defense are denial of **facts**, denial of **implications**, denial of **change** and denial of **feelings** about themselves and/or their effect on others (see Figure 1). Although we discuss the layers of denial in a linear manner, note that individuals in denial move between layers, sometimes fluidly and at other times erratically.

**Layers of denial.** Denial of **facts** involves rejecting objective evidence of an individual’s addiction or addictive behavior (“I was not drinking last night”). Denial of facts can also include the creation of favorable evidence (“I wasn’t at a bar; I was working late at the office”). Denial of **implications** occurs when evidence of behavior is unassailable, but the individual disputes the conclusion drawn from that evidence (“I was drinking last night, but that doesn’t mean I was drunk” or “Yes, I was drunk last night, but that doesn’t mean I have a problem.”). Denial of **change** can be evidenced in several ways, either by minimizing the need for change (“I did wreck the car after drinking, but it that will not happen again so I don’t need to get treatment”), or dismissal by comparison (“I may have a problem with alcohol, but [another person] has a problem with alcohol and is doing drugs; that’s who really needs to change”).

Denial of **feelings** is the innermost line of defense for an individual suffering from addiction. As Kearney (1996) observed, “Getting sober requires confronting one’s own self-image. Staying sober means saying good-bye to some of the oldest and most deeply held beliefs about self and others” (p. 26). Thus, the feelings being denied are not just those of

![Layers of maladaptive denial in defense of power-addiction](image)

*Source(s):* Weidner and Purohit (2009) and Kearney (1996, p. 13)
others who have been hurt but also of the addicted individual protecting themselves from uncovering and exposing those feelings about themselves. Taken together, the layers denial are a collection of defenses that are used to resist a demand to change or to confront a truth that displaces – often painfully – the previous self-image.

**Power-addiction and maladaptive denial among leaders.** Although power can be addictive, not all leaders become power-addicted. Many public leaders wear power unassumingly and wield it carefully, and following their public service, easily relinquish the power vested in their former position. For some leaders, however, power-addiction can fuel a relentless pursuit and desire for more power. Power becomes both a means and an end. Research by Weidner and Purohit (2009) illustrates that for corporate leaders such pursuit can lead to monopolistic practices or even criminality.

**Power-addiction and maladaptive denial in organizations.** Power is the currency of leadership. In the management literature, effective management of power differentials between levels of an organization has been recognized as essential to organizational communication, interpersonal relations at work, effectiveness and innovation (Diamond, 1993). Understanding the defenses that prevent effective functioning can also be used to diagnose organizational failures (Finkelstein, 2003; Weidner and Purohit, 2009). As with individual addictions outside the workplace, leaders’ addiction to power and its attendant maladaptive denial works both consciously and subconsciously to reject acceptance of an unwelcome reality (as depicted in Figure 1 above).

Weidner and Purohit (2009) argue that maladaptive denial in organizations often reveals an addiction to power, either by an individual, a group or an entire organization. Various public leaders can and have used or coopted the state’s power as their own, resulting in authoritarianism, theocracy or other single-party nation states.

Maladaptive denial (and power-addiction) can be quite forceful. Power-addicted leaders not only cling to their position’s legitimate power, they refuse to acknowledge that the grip power has on them is perhaps stronger than the grip on power they are trying to maintain. Any threat is challenged, and power-addicted public leaders have at their disposal the levers of state authority to perpetuate their own tenure and degrade the capabilities of challengers to usurp them. If a leader is power-addicted, then denial is essential to survival.

**Power-addiction and maladaptive denial of facts**
The outermost layer of denial – the denial of facts – is the most common. Denial of facts can involve selective perception and the blocking of legitimate and credible information. Tactics can include fabricating favorable data or ignoring or discounting contradictory or critical data. This layer of denial is often the first response to confrontation, with the intent – often a matter of instinct – of disavowal or refusal to face any facts. The power-addicted leader may be confronting criticism or acting to protecting their statement or perspective as the one “right way.” Individuals in this layer of denial can be vigorously confrontational, bullying, as well as charming or charismatic as they tighten their grip on their own point of view and their own “facts.”

