Acculturating again: Taiwanese migrants' enduring COVID-19 coping paradox in the UK

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Abstract

Purpose – The COVID-19 pandemic has caused severe challenges to ethnic minorities in the UK. While the experiences of migrants are both complex and varied depending on individuals' social class, race, cultural proximity to the host country and acculturation levels, more in-depth studies are necessary to fully understand how COVID-19 affects specific migrant groups and their health. Taiwanese migrants were selected because they are an understudied group. Also, there were widespread differences in pandemic management between the UK and Taiwan, making this group an ideal case for understanding how their acculturation journey can be disrupted by a crisis.

Design/methodology/approach – Qualitative data were collected at two different time points, at the start of the UK pandemic (March/April 2020) and six months on (October/November 2020), to explore migrant coping experiences over time. Theoretically, the authors apply acculturation theory through the lens of coping, while discussing health-consumption practices, as empirical evidence.

Findings – Before the outbreak of the pandemic, participants worked hard to achieve high levels of integration in the UK. The pandemic changed this; participants faced unexpected changes in the UK's sociocultural structures. They were forced to exercise the layered and complex "coping with coping" in a hostile host environment that signalled their new marginalised status. They faced impossible choices, from catching a life-threatening disease to being seen as overly cautious. Such experience, over time, challenged their integration to the host country, resulting in a loss of faith in the UK's health system, consequently increasing separation from the host culture and society.

Research limitations/implications – It is important to note that the Taiwanese sample recruited through Facebook community groups is biased and has a high level of homogeneity. These participants were well-integrated, middle-class migrants who were highly educated, relatively resourceful and active on social media. More studies are needed to fully understand the impact on well-being and acculturation of migrants from different cultural, contextual and social backgrounds. This being the case, the authors can speculate that migrants with less resource are likely to have found the pandemic experience even more challenging. More studies are needed to fully understand migrant experience from different backgrounds.

Practical implications – Public health policymakers are advised to dedicate more resources to understand migrants' experiences in the host country. In particular, this paper has shown how separation, especially if embraced temporarily, is not necessarily a negative outcome to be corrected with specific policies. It can be strategically adopted by migrants as a way of defending their health and well-being from an increasingly

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hostile environment. Migrants' home country experience provides vicarious learning opportunities to acquire good practices. Their voices should be encouraged rather than in favour of a surprising orthodox and rather singular approach in the discussion of public health management.

Social implications – The paper has clear public health policy implications. Firstly, public health policymakers are advised to dedicate more resources to understand migrants' experiences in the host country. Acknowledging migrants' voice is a critical first step to contribute to the development of a fair and inclusive society. Secondly, to retain skilful migrants and avoid a future brain-drain, policymakers are advised to advance existing infrastructure to provide more incentives to support and retain migrant talents in the post-pandemic recovery phase.

Originality/value – This paper reveals how a group of previously well-integrated migrants had to exercise "coping with coping" during the COVID crisis. This experience, over time, challenged their integration to the host country, resulting in a loss of faith in the UK's health system, consequently increasing separation from the host culture and society. It contributes to the understanding of acculturation by showing how a such crisis can significantly disrupt migrants' acculturation journey, challenging them to re-acculturate and reconsider their identity stance. It shows how separation was indeed a good option for migrants for protecting their well-being from a newly hostile host environment.

Keywords UK, Taiwan, Migrants, Coping, Acculturation, COVID-19

Paper type Research paper

1. Introduction

The severe challenges that the COVID-19 pandemic has caused to ethnic minority migrants are recognised by policymakers, academics and media (Ullah *et al.*, 2021). The emerging literature highlights how ethnic minority migrants have been affected by preexisting racial inequalities and health disadvantages (Crockett and Grier, 2021), as well as more recent scarcity of health products and services. It shows how the experiences of migrants are both complex and varied depending on individuals' social class, race and cultural proximity to the host country and acculturation levels; hence, there is a need to better understand the experience of different groups of migrants during the pandemic (Hendy *et al.*, 2019; Yen *et al.*, 2021).

Recent literature on migrants' experience of the pandemic has focused mainly on asylum seekers, temporal migrants and non-status migrants, who are not integrated in the host country and have difficulties in accessing health services (Dhungana, 2020; Sengupta and Jha, 2020). Much less is known about the experience of other groups, including those previously considered to be economically stable and culturally well-integrated. To contribute to a more in-depth understanding of how specific groups of migrants experienced the current pandemic and their "real-world acculturation" (Viruell-Fuentes *et al.*, 2012), this paper investigates how a group of integrated middle-class Taiwanese migrants coped during the COVID-19 pandemic in the UK and the implications of their coping experience on their acculturation outcomes and identity, over time.

Qualitative data were collected at two different time points, at the start of the UK pandemic (March/April 2020) and six months on (October/November 2020), to explore migrant coping experiences over time. Theoretically, we apply acculturation theory through the lens of coping (Kuo, 2014; Berry, 2008), while discussing health-consumption practices as empirical evidence. Our findings reveal that this group of previously well-integrated migrants had to exercise "coping with coping" continuously during the COVID-19 crisis. Such experience, over time, challenged their integration to the host country, resulting in a loss of faith in the UK's health system, consequently increasing separation from the host culture and society.

This paper contributes to the understanding of acculturation by showing how a such crisis can significantly disrupt migrants' acculturation journey; challenging them to re-acculturate and reconsider their identity stance, as a result of having to endure the paradoxical "coping with coping" (see Yen *et al.*, 2021) over time. It shows how separating from the host culture – which is viewed in the literature as *problematic,* an acculturation outcome to avoid and correct with *ad hoc* social policies – is a good option for migrants in terms of protecting their well-being from a newly hostile host environment.

2. Literature review

2.1 The acculturation debate

To understand how a group of well-integrated migrants experience the COVID-19 crisis, we adopt the theoretical lens of coping and Berry's theory of acculturation (Berry, 2008; Kuo, 2014). Acculturation refers to a person's cultural adaption to a new cultural environment, during which four different acculturation strategies may be employed: 1. Assimilation (embracing the host culture), 2. Separation (maintaining the home culture), 3. Marginalisation (withdrawing from both cultures) and 4. Integration (incorporating both cultures) (Berry, 2008; Cappellini and Yen, 2013). While recognising the importance of this work, interpretivist studies demonstrated that acculturation outcomes, which are also seen as a proxy of identity projects, are not mutually exclusive, but fluid and context-dependent (Üstüner and Holt's, 2007; Luedicke, 2015). In looking at how migrants consume products, brands and services from the home and host culture, marketing studies have shown how individuals have hybrid, fluid identities, where elements of the host and home culture are combined and exhibited, depending on the situation (Peñaloza, 1994; Oswald, 1999; Cappellini and Yen, 2016).

Peñaloza (1994) showed how Mexican migrants living in the US tend to consume American products in public occasions, but opt for Mexican products inside the home. This has been confirmed by more recent works showing how migrants exhibit a fluid identity where integration with the host culture is performed outside the home, while maintenance to the home culture is perpetuated in the safe-space of the domestic sphere (Cappellini and Yen, 2016). For example, in describing this interchange between the home and host culture, Oswald (1999, p. 315) revealed a process in which migrants operate via "*culture swapping as they go*".

