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I Want to Move, But Cannot: Characteristics of Involuntary Stayers and Associations With Health Among Canadian Seniors

Lisa Strohschein, PhD[1]

Abstract

Objectives: The purpose of this study was to investigate characteristics of seniors in the Canadian population who are involuntary stayers and to assess associations with health. **Method:** Data come from the 1994 Canadian National Population Health Survey, with the sample restricted to those 65 and older (*N* = 2,551). **Results:** Nearly 1 in 10 seniors identified as an involuntary stayer. Seniors with few socioeconomic resources, poor health, greater need for assistance, and low social involvement were more likely to identify as an involuntary stayer. Furthermore, seniors who were involuntary stayers report significantly more distress and greater odds of low self-rated health than other seniors. **Discussion:** This study brings into visibility an understudied segment of the elderly population: seniors who are unable to move from their present location despite their desire to do so. Further research and policy responses assisting seniors to age in a setting of their own choosing are needed.

Keywords

health, involuntary stayers, residential mobility, stress process

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The rapid growth of older populations in Canada and other countries has stimulated debate regarding the pressures that will be placed on health care, pensions, labor markets, and housing but has also raised questions about the adequacy and effectiveness of supports for seniors. Understanding patterns of residential mobility among the elderly is seen as an important way of providing researchers and policy makers with insight into how seniors navigate decisions about where to live in later life and how these choices might ultimately affect their health and well-being.

Reflecting a general preference to age in place, the elderly are less likely to move and they move for different reasons and to different places compared with younger Canadians (Che-Alford & Stevenson, 1998; Lin, 2005; Marr & Millerd, 2004). Notwithstanding generic differences in residential mobility between seniors and the rest of the population, seniors who change their residence are not a homogeneous group. Early researchers theorized residential moves according to their triggering mechanisms, circumstances, and outcomes (Wiseman & Roseman, 1979; Wiseman, 1980). Triggering mechanisms initially push or pull seniors into considering residential change and may occur when seniors move to be closer to their families or the amenities of retirement, to escape a deteriorating neighborhood, or because declining health or a critical life event changes their ability to maintain the status quo. Whether a move occurs depends on the relative weighting of endogenous (socioeconomic resources, ties to community) and exogenous (housing market conditions) factors that either build momentum or dampen enthusiasm for a residential change. Consequently, outcomes are diverse including moves to retirement communities or sunshine states, local moves, institutionalization, moving in with kin, as well as the possibility that one makes no move at all.

Of those outcomes where no residential change is made, Wiseman (1980) identified three types of nonmovers. Seniors may make physical alterations to their homes so that a move is no longer necessary, make personal adjustments that allow them to be content with their residence, or may become what he labeled involuntary stayers. Involuntary stayers remain dissatisfied with their residence and desire to move but for various reasons are not able to realize residential mobility. Wiseman suggested that given the low rates of mobility among the elderly, involuntary stayers may comprise a large number of the population. He also indicated that it was likely that these seniors were constrained from moving by low resource levels but would have a high potential for moving at some point in the future.

Although the pioneering work of Wiseman (1980) and others (e.g., Litwak & Longino, 1987) has, more than thirty years later, resulted in a large and growing literature on residential mobility in later life; remarkably, there is no

research on involuntary stayers, outside intermittent and brief reference to their existence (e.g., Liaw & Kanaroglou, 1986; Moore & Rosenberg, 1994; Robison & Moen, 2000). As such, estimates of involuntary stayers in the population are unavailable and what could be known about this group must be gleaned from research on the broader category of nonmovers. That nonmovers are not uncommon in the senior population has been uncovered in longitudinal research that compares a senior's expressed desire or expectation of moving at a given time point with the likelihood that he or she will subsequently change residences. For example, Ferraro (1981) reported that 15.7% of seniors expressed a desire to move, but approximately 80% of those had not moved 1 year later. Erickson and his colleagues found that 13.2% of seniors were currently considering a move at initial interview, but after 2 years, nearly a third of those seniors had not made a move (Erickson, Krout, Ewen, & Robison, 2006). Sergeant and her colleagues (Sergeant, Ekerdt, & Chapin, 2010) reported that approximately 8% of seniors rated their expectation of moving in the next 2 years as higher than 67% (from a possible range of 0 to 100%) but found that more than 75% of them were still living in the same residence 2 years later. Using the same data, Bradley and his colleagues (Bradley, Longino, Stoller, & Haas, 2008) found that only about half of those who expressed a 100% expectation of moving had actually moved 2 years later. Given the two other categories of nonmovers described by Wiseman (1980), nonmovers cannot be treated as equivalent to involuntary stayers and the subset of nonmovers that would identify as involuntary stayers remains unknown. As such, the current study is the first to document the proportion of involuntary stayers in the senior population.