**Power-addiction and maladaptive denial of implications**
When denial of facts is no longer feasible, either because unfavorable facts are well-established or irrefutable, a power-addicted leader moves to minimize the implications of their behaviors. That minimization may concern the type, amount, frequency or seriousness of the facts previously challenged, essentially accepting the negative “facts” but disagreeing that those facts suggest or imply that the leader has made a mistake. One aim is to mischaracterize cause and effect and may include taking credit for imagined or preferred success(es). While the power-addicted leader is concerned about losing their grip on power, the piercing of the leader’s veil of misleading or nonexistent facts exposes the leader to greater culpability.
Power-addiction and maladaptive denial of change
Power-addicted leaders cannot refute facts or implications once objective evidence establishes the leader’s responsibility (e.g. President Nixon’s Oval Office tapes). In the third layer of defense, denial of change, the power-addicted leader’s aim is to dismiss the need to change their approach or actions and to strive to avoid any responsibility for making those changes. The consequences of doing something and doing nothing are distorted in the denial of change. If the consequences cannot be avoided, then the situation “is not my fault,” and the leader tries to make others responsible for their behavior and its consequences. Such leaders claim imaginary success, have excuses for everything and none of the excuses implicate the leaders themselves.

Power-addiction and maladaptive denial of feelings
The innermost wall of self-protection is the denial of feelings and the exclusion of feelings from awareness. Denial of feelings differs from the other three layers; while denial of change shuts off ideas, memories or even consciousness, denial of feelings protects years of self-doubts, insecurity, shame and the secrets of the soul (Barfield, 1979; Kearney, 1996). Power-addicted leaders protect themselves from feelings that are too strong. To undermine a narrative of failure, a power-addicted leader may claim “victory” or “mission accomplished.”

Methods
Having earlier summarized the US federal response to the COVID-19 pandemic in terms of events, actions and outcomes, we now turn to examine government websites and credible media reports of statements made from January through August 2020 in a variety of forums (e.g. media interviews and press briefings) by President Trump and administration officials with regard to the pandemic, the federal response and the effectiveness of that response.

A general COVID-19 crisis events timeline would begin in mid-November 2019 (emergence of potential “patient zero” in Wuhan, China; see United States Department of Defense, 2020). Using a variety of media sources (e.g. major American and international news networks, the New York Times, the Washington Post and USA Today) as well as government agency sources (United States Department of Defense, 2020), we created an aggregate timeline of the first eight months of the crisis (January 1 through August 31, 2020). Combining media and government sources enabled us to glean a rich repository of domestic and international events as well as publicly available evidence of a federal COVID-19 crisis response.

Our evidence comprises a sample of over 200 crisis response “indicators” – false claims, misleading statements, counterproductive actions and detrimental inactions – perpetrated by President Trump and senior federal officials. We view statements and decisions made by Trump and his administration as “performative speech” (see Dzhurova, 2020, p. 6) that not only symbolizes the leadership’s stance on the crisis and attempts to control the crisis narrative but also is intentionally used to manipulate constituents to act in a manner that serves leadership’s denial and power-addiction. The statements were made by President Trump and other top-level officials and covered a wide range of topics related to the pandemic and response, including (but not limited to) illness characteristics, population susceptibility and mortality, extent and duration of public health impact, testing, economic impact, treatments, assigning or deflecting blame, and day-to-day mitigation.

Collectively, the crisis response indicators demonstrate a state of maladaptive denial that permeates the administration’s mindset and, as disclosed in Bob Woodward’s Rage, intentionally frames the COVID-19 crisis response. We coded each indicator in our sample based upon the description of each layer of the maladaptive denial framework introduced earlier. We coded indicators of blocking data, fabricating data or ignoring contradictory facts
as denial of facts. We coded indicators of officials’ rejections of the notion that the administration’s approach was ineffective – expressed in the face of irrefutable, unfavorable facts – as denial of implications. We coded indicators of attempts to absolve the administration of responsibility or blame others as denial of change. Lastly, we coded indicators that failed to recognize the loss of life, prioritized economic activity over illnesses and death, or promoted overly optimistic feelings while the administration was losing the battle with COVID-19 as denial of feelings. A summary of illustrative indicators is available in Table 1.

