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Older peoples' perceptions of oral health: 'It's just not that simple'

Running title: Older people and oral health care

B. McKenzie-Green, RN, Post Grad Dip Couns. MHSc (Hons). Edith Morgan Chair in Aged Care, School of Nursing, Australian Catholic University (National)

L. S. Giddings, RN, RM, PhD, Associate Professor, School of Nursing, Faculty of Health and Environmental Sciences, Auckland University of Technology

L. Buttle, BDS, NZ Cert. Management, Post Grad Dip Teaching. Senior Lecturer, School of Oral Health, Faculty of Health and Environmental Sciences, Auckland University of Technology

K. Tahana, Dip Dental Therapy Clinical Educator, School of Oral Health, Faculty of Health and Environmental Sciences, Auckland University of Technology

Departments & Institution for attributing this work: This study was conducted by School of Nursing & School of Oral Health, Faculty of Health and Environmental Sciences, Auckland University of Technology, Aotearoa New Zealand

Corresponding author:

L S Giddings, Associate Professor

School of Nursing, Faculty of Health & Environmental Studies

Auckland University of Technology

Private Bag 92006

Auckland, Aotearoa New Zealand

Email: lynne.giddings@aut.ac.nz

Phone: +64-9-921-9999 ext 7013

Fax: +64-9-921-9796

Abstract

Objectives

Little is known about older persons' perceptions of oral health and oral health care. The purpose of this study was to explore the viewpoint of older adults' regarding their oral health care practices.

Methods

A qualitative interpretive approach comprising three levels of analysis was employed. NVivo qualitative software was used for data management. In-depth individual interviews were conducted with 19 participants aged 65 to 87 years.

Results

Older people don't 'just go' to the dentist. Their decision to access oral health care involves complex and personally meaningful strategies. A dental visit surfaces hopes and fears. Many decide they 'can't afford not to go'. Mouth and teeth are embodied; they are not merely objects of dental care; they represent a person's social and relational self. Ageing related changes challenge the relational self as represented in societal ideal images of youth and perfection (the perfect smile). This study highlights older peoples' resilience and determination when faced with the dilemmas of accessing oral health care – it costs. The costs are personal as well as financial. It is often assumed that older peoples' oral health status is related to neglect. In this study, we found that for many, their current status reflects the intersection of their history with technological advances rather than deliberate neglect.

Conclusions

These findings challenge oral health care practitioners to be sensitive to the contexts that may have affected their older client's current oral health care status. They don't 'just go' the dentist; they bring with them their past dental experiences and their hopes for the future. How one is treated at this vulnerable time, matters.

Key words: Older people; oral health; dental care; embodiment; oral health practices

Background

There has been limited research into the older person's attitudes and beliefs concerning oral health care in Aotearoa New Zealand. Often coming from a different era to their oral health care practitioners, older people can often feel judged and in turn can misjudge their practitioners. A study of elderly Greek and Italian born Australians has shown that past experiences, false beliefs and negative attitudes towards dentistry, can negatively affect the treatment sought and their subsequent oral health status. Although participants generally knew about major oral conditions and treatments, they reported many barriers to seeking oral health recall and maintenance care, including costs, waiting lists, and lack of confidence in the public system (1). From the dental health professionals' perspective, additional stress is reported when working with people who are still affected by previous negative dental experiences (2,3).

The 'one size fits all' attitude commonly held by those in dominant cultural groups, such as health professionals, is often applied to older people. These hegemonic attitudes ignore the diversity inevitably present in such populations. Ettinger (4) highlighted the heterogeneity of older populations, and argues that it is inappropriate to assume that all people aged 65 and over are largely similar. Different gender, culture, class, religion, sexual identity and so on, influence different life experiences, expectations and attitudes, and the value which an individual may place on healthy teeth. The few published studies focusing on elderly peoples' oral health care in Aotearoa New Zealand (5) have collected useful quantitative data. To date few in-depth qualitative studies on community dwelling older people has been undertaken.