Other clues about involuntary stayers come from those concerned that socioeconomically disadvantaged seniors are at risk for becoming trapped in unsuitable and potentially hazardous homes and neighborhoods (Golant, 2008a, 2008b; Klinenberg, 2002). Burkhauser and his colleagues showed that seniors were much less likely to leave a distressed neighborhood than younger adults and that poor seniors were at the greatest risk for not moving (Burkhauser, Butrica, & Wasylenko, 1995). In his social autopsy of the 1995 killer heat wave in Chicago, Klinenberg (2002) eloquently argued that the observed excess mortality could be attributed to the social isolation of the elderly poor who aged in place while the communities around them changed. Although both studies illuminate one pathway through which seniors may become involuntary stayers, neither actually assessed the mobility intentions of seniors. Thus, it is impossible to know how many of these residentially stable seniors could be characterized as involuntary stayers. These results lend credence to Wiseman's hypothesis that

socioeconomically disadvantaged seniors are more likely to be involuntary stayers than their more advantaged counterparts, but there is a lack of empirical evidence to support that seniors who are involuntary stayers are disproportionately poor or share any other distinguishing sociodemographic characteristic.

Whether involuntary stayers are at risk for poor health outcomes is also an open question. Researchers have already linked patterns of residential mobility to health outcomes for seniors (Bradley & van Willigen, 2010; Chen & Wilmoth, 2004; Choi, 1996; Smider, Essex, & Ryff, 1996), and many have incorporated a stress process approach on the assumption that some types of moves are more stressful than others. However, by focusing only on the health consequences of moving, there has been a failure to recognize that the universe of stressors also extends to nonevents (Wheaton, 1994). That is, when a change is desired but does not occur, the lack of change, or in this instance, the inability to move, operates as a chronic stressor that potentially erodes health and well-being. It is quite possible then that there is a segment of seniors in the population who desire to move from their current residence, who are restricted in their ability to make a change, and for whom this stressful situation may exact a toll on physical and psychological health.

The purpose of this study was twofold. First, this study was aimed at providing an estimate of how many seniors in the population identified as an involuntary stayer and exploring characteristics associated with being an involuntary stayer. Drawing on Wiseman's conceptual model of the elderly migration decision-making process, it was hypothesized that seniors who were involuntary stayers would continue to be motivated by factors that led them to contemplate a move in the first place and thus might be distinguishable from other seniors in terms of reporting poorer health, greater need for assistance in daily activities, and greater social isolation. Moreover, Wiseman's model predicts that seniors who are involuntary stayers would be more likely to experience indigenous factors that reduce the probability of a move (e.g., few socioeconomic resources). Based on the conceptual model of a stress process approach that contends stressful conditions are damaging to health and well-being (Ensel & Lin, 2000; Pearlin, 1999), a second aim of this study was to test status as an involuntary stayer as a predictor of psychological distress and lower self-rated health, net of controls. The apparent contradiction of conceptualizing health both as cause and as consequence of status as an involuntary stayer in a cross-sectional study is addressed in the discussion.

Method

Sample

Data come from the first wave of the National Population Health Survey (NPHS), an ongoing longitudinal survey conducted by Statistics Canada that has interviewed survey participants on a biennial basis since 1994. The target population for this survey is household residents in all provinces with the exclusion of those living in institutions, on First Nations reserves, Canadian forces bases and some remote areas in Ontario and Quebec. The NPHS collects general sociodemographic and health information on all members of selected households as well as in-depth health information on one individual, aged 12 and older, randomly selected from each household. The initial household response rate in 1994 was 88.7% whereas the selected person response rate was 96.1%. For the current analysis, the sample was restricted to respondents who were 65 or older in 1994 (n = 2,776). A small amount of missing information on key variables resulted in a final sample size of 2,551.