Further studies contribute to the acculturation debate by showing how migrants reshape their identity combining elements of home, host and global consumer culture (e.g. Askegaard *et al.*, 2005; Yen *et al.*, 2018; Yu *et al.*, 2019). As they investigate the pervasive nature of globalisation in consumption choices, these studies reveal how migrants, who are resourceful and capable of extraordinary mobility, oscillate between various cultures, including global consumer culture, to construct and perform a swift transformative identity (Yen *et al.*, 2018). Consuming global brands and services can be seen as a resource for sojourners in countries whose culture is seen as alien and complex (Bardhi *et al.*, 2010; Cappellini and Yen, 2013). This is indeed the case of British sojourners in China, who saw global brands as reassuring options supporting their gradual learning of the host culture. Food, in particular, was seen as one of the most accessible aspects of the new culture; however, they took a separated approach relating to traditional media, especially the consumption of news (Yu *et al.*, 2019). In showing how sojourners adopt different consumption strategies depending on the area of consumption, Yu *et al.* (2019) demonstrate the complexity of mapping specific areas of consumption with acculturation outcomes.

Nevertheless, not all migrants manage to adapt and acculturate to the host environment with identity fluidity. Working with marginalised migrants, Üstüner and Holt (2007) identified another acculturation outcome. They showed, over time, some poor and resourceless migrant women living in a Turkish squatter eventually gave up pursuits of integrating to either the dominant culture through ritualised consumption, or the reconstitution of village culture in the city. This resulted in a "*shattered identity project*", illustrating an uncomfortable "betwixt and between" lived reality (Üstüner and Holt, 2007, p. 53). The confined economic, social and cultural capital placed migrants in a disadvantaged position. Their acculturation journey was shaped by structural inequalities including their low social class, the ideological conflict between village culture and the more hegemonic consumer culture of the host society.

While Üstüner and Holt (2007) highlighted the importance of understanding the effect of sociocultural structures on consumer acculturation, Jafari and Goulding (2008) discussed the "torn self" experienced by young Iranians. They faced paradoxes and dilemmas during their

negotiations of ideological tensions in their sociocultural settings both in Iran and in the UK. Confronted by a complex set of clashes between "*political and institutional dynamics and emancipatory forces of Western consumption*" (Jafari and Goulding, 2008, p. 73), the "*torn self*" results in feeling of confusion, discomfort and lack of belonging, reflecting a contradictory identity in conforming to contrasting ideologies and cultures.

From this overview, it emerges how the extant literature covered two streams of focus. Early works focused on understanding agents that affect individual consumers' acculturation outcomes and consequent identity fluidity (e.g. Oswald, 1999; Askegaard *et al.*, 2005; Cappellini and Yen, 2013). Later studies discussed how sociocultural structures shape the acculturation context, with a particular interest in understanding marginalised consumers' acculturation journey (Üstüner and Holt, 2007; Jafari and Goulding, 2008). While both streams of work provided an in-depth understanding of how a migrant's acculturation journey is influenced by contextual and structural aspects, none of the existing studies have investigated how sudden changes in sociocultural context could disturb a migrant's acculturation journey and, subsequently, their identity.

Existing studies on migrant health highlighted that the better the migrants assimilate to the host culture, the better their health outcomes, for example, showing lower levels of depression, anxiety and obesity (Salant and Lauderdale, 2003; Bhui *et al.*, 2005). Once consumers develop the needed relational competencies to understand health service systems as cultural systems, they can synthesise the cultural market into market knowledge, using such knowledge to better navigate health services (Helkkula *et al.*, 2023). Specifically, a high level of assimilation has been linked to the adoption of healthy behaviours, access to local health services and support and lower levels of stress (Hunt *et al.*, 2004). Migrants with such an integration strategy are typically from upper- or middle-class backgrounds and have the best health outcomes (Salant and Lauderdale, 2003; Bhui *et al.*, 2005). Nevertheless, all the previous empirical evidence were collected at times when sociocultural structures in the host environment remained relatively stable. They were unable to explain how migrants' acculturation and health outcomes might be affected during a crisis, such as the recent pandemic.

2.2 Migrants' coping during COVID-19

Coping is understood as "the constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus and Folkman, 1984, p. 141). Migrants are familiar with coping – their acculturation strategies embody their coping attempts, as they make sense, adapt, interact and manage their relationship with the host environment, as well as the indigenous majority (Kuo, 2014; Luedicke, 2015; Hajro *et al.*, 2019). To "manage" such relationships, migrants engage in various cognitive, emotional and behavioural strategies to master, endure, reduce, harmonise or avoid conflicting environmental and internal demands (Lazarus and Folkman, 1984; Berry, 2006; Dey *et al.*, 2019), through three types of coping strategies: problem-focused, emotion-focused and avoid-focused (Kuo, 2014). All three strategies involve stressful experiences. However, problem-focused and emotion-focused strategies are mostly related to a person's positive adaptation to a stressful situation, although these strategies may sometimes lead to the feeling of depression because of the insoluble nature of the many challenges faced (Cobb *et al.*, 2016). In contrast, avoidant coping may develop as an adaptive response to uncontrollable stress, but in the long term such strategies can become maladaptive and contribute to prolonged stress (Newman *et al.*, 2011).

When COVID-19 brought a sudden and life-threatening disruption to the UK in early 2020, everyone was forced to readapt their relationship with the changing environment. Coping became the primary task for all, with COVID-19-related stressors expanding, over time, beyond fears of infection or life threats, to a variety of context-specific causes, ranging from

economic, experiencing lockdown, grief, protecting the NHS (National Health Insurance System in the UK), experiencing racism, resulting in negative well-being, that is distress and depression (Kirk and Rifkin, 2020; Yen *et al.*, 2021).

Compared with non-migrants, coping with COVID-19 was more complex for migrants (Hu, 2020; Ullah *et al.*, 2021; Crockett and Grier, 2021). With data collected from Chinese, Italian and Iranian migrants in the UK, Yen *et al.* (2021) revealed that when migrants exercised dissimilar health-protection practices acquired from home countries to cope with the life-threatening disease, they were frowned upon, putting them at risk of discrimination. This results in coping with coping – a paradox, where migrants adopt new *ad-hoc*, complex and compromising strategies in response to the hostile reactions that they receive from non-migrants in the UK. As such, coping with coping is nowhere ideal, but a compromising solution that signals migrants' difference as marginalised citizens. The coping with coping paradox was discussed using data collected at the beginning of the COVID-19 pandemic (Spring 2020), with more research needed to investigate how migrants' coping strategies might change over time.

3. The context

Taiwanese participants were selected during the time of data collection for two main reasons. First, they are an understudied group, which have only recently attracted attention due to the growing political tension between China and Taiwan. Studies looking at the specific case of Taiwanese middle-class migrants show how they generally maintain a strong link to their country of origin and ethnic networks (Cappellini and Yen, 2016; Khawaja *et al.*, 2016). Many overseas Taiwanese continue to use the Taiwanese National Health Insurance (NHI) system as an additional healthcare resource, in addition to host-country healthcare (Lee *et al.*, 2018). Taiwanese migrants are active in transnational online networks for accessing information on well-being practices and health-related consumption practices (Cappellini and Yen, 2016). These migrants adopt a balanced health lifestyle, feeling well-supported by both cultures (Lee *et al.*, 2000; Miao and Xiao, 2020). They pick and choose treatments, products and practices from the home and host country and combine the health recommendations and practices of both.