The purpose of this study was to explore the perceptions of older adults regarding their oral health care practices. We use the concepts described by Peterson (6) of 'oral health' as being "more than good teeth; it is integral to general health and essential for well-being" p.4. Implicit in this concept are the notions of also being free from pain, disease, chronic conditions, and congenital conditions which affect a persons ability to "…speak, smile, kiss touch, smell taste, chew, swallow and to cry out in pain" p.4. (6)

Method

This qualitative interpretive study involved semi-structured interviews (45 to 90 minutes duration) with older adults (n = 19; 5 male and 14 female), aged 65 to 87 years. The philosophic assumption underlying this approach was that oral health is more fully understood by examining older adult's perceptions within the specific context of their everyday living. Ethical approval for the study was obtained from the Auckland University of Technology Ethics Committee.

Participant recruitment was by way of purposive sampling using snowball technique (7). All interviewers (x3) received training sessions (2x2 hours) in the use and special cultural application of the interview schedule and qualitative interviewing style. Interviews were audio taped, transcribed, and identifying information removed to ensure participant confidentiality and public anonymity. Data were analysed using a three level inductive interpretative approach (8). Preliminary analysis highlighted salient concepts and concept indicators were systematically coded. Relationships between concepts were then

examined. Further analysis involved an exploration of how participants' perceptions influenced strategy adjustments across and within a range of contexts.

NVivo qualitative analysis software was used for data management. Rigour was ensured through collective agreement (co-investigators x2) on the coding process and conceptual development. Memos recorded reflections and decisions made during the analytic process.

Results

Data analyses revealed a dynamic and meaningful relationship between participants' early dental experiences and sometimes their families, and current dental health visits. While there was a range of previous oral health care experiences, there was similarity in their day-to-day oral care practices. Regardless of past experiences, oral health was a priority. While, for the majority of participants' income had reduced on retirement and the cost of dental health care had increased, they continued to persevere with dental treatment. For some, a decision point concerning ongoing treatment was reached when costs outweighed perceived benefits. Daily oral health maintenance was seen as a way to put off this moment of decision.

The dynamic influence of past experiences

For some participants, their primary stories were of childhood dental care visits. These sharp images carrying painful memories were told with immediacy and recounted effortlessly during interview:

> *I can remember … going to the dental clinic and the nurse pulling out teeth and me crying the place down and being so frightened and upset and … the nurse telling me off and saying, I was a very naughty little girl for making such a bad noise in her clinic. So that's my first experience.*

If we knew our name was coming up to go to the dental nurse we would wag. We wouldn't want to go to the murder house.

For others, their primary story concerned loss of teeth. Regardless of their age at the time (adolescence, early adulthood, mid-life or older age), the loss was mourned. For some this had been a lifetime of grief. For those with more recent extractions, the feelings of loss were no less acute. *He lost his teeth when he was 19 and that was what happened in those days and he hated his false teeth.*

…He looked after his teeth … he was determined that he would have his teeth until he died… Then … he had to have all of them out and it was absolute disaster for him. …There was so much infection in his body and we hadn't realised it was coming from his teeth because he had been going to the dentist regularly … he must have been about 65 …I've never known anybody to be so particular about his teeth… 3 months later he was full of energy.

Some stories told of early inevitable tooth loss according to cultural beliefs and dental practices of that time. Participants talked of loosing their teeth either as a result of war, pregnancy or poverty.

She had a baby and she was very good and she was going to the dentist in her pregnancy … but after the baby was born she had to have all of her teeth removed because … you know the gums had decayed and she had

been going to Mr. […] and we were all a little bit upset about this because suddenly she had dentures.

I was 16 when I had them out … in those days you had to have 3 months with absent teeth before you got your next lot in and I had my first boyfriend and I was going to work, going on the tram. He was so nice, he used to sit at the front of the tram and I would be up the back, he would pull faces at me and make me laugh. I still get embarrassed about that.

Personal stories were joined with family stories. Memories of mothers, fathers, aunts, uncles, sisters and brothers entered the storyline and on occasions were accompanied by the showing of photographs. Often related to tooth loss, but also to the experience of family members having dentures, these stories served to reinforce a particular perspective towards tooth maintenance. In some cases, the perspective was that false teeth were never good; in others it was that one-day they might be inevitable.