Measures

Psychological distress is defined as a subjective, emotionally negative mental state. Based on a subset of questions taken from the Composite International Diagnostic Interview, psychological distress comprises a six-item scale assessing the frequency of feelings of sadness, nervousness, restlessness, worthlessness, hopelessness, and daily life as an effort. Summed items produce a scale, ranging from 0 to 24, with higher scores associated with greater distress. The scale has strong psychometric properties with excellent internal consistency reliability and can discriminate between the clinically depressed and nondepressed (Kessler et al., 2002). Low self-rated health is based on the respondent's assessment of whether they are in excellent, very good, good, fair, or poor health. Low self-rated health distinguishes between respondents whose self-rated health was either fair or poor (coded 1) and those who rated their health as excellent, very good, or good (coded 0).

The variable identifying a senior as an involuntary stayer is constructed from a single question that asked the senior whether he or she would like to move but cannot (coded 1 if *yes* and 0 if *no*). Age, gender, rural versus urban residence, home ownership, educational attainment, living arrangements, assistance with daily activities, and social integration were included in the analysis to explore ways in which involuntary stayers might differ from other seniors and as controls to reduce the plausibility of spurious associations

between status as an involuntary stayer and health outcomes. The age of the respondent was assessed as years of age. Male respondents were coded 1 and female respondents were coded 0. Seniors who live in rural areas were coded 1 and urban residents were coded 0. Home ownership and educational attainment were selected as measures of socioeconomic resources. Household income was not used because income sources in old age do not always reflect the material living standards of the elderly and income tends to have a high level of nonresponse (Dalstra, Kunst, Mackenbach, & the EU Working Group on Socioeconomic Inequalities in Health, 2006). Home ownership represents the accumulation of resources over the life course and is typically the single largest asset of older adults (Fisher, Johnson, Marchand, Smeeding, & Torrey, 2007). Home ownership is a dummy variable that indicated whether the residence the respondent lived in was owned (coded 1) or rented (coded 0). During their adult years, education enables people to obtain better-paying jobs that more rapidly increase the acquisition of material resources and provides greater economic security later in life (Reynolds & Ross, 1998). Educational attainment is a dummy variable that compares seniors who have less than a high school education (coded 1) with those who have attained higher levels of education (coded 0). Living arrangements is a four-level categorical variable specified with dummy variables distinguishing between seniors who were unattached and living alone; unattached and living with others (such as adult children, siblings, or nonrelatives); seniors in couple-only households (the omitted reference category); and married or partnered seniors living with others. Needs Help With Daily Activities is a scale ranging from 0 to 6 that counts the number of different daily activities the respondent reported needing the help of another person to perform. These daily activities included preparing meals; shopping for groceries or other necessities; doing normal everyday housework; doing heavy household chores such as washing walls and yard work; personal care such as washing, dressing, or eating; and moving about inside the house. Social Involvement is a scale derived from two items that assessed the frequency over the past 12 months that respondents attended religious services and participated in meetings or activities of voluntary organizations community centers, ethnic associations of social, civic, or fraternal clubs. Response categories include not at all, at least once a year, three or four times a year, at least once a month, and at least once a week that were coded 0 to 4, respectively. The summed items produce a scale ranging from 0 to 8 with higher scores indicating greater social involvement.

Analytic model. Both health outcomes violate the assumption that the conditional distribution of the dependent variable is normal and the error is homoskedastic;

therefore, analysis involved using generalized linear models (McCullagh & Nelder, 1989), assuming a Poisson distribution for psychological distress and a binomial distribution for low self-rated health. In a Poisson model, regression coefficients are interpreted as the logarithm of the ratio of the expected value before and after a one-unit change in an explanatory variable, with all other terms held constant. In a logistic regression model, regression coefficients are interpreted as the log of the odds of an event before and after a one-unit change in an explanatory variable, with all other terms held constant.

Normalized sampling weights were applied to all estimations to adjust for nonresponse and differential selection probabilities.

Results

Approximately 1 in 10 Canadian seniors reported that they would like to move but cannot (n = 248, 9.7%). Table 1 presents sociodemographic characteristics of the sample stratified by status as an involuntary stayer. There were no significant differences between the two groups in terms of age, gender, rural residence, and living arrangements. A significantly higher proportion of involuntary stayers had attained less than a high school education and rates of home ownership were significantly lower among involuntary stayers compared with other seniors. Seniors who were involuntary stayers reported on average a greater need for assistance with daily activities and lower levels of social involvement relative to seniors who did not identify as an involuntary stayer. Involuntary stayers were also in worse health relative to other seniors, with higher levels of psychological distress and a greater proportion reporting low self-rated health.