Currently, there are about 11,000 Taiwanese migrants in the UK (OCAC, 2020). Pursuing education and qualification are the initial motives for many Taiwanese migrants (Gov.UK, 2021), whilst job opportunities and lifestyle are the main reasons they chose to stay in the UK, post-study (Mok and Platt, 2020). In the UK, Taiwanese migrants are often homogenised to the group of ethnic Chinese by classification (Su, 2017), although this classification often receives Taiwanese' objections (Cappellini and Yen, 2016). Past migration waves and historical events have a great impact on Taiwanese culture and identity, with ethnonational identity currently a major debate in Taiwan, due to increasing political tensions between Taiwan and China (Lin *et al.*, 2020). Colonised in the past by countries such as the Netherlands, Spain, Japan and China and heavily influenced by the United States post-Second World War (Su, 2017), Taiwan has a fluid and hybridised culture, with Taiwanese people considered highly adaptable to different cultures (Wang, 2009).

The second reason for selecting Taiwanese participants is that differences between the UK and Taiwanese governments in managing the pandemic have been widespread, making this group an ideal case for understanding how their acculturation journey can be disrupted by a crisis. Taiwan and the UK governments adopted very different strategies in response to the pandemic: the first implemented an elimination strategy, while the second took a mitigation strategy. In March 2020, the Taiwanese government took an immediate and extremely cautious and proactive stance to manage the pandemic due to its prior experience with SARS (Wang *et al.*, 2020), while the UK government was criticised for being clumsy and delayed. By the end of 2020, there were 2,496,235 COVID-19 infection cases in the UK, with 73,622 recorded deaths. In comparison, there were 797 cases and 7 deaths recorded in Taiwan

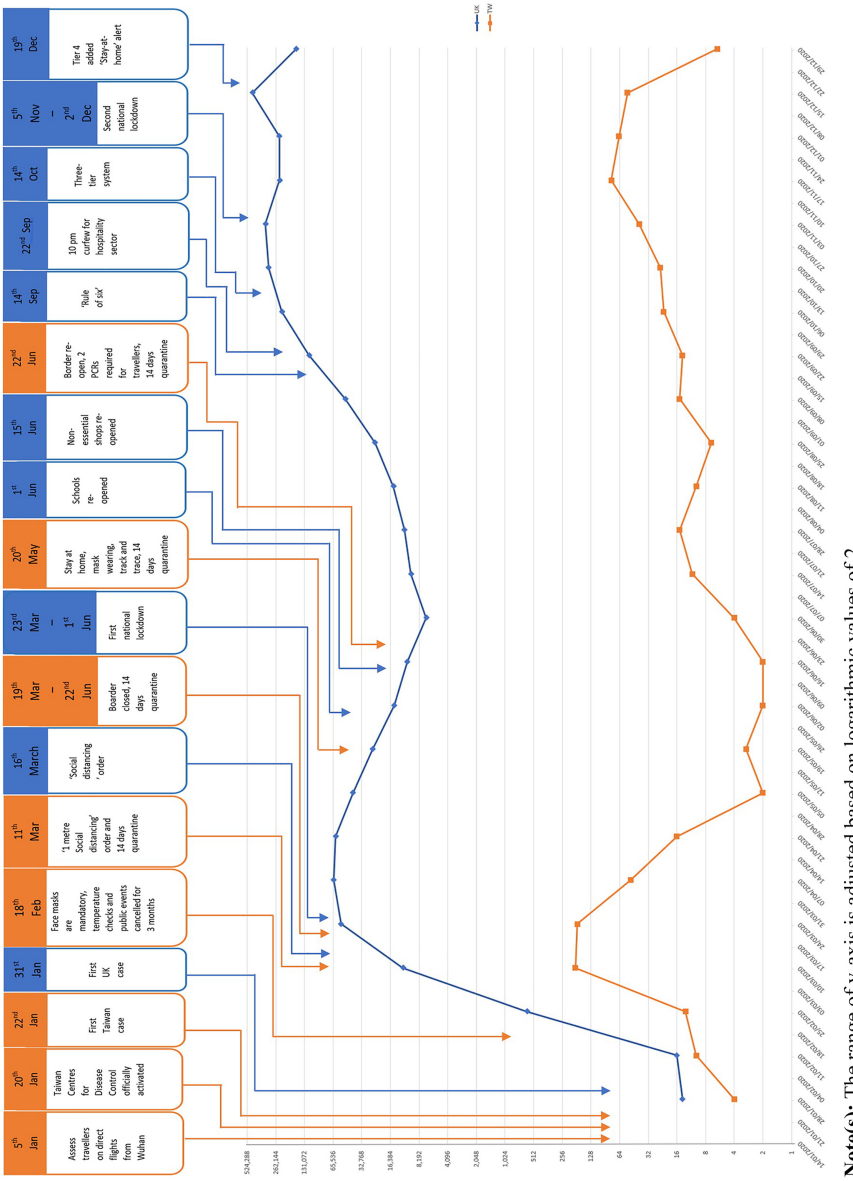

Figure 1.
COVID-19 infection in the UK versus in Taiwan. In order capture the very different characteristics of both countries

Note(s): The range of y-axis is adjusted based on logarithmic values of 2

Source(s): Authors' own creation

(Ritchie *et al.*, 2020). Figure 1 illustrates the number of cases in the UK versus the number of cases in Taiwan during 2020, along with major policy implementations and COVID-19 development milestones.

4. Research methods

4.1 Study design and recruitment

This study employed a qualitative research design, using focus group interviews with 22 Taiwanese migrants in the UK. Data were collected over two different time periods – March/April and October/November 2020 – to capture the development of their experience. Prior to participant recruitment, ethical approval was obtained. Participants were recruited through a recruitment advert posted on several Taiwanese groups on Facebook, including "Taiwanese in the UK" (44K registered users), "Taiwanese mothers in London" (1.6 K registered users) and "Taiwanese professionals in the UK" (474 registered users) in March 2020. Unusual and privileged access was obtained because the first author is a Taiwanese migrant member of these groups, which provides an in-depth and rich understanding that would be difficult to obtain otherwise (Cappellini and Yen, 2016).

Eligibility criteria were being over 18 years of age and a first-generation migrant with a minimum of 5 years residency in the UK. Second-generation migrants were excluded as they have a different acculturation experience (Hu, 2020). A detailed information sheet and a consent form in both Mandarin and English languages were distributed to participants prior to the interview. In total, 22 Taiwanese participants were recruited, including 14 females and 8 males, aged from 28 to 47 (see Table 1).

4.2 Data collection

Online focus group discussions were conducted via either Zoom or Facebook Messenger. This helped mitigate COVID-19 transmission risk and obtain a collective view of how Taiwanese migrants coped with COVID-19, while making sense of the cultural disparities between Taiwan and the UK and the implications of this on their sense of identity and well-being. The interviews were conducted mainly in Mandarin Chinese by two authors, with the occasional references to certain objects in Taiwanese dialect or even in English. Since many of the participants have lived in the UK for a long time, English phrases are often used as part of their sentences, especially when participants could not think of a better way of expressing themselves in Mandarin Chinese. By having the chance to use metaphors and popular cultural phrases in Mandarin, Taiwanese dialect and English, the discussions were lively and friendly. Intimate conversations occurred regularly, and a high level of trust was observed because many of the participants were already connected with each other, or as friends of friends, on Facebook.

Focus group discussions started with general questions about personal background, profession and health practices (before COVID-19). Follow-up questions included participants' understanding of COVID-19, the governmental measures in Taiwan and in the UK, participants' health practices and their acculturation experience. Each focus group interview lasted between 70 and 140 min. In total, five group interviews were arranged in March/April, and then six in October/November 2020. Twenty-two participants took part in both interviews, with an average group size of between four to five participants, with the smallest group of three and the largest of six. Group discussions were video recorded with participants' permission and were transcribed verbatim, before being translated into English by two authors independently to ensure accuracy. In total, the transcription was of 207 pages, with 96,997 words.