While, there were few stories that supported the efficacy of false teeth, there were many that had influenced the day-to-day tooth maintenance and care. The response to painful memories of personal or family dental experiences ranged from: never going to a dentist again *I'm not going back to the murder house thank you* , and going when called, I *must say we go because the dentist sends a card along with an appointment every 6 months.*

Dental 'calling' rituals

Being called appeared within the participants' stories as part of the dental ritual. As participants recalled their childhood memories, they spoke metaphorically of 'the murder house' and 'the torture chamber'. They told stories, peppered with nervous laughter, of waiting in terror for their name to be 'called' to go to the dental clinic; "wetting myself", and taking turns to avoid the call. In contrast, there were different childhood memories of regular and fun 'dental callings'. *I used to have to go into the city by tram and I always quite liked it, I've never been frightened of the dentist*.

In adult life, 'dental calling', evoking childhood memories, continued. Participants were 'called' either by the dental surgery receptionist to remind them of visits, or by a dental problem such as toothache, gum soreness, loose teeth or painful ill fitting dentures. One participant had not visited the dentist for five years because she had not been 'called': *I might go for a check up if he rings but he always sends me a note or if I got toothache. Like I said, I've never ever had toothache*.

Those with undisturbed childhood memories or who had developed a determination not to repeat the denture experiences of family members were assertive about their dental care. They visited regularly: *I've been going to the dentist every 6 months in the last 24 years since we retired*. They were knowledgeable about the dental work they received and engaged in conversation

with their dental professional. "*I'm going to see him next month and I will talk about it with him*". When their dentist retired or moved, they *"shopped around"* and "*searched carefully"* for a replacement and if satisfied, stayed. *"I've been with him ever since*". Regardless of whether the experience in childhood was horror-filled or everyday, all participants had ongoing concerns about their teeth in the context of growing older.

Hopes and fears associated with dental visits

The participants reported a change in oral health care treatment need relative to growing older. They had lost the ability to eat particular foods. They described receding gums and fillings falling out. "*They drop off my teeth; I heard the actual clatter of metal of fillings falling off onto my plate*". Each dental visit was a personal and financial cost. They needed to work out what they were going to do each time something happened to their teeth or when they discovered the need for further treatment during a clinic visit. Yet they persevered because in their opinion, they could not afford not to.

My dentist, my dental hygienist: Choosing the right oral health professional

Participants sought approval about the state of their teeth and mouth from the dentist. They talked about the quality of their dentist, dental hygienist or dental technician. While they strategised to get the cheapest possible option, their decision was not always dependent on financial cost. Before deciding where to go for treatment, a number of issues were considered: the dental professionals' credentials; their personality; presentation; reputation and dental clinic access and location. One participant told how

her husband insisted that she choose a specialist for treatment rather than their regular dentist. *He hated his false teeth so he said 'I don't care what it costs go to someone else*.

Rituals associated with going for dental care

A great deal of planning went into each visit to the dentist. The participants talked of working around driving routes, heavy traffic times, dental surgery access (parking and stairs), and making sure there was a back up if they could not drive home. Two processes were evident in their planning. While they attended to the practical realities of going to the dentist, they also re-enacted rituals from childhood. The recalled fear had its corollary – a system of rewarding.

Horror stories were twinned with rewarding stories. Childhood rewards took a variety of forms and came primarily from the dental nurse or parents. The participants remembered the dental nurse's gift of a happy face or a buzzy bee made out of cotton mouth plugs; special food or visits with their parent to the local tea rooms; and for good behaviour, the liberal receipt of praise. One participant, who was a child during the depression of the 1920s, told of the precious gift of an apple – rare and costly in the context of the time.

Adult rewarding rituals mirrored those of their childhood in that self-initiated, adult rewarding contained the symbolic meaning of childhood treats. A number of participants carefully planned coffee or a special lunch with friends, a shopping spree, or just making a day of it. *"Then I went down and shouted myself a coffee."* Both in childhood and adulthood, these rewards reflected achievement and the

overcoming of a challenge. In their mature years, these participants were focused on the 'preservation of the self' as they worked to avoid further tooth loss.

