THE RELATIONSHIP OF PERCEIVED ORAL HEALTH, BODY IMAGE AND SOCIAL

INTERACTIONS AMONG INSTITUTIONALIZED ELDERS

by

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ABSTRACT

Objective: Social interactions among frail elders in long-term care facilities are limited, but to what extent body image and perceived oral health influence their social relations are poorly understood. A positive body image and the perception of adequate oral health are linked to increased social contacts, as well as improved health and well-being irrespective of age. However, as frailty increases it is unclear if appearance and oral health priorities remain stable. This study explored the relationship between oral health, body image and social interactions among a diverse group of frail elders. The research question underlying the study is "*how are social interactions influenced by perceived oral health and body image in elderly people who live in long-term care facilities*?"

Methods: Open-ended interviews were conducted with a purposefully selected group of cognitively intact, institutionalized elderly men and women who exhibited varying degrees of frailty, social engagement and oral health conditions, and lived in one of eight long-term care facilities.   The interviews were analyzed using a constant comparative technique, and a second interview with each participant checked the trustworthiness of the analysis.

Results: Three major categories influenced the social interactions of the participants: 1) perceived oral health; 2) priorities and perceived access to care; 3) institutionalization and frailty.   The major categories were influenced by the coping and adapting strategies, health status, dependency, institutional culture, investment, support,

personality, socio-economic status, comfort, function, cleanliness and noticeability of oral conditions among the participants.

Conclusions: Perceived oral health and body image among institutionalized frail elders were influenced by comfort, hygiene, cleanliness and noticeability of oral conditions. These findings were similar to reports of elders who reside in the community; however the extent to which social interactions were negatively impacted depended on multiple aspects of living in a care facility, degree of frailty, and priorities of care.

PREFACE

Ethical approval for this study (H08-01941) was received from the University of British

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DEDICATION

To my mother and father,

Evelyn and Ed Donnelly

& my brother,

Tony Donnelly

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patience, love, trust, and encouragement you each have shown me over the years.

You always believed in me.

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CHAPTER 1: INTRODUCTION

An encounter I had as a dental hygienist with an elderly woman in a long-term (LTC) facility indicated that oral health conditions can have a definite impact on social interactions. I had cleaned the woman's teeth every three months for more than two years during which time she did not speak but communicated solely by nodding in response to questions, which I attributed to a past stroke and increasing frailty. Due to an infection in her mouth, she received additional daily oral care from the nursing staff and several sessions of professional oral hygiene. Soon after this extra care she began to speak, and when I congratulated her on her improvement, she replied, "*my breath doesn't smell anymore*".   Further discussions with staff and family revealed that in the past she had been very proud of her appearance and had been very attentive to the health and appearance of her mouth. The woman's improved oral hygiene seemed to revitalize her self-confidence and willingness to communicate despite broken teeth. Unfortunately, a search of the literature failed to offer a substantial explanation of why oral hygiene could have such a profound impact on this woman.

Older adults are the fastest growing segment of our population. Those aged 65 and older currently account for approximately 13% of the Canadian population and this number is projected to increase to nearly 25% by 2040 (Statistics Canada, 2010). At the present time approximately 14% of those over the age of 75 live in LTC facilities due to declining cognitive or physical health and dependence on others for help with daily activities (Statistics Canada, 2007).   Social isolation among the residents of these facilities is a growing concern because of the association between weak social contacts

and multiple disease processes such as cardiovascular disease, cancer, reduced host resistance, and impaired cognitive function (Beland, Zunzunegui, Alvarado, Otero, & del Ser, 2005; Berkman & Syme 1979; Fiori, Antonucci, & Cortina, 2006; Uchino, Cacioppo, & Keicolt-Glaser, 1996; Vogt, Mullooly, Ernst, Pope, & Hollis, 1992) and even with increased mortality and morbidity (Berkman, 1995; House, Landis, & Umberson, 1988). In fact, as a health risk, social isolation has been equated to cigarette smoking, hypertension, elevated levels of cholesterol, obesity, and to physical inactivity (House *et al.,* 1988).

Social isolation can be a complex phenomenon (House *et al.*, 1988; Wenger & Burholt, 2004), and to date we know very little about how it is influenced by poor oral health or dental impairment. We know that bad breath can negatively impact self-confidence and lead to insecurity during social relations (McKeown, 2003). We also know that tooth loss can be socially disabling due to the profoundly negative impact on appearance satisfaction, self-image, confidence and the formation of close relationships (Fiske, Davis, Francis, & Gelbier, 1998). Furthermore, unsightly teeth or even minor deviances in dental appearance can cause significant concern in social situations (Klages, Bruckner, & Zetner, 2004). Fortunately the restoration of broken teeth, replacement of missing teeth and improvement of facial profile can all improve social confidence (Fiske, *et al.,* 1998; Kiyak, Beach, Worthington, Taylor, Bolender, & Evans, 1990; MacEntee, Hole, & Stolar, 1997), but the extent of this influence and impact among frail elders in LTC has received little attention (MacEntee, 2006).