The transcriptions were studied by two people within the research team, by manually developing initial notes and an analysis framework in relation to acculturation, coping

Participants	Age	Gender	Occupation	Education level	Years in the UK	Size of household	Spouse nationality
1	43	F	Stay-at-home mother	PhD	18	4	New Zealander
2	42	F	Engineer	Undergraduate	23	3	White English
3	44	F	Architect	Master	8	3	Taiwanese
4	42	F	Academic	PhD	9	4	Taiwanese
5	45	M	Academic	PhD	27	4	Taiwanese
6	47	F	Estate agent	Undergraduate	14	4	Egyptian
7	46	F	Cabin crew	Undergraduate	11	2	White English
8	44	F	Corporate strategist	Master	13	3	Italian
9	38	F	Administrator	Master	5	4	White English
10	39	F	Stay-at-home mother	Master	10	4	Second generation (from Taiwan)
11	37	F	Education agent consultant	Master	9	3	White English
12	32	F	PT waitress and data collection assistant	Diploma	17	3	Second generation (from Vietnam)
13	37	F	Housekeeping	Master	14	4	White English
14	35	F	Stay-at-home mother	Master	13	3	Second generation (from Hong Kong)
15	33	F	Engineer	Master	9	3	Second generation (from Hong Kong)
16	46	M	Finance analyst	Master	14	2	Taiwanese
17	46	M	University tutor	PhD	16	3	Taiwanese
18	44	M	Entrepreneur	Undergraduate	19	3	Taiwanese
19	28	M	Design architect	Undergraduate	15	1	Single
20	39	M	Lecturer	PhD	8	1	Single
21	46	M	Engineer	Master	15	3	Taiwanese
22	44	M	Research engineer	PhD	10	2	Taiwanese

Table 1.
Profile of participants

Source(s): Authors' own creation

strategy and behaviour, following the open coding technique (Gioia *et al.*, 2013). The notes were then exchanged and discussed among the wider research team to reach consensus, resulting in a collective interpretation, where cultural identity, emotions and health practices were selected as predominant themes, taking a grounded theory approach (Gioia *et al.*, 2013). Then the data analysis was conducted with NVivo, where all the transcriptions were systematically coded. Themes and subthemes were structured in charts, including first-order quotes, second-order themes and aggregated dimensions.

5. Results

Findings are presented in three different sections, revealing how participants' identity, coping and health-protection practices change over time and in relation to the evolving pandemic, as people's practices are contextually bonded (Sheth, 2020). In each phase, a data structure chart is provided, illustrating how the first-order quotes, second-order themes and aggregated dimensions were developed (see Figure 2–4).

5.1 Pre-COVID-19 dispositions: successfully coped and well-integrated migrants with mixed home and host health practices

As shown in Table 1, 16 out of 22 participants have been in the UK for more than 10 years; an average of 13.5 years. Many participants have at least one master's degree and work as professionals or have management positions. Some are married to British spouses, and all self-identify as middle-class, living in the Southeast of England. Their acculturation outcomes resonate with integration (Berry, 2008), exhibiting a lifestyle that is a combination of Taiwanese and British cultures and consumption choices, which is reflected in their having hybrid identities. Participant 2's experience epitomises their successful acculturation, feeling welcomed and settled in the UK, having positive relationships with others around them and identifying with both cultures and identities.

> I studied electronic engineering here; when I graduated, my friends have all been British. I have been living here for 23 years. I can say that I am both British and Taiwanese. My experience of living here is all positive, so many supportive British friends . . . I have never experienced racism here. I made effort to understand and embrace the culture . . . Here is like my second home . . . I can say that I am British. Notably, the feeling I have for Britain is as much as I have for Taiwan. (P2-F-42)

Speaking to their hybrid identity, many talked about their broader lifestyle, in which their consumption patterns revealed a combination of Taiwanese culture and so-called Western culture. For example, as an architect working in London, participant 3 described her typical week, where she goes to the pub with colleagues from all over the world to socialise during the week, while staying at home and cooking Taiwanese food for the family during the weekend, as a "*happy balance*" (P3-F-44). Participants' satisfaction with their integrated lifestyle shows contentment with their acculturation, a reward for successful adaptation to the new host country (e.g. Peñaloza, 1994; Cappellini and Yen, 2013; Yu *et al.*, 2019). Feeling part of the host country, some participants actively contribute to local communities and keep informed about

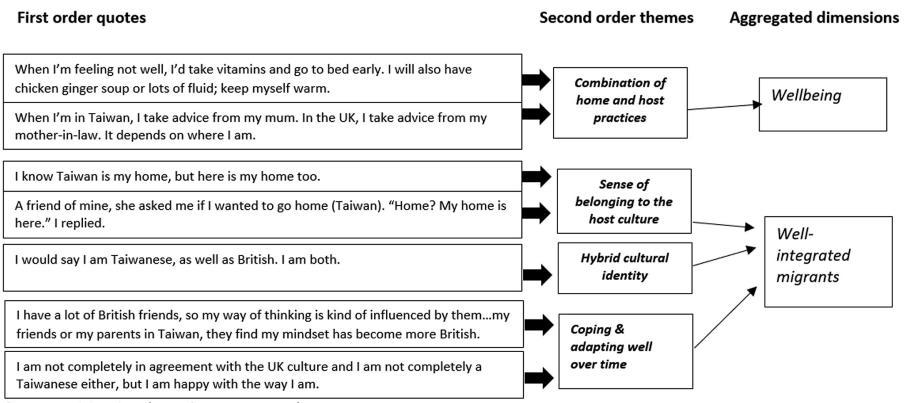

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Figure 2.
Pre-COVID

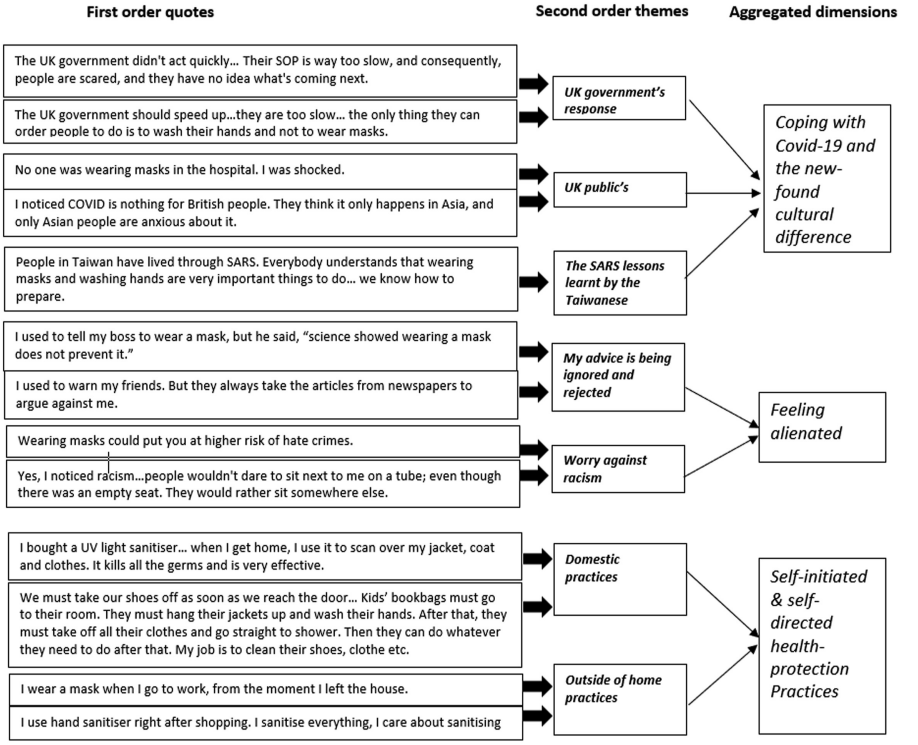

Figure 3.
Crisis coping

Source(s): Authors' own creation

the political and cultural events in local society. Having completed her doctorate from a prestigious university, then living in London for over a decade, participant 1 commented:

> I know Taiwan is my home, but here is my home too. Criticising the UK government or society does not mean you don't have a sense of belonging. It is a type of involvement, like you play a part in society. I care about local politics, join events, community events such as helping each other, and support local activities . . . If you do the calculation, after all, you will see how much of that sense of belonging you achieved in your acculturation. (P1-F-43)

Satisfied with their lifestyles in the UK and feeling part of the society, beyond simple culture swapping but blending both worlds into everyday practices (Oswald, 1999; Cappellini and Yen, 2013), this group of Taiwanese migrants proudly described how they engaged both home and host practices and consumption choices, including healthcare options.