Tables 2 and 3 present models that tested whether involuntary stayer status was associated with higher psychological distress and higher odds of low self-rated health, respectively. Adjusting for other terms in the model, higher levels of psychological distress were associated with younger age, being female, living in a rural area, not owning one's home, having less than a high school education, greater need for assistance with daily activities, and lower levels of social involvement (Table 2). Adjusting for these characteristics, levels of psychological distress were on average 84% higher ($e^{.61}$) among involuntary stayers relative to other seniors.

The odds of reporting low self-rated health were higher for men than for women, for seniors who rented rather than owned their home, and for seniors with less than a high school education compared with seniors with higher levels of education (Table 3). Seniors who lived with a spouse/partner and

Table 1. Sociodemographic Differences Between Seniors Who Are and Are Not Involuntary Stayers 1994 National Population Health Survey (N = 2,551)

	Involuntary stayer	
	No	Yes
Age (in years)	73.2 (6.5)	72.3 (5.6)
Respondent is male	40.8	43.7
Rural residence	18.1	15.3
Homeownership	70.9	49.0***
Respondent has less than high school	51.7	60.5**
Living arrangement		
Unattached, living alone	33.8	37.7
Unattached, living with others	7.8	5.0
Spouse/partner, living with others	8.8	9.4
Couple-only household	49.6	47.9
Needs assistance with daily activities	0.6 (1.2)	0.8*** (1.4)
Social involvement scale	3.5 (2.7)	2.9** (2.8)
Psychological distress	2.4 (3.1)	5.1*** (5.0)
Low self-rated health	23.1	42.3***
Total	2,303	248

Note: Data presented as mean (standard deviation) for age, need for assistance, Social Involvement Scale, and psychological distress. Remaining variables are presented as percentages.
**p < .01. ***p < .001.

others were more likely to report low self-rated health compared with seniors in a couple-only household, and the odds of low self-rated health were also higher for seniors reporting a greater need for assistance with daily activities and lower levels of social involvement. Adjusting for these characteristics, the odds of reporting low self-rated health were 88% ($e^{.63}$) higher among involuntary stayers relative to seniors who did not identify as an involuntary stayer.

Discussion

As the number of seniors in the population continues to swell, there is a critical need to ensure that seniors are well served by a continuum of supports that enable them to age in place or to age in a setting of their own choosing.

Table 2. Predictors of Psychological Distress, 1994 National Population Health Survey (*N* = 2,551)

	Psychological distress		
	b	*SE*	e^b
Age	–.01	.00***	0.99
Respondent is male	–.32	.03***	0.73
Rural residence	.08	.03**	1.08
Homeownership	–.13	.03***	0.88
Respondent has less than high school	.29	.02***	1.34
Living arrangement[a]			
Unattached, living alone	–.04	.03	0.96
Unattached, living with others	–.09	.05	0.91
Spouse/partner, living with others	.05	.04	1.05
Needs assistance with daily activities	.19	.01***	1.21
Social involvement	–.01	.00*	0.99
Involuntary stayer	.61	.03***	1.84
Deviance		7,926.85	
Pseudo-R^2		.10	

[a]Reference group is couple-only households.
*p < .05. **p < .01. ***p < .001.

Involuntary stayers represent a segment of the senior population who can be considered to be involuntarily aging in place and, as such, invite closer scrutiny. Curiously, beyond their initial classification as a particular type of nonmover in Wiseman's typology of elderly residential migration, involuntary stayers have received scant attention in the literature. As the first to make involuntary stayers the focus of systematic investigation, this study makes the following three contributions:

First, as Wiseman (1980) suggests, the number of seniors who are involuntary stayers is not negligible. Approximately 1 out of 10 Canadian seniors wants to move but is unable to make a change. As this is the first study to produce an estimate of involuntary stayers in the elderly population, it is not possible to make comparisons with estimates derived in other time periods or jurisdictions. Previous studies have documented that a sizeable proportion of seniors do not actuate an expressed desire or intention to move (Bradley et al., 2008; Erickson et al., 2006; Ferraro, 1981; Sergeant et al., 2010). Although it is likely that some of these nonmovers could be categorized as involuntary stayers, it is important to engage in further research that would