Avoiding further loss and cost: Oral health preventive care

The participants paid attention to changing and improving their oral hygiene practices. This attentiveness reflected their serious concern about their teeth and mouth. They not only listened to the advice of dental hygienists but also informed themselves of new techniques and oral hygiene products.

Two years ago I was put onto Colgate Neutro-Fluro 5000-plus. And you do it every night and you brush for about 2 minutes and then you don't rinse and you are not supposed to drink for half an hour.

If the new information fitted their social belief systems, they comfortably incorporated the technique or product within their everyday dental rituals. If contrary, they were not considered. For example, the advertising of gum as a dental hygiene product has had little effect on these participants. All said they would never chew gum, although one admitted to this practice but ONLY in the privacy of her car.

While many attended for periodontal care, few participants flossed regularly. Some had heard about tongue cleaning but the majority did not consider this a usual practice. Daily oral health maintenance included brushing between three and four times a day, using mouthwashes and fluoride preparations and not eating after their last clean at night. Specific brushes, dental sticks or toothpicks were often used and they adopted cleaning

techniques as taught by the dental hygienist. Participants with dentures used a wide variety of cleaning products, from denture specific cleansers to household bleach.

For all participants, the maintenance of physical health gained via nutrition was a priority. They connected their eating habits with healthy teeth and commented on the change in food choice that either ageing or dentures had produced. Following the advice of health professionals, the participants stopped eating hard foods though for many, their fears of breaking a tooth or difficulty with dentures had already modified the variety of food intake. Their efforts to maintain the health of their mouth and teeth, however, were more than utilitarian; they were central to their sense of self-esteem.

Mouth and teeth are embodied: The social and relational self

Many participants were exquisitely aware of their public presentation. Over the years they had learned mannerisms and ways of posturing that presented their best 'side'. A number of the women talked about how they practiced 'not smiling' or covered their mouth when being photographed. Mannerisms even extended to everyday social contact. *It's your image when you are mixing with other people; it's… your relationship more personally for breath control, bad breath*. There was a sense that appearances could be potentially embarrassing as growing older increased the gaps between teeth and caused food to be caught. They noted the impact of others' false teeth on their resolve to keep their teeth or their remaining teeth.

> *I was standing at the door with another ex-solider and he said to me 'you know …, I don't recognise any of these men'. I said 'Don't you'. He said 'No. They've*

all got false teeth and their expressions are different'. I've often thought of that and it's true that once people lose their own teeth their expressions change.

On the other hand, those with dentures 'made the best of it', recognised that their situation was different but still faced the dilemmas of maintenance of their dentures.

Getting to the bottom line: Resolving tensions and dilemmas

Regardless of whether the participants were dentate, partially dentate or edentulous, they wrestled with dilemmas and tensions. On the one hand it was important that they maintained their health and comfort in their social milieu. On the other hand, ageing brought with it increased dental care needs and associated costs. They weighed up the pros and cons before deciding their bottom line. For some, it was when they required endodontic therapy. For others it was whether their current set of dentures would be 'good enough for the years remaining'.

For all participants, considering the future was a challenge as they wrestled with issues of continued access to dental care, balanced with dwindling funds and minimal reimbursements. The hopes for each dental visit were that it would be affordable and that no treatment would be required. They feared that their bottom line would be reached.

I… would have descaling of my gums and I really realised how lucky I was because I hear of other people who have had abscesses and goodness knows what and lost teeth and everything. Here I am 76 and I'm still going fine. I'd better not speak too soon.