Poor oral health can evoke negative body images when cultural ideals are not met, and the inability to achieve a facial image deemed acceptable to society can lower self-esteem. This relationship has been demonstrated among children with developmental malformations (Hunt, Burden, Hepper, & Johnston, 2005), adolescents and young adults undergoing orthodontic treatment (Kiyak, 2000a), as well as adults with facial injuries (Levine, Degutis, Pruzinsky, Shin, & Persing, 2005; Shetty, Dent, Glynn, & Brown, 2003), facial cancer (Fingeret, Vidrine, Reece, Gillenwater, & Gritz, 2010), and malocclusions (Kiyak, 2000a).   However, with the exception of tooth loss, little focus has been given to how body image of older adults is impacted by poor oral health conditions (Davis, Fiske, Scott, & Radford, 2000).

Majercsik (2005) in his hierarchy of needs places self-actualization and esteem very high at least in societies where subsistence needs are met. Having a firm belief in self-worth and self-esteem are important in old age and are in contrast to Maslow's hierarchy of other age groups where physiological needs take precedence (Maslow, 1943). It is likely also that older people, on realizing their limitations, strive for confirmation that they have achieved their full potential (Majercsik, 2005).   This struggle has important implications in our approach to care so that physiological needs do not supersede psychosocial needs (Majercsik, 2005). The psychological impact may be more important than the biological consequences of oral disease to older people. Therefore if poor oral health disturbs body image in old age, it is possible that it can influence self-esteem negatively and result in avoidance of social interactions, which could contribute to a general decline in overall health.

Eriksen and Dimitrov (2003) proposed that research related to oral health needs to move from the biomedical context of function, dysfunction and malfunction to a broader social context. They suggest that focusing on "biological responses to dental health and disease", limits understanding of how this complex body part impacts overall well-being. For example, by focusing only on physiological disturbances to chewing and swallowing when teeth are broken, the risk of social isolation from embarrassment of eating with others could be overlooked. Current models of oral health in old age, suggest that the full impact of tooth loss is dependent as much on the social environment as it is on the physical attributes of the individual (MacEntee, 2006a). As yet, little attention has been paid to the psychosocial impact of oral conditions.

1.1 Research Design

This study was designed to explore how oral health and disease influence appearance-related concerns and social behaviour of elders in LTC. I used a qualitative research method from a social constructivist perspective to interview 23 elderly people who had been living in LTC for intervals ranging from six months to 10 years. The interviews focused on the participants' perceptions of social activities, personal appearance and oral health. The concepts underlying my questions drew upon theories of aging, oral health, body image, and disfigurement. In particular, I aimed to build upon existing knowledge of concerns about oral health in old age, social interactions, and personal appearance by considering the added influence of frailty and institutionalization.

1.2 Research Question

The exploration of these issues was guided by the following question:

How are social interactions influenced by perceived oral health and body image in elderly people who live in long-term care facilities?

CHAPTER 2: LITERATURE REVIEW

2.1 Institutionalization

Declining physical or cognitive function and the inability to receive needed care in the community often necessitates institutionalization and is one of the greatest fears and stresses that elders experience (Lee, 1997). Moving to a LTC facility is not usually a choice made by an older person, but instead a decision made by family and health care professionals (Chenitz, 1983). How each person adapts and adjusts to such a move is as unique as the individual (Wadensten, 2007). Some residents thrive in their new surroundings, while others become reclusive and depressed (Wadensten, 2007). Direct involvement in the decision to move to a care facility helps the elderly person to accept the transition with less stress, as it enhances their sense of autonomy (Eales, Keating & Damsma, 2001). When in the facility, being able to retain a sense of control over decisions is also important to help the adaptation (Hwang, Lin, Tung, & Wu, 2006; Park, 2009).

Loss of control is particularly difficult for elders who move to an institution; therefore the preservation of daily activities encourages autonomy and well-being (Hwang *et al.*, 2006). Being able to complete even simple tasks help residents feel less dependent (Rodgers & Neville, 2007), and even when unable to complete daily self-care, it is encouraging to residents if they have opportunities to direct the care received from others (Eales *et al.*, 2001). The ability to direct care can reinforce a sense of self-worth and enhance quality of life (Jonas- Simpson, Mitchell, Fisher, Jones, & Linscott, 2006).

However, the degree to which this is possible is dependent on the culture of the institution and the elder's ability to express their needs (Bland, 2007).