Table 3. Predictors of Low Self-Rated Health, 1994 National Population Health Survey (N = 2,551)

	Low self-rated health		
	b	*SE*	Odds ratio
Age	.02	.01	1.02
Respondent is male	.30	.11**	1.35
Rural residence	.25	.13	1.28
Homeownership	−.40	.11***	0.67
Respondent has less than high school	.69	.10***	1.99
Living arrangement[a]			
Unattached, living alone	−.05	.12	0.95
Unattached, living with others	−.01	.20	0.99
Spouse/partner, living with others	.84	.17***	2.32
Needs assistance with daily activities	.57	.04***	1.77
Social involvement	−.08	.02***	0.92
Involuntary stayer	.63	.15***	1.88
−2 log likelihood		2,478.02	
Pseudo-R^2		.14	

[a]Reference group is couple-only households.
*p < .05. **p < .01. ***p < .001.

distinguish between different types of nonmovers more generally and involuntary stayers in particular. Given the obvious concern that nearly 10% of Canadian seniors feel constricted in their ability to move, intensive efforts to learn more about this segment of the senior population are an important area for future research.

A second contribution of this study is that it provides a preliminary demographic profile of involuntary stayers. Previous research on nonmovers has intimated that it is poor seniors who are likely to become trapped in deteriorating or changing neighborhoods (Burkhauser et al., 1995; Klinenberg, 2002), which is consistent with Wiseman's (1980) earlier conjecture that involuntary stayers would be more socioeconomically disadvantaged than other seniors. Wiseman's conceptual model of the elderly migration decision-making process was also the basis for positing other potential differences. As involuntary stayers have a desire to move, it was hypothesized that they would be distinguishable by the same characteristics that are typically associated with the initial decision to change residences, including poor health, greater need for assistance, and social isolation. As expected, involuntary

stayers were more socioeconomically disadvantaged relative to other seniors, in that they were more likely to have low educational attainment and to rent rather than own their home. Involuntary stayers were also more likely than other seniors to be in poorer physical and mental health, to require greater assistance in performing daily activities, and to report lower levels of social involvement.

Researchers have already highlighted the need to be sensitive to the residential challenges that seniors face including affordable housing (Clark, 2005), accessible housing that accommodates different types of disability (Smith, Rayer, & Smith, 2008), and communities that encourage the social integration of seniors (Bookman, 2008). That involuntary stayers are more likely than other seniors to face deficits in economic resources and to report poorer health, greater need for assistance and lower levels of social involvement suggest that identification as an involuntary stayer is a meaningful category that is tangibly connected to these barriers.

Finally, drawing on a stress process approach, this study tested whether status as an involuntary stayer predicted psychological distress and low self-rated health, net of controls. The findings of this study showed that involuntary stayers were in worse health than other seniors, with higher average levels of psychological distress and a greater likelihood of reporting low self-rated health, controlling for age, gender, rural residence, living arrangements, socioeconomic resources, need for assistance with daily activities, and social involvement. Control variables also operated in the expected direction, with seniors who had fewer economic resources, higher need for assistance, and low social involvement reporting higher levels of distress and a greater probability of low self-rated health. A commonly reported curvilinear relationship between age and distress that suggests that older seniors have higher levels of distress than younger seniors (Mirowsky, 1996; Mirowsky & Ross, 1992; Schieman, Van Gundy, & Taylor, 2001) was not found in this study; however, the negative association between age and distress observed in the current study corresponds with studies that report a linear decline in distress with age across the entire life course (Chittleborough, Winefield, Gill, Koster, & Taylor, 2011; McDonough & Strohschein, 2003; Umberson, 1993).

There is growing interest in integrating a life-course approach and the stress process to understand how stressors, including the impact of residential relocation, affect the health and well-being of individuals in later life (Pearlin, 2010). A stress process approach has already illuminated that the negative health effects of residential mobility accrue disproportionately to seniors whose moves are made under duress or pressure (Bradley & van Willigen, 2010; Chen & Wilmoth, 2004; Choi, 1996; Smider et al., 1996). Just as certain types of

moves are more damaging to health, the findings of this study show there are equally harmful associations with health and well-being that are linked to finding oneself unable to effect a desired residential change. By drawing attention to the health deficits associated with being an involuntary stayer, this study builds on and adds nuance to the existing stress process literature.