Participants were capable of navigating through the difference in the healthcare systems and maximising the benefits of having accesses to both home and host options, which range from herbal teas, chicken soups, over-the-counter medicines, specific traditional Chinese medicine (TCM) [1] brought from Taiwan, to prescribed medicine following GP appointments. There were no tensions reported. Their choices of healthcare options and practices were determined by convenience and availability, pragmatically reflecting the success of their integration and competencies in understanding the healthcare service systems as cultural systems (Helkkula *et al.*, 2023). This finding echoes previous studies (Peñaloza, 1994; Oswald, 1999; Askegaard *et al.*, 2005), where the integration is effortlessly celebrated through their

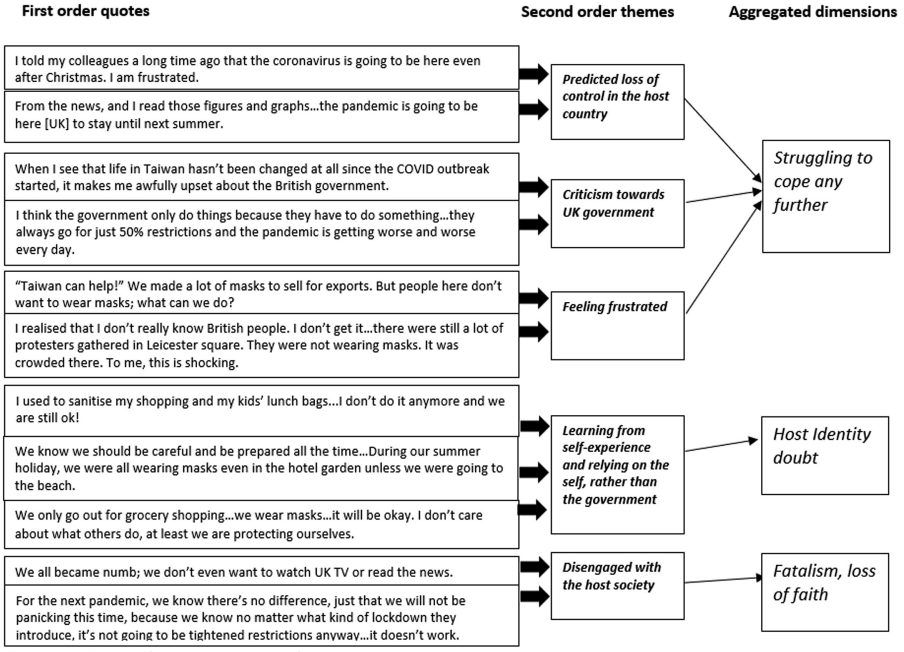

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Figure 4.
An enduring coping paradox and the consequence

pick and mix of available home and host healthcare options. Our participants also demonstrated good knowledge of the structural differences between the UK and Taiwan health systems and associated cultural behaviours. Participant 9 explained how she had modified her healthcare behaviour since moving to the UK:

> In Taiwan, when I felt a bit sick or had a headache, I'd take some rest first. But if it gets serious, I will definitely go to see a doctor. After moving to the UK, I don't normally go to see a doctor. Instead, I will go to a pharmacy to get some medicine, when feeling under the weather. In Taiwan, I don't normally go to a pharmacy directly because it is easy for us to see a doctor, I would have been given prescribed medicine by the doctors. (P9-F-38)

Being able to navigate both health systems and clearly articulate their differences with ease, participant 9 demonstrated her ability in adapting and making a choice that was deemed as culturally fitting within different contexts. Her choice shows her cultural health capital (Shim, 2010) and reflects her "*culturally shaped understanding of health, illness and treatment*" (Helkkula *et al.*, 2023, p. 245) in both Taiwan and the UK. Acknowledging the differences, participants were able to gain the most from both home and host health systems, revealing how well they coped with the changes associated with moving to a new country. Participant 1 further explained how she took advantage of the available, affordable private care options in Taiwan for services that are not conveniently available via the UK NHS:

> *"I often plan a health check when I go back to Taiwan because it is much quicker and easier to arrange a health appointment with a specialist to get things checked. In the UK, you will have to speak to your GP and get a referral before you can speak to a specialist. In Taiwan, the healthcare system is different; you just go and book an appointment with a specialist. A friend of mine always get her mammography done every year when she goes back, as she is worried about breast cancer. Why not? It is very convenient, just one appointment with the gynaecologist clinic.* (P1-F-43)

In short, participants were content and healthy pre-pandemic, satisfied with their integration and achieved well-being, echoing the works of Salant and Lauderdale (2003) and Bhui *et al.* (2005) about how integrated migrants tend to enjoy better health.

5.2 Initial COVID-19 crisis: disorientation and making sense of the new hostile environment

When the pandemic started in March 2020, participants expressed great concerns about the UK government's approach in controlling the spread of the disease. Many shared a sense of disapproval regarding the UK government's initial measures. Being a flight attendant, participant 7 expressed her worry:

> Because of my job, I am in different airports all the time. In Taiwan, there were body temperature monitors to measure every single passenger in the airports since the SARS pandemic. The airports in Hong Kong also does it; almost all the airports in Asia do it, and if the UK government wants to do the same, they just have to buy the machines. They still haven't! Even after it started to spread here! I don't get it and am really worried . . . (P7-F-46)

Benchmarking against Taiwan was used by all participants as a way of assessing COVID-19 crisis management in the UK, while acknowledging contextual differences and how people's behaviour and practices were shaped accordingly (Peñaloza, 1994; Sheth, 2020). The Taiwanese government was largely viewed more positively, with panic and uncertainty expressed about the UK's approach to public health safety. Some attempted to justify and attributed the differences between home and host to the UK's lack of experience in dealing with similar health crises, such as SARS that Taiwan had gone through in 2003. Nevertheless, frustration started to grow among the participants through their interactions with "others" around them. For instance, as a university lecturer, participant 5, shared his experience.

> Just a few days ago, I was chatting with my students on campus. There was a teenage boy, maybe 15 years old; he cycled towards us and coughed at me on purpose. I was outraged. I yelled Hey! But the boy just ran away. You are not supposed to do that! I think everybody has got to know this . . . for many of the Brits to see another person coughing aggressively in public is okay; they don't feel the danger. But this is not how we think in Taiwan. After SARS, we knew we are not supposed to cough in public because disease could be passed over in such way . . . It is also against the social norm. (P5-M-45)

Participant 5's personal experience prompted him to reflect and discuss the cultural difference regarding coughing in public. His observation of the ideological conflict (Üstüner and Holt, 2007) triggered other participants to share similar observations of how ill-prepared their fellow British colleagues and friends were towards COVID-19. As a finance analyst, participant 16 added, when he attempted to alert his British colleagues about the seriousness of the disease and the importance of purchasing and wearing facial masks or facial coverings to prevent passing on the disease to others, his advice was ignored and regarded as "*overreacting*" (P16-M-46).