2.2 Reformation of LTC Facilities

Long-term care facilities provide housing, recreation and healthcare for people who can no longer live independently. They have undergone extensive changes in structure, appearance and delivery of care over the past decade (Ragsdale & McDougall, 2008). Some of this change has been influenced by a better understanding of how institutionalization can contribute to loneliness, helplessness, and boredom (Slama & Bergman-Evans, 2000). Today, many of the more progressive facilities have reformed from the previous barren, white, sterile, hospital-like settings, in efforts to be more like "a home away from home" (Bland, 2005). Many facilities in Canada offer residents a private room with a bathroom, along with the opportunity to make the room look a little like "home". The concept of "home" also includes the autonomy and individuality accorded to the residents. This reformation has been described as "individualized", "person-centered", "client-centered" , "relationship-centered" or "holistic" care in which LTC facilities strive to work with residents, families and healthcare professionals to meet both medical and psychosocial needs (Nolan, Davies, & Brown, 2006; Bland, 2007).

2.3 Residents in LTC Facilities

Most residents of LTC facilities in Canada are over the age of 75 years, have multiple chronic health conditions, take numerous medications, require nursing care and have varying degrees of independence for activities of daily living (ADL), such as

bathing, toileting, personal hygiene, mobility and eating (Canadian Institute for Health Information, 2010). Those who are cognitively impaired usually experience the greatest decline in ADL and require more assistance from care-staff (Njegovan, Man-Son-Hing, Mitchel, & Molnar, 2001). Cognitive impairment ranging from mild dementia, such as slow recall and some degree of short term memory loss, to more severe forms such as advanced Alzheimer's disease affects nearly 75% of the residents (Canadian Institute for Health Information, 2010).

Residents in LTC facilities are often stigmatized as sick, old people who are frail (Dobbs *et al.*, 2008). Although frailty is often associated with old age and illness, it is not an inevitable consequence of aging, nor is it always associated with an identifiable disease or disability (Abellan van Kan *et al.*, 2008). To date there is no consensus on the most appropriate definition or clinical assessment tool for frailty, leading to varied prevalence rates among residents (Abellan van Kan *et al.*, 2010). Yet it is generally accepted that older adults who are frail are in a pre-disability stage and more vulnerable to adverse health outcomes, mortality and institutionalization (Abellan van Kan *et al.*, 2008).

Early definitions of frailty revolved around the inability to live alone due to being old and dependent on others (Woodhouse, Wynne, Baillie, James, & Rawlins, 1988), or being old and having multiple illnesses (Pawlson, 1988), but today it is considered to be much more complex.   Brocklehurst (1985) depicts frailty as a dynamic balance of assets and deficits of biomedical and psychosocial components of health that enable

independent living.   When deficits outweigh assets, elders are considered frail and usually live in institutions; however, Rockwood & Mitnitski (2011) add that it is not just the presence of deficits, but the accumulation and quantity that matters when considering frailty. Conversely, Fried *et al.* (2001) describe frailty based on a physical phenotype that is evidenced by the occurrence of at least three deficits, such as slowed gait, self-reported exhaustion, declining activity levels, unintentional weight loss, and decreased grip strength. This assessment protocol, although it does not consider psychosocial and environmental factors, is considered by Abellan van Kan *et al.* (2008) as a reliable predictor of adverse health outcomes and loss of independence among older adults.

2.4 Provision of Care in LTC Facilities

Improved medical management of disease generally has increased life-expectancy so that the residents of LTC facilities today are older, frailer, and sicker than ever before (McGregor *et al.*, 2010). The changing demographics of residents necessitate an increase in care, but this has not translated into an increase in the care-giving workforce (McGregor *et al.*, 2010). This poses not only a problem in delivering basic care, but makes it almost impossible to provide individualized care. The daily routines within most of the facilities are directed at maximizing the efficiency of staff- time, while preserving the health of the residents (Rodgers & Neville, 2007).   Consequently, the staff who believe that they are limited by time tend more to activities that are measured by their superiors (Bowers, Esmond, & Jacobson 2000). In this way the goal of care is to get residents clean and tidy, but with little care for the autonomy and personhood or

social life of each resident (Lee-Treweek, 1994; Rodgers & Neville, 2007; Nolan, Grant, & Nolan, 1995; Kitwood, 1997).

Positive relationships with staff are very significant to elders (Jacelon, 2002; McKee, Harrison, & Lee, 1999; Mattiason & Andersson, 1997). Staff also indicate that it is a high priority for them to talk with residents, but this is not always feasible given imposed time pressures (Armstrong-Esther, Browne & McAfee, 1994). Consequently, there is insufficient time for staff to become familiar with each resident, and therefore individualized care that respects personal values and preferences is challenging to provide (Keating, Fast, Dosman & Eales, 2001).

2.5 Social and Emotional Isolation in Old Age

Inability to form social ties in LTC can result in an elderly resident spending the majority of their time alone (Harper Ice, 2002). Social isolation is an objective measure of physical separation from others that can increase with impaired mobility, retirement from work, or death of family and friends (Havens & Hall, 2001). Usually it is measured as the number of social contacts, hours spent alone, and the size and type of social networks (Seeman, Bruce, & McAlvay, 1996). Emotional isolation or loneliness is a similar but subjective assessment of social relationships, and measured typically on a loneliness scale (de Jong Gierveld & Havens, 2004). The objectivity of social isolation and the subjectivity of loneliness share common personal, social and health-related characteristics, but they are caused by different psychosocial conditions as witnessed frequently in LTC where some elders prefer long periods alone without obvious signs of

loneliness (Havens, Hall, Silvestre, & Jivan, 2004; Wenger & Burholt, 2004), while others are profoundly lonely despite high degrees of social relations (Perlman, 2004).