Although this study has established the links between involuntary stayer status and health, it is based on cross-sectional analysis; therefore, it is impossible to establish a causal relationship or discern the direction of the association between status as an involuntary stayer and health. In this study, health has been conceptualized as both logically prior and consequent to status as an involuntary stayer: both interpretations are valid and supported in the literature. Wiseman's conceptual model of the decision-making process makes clear that health is a factor in each step of the process. A sudden change in health is often the triggering mechanism that motivates seniors to consider changing their residence (Choi, 1996; Stoeckel & Porell, 2010). Moreover, health status may operate as an inhibiting endogenous factor such as may occur when a senior in poor health feels stuck because his or her health limitations preclude a desired amenity move to a sunshine state. It is also possible that a depressed senior may want to move, but feelings of helplessness that are symptomatic of the disorder prevent a move from occurring. In each of the above scenarios, health is temporally prior to one's status as an involuntary stayer, although it is only in the latter two situations that health influences one's status as an involuntary stayer. Conversely, a stress process approach has amply demonstrated that stressful situations, including stressors associated with residential mobility, exert harmful effects on both physical and mental health. Recognizing that health status is a factor in each step of the decision-making process and operates as both cause and consequence of status as an involuntary stayer is critical for understanding the complex dynamics that characterize patterns of residential mobility in later life. Disentangling the precise ways in which the links between health and the housing choices of seniors are interwoven cannot be resolved here but awaits longitudinal research with multiple waves of data.

More broadly, the findings of the current study lend support to an emerging critique of public policies that place too much social value on aging in place (Rowles, 1993; Golant, 2008a, 2008b). Such critiques contend that not all seniors are attached to their residences (Rowles, 1993) and that policies that serve to maintain seniors in their homes may in some cases be misdirected and even harmful to health and well-being (Golant, 2008a, 2008b). There can be no doubt that most seniors express the desire to remain in their homes as long as possible (Wagnild, 2001). Nonetheless, a narrow focus on the preferences

of the majority shifts attention from the minority of seniors for whom aging in place is not necessarily a priority, including those seniors who clearly want to move but face obstacles in accomplishing this goal. Shining a stronger spotlight on the plight of those who are involuntary stayers may advance the argument that aging in place policies are not always appropriate.

Limitations and Future Directions

Although it is clear that involuntary stayers experience a gap between their preferences and actual living conditions, this study cannot reveal the specific constraints that underlie these seniors' inability to make a residential move. They are likely a diverse group that comprises seniors who can't afford to leave distressed neighborhoods, those on waiting lists for institutional care or seniors trying to sell their home in a challenging real estate market. These examples illustrate some of the endogenous (lack of finances) and exogenous (shortage of beds in care facilities, depressed real estate market) factors that may inhibit a move for those seniors who have already been pushed or pulled into the decision to make a residential move. It was not possible in the current study to evaluate exogenous factors associated with status as an involuntary stayer; this is an area for future research. To understand how involuntary stayers differ from the rest of the senior population, we need to know more about the reasons why seniors want to move and the factors that prevent some of them from realizing their mobility intentions. Similarly, there is a need for longitudinal studies that can track subsequent patterns of residential mobility among those who identify as involuntary stayers to evaluate whether Wiseman's prediction that involuntary stayers will have a high likelihood of moving in the future is borne out. These represent promising avenues for future research.

Finally, it should be noted that this research extends beyond what is already known about the associations between residential satisfaction or attachment to place and the health of seniors (Evans, Kantrowitz, & Eshelman, 2002; Oswald et al., 2007). Seniors who are dissatisfied with their housing are likely be in different stages of the decision-making process and, as has been shown, have a high probability of moving at some future point (Erickson et al., 2006; Oh, 2003). In contrast, involuntary stayers represent the end-stage of the process inasmuch as they have already (expressed the desire) made the decision to move but find themselves unable to make a residential change. Nonetheless, studies that can bring together these different threads of research will undoubtedly enhance our understanding of residential mobility in later life.

Conclusion

This study has shown that there is a segment of the senior population who desire to move but cannot. Given that their status as an involuntary stayer is linked to economic disadvantage, decreased social involvement, and worse health, further research and greater sensitivity to the needs of this group in policy circles are warranted.

Author's Note

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