Results
Maladaptive denial among Trump and administration leaders before COVID-19
It would be an understatement to describe Trump as an unconventional presidential candidate. Before Trump’s election, some observers expected that the presidency would

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<tr>
<th>Layer of denial</th>
<th>President Trump</th>
<th>Response indicators</th>
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<tbody>
<tr>
<td>Denial of facts</td>
<td>COVID-19 is just like the flu</td>
<td>Various: Marginalizing of CDC and experts</td>
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<td>Children are immune</td>
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<td>The United States…</td>
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<td>…has the best testing</td>
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<td>Denial of implications</td>
<td>The United States…</td>
<td>McEnany: “Science should not stand in the way” of school reopenings</td>
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<td>…has a plan for control</td>
<td>Navarro and others: Discrediting Dr. Fauci</td>
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<td></td>
<td>…has very few cases</td>
<td>Various: Withdrawal from WHO</td>
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<td>Insisting virus will disappear</td>
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<td>Focusing on the stock market</td>
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<td>“I take no responsibility at all”</td>
<td>Kushner…</td>
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<td>Politicization of mask wearing</td>
<td>…Response is “a great success story”</td>
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<td>Blaming…</td>
<td>…“How did we test so quickly?”</td>
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<td>…China let it escape; “we shut it down”</td>
<td>…Blaming states for unpreparedness</td>
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<td>…Do-nothing” Democrats</td>
<td>…misrepresenting national stockpile</td>
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<td>…the “fake news” media</td>
<td>Various: Politicization of mask wearing and social distancing</td>
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<td>…the states for unpreparedness</td>
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<td>Denial of feelings</td>
<td>Focusing on ratings</td>
<td>Navarro: Touting hydroxychloroquine</td>
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<td>Predicting US deaths to peak in March</td>
<td>Various: Expressing hope for remdesivir therapy</td>
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<td>Promising vaccine by end of year</td>
<td>Kushner: Country “rocking” in July</td>
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<td>Promoting convalescent plasma therapy</td>
<td>Various: Posing tradeoffs between life vs. economy</td>
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<td>Claiming US is in recovery</td>
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<td></td>
<td>Testing delays: “Nothing you can do.”</td>
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Table 1.

Source(s): All response indicators are cited in the main body of the paper
change him. Trump, by his own admission, said in an August 2020 interview that he has changed little since elected (Baker, 2020). Evidence abounds (see Honl-Stuenkel, 2020) that Trump often views the government in service of Trump rather than his own role as one of service to the entire populace. This co-option of the state included the unprecedented use of the White House lawn to stage a portion of the 2020 Republican National Convention, an action widely assailed as one of several COVID-19 “super-spreader” events hosted by Trump to promote his reelection campaign. The President has regularly encouraged the Department of Justice to go after his “enemies” and release or go easy on his “friends” (see Lynch and Freifeld, 2020).

President Trump opened his reelection campaign five hours after he was inaugurated, earlier than any previous president had begun their reelection campaign (Gold, 2017) in order to receive campaign contributions continuously and also to preempt any potential primary challengers. Part of Trump’s appeal to supporters and his self-image is one of perceived strength, being in control and above all, being infallible (Goldberg, 2019). European leaders have been described as waiting out Trump’s presidency, hoping it will end with one term (Severgnini, 2019). Diplomats of other countries have been keen to play to Trump’s image and his need for ego-gratification, further adding to a narrative that his presidency is more about fealty to him than it is to service to his country. Across the world Trump has fallen out with world leaders, one after another, from Canada to France to Japan to Brazil (Specia, 2019).

**Denial of facts during the COVID-19 response**

**Denial of facts by Trump.** President Trump has consistently conveyed and defended a self-constructed, preferred “reality” about COVID-19 that diverges from irrefutable basic facts regarding the virus itself and the US’s handling of the crisis. A common refrain by Trump has involved the characteristics and contractibility of the disease. Citing anecdotes of milder symptoms in some COVID patients, Trump has contradicted the CDC and other experts by insisting that COVID compares to having the flu (Qiu, 2020) and that children “are almost immune” (Sherman, 2020c, para. 2).