Neither participant 5 or 16 related their personal experiences to potential racism, instead putting them down as different cultural perspectives and norms. Nevertheless, others developed negative feelings regarding being a victim of racism, and how their newly acquired cultural separation made this an increasing possibility. Participant 7 commented:

> I look just the same as Chinese [from China]. People don't know my nationality by look . . . My experience of wearing a mask wasn't very pleasant last week. I was in a supermarket. There was a woman; she came to my face and said 'HA!' loudly, with an angry expression on her face. However, my [white British] husband had a completely different experience of wearing masks in public. Someone approached him and asked if he knew where to buy masks. (P7-F-46)

The fear of being attacked, of feeling newly separated and targeted, made some participants hide away as an avoidant coping strategy. They limited their visits to local shops and

supermarkets, while others took a more pro-active approach against attack and brought self-defence equipment, including pepper spray. Working as an education agent, participant 11 expressed her frustration:

> My co-workers are Asian, from South Korea, Japan . . . etc and they share a similar fear. We are afraid of wearing our masks, and we have to worry if anyone will attack us because of our look. I've never experienced racism until now. This experience just makes me angry and I do not want to be part of this [Britishness]. It has made me want to be Taiwanese more. (P11-F-38)

Hate crime related to mask-wearing was seen as a growing threat, especially for Taiwanese participants whose children could be bullied at school. They worried about the UK government's lack of action in controlling the pandemic and were angry about the government's reluctance in advocating the use of facial masks, which was seen by participants as a crucial and successful tool for stopping the spreading of the virus. This finding speaks to the ideological conflict raised by Üstüner and Holt (2007), when taken-for-granted assumptions are directly challenged by the dominant host society. While Jafari and Goulding (2008) suggest the consequence of developing a torn self to indicate "*the inner conflicts and tension that result from extreme systems of domination and the desire to resist*" (p. 88), this conflict, experienced by our participants, was new and unexpected. In the past, they had not experienced such hostile scrutiny in the host country while exercising their integrated healthcare practices.

Participant 11 illustrated how the pandemic and related health crisis dramatically changed the way participants saw their life in the UK. Participants who previously claimed to have hybrid dual identities now raised their concerns. Suddenly, they felt misunderstood and unwelcomed by British friends and colleagues, leaving them anxious and confused. They reflected on how the host culture that they once integrated into has abruptly changed, now subjecting them to potential attacks and racism, especially when they were exercising Taiwanese health protection practices in public. They are unable to relate to the previously well-understood dominate culture or indigenous population (Luedicke, 2015); some chose not to conform, revealing a new dimension of the "*torn self*" (Jafari and Goulding, 2008).

Similar to the findings of Yen *et al.* (2021), we also noticed the "*coping with coping*" phenomenon. Participants expressed anxiety towards two different stressors: the life-threatening disease and the hostile response they encountered from the host environment. The initial coping mechanism was developed to protect themselves and their families from the disease, with the second coping mechanism kicking in, when they realised that their initial coping practices acquired from Taiwan was disapproved of by the host majority (Kirk and Rifkin, 2020). Unsurprisingly, this creates greater anxiety and self-directed and self-engaged health-protection practices, echoing the findings of Yen *et al.* (2021).

While the ideological conflict between home and host was deemed as uncompromisable (Üstüner and Holt, 2007), participants sought reassurance by referring to the online medical support and information-sharing groups from Taiwan. They pursued a sense of community support from other Taiwanese through social media because "*everyone is trying to create a safety net, and we all work together, sharing and exchanging tips and best practices so that we are better equipped to protect ourselves and family*" (P4-F-42). Obtaining and following health advice and information from fellow Taiwanese, participants revealed how their shopping routines and cleaning practices were changed, ranging from opting for online shopping only, wearing masks, sanitising hands frequently, to more extreme new routines at home (as evidenced by participant 1), which she shared with her Taiwanese community in the UK.

> I divide my home into two areas; one is green and the other is red. The red zone is the highest risk level and is used for anything that we brought home from outside. I bought Isopropyl alcohol spray and rubbing alcohol to deep clean everywhere in my house, especially the stuff we brought from outside (in the red zone), such as jackets, clothes, mobiles, etc. (P1-F-43)

While participant 1's health protection practices require negotiation and understanding from all family members at home, home remains a safe space that is not being subject to others' scrutiny. This is different from practices being exercised or performed in public, which could draw unwanted attention from other audiences and create alienation. As a mother of two young children, participant 9 explained:

> I go to the school to pick up my son and my two-year-old daughter from her nursery every day. Since the pandemic started, I brought hand sanitiser to clean their hands every day before getting them into the car. I know people around are watching me in an odd way, but I don't care! Keeping them safe is more important to me. (P9-F-38)

Again, participant 9's account revealed a paradoxical stance of coping with coping. By deciding to implement a cleaning routine that was not yet accepted by the dominate majority outside of home for her children's safety, she had to endure the uncomfortable feeling of being "strange". Others' responses in the host country caused anxiety and alienation, making participants feeling ridiculed and less accepted, sharing similar feelings with Chinese, Italian and Iranian migrants during the COVID-19 pandemic (see Yen *et al.*, 2021).

5.3 Prolonged coping, rebalancing integration and loss of faith in host country health culture

In autumn 2020, when the second wave of interviews were conducted, COVID-19 infection cases were rising again in the UK. Enduring the coping-with-coping paradox for over six months in the UK, making comparisons to the zero-infection scenario in Taiwan triggered even stronger and more intensive negative emotions. Divides between themselves and the UK people grew ever wider, with the anxiety that accompanied this spiralling, to create huge levels of anger and distress.

> Awful is the only word to describe the situation [in the UK]. When I see that life in Taiwan hasn't changed at all since the COVID-19 outbreak started, it makes me awfully upset about the British government and how they handled everything. (P11-F-45)

Participant 11 was not alone in expressing anger, fear, frustration and disappointment, which were shared by all, even those who were previously supportive of the UK government's approach at the beginning. For instance, participant 6, who was very supportive of the UK's approach in the previous interview, said:

> I think the [UK] government only do things because they have to do something. The truth is that it's all nonsense! . . . The second lockdown is not as strict as the first lockdown. Why isn't it? The confirmed cases and death toll are not decreasing. What is this second lockdown? It does not even work . . . I just don't get it . . . why do they always go for just 50% restrictions and the pandemic is getting worse and worse every day. They are repeating their mistakes! (P6-F-47)

Angry with the confusing rules and lockdown restrictions and the lack of enforcement of the newly released COVID-19 policies, participants felt disoriented and increasingly isolated. The perceived disorderly implementation of the second lockdown resulted in a health system that failed to meet their expectation (Helkkula *et al.*, 2023). If the initial coping with coping paradox and experience of alienation has challenged them to reconsider their acculturation stance (Yen *et al.*, 2021), the apparent and endless comparison with life in Taiwan over the past six-month time has made them very critical of the UK government's approach and the behaviour of people in the UK, revealing signs of separation. Participants appeared to use this to direct their negative emotions towards the UK government, but they also struggled to cope with the growing chasm between themselves (as Taiwanese) and other people, with increasing frustration, anger and clear cultural separatism.