Social and emotional isolation can have a negative impact on health, however this complex process is not well understood due to the multiple social variables involved (Tomaka, Thompson, & Palacios, 2006).   Social relationships can induce feelings of belonging and well-being, whereas isolation can lead to depression, unhealthy behaviour and increased susceptibility to disease, possibly through alterations in neural, hormonal and immunological pathways (Berkman & Syme, 1979; House *et al.*, 1988). Social relationships are also strong predictors of mortality that operate independently of gender, ethnicity or other risk factors to diseases and illness (House *et al.*, 1988; Seeman, 2000). Yet it remains unclear whether social and emotional isolation cause disease or if disease limits social relations. Indeed, it may operate as a reciprocal relationship in which social interaction helps to prevent disability that in turn promotes social interaction (Mendes de Leon, Gold, Glass, Kaplan, & George, 2001; Tomaka *et al.*, 2006).

Much of the interest in social interactions in old age has focused on the measurement of social networks (Giles, Glonek, Luszcz, & Andrews, 2005; Tomaka *et al.*, 2006; Seeman, 2000), social support (Peeninx *et al.*, 1997) and social participation (Glass, Mendes de Leon, Marottoli, & Berkman, 1999; Maier & Klumb, 2005).   There have been very few attempts to explain how health rather than the consequences of disease influence social behaviours (Hunt, 1997; Ustun, Chatterji, Bickenbach,

Kostanjsek, & Schneider, 2003).   Oral health, for example, is assessed usually from the negative perspective of diseases and dysfunction, while psychosocial indicators of oral health (or socio-dental indicators) relate predominantly to the negative effects of oral diseases and dysfunctions on social and psychological well-being or quality of life (Brondani, Bryant, & MacEntee, 2007; MacEntee, 2006a).   Yet oral health is a dynamic phenomenon influenced by many factors that change with time and circumstances, and that generate positive as well as negative emotions (Brondani *et al.*, 2007; Gregory, Gibson & Robinson, 2005; MacEntee, 2006a). Nonetheless, we have limited understanding of how much positive or negative influence oral health or disease imposes on people when they are frail and in LTC.

2.6 Social Interactions and Theories of Aging

A lack of social interactions can be harmful from a biomedical perspective, but from a psychosocial perspective it is unclear whether or not self-imposed isolation is a bad thing. This becomes even less clear considering the heterogeneity of the elderly population.   Not everyone experiences aging in a negative manner. Rowe and Khan's Model of Successful Aging (1987) suggests that aging is either "usual" and accompanied by typical age-related losses, or "successful" and unencumbered by losses. They suggest that aging generally is dependant not on chronological age but on extrinsic factors such as lifestyle, living arrangement, habits, diet, autonomy, control and support. They maintain that these factors are largely underestimated as contributing factors in the aging-related declines. Therefore, individual life factors may play a more important role in physiological or psychological declines, than being alone. Theories of

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aging, such as the Socioemotional Selectivity Theory (Carstensen, 1992),

Disengagement Theory (Cumming, Henry, & Damianopoulos, 1961), and the

Gerotranscendence Theory (Tornstam, 1997), contend that limited or discretionary

social relations and activities are a normal and healthy part of aging.   In contrast,

Activity Theory purports that social engagement is necessary for good health and well-

being (Lemon, Bengston, & Peterson, 1972), and Continuity Theory contends that social

behaviours and activities are maintained as we age (Atchley, 1971).

    Our ability to adjust contributes to successful aging.   Activity Theory holds further

that social roles and activities support social and psychological needs as we age

(Havinghurst & Albrecht, 1953). This theory contends that social interactions and

activity are desirable in mid-life, but with declining health, retirement and relocation, we

need to replace our past activities, roles and social relations. For example, an elderly

person actively involved in a community church, and now in LTC, should enjoy

attending the facility's church services according to this theory.   However, Activity

Theory has been criticised because not all activities and relationships are beneficial

(Lemon *et al.*, 1972). Furthermore, social and psychological needs can change over a

lifetime, and not everyone has the resources or the ability to adjust (Hoyt, Kaiser,

Peters, & Babchuk, 1980). Therefore, the elderly church-goer above might get little

satisfaction from the church in the facility if her previous social ties were to a particular

congregation. In this way it is not the activity per se that contributes to well-being, but

instead the enjoyment from being in the presence of others who are important. These

informal social activities have been shown in numerous studies to positively influence

well-being in old age (Ritchey, Ritchey, & Dietz, 2001; Warr, Butcher, & Robertson).