Trump has mischaracterized data related to testing, insisting that the US’s program is the best and the “envy of the world” (Fox News Sunday, 2020, pp. 5–15), with tests that are “all perfect” (Hauck et al., 2020; Taylor, 2020) and readily available (Hauck et al., 2020; Watson, 2020). When confronted with proof that the US has the highest number of COVID-19 cases in the world, Trump explained, “[B]y having more tests, we have more cases” (Vazquez, 2020, para. 3). The US, Trump suggested, would “look better” (para. 8) with less testing; also, “[t]he manuals” say not to test too much (Axios on HBO, 2020, p. 10). Contradicting available statistics to the contrary, Trump claimed that the US has the “number one” low mortality rate (Fox News Sunday, 2020, pp. 2–30).

**Denial of facts by administration officials.** The Trump administration has repeatedly sought to marginalize the role of the CDC and other experts; in one instance, the administration suppressed a 17-page CDC report providing step-by-step guidance regarding reopening the economy (the Associated Press, as cited by Hauck et al., 2020). “The CDC was told that the guidance ‘would never see the light of day’” (Associated Press, as cited by Hauck et al., 2020). Reuters (as cited by Dilanian et al., 2020) reported that the White House deemed all top-level COVID-19 meetings as classified, shutting out critical expert voices without security clearances (Dilanian et al., 2020).

**Denial of implications during the COVID-19 response**

**Denial of implications by Trump.** At the World Economic Forum in Davos, Switzerland in January 2020, Trump assured the assembled global press that the US had a plan in effect. The virus, Trump said, would be “handled very well” (Dilanian et al., 2020). “We have it totally...
under control" (Watson, 2020). Again in March, Trump (2020a) tweeted assurance: “We have a perfectly coordinated and fine tuned plan.”

Despite the rising cases and deaths, Trump has underestimated the severity of both the crisis and the illness itself, opining that the virus would weaken with warmer weather, then “miraculously” disappear (Hauck et al., 2020; Watson, 2020). Trump surmised in late February that the US Case level was “15 people” and “within a couple of days,” would be down to “close to zero” (Watson, 2020). Concerned about the stock market, Trump (as cited by Dilanian et al., 2020) has derided what he calls “fake news” networks “doing everything possible” to make virus “look as bad as possible, including panicking markets.”

Denial of implications by administration officials. White House Press Secretary Kayleigh McEnany staunchly defended and reinforced Trump’s stance that schools must reopen. Not only has she insisted that it is safe to reopen schools, she has asserted that “science should not stand in the way” of reopening (McEnany, 2020; see also Behrmann, 2020). Trade advisor Peter Navarro (as cited in Barr, 2020) in a July submission to USA Today, inflated his own influence regarding crisis management while pillorying national infectious disease expert Dr Anthony Fauci. “Fauci has been wrong about everything I have interacted with him on.” (para. 2). (USA Today later publicly admitted the piece failed to meet its fact-checking standards.)

Denial of change during the COVID-19 response

Denial of change by Trump. Trump has frequently blamed others for the presence of COVID-19 in the US and refused to accept responsibility for any difficulties encountered in managing the crisis, stating, “I do not take responsibility at all” (Trump, 2020b, p. 10). At various times Trump has attacked:

(1) **China.** In a 19 July interview Trump reminded the public, “It came from China. They should’ve never let it escape. They should’ve never let it out” (Fox News Sunday, 2020, pp. 6.07–6.10).

(2) **Democrats.** Democrats, as perceived by Trump, intend to make him look bad. He cited an imagined opposition to his “China ban” (Dilanian et al., 2020) and has described Democrats as un-American, “Do Nothing Democrat comrades” who are “all talk and no action.” Blaming Democrats generally has reinforced political polarization and contributed to the ongoing politicization of mask wearing (Hauck et al., 2020; Leonhardt, 2020b; Taylor, 2020).

(3) **The news media.** Trump has viewed what he calls “fake news” networks as complicit in a perceived effort to disparage him (Dilanian et al., 2020); he nicknamed MSNBC as “MSDNC” (referring to the Democratic National Committee).