> I'm extremely surprised when I see Western attitudes towards the pandemic. It's like a real eye-opener. The health education [about mask-wearing] here is appalling. Before the COVID crisis, we

> would turn a blind eye and adapt to the culture. But when it matters, it really matters! Secondly, in my opinion, there are too many Western people that are too arrogant. I know they are always arrogant because of their white supremacy, but seriously? It is a COVID pandemic, life-threatening, and they insist on being arrogant. (P8-F-44)

Having lived in Western countries for more than thirty years, participant 8 shared her disbelief of how the pandemic forced her to see herself so differently from the hybrid self she previously cherished. In her narrative, there is a clear distinction between "they" – Western people – and "us"– the Taiwanese people. Her language is revealing as it emphasises a new divide between Taiwanese life and culture, and what she refers to as Western culture. Educated in the West, participants' integration to the host culture goes hand-in-hand with their understanding of apparent white supremacy (Peñaloza, 1994). If white supremacy was previously regarded as a "necessary evil" in order to successfully cope during their acculturation in the UK, the pandemic has triggered a re-evaluation of their acculturation stance and appeared to challenge many years of identity work (Hajro *et al.*, 2019). The pressure of having to exercise coping with coping repeatedly during Covd-19 pandemic forced them to re-evaluate the white supremacy they had previously ignored.

We saw this chasm also expressed in actions, as one participant fled to Taiwan "*for safety*" with her entire family (P10-F-39). Accounts of fear over how and what to do were very common among participants who remained in the UK. For example, those who used testing facilities reported very different experiences – some were positive, while for others it was stressful and concerning – confirming the shared view that there was not a coordinated and well-implemented health strategy. Feeling unsupported in navigating through the pandemic safely and concerned about a disorderly health system that failed to meet their expectations (Helkkula *et al.*, 2023), participants had to exercise coping with coping over a long time, which was cognitively and emotionally exhausting. Participant 8 illustrated:

> I have been wearing a mask since COVID-19 starts in the tube; I don't care what others think of me. But I noticed I was the only one wearing a mask the last time I went out; there were probably 1000 people there. I got some dirty looks. It made me mad in the beginning, but now I just think of this; 'If you want to die, you go ahead.' (laughter) Right? We do whatever we can to protect ourselves; we don't need to care if they want to die or not. (P8-F-44)

Participant 8 was not alone in pointing out that mask-wearing made her isolated and a target for aggression – "*dirty looks*". Further, it is important to note that, over time, she shifted her identity alignment, from feeling angry about being isolated by the dominant others to feeling disengaged, resigned and righteous. Rather than being torn, she exhibited signs of separation as a way of avoiding further cognitive and emotional exhaustion, if she had to exercise coping with coping continuously. Nevertheless, not all participants shared her confidence to stand out, with the fear of extreme isolation. For instance, participant 9 commented:

> Well, my kid's school allows mask-wearing. But even so, my son was the only child who was wearing a mask all day at school. He is only five years old. Other parents told me that my child is very self-disciplined. But after about a week, a teacher from the school told me that my son was walking around alone and not playing with other kids. Then she kindly asked me, 'do you think it is because of mask-wearing?' The teacher is from Taiwan. I don't want my son to suffer. He is only five years old. It's cruel if I force him to wear masks and make him stand out . . . I was very sad and I decided to drop it . . . (P9-F-38)

Participant 9's quotes highlight the psychological pain, fear and uncertainty participants endured during the pandemic. Whilst participant 9 felt sad for her son being marginalised by other kids at school, she decided that her son's well-being had to be prioritised – a hard choice between a healthy life or loneliness, again continuously experiencing the torn self, as described by Jafari and Goulding (2008). Some admitted reducing the number of visits outside the home,

feeling disconnected to the UK society and losing their feeling of belonging and their faith in UK health-protection policy and the country, where they once felt belonged. If coping with coping was demanding at the beginning, over time coping with coping has a more damaging effect to participants' well-being and identity work due to having to endure the constant and continuous compromising of practices. Exhausting both emotionally and cognitively. The responses participants received from the host environment undermined their acculturation efforts to integrate and embrace the host country, denying their desire to be understood and appreciated as equals. This revealed a new tension and caused conflictual authority ranking (Luedicke, 2015), where participants started to question whether the UK's approach was very responsible, and what that meant for their own belonging. Participant 11 summarised this feeling:

> Now we have all become numb; we don't even want to watch TV or read the news. It is all useless. I change the channel as soon as I see Boris Johnson's face on the TV . . . Is this the place where I want to be for the rest of my life? (P11-F-38)

6. Discussion

Findings have shown how a group of middle-class and previously well-integrated Taiwanese migrants experienced the COVID-19 pandemic in the UK through the lens of acculturation and coping. Before the pandemic, participants described their lives in the UK as a positive acculturation journey. Following many years of purposeful adaptation, they successfully integrated into the UK, where various healthcare choices were swiftly and pragmatically consumed, revealing their cultural health capital (Shim, 2010; Helkkula *et al.*, 2023). Both home and host cultures were resourcefully employed, showing relative ideological compatibility, where personal preferences and inflections of values were expressed and celebrated (Askegaard *et al.*, 2005).

The pandemic abruptly transformed and brought unexpected changes in the sociocultural structures. New cultural disparities between Taiwan and the UK started to show, from the early debate of how cautious a country should be in disease prevention and management, to more personal matters – how people should behave for self-protection and the public's health. Previously, there was relative ideological compatibility between Taiwan and the UK, but the pandemic revealed unpredicted tensions regarding health protection practices between the Taiwanese migrants and the dominant majority (Üstüner and Holt, 2007). Such ideological conflicts were not seen as innocuous but life-threatening, with our findings revealing complex and layered coping with coping behaviours where various conflictual and compromising strategies were adopted (Yen *et al.*, 2021).

The initial coping with coping that we observed in spring 2020 was very similar to findings of Yen *et al.* (2021). However, by autumn 2020, the Taiwanese migrants had endured and exercised coping with coping for more than six months, with seemingly *ad hoc* and compromising coping strategies becoming the new norm. Coping with coping over time was exhausting. It severely tested migrants' relationships within the host society (Luedicke, 2015), and such exhaustion created cultural separation, which was an unexpected finding. If the initial coping with coping triggered feelings of confusion and panic, infused with the fear of a life-threatening disease, coping with coping over a long period of time led to feelings of alienation, separation and detachment. Our findings revealed a withdrawal from the host identity and a realignment to the home identity, undoing previous identity work and leaving feelings of isolation.