While others contend that productive activity is important for improving mental and

physical health (Werngren-Elgstrom, Brandt, & Iwarsson, 2006).

    Continuity Theory builds on Activity Theory and describes normal aging over a life-

course (Atchley, 1971). It purports that activities, relationships and personal preferences

during mid-life continue into old age. Internal and external structures of the past form

the foundation that guides future goals and decisions. In this way, the internal structure

of our personality, ideas and beliefs along with the external structures of our social roles

and relationships remain constant and help to maintain our identity. These structures

classify the continuity in our lives as "too little, optimum or too much" (Atchley, 1989),

and a positive adjustment to old age occurs when we achieve an optimal continuity of

our self and relationships.   The continuity intrinsic to this theory suggests that our

elderly church goer would make a positive adjustment to old age by attending the same

church as before, even if it was less often. Recently, Pushkar *et al.* (2010) in their study

of retired men and women found that continuity of activities and their emotional impact

remain relatively stable into later years, most likely due to established preferences for

activities that impart enjoyment. Agahi, Ahacic & Parker, (2006) also contend that

continuity of activities enjoyed in mid-life, carry into later years, while others have found

that participation in activities can either increase or decrease with age (Bukov, Mass, &

Lampert, 2002). With advancing age, less strenuous activities such as watching

television and reading may be more likely to be continued, but these changes are often

associated with marital status, health, education and gender (Strain, Grabusic, Searle, & Dunn, 2002).

In contrast to aging theories that encourage social interactions and continued activity, <u>Disengagement Theory</u>, one of the earliest and most contentious theories of aging, describes aging as a gradual and mutually beneficial withdrawal or "disengagement" of older people from society (Cumming *et al*., 1961). It proposes that withdrawal from social roles and activities is inevitably due to retirement, relocation, declining health and loss of friends and family, while society expects it's less productive elders to help maintain social "equilibrium" by withdrawing from the workforce. Although it suggests that mutual disengagement relieves elders of their social responsibilities and provides time for self-reflection, it also recognizes that social isolation is unpleasant, even if self-imposed. Hochschild (1975) contends that elderly people don't always want to disengage, and they can be very unhappy and feel undervalued when forced to do so. Cumming (1963) added the dimension of personality to the way in which individuals disengage. She described older adults as either "impingers" who want to remain active within society or "selectors" who are more likely to disengage. Those unwilling to disengage are disruptive to the social system when they die because they leave an unstable void in the system, which requires adjustment. Yet the theory holds that eventually, even the "impingers" will disengage, so that our elderly church member would age successfully by disengaging from her church, as the church's congregation withdrew from her.

Criticisms of Disengagement Theory lead to newer ways of looking at how and why social activities and relationships decrease with age. Tornstam (1997) proposed in his Gerotranscendence Theory that elders find fulfillment and life-satisfaction in solitude, reflection and meditation. Our perspective as we age shifts, he contends, from an interactive, materialistic and pragmatic view of our role in the world towards a more reflective and spiritual view, which is normally accompanied by an increase in life-satisfaction. Therefore, an elderly person who is reconciled to old age may quite reasonably feel little obligation to socialize or to establish casual relationships, but prefer a more contemplative state. Consequently, according to this theory, the imposition of social activities that so often pervades daily life in a LTC facility might impede the development of "gerotranscendence" and reduce life-satisfaction. It could explain also why some people with many social contacts are profoundly lonely and unhappy when social engagements are persistently forced upon them (Pinquart & Sorensen, 2001). Therefore, elderly people may be very dissatisfied if forced or coerced to attend church services.

Giles *et al.* (2005) contend that it is the quality rather than the quantity of social interactions that matters in old age, and they support Carstensen's Theory of Socio-Emotional Selectivity, which, like Tornstam's theory of Gerotranscendence proposes that the motivation for social interaction in old age is driven mostly by a search for intimate and fulfilling emotional experiences. Carstensen believes that motivation for social interactions in old age no longer focuses on optimizing the future through new knowledge, but shifts to the pursuit of meaningful emotional experiences due to a

realization of limited time. Elders no longer feel compelled to engage in trivial social

relationships or activities, but instead want to make the most of their remaining time with

people who are important to them. Unfortunately this quest for intimacy can be

thwarted by the physical and cognitive disabilities that lead to placement in an LTC

facility (Buckley & McCarthy, 2009).

Social interactions and activity levels in old age can be as heterogeneous as the

individuals themselves. It is therefore no surprise that numerous theories on aging try

to explain how and why we spend our time as we grow old. Whether social activities or

solitary pursuits confer health benefits as we age cannot be explained by one theory

alone given the complexity of personal and environmental characteristics that influence

health (MacEntee, 2006a; WHO, 2001). Despite the differences between the various

theories of aging, most share the premise that social interactions and activities should

be meaningful rather than frivolous if they are to promote health and satisfaction.