(4) **The Obama administration.** The Obama administration left a 69-page pandemic plan (Knight, 2020), but Trump has repeatedly, falsely blamed the previous administration for a lack of preparation (“The cupboard was bare,” Sherman, 2020b) and tests (Dale, 2020), and for “complicat[ing the CDC testing system]” (Dilanian et al., 2020).
Denial of change by administration officials. Jared Kushner, senior advisor to the president, has also blamed states for unpreparedness. He has contested their entitlement to the federal stockpile stating it is “our stockpile” and not for states to use (Gittleson, 2020).

Also, according to Kushner, despite all obstacles (real or imagined) in the administration’s way, the US response to COVID-19 is “a great success story” (Cathey, 2020); when challenged about the lack of testing, the question, Kushner averred, should be, “How did we [test] so quickly?” (Cathey, 2020).

Despite the rising US death toll, Trump and some of his administration’s officials repeatedly set poor examples for the public by flouting health experts’ guidelines on mask wearing and social distancing. At the 26 September White House event announcing the nomination of Judge Amy Coney Barrett to the US Supreme Court, Trump and some officials, including Attorney General William Barr and coronavirus task force member Dr Scott Atlas, eschewed masks and social distancing (Stracqualursi and Bennett, 2020). By late September, American deaths exceeded 200,000.

Denial of feelings during the COVID-19 response

Denial of feelings by Trump. Rather than accept or address any criticism of the initial response, Trump (as cited by Dilanian et al., 2020) tweeted on 5 March that “Gallup just gave us the highest rating ever” for the administration’s handling of the crisis (see also Yen, 2020). He was, however, misrepresenting results from a Gallup public approval poll conducted several weeks earlier, before the US had reported any cases of community transmission.

Trump has consistently expressed unrealistic hope for a vaccine, saying early in March that one would be ready in June or July (Dilanian et al., 2020; see also Perlstein, 2020). In mid-May, Trump announced “Operation Warp Speed,” a program with a goal of producing a vaccine by year-end (Hauck et al., 2020; see also White House Remarks cited by the United States Department of Defense, 2020). Throughout the summer, he expressed the unsupported claims that treatments, a cure or a vaccine would be available before or shortly after the upcoming November election. Promoting imminent success has the potential effect of maintaining voter support.

At the time of Trump’s unsupported claim that Gallup poll results indicated public support for his handling of the pandemic, the coronavirus had taken 21 lives and totaled 500 cases in 30 states (Yen, 2020). American deaths, Trump opined, would peak in March (Hauck et al., 2020). In interviews in July and August, Trump appeared to surrender to the knowledge that Americans were dying, externalizing blame: “it is what it is” (Fox News Sunday, 2020).

Testing delays have rendered many tests useless, though Trump said “there is nothing you can do” (Axios on HBO, 2020, pp. 11–20). The crisis is under control “as much as you can control it” (pp. 7–27), implying that the government response was failing, but he was not responsible for that failure.

Denial of feelings by administration officials. Trade advisor Peter Navarro has touted hydroxychloroquine (Lantry and Crawford, 2020), and the US Food and Drug Administration has issued emergency authorization for using remdesivir in hospitalized patients (Hauck et al., 2020). Neither treatment is supported by evidence (Farley and Kiely, 2020).

In late April, Jared Kushner predicted that the US economy “will be rocking” by July (Cathey, 2020). Despite the human toll of the pandemic, Trump administration officials and Allies have argued that reopening the economy to spur economic recovery is of greater priority. Dan Patrick, the Republican lieutenant governor of Texas, in March and April,
stated, “There are more important things than living” (Leonhardt, 2020b; also see Madani, 2020).

**Conclusion**

This analysis demonstrates the use of denial as a theoretical lens to better understand the extent to which maladaptive denial and power-addiction among officials can inhibit effective response to a public health crisis – a significant violation of public trust. Just as the people around a person in denial struggle to respond to the various forms of resistance they experience, American media and society have struggled to make sense of the Trump administration’s COVID-19 response.

In an election year, President Trump staked his reputation on the economy, largely as measured by the stock market. COVID-19 was largely seen as a threat to the economy – and therefore his reelection and ability to retain the presidency – rather than a threat to public health (Leonhardt, 2020a). This relationship with and dependency upon power have guided the Trump administration’s response to COVID-19 (Woodward, 2020). What should have been a public health response to a pandemic was seen as a political problem that threatened Trump’s overall image of infallibility.