Discussion

Central to this study is the notion that the mouth and the teeth represent the embodied self. They are the objects of the personal, public and professional gaze. For many this surveillance results in self-protective behaviours to avert shame. In the social context, the state of a person's mouth and teeth can have a profound impact on their self-esteem. This is particularly so in the current world of pearly whites that are even, glowing and seated within a young unlined face as promoted by the media. Ageing challenges the symbolic representations of the ideal healthy oral appearance. Teeth may discolour with age, fillings fall out and food gets caught between the gaps. Their everyday reality starkly contrasts with media images. There is however, an increasing demand for aesthetic and restorative dentistry as well as an increasing ability for oral health professionals to meet this demand (9). Unfortunately for many of these participants, the cost of accessing such dental treatment would be prohibitive.

The age group represented in this study came from an era when dentistry was in its infancy, technologically and professionally. Many participants had lived through war and depression, times when removing teeth and having dentures were the norm and these findings have some similarity with those of Marino, Minichiello, Wright & Schofield (1). Such findings challenge the societal myth that older people's oral health status is the result of neglect and an inability to change with the times. These women and men 'got on with it'. They adapted to and incorporated many new oral health techniques and practices. Going for dental treatment was multidimensional. Yet in today's culture, having false, crooked or discoloured teeth is often attributed to neglect. A recent Australian study reported no relationship between socioeconomic status, poor oral health

and neglect in self-care (10). The older people in this study were aware of the current social discourse regarding healthy teeth. They were sensitive to the approval or disapproval of others, particularly their dental carers.

These participants demonstrated remarkable resilience and determination. They learned new techniques of daily oral hygiene, adjusted the type of food they ate and maintained their dental health until they just couldn't afford it any more. Some overrode previous negative experiences and family stories to visit the dentist. They were assertive. They looked for a collaborative partnership with their oral health professional that would involve mutual respect, information sharing and collaborative decision-making.

> *I know I went back to my original dentist and I said to him I had left you because you keep nagging me because I can't open my mouth and I can't open my mouth. He never nagged me anymore.*

The complex dimensions of daily living experienced by the participants captured in the interviews were a strength of this study. The results demonstrate the care that people take with their teeth even though for some, their visits are 'problem oriented' rather than preventive.

A limitation of this study is the homogeneity of the participants. The majority came from working or middle class backgrounds, owned their own homes and cars, and were predominantly women. Additionally, we were unable to recruit Maori. The findings therefore, are more representative of mainstream European oral health care experiences. A more heterogeneous sample could have added

complexity. For example, the male participants, though small in number, recounted poignant stories of their dental experiences in the field of war. Future studies involving a more diverse sample, might examine more fully, the impact of previous experiences on older peoples' current oral health status.

References

1. Marino R, Minichiello V, Wright C, Schofield M. Oral health beliefs and practices among Greek and Italian Older Australians: A focus group approach. Australasian Journal on Ageing 2002; 21(4): 193-198.
2. Cohen S, Fiske J, Newton J. The impact of dental anxiety on daily living. Br Dent J 2000; 189(7): 385-390
3. Kvale G, Milgrom P, Getz T, Weinstein P, Johnsen TB. Beliefs about professional ethics, dentist-patient communication, control and trust among fearful dental patients: The factor structure of the revised dental beliefs survey. Acta Odontol Scand 2004; 62: 21-29.
4. Ettinger RL. Cohort differences among aging populations: A challenge for the dental profession. Spec Care in Dentist 1993; 13: 19-26.
5. National Health Committee. Preventive dental strategies for older populations June 1997. Available online: URL: http://www.nhc.govt.nz/publications/dental/prevent.html Accessed March, 2006
6. Petersen PE, Yamamoto T. Improving the oral health of older people: The approach of the WHO Global Oral Health Programme. Community Dent Oral Epidemiol 2005; 33(2): 81-92.
7. Patton, MQ. Qualitative research & evaluation methods (3rd ed.). Thousand Oaks: Sage Publications, 2002
8. Grbich C. Qualitative research in health. St. Leonards: Allen & Unwin, 1999
9. Niessen LC. Geriatric Dentistry in the Next Millennium: Opportunities for Leadership in Oral Health. Gerodontology 2000; 17(1): 3-7.

10. Sanders AE, Spencer AJ, Slade GD. Evaluating the role of dental behaviour in oral health inequalities. Community Dent Oral Epidemiol 2006; 34(1): 71-79.