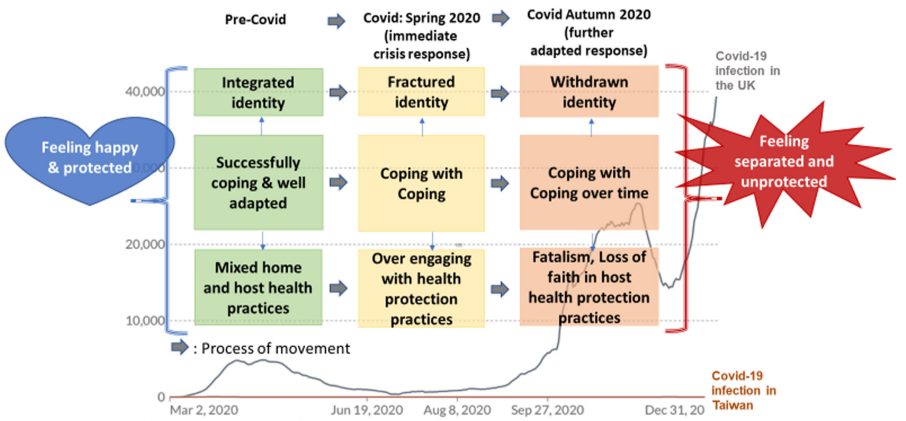
Many participants felt disengaged and lost faith in the UK health-protection mechanisms and the host society more generally (Helkkula *et al.*, 2023), readjusting their acculturation stance and coming to rely on more cautious, self-directed and initiated health-protection practices, acquired from Taiwan. Separation from the host culture – which has been seen in the literature as a problematic outcome – emerges as the result, when agentic and previously well-integrated migrants respond to the hostile host environment by adopting defensive

strategies to survive and protect their well-being. This provides a new insight into an acculturation outcome that has been seen as one to be avoided and corrected. Indeed, separation, as practised on a temporary basis, emerges as a positive and self-preserving outcome which preserved migrants' health.

This self-solving approach offered better protection in avoiding COVID-19 infection, but came at a high cost, as their continued, more cautious health-protection practices left them feeling separated and criticised by the host nation. This reflects the power imbalance of the ideological conflict between migrants' culture and host society (Üstüner and Holt, 2007; Luedicke, 2015), in which migrants' more cautious ideology was marginalised in the dominant society, both socially and politically. The negative responses from this extra protection work led to feelings of racism and alienation and required coping with coping; a layered and distressing, spiralling "out-of-control" experience of being constantly under attack at an individual level. Thanks to their social, economic and cultural capitals, our participants were not shattered. However, having to go through coping with coping has affective consequences, including negative emotions, exhaustion and anger towards the host country and its political and cultural understanding of the pandemic.

By summarising the findings into a conceptual framework (see Figure 5), this paper contributes to existing coping and acculturation debate in three ways. Firstly, it extends previous understanding on coping with coping (Yen *et al.*, 2021) by revealing how coping with coping over a long period of time has the potential to reshuffle acculturation outcomes, leading to fatalism and loss of faith, creating separation in the host environment. While coping with coping demands cognitive and emotional effort to engage in *ad hoc* problem-solving using compromising solutions, coping with coping over time has a more insidious affective consequence, draining and deflating one's energy to cope. While some participants still attempted to exercise *ad hoc* and compromising coping strategies in autumn 2020, some seemingly previously well-integrated migrants had decided to stop exercising coping with coping all together to avoid feeling torn (Jafari and Goulding, 2008). They started to exhibit traits resonating with the acculturation outcomes of separation (Berry, 2008). This is a novel contribution of this paper, contributing to the understanding of migrants' coping behaviour, specifically in time of crisis (Kuo, 2014; Yen *et al.*, 2021).

Secondly, findings reveal how Taiwanese migrants started to question their previous acculturation stance, when struggling to agree with the host country's approach in managing the COVID-19 pandemic. This supports previous acculturation debates, where acculturation



Source(s): Authors' own creation

Figure 5.
Conceptual framework

becomes nonlinear (Peñaloza, 1994; Oswald, 1999; Askegaard *et al.*, 2005). It also highlights an alternative way to understanding migrants' acculturation outcomes, as context-specific responses to the sociocultural structure change (Üstüner and Holt, 2007). In life-threatening crisis, where the dominant group's practice is evaluated as hostile yet lacking authority (Luedicke, 2015), even those who were well-integrated will reconsider the appropriateness of their previous acculturation and identity alignment. Our findings explain why acculturation journey is non-linear and nondirectional. In our case, when participants were required to acculturate again to the changing sociocultural structures, separation occurred because it was regarded as the safer and better option, rather than conforming to the dominant ideology.

While existing acculturation literature suggests that well-integrated migrants tend to have good health outcomes (Lee *et al.*, 2000; Miao and Xiao, 2020) because their agency enables them to combine best health practices and solutions from both countries (Villa-Torres *et al.*, 2017), this paper reveals complex evidence that challenges this assumption. Our findings showed it was the separation strategy that this group of migrants exercised successfully that helped protect them from the life-threatening disease. However, while their agency enabled them to critically evaluate the host country's health-protection mechanism and adopted coping with coping, it also made it harder for them to compromise by accepting practices that were deemed less superior, despite their being accepted and appropriated by the dominating host group. Hence, this separation came with a consequence – with this group of well-integrated, resourceful, middle-class migrants being alienated and exposed to racism, damaging their well-being and sense of belonging. Although their agency and social, cultural and economic capital enables them to develop better self-directed protection practices, having to constantly challenge dominant social norms created conflict and frustration, echoing the work of Luedicke (2015). This led to a loss of faith in the host institution and caused them to feel alone and unprotected, despite their efforts to engage cautious self-protection practices.

7. Conclusion and implications

This paper contributes to the scant literature on acculturation and coping, associated with the COVID-19 pandemic. It provides a novel understanding of how a group of well-integrated migrants experience stress, anxiety and fear and a consequent identity crisis through a prolonged coping with coping experience. It also has clear public health policy implications. Firstly, while acknowledging the negative effect of coping with coping over time, public health policymakers are advised to dedicate more resources to understand migrants' experiences in the host country. In particular, this paper has shown how separation, especially if embraced temporarily, is not necessary a negative outcome to be corrected with specific policies. It can be strategically adopted by migrants as a way of defending their health and well-being from an increasingly hostile environment. As such, the problematic aspect of separation is not on the side of migrants to be "fixed" but indeed on the side of the host society and its racism. Acknowledging migrants' voice is a critical first step to demonstrate respect and willingness to see migrants as equals in society (Villa-Torres *et al.*, 2017), contributing to the development of a fair and inclusive society.

While the much more cautious approach in Taiwan successfully controlled the COVID-19 death figure, it highlights the importance for the UK to embrace vicarious learning from other countries and acquire "others'" good practices. Migrants are windows to their country of origins. They bring with them their culture, traditions and experiences from their home country, acting as a bridge through which people in the host country can gain insights, lessons and effective practices of the migrants' country of origin. While there were attributes that contribute to the UK's high COVID-19 death figures, migrants' voices were largely ignored, in favour of a surprising orthodox and rather singular approach in the discussion of public health management.

Thirdly, the pandemic has forced a group of resourceful and well-integrated middle-class migrants to contemplate the appropriateness of their alignment with the host culture, leading to anxiety and suffering. These negative effects are likely to be further heightened for less resourceful and marginalised migrants. To retain skilful migrants and avoid a future brain-drain, policymakers are advised to advance existing infrastructure to provide more incentives to support and retain migrant talents in the post-pandemic recovery phase.

7.1 Limitations

This paper has provided an in-depth longitudinal overview of the experience of a group of well-integrated migrants in the UK. It provides a novel account of how cultural differences and disparities between governmental health strategies have an impact on the well-being, health practices and acculturation outcomes. However, it is important to note that the Taiwanese sample recruited through Facebook community groups is biased and has a high level of homogeneity. These participants were well-integrated, middle-class migrants who were highly-educated, relatively resourceful and active on social media. This being the case, we can speculate that migrants with less resource are likely to have found the pandemic experience even more challenging. More studies are needed to fully understand the impact on well-being and acculturation of migrants from different cultural, contextual and social backgrounds.

Note

1. Traditional Chinese medicine (TCM) is regularly used as part of the available treatment in Taiwan. Approximately 4% of Taiwanese NHI claims were based on TCM, compared to 96% on Western medicines (Liu and He, 2020).

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