Donald Trump’s relationship with and dependence upon power predates his political candidacy. Once in office, his intolerance for uncomfortable truths was immediately evident, with laughable claims about the size of his inauguration crowd. The volume of misleading statements by Trump and administration officials has spawned an entire network of day-round, fact checkers, including clinical, opinion-free wire services such as the Associated Press and Reuters. Fact checkers have openly described the futility of their work when confronted with a flood of misrepresentations and false claims (Beneveniste, 2020).

**Implications**

*For research.* While Weidner and Purohit (2009) conducted their analysis of denial of two former corporate CEOs with the benefit of hindsight (including the criminal conviction of one of them), we have collected and analyzed data both after failure has been identified and while it is occurring. Future research exploring maladaptive denial and power-addiction in organizations might explore ways to protect and improve public institutions – and, by extension, the public – through robust organizational structures, processes and protocols (see Mitroff, 2004). A plane crash investigation provides a useful analogy. It is insufficient to understand what occurred and why; it is most necessary to understand how to prevent future crashes.

*For practice.* It is troubling to consider the lengths to which power-addicted officials can erode the public’s confidence in previously trusted institutions during a crisis. Such a pursuit of concentrated power in the United States, a liberal democracy characterized by freedom of political expression, is inconsistent with both the US Constitution and well-established norms. There is no guarantee that previous norms will constrain executive behavior. Ideally, “holding powerful leaders accountable will result in less self-serving behavior” (Rus et al., 2012, p. 13), though at present, the checks and balances of the American system appear wanting.

Organizations, including governments, must be equipped and ready to handle “wicked” (Moon, 2020) or “turbulent problems,” which are “characterized by surprising, inconsistent, unpredictable, and uncertain events” (Ansell et al., 2020, p. 1), of which the COVID-19 crisis is one exemplar. According to Ansell et al. (2020), “the COVID-19 crisis is a “game-changer for public administration and leadership, as it reveals the demand for robust governance strategies to deal with turbulent problems and demonstrates the need for public sector transformations to support the robust governance of turbulence” (p. 2).
Transparency by government and public administration officials is critical (see Moon, 2020). An active and free press assists in the effort as an advocate for the public. The inadequacies of US federal COVID-19 response and the concerns of Trump and senior US officials about Trump’s reelection – witness the continual prioritization of economic recovery over public health – have been documented in real time by an active and free press. In societies where such institutions do not exist or are compromised, public leaders may be able to propagandize their continued hold on power. Strong, effective institutions need to take into account the potential for the use and abuse of official government positions for self-dealing political advantage and robust mechanisms preventing such actions are needed to protect both established and emerging democracies. In the absence of rigorous checks and balances, there may be a short line between one-party rule and a one-party state.

At the individual level, selflessness and the ability to engage in critical self-reflection would seem to be antithetical to the robust defenses that comprise denial. Boddy (2016) suggested the use of screening of potential public leaders either in (on the basis of servant leadership) or out (e.g. for psychopathy). However, based on this study, we believe that deeper exploration of potential leaders’ selflessness versus selfishness to be an especially important personality indicator for future public leaders (see Brookes, 2014), whether hired, appointed or elected. Both the value and feasibility of somehow “gatekeeping” leadership positions in general are low (Weidner, 2018), and we do not see such screening as feasible for the United States for either elected officials or political appointees.

As the human cost of COVID-19 in the US continues to climb, scientists around the world are racing to create and test an effective and safe vaccine. It is unknown how and when the pandemic will draw to a close, but COVID-19 is not likely to be the last dangerous virus that future public health officials will confront. Governments of a number of other countries responded to the COVID-19 pandemic in ways that prevented the tragic loss of life seen in the United States. Hopefully lessons will be learned, from abroad as well as from the US, about how best – and how not – to manage public health through a pandemic. Less clear is how the political environment in the US might evolve post-COVID. While reimagining more effective checks and balances of power may seem less urgent than the coronavirus, it remains to be seen whether such measures will be regarded as important.

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