Therefore we need input into how we spend our time. This is especially important for

people who live in LTC facilities as it offers a sense of identity and autonomy (Phinney,

Chaudhury & O'Connor, 2007; Schourfield, 2007).

2.7 Body Image

First defined in 1935 by Schilder as "the picture of our body which we form in our

mind", body image refers to how we view our bodies, how invested we are in our

appearances, and how others perceive and react to us (Cash & Pruzinsky, 1990). Body

image is "the combination of an individual's psychological experiences, feelings and

attitudes that relate to the form, function, appearance and desirability of one's own body which is influenced by individual and environmental factors" (Taleporos & McCabe, 2002).   Men's and women's concerns with appearances are strongly influenced by cultural standards of masculine and feminine attractiveness, which in Western society emphasize youthful characteristics such as smooth skin, slimness, physical fitness, non-gray hair, and perfectly aligned white teeth. The drive to achieve such ideals can lead to eating disorders, excessive exercise, drug use, invasive surgical procedures, and expensive beauty practices (Hurd Clarke & Griffin, 2007).   Body image is also part of our self-identity and can influence self-esteem, usually by how well we project socially accepted characteristics of masculinity and femininity (Davidson & McCabe, 2005).

Investigations of body image have focused mainly on women, although there is growing evidence that men also experience concerns about body image, albeit differently (Davison & McCabe, 2005; Halliwell & Dittmar, 2003; Hayslip *et al.*, 1997; Kaminski & Hayslip, 2006). In Western culture the male body has traditionally been valued for strength and function, while women's bodies have been viewed as objects that are valued for their beauty (Franzoi & Koehler, 1998). Therefore women are encouraged to focus on components of their bodies which affect their external beauty, such as tight and wrinkle-free skin, while men are directed towards their body as a whole and how it functions (McCabe & Ricciardelli, 2004).   Consequently, the surface wrinkles and sagging of old skin may have a more disturbing effect on women (Hurd Clarke & Griffin, 2008).   Yet, there are signs that a preoccupation with appearance is not exclusively the concern of women (Farquhar & Wasylkiw, 2007). Body

dissatisfaction regarding weight and muscularity has emerged in recent years as serious concerns also of men (Bergeron & Tylka, 2007; Ridgeway & Tylka, 2005). Muscularity, in particular appears to be an important issue as it is a physical feature that projects the socially endorsed stereotype of masculinity; strength, power, virility and dominance (Connell & Messerschmidt, 2005). Yet men's preoccupation with muscularity can diminish when socioeconomic status and career enables a projection of masculine ideals, such as power and dominance, rendering body attributes less important (Wienke, 1998). In this way, higher socio-economic status seems to enable some men to avoid dissatisfaction with their appearance in a way that is not possible for women due to the ideals of feminine beauty (McKinley 2006). Whereas men tend to invest less in their appearance as they grow affluent, women tend to invest more in their appearance and experience greater dissatisfaction with their bodies as they become more affluent. Nonetheless, affluent women have the financial ability to improve their appearance through expensive "beauty work", designer clothes, non-fattening but nutritious food and personal trainers (Dumas, Laberge & Straka, 2005). This investment in a "good" appearance helps affluent women project more than just cultural ideals of femininity, but also provides a means of projecting social status (Dumas *et al.,* 2005). Conversely, women with less financial means tend to find satisfaction in other aspects of life typically by minimizing the significance of their appearance, unless of course they work in fashion or other industries where appearance is highly valued (Dumas *et al.*, 2005).

2.7.1 Theories of Body Image

Body image is a multi-faceted construct that can be influenced by numerous personal and societal characteristics such as gender, sexual orientation, ethnicity, socioeconomic status and culture (Cash & Pruzinsky, 2004). Individuals place value on particular body parts, which leads to either a positive or negative evaluation of the part, and which may or may not be of consequence to the individual's self-esteem (Cash, Theriault, & Annis, 2004). For instance, a woman in Western society with large thighs but straight teeth will probably be dissatisfied with her legs but pleased with her teeth, because western society generally favours thin thighs. Other cultures have different ideals of personal beauty. A Sudanese woman, for example, is less likely to value the appearance of her teeth because tooth loss in the Sudan signifies adulthood, beauty and tribal identity (Willis, Schacht & Toothaker, 2005).

A number of different theoretical models have been utilized in the study of body image. The Tripartite Influence Model asserts that the formation of body image is influenced by messages from parents, peers and the media (Keery, van den Berg, & Thompson, 2004). Mothers and fathers who show concern for a child's appearance, or a preoccupation with their own, send both direct and indirect messages to their children about what is acceptable. These perceptions can be confirmed and strengthened through comments from peers and from images portrayed in the news media. A child who receives parental messages about obesity, is teased by peers, and is exposed to images of thin fashion models, is quite likely to be concerned about body weight (Markus, 1977; Markus, Hamill, & Sentis, 1987).

The Theory of Social Comparison proposed by social psychologist Leon Festinger (1954) also helps to explain the formation of body image by illustrating our innate drive to compare ourselves with others. The theory suggests that lateral comparisons place us within the group, whereas an upward and downward comparison relates us as better as or worse than others. Self-esteem, in turn, is influenced by where we fit compared to others (van den Berg & Thompson, 2007), and can be deeply disturbed when we pitch ourselves against the unattainable western ideals of masculinity and femininity (Farquahar & Wasylkiw, 2007; Tiggemann & McGill, 2004; Tiggemann & Slater, 2004).

An important aspect of body image is the influence of societal norms on an individual's belief of what their body should be. From a feminist perspective, the Theory of Objectified Body Consciousness (OBC) asserts that a body is an object to be viewed and evaluated against cultural ideals. Through "body surveillance" we are matched continuously by society to a standard deemed ideal for our culture, and through an "internalization of a cultural standard", we view these cultural ideals as our own (McKinley, 2006). Our ability to meet the ideal, therefore, is considered as either achievement or failure, and it is a continuous process directed by our "appearance control beliefs" regarding the possibility of attaining the ideal. Of course, many of the cultural standards and ideals of Western societies are based on youthful characteristics that are utterly unattainable as we age, and even more so if we are poor and disabled. Although the theory of OBC has been used mainly to explain feelings about body weight and to study eating disorders among young women, it has been used also to explain

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depression in men and women of different ages as a result of increased body shame and appearance anxiety (Tiggeman & Kurring, 2004).

2.7.2 Body Image in Old Age

Typically, the study of body image has focused on young or middle-aged adults (Tiggemann, 2004), yet concerns about body image might be equally troublesome to older women and men (Kaminski & Hayslip, 2006). This segment of the population experiences greater changes in body function, composition and appearance than younger cohorts, and an increasing interest in body image among older adults is providing evidence that dissatisfaction with the body occurs across the lifespan and remains somewhat stable (Hayslip *et al.*, 1997; Tiggemann, 2004). For example, appearance rather than health is identified as a key motivation for losing weight among older women (Hurd Clarke, 2002), and may be a reflection of a life-long battle with weight (Pruis & Janowsky, 2010). Certainly, older women are concerned about health risks and related benefits of weight loss, but there are many who are seriously motivated to lose weight by a desire to improve their appearance (Hurd Clarke, 2002). A notable difference in body image emerging between the young and old is the relative importance that is placed on appearance (Tiggemann, 2004). Although body image dissatisfaction can be stable across the lifespan, the degree to which one is invested in their appearance may decrease with advancing age (Kaminski & Hayslip, 2006; Pruis & Janowsky, 2010). Even though anxiety about weight and muscularity can persist into old age (Hurd, 2000; Lewis & Cachelin, 2001; Mangweth-Matzek *et al.*, 2007), whether or not this or other body concerns persist as we grow frail and lose control over our

ability to maintain an acceptable appearance is unknown. While the young seem to experience body dissatisfaction mainly due to the inability to meet masculine and feminine cultural ideals related to physical appearance, older men and women are more troubled by functional declines (Reboussin *et al.*, 2000). This may partly explain the observed decrease in appearance-related concerns of the very old (Umstattd, Wilcox, & Dowda, 2011). Yet, at the same time, the social emphasis on youthful appearances leads to the disparagement of aging and aged bodies with concomitant negative effects for many older adults' sense of self-esteem (Baker & Gringart, 2009; Bedford & Johnson, 2006; Hayslip *et al.*, 1997).

Influences on body image such as socioeconomic status also appears to remain stable across the lifespan since older women with less affluence in our society appear better able to adapt to body changes than those who are more affluent, possibly due to the difference in life-stress the groups have needed to overcome, or the different emphasis the groups place on appearance (Dumas, *et al.*, 2005). As well the more affluent have the financial ability to counter age related appearance changes through beauty practices thus mitigating the negative appearance related consequences of aging (Hurd Clarke & Griffin, 2007). Among older men, socio-economic status may not be as powerful in protecting against body dissatisfaction as it was in earlier years since older men seem to experience a greater decline in self-esteem related to body image (Baker & Gringart, 2009). This is most likely attributable to their perceived loss of power that accompanies functional decline.   However few studies of body image among older

men have been conducted, therefore much more investigation needs to be undertaken for this to be substantiated.

2.7.3 Body Image and Social Interactions

A positive body image provides confidence to engage in social relations, whilst an altered image decreases the ability and desire to socialize (Cash *et al.*, 2004; Rumsey, Clarke, White, Wyn-Williams, & Garlick, 2004).   Disruption of social interactions from weight and shape are well documented, however other aspects of body dissatisfaction also influence social interactions. For instance, the face is the focal point of both verbal and non-verbal communication. Undoubtedly, facial anomalies or disfigurement can impact body image and social functioning. The Fear Avoidance of Psycho-Social Difficulties Following Disfigurement Model helps to explain the experiences and behaviours of people who have visible deformities of the mouth and lower face (Newell, 1999; Newell & Marks, 2000).   Apparently, a "phobic anxiety" and the fear of how others will respond to a visible deformity can lead to avoidance of social situations (Newell & Marks, 2000).   While those with normal facial appearances are afforded the common courtesy of going about their daily lives with relative anonymity, those with facial disfigurement experience anxiety when they are forced to endure much unwanted attention from others (MacGregor, 1990). The attention they receive often blatantly disregards the common rules of socially acceptable behaviour, such as eye contact while speaking, proxemics, and avoidance of personal questions and topics that are inappropriate (MacGregor, 1990). Facial cancer survivors, who have become disfigured from their disease and subsequent treatment, also report that they feel stigmatized by

others and experience negative social exchanges such as naked staring and negative

remarks (Clarke, 1999; Strauss, 1989). Those with facial anomalies such as scars,

burns, birthmarks or bruising find that when in public, strangers position themselves

significantly farther away and on the non-affected side (Houston & Bull, 1994; Rumsey,

Bull & Gahagan, 1982).

Sensitivity to a stranger's behavior and negative beliefs about how others judge

one's appearance can alter body image, diminish self-esteem and result in

inappropriate interactions such as aggression toward others (Newell & Clarke, 2000).

Cognitive-behavioural approaches can help reduce the fear, dispel some of the negative

beliefs, and provide strategies for coping positively in social situations instead of using

aggression or even avoidance (Newell & Clarke, 2000). For example, cancer survivors

who experience a facial disfigurement due to surgery benefit from understanding that

the stares they receive are often out of curiosity, not disgust or horror. Cognitive-

behavioural approaches help the disfigured individual understand the behaviour of

others towards them so that more positive interactions occur. Learning to be open

about their disfigurement and improving their social skills with a range of appropriate

responses to an observer's questions or facial communication can positively influence

how both experience the social encounter and can help to maintain self-esteem.

Repeated exposure to social situations with positive outcomes further reinforces the

positive beliefs and interactions. Cognitive-behavioural therapy has been especially

helpful for those who have relatively minor disfigurements and for whom low self-

esteem is more related to their own negative expectations of a social encounter or their own negative beliefs about their appearance (Clarke, 1999).

Body odour (Low, 2007; Roberts, Little, Lyndon, Havlicek, & Wright, 2009), disability (Rumsey *et al.*, 2004; Yuen & Hanson, 2002), and personal grooming (Campbell, 2005), also influence the body image and social behaviours of adults. Consequently, the Fear Avoidance of Psycho-Social Difficulties Following Disfigurement Model has been employed to explain how people with badly smelling wounds behave and cope in social situations (Piggin, 2003; Rumsey *et al.*, 2002). While malignant fungating wounds can be visually concealed, they are still apparent from an olfactory perspective and a source of anxiety for individuals in social situations. Even body odours that are not as pungent as a fungating wound can decrease self-confidence (Roberts, *et al.*, 2009) and elicit thoughts of disgust and moral irresponsibility when detected (Curtis & Biran, 2001). Therefore it is not difficult to believe that other body odours, such as bad breath can cause a marked disturbance of body image and social behaviour, although the extent of the disturbance probably depends largely on the social and cultural context in which people live, and on their sense of smell (Rayman & Almas, 2008). Both real and perceived bad breath can upset body image and self-confidence as well as negatively impact social interactions (McKeown, 2003; van den Broek, Feenstra & de Baat, 2008). Consequently, Eli and colleagues (2001) have proposed that each of us has a "breath odour image", and which, similar to other self-schema, may not be an objective assessment of reality. Whether real or not, the perception of bad breath can lead to embarrassment and avoidance of intimate social encounters (van den Broek *et al.*,

2008); it can result in the removal of teeth and in the extreme, has led to suicide (Scully & Greenman, 2008).

2.8 Oral Health and Aging

As with other parts of the body, the mouth undergoes changes with age. In the past, tooth loss was an unfortunate but accepted consequence of growing old with nearly half (43%) of the Canadian population in 1990 over 60 years of age edentate or without any natural teeth (Statistics Canada, 2010). With a strong emphasis on prevention of dental diseases and sophisticated treatment options, the edentulous rate in Canada had dropped to about one-in-five (22%) by 2009, and will probably continue to decrease with the next generation of elders, since currently less than one-in-ten (~6%) adults 20-60 years of age are edentate (Statistics Canada, 2010).

Caries, or tooth decay, is the leading cause of tooth loss in all age groups with an incidence that depends on many factors relevant to old age, such as medications, diet, hygiene, and access to dental care (Saunders & Meyerowitz, 2005; Wyatt & MacEntee, 1997). Many medications taken by older adults disturb salivary flow which greatly increases the risk of caries, dries the mouth, makes it very uncomfortable to speak, taste, eat, and swallow, and causes halitosis (Gueiros, Sores, & Leao, 2009; Turner & Ship, 2007).   This leads also to preference for a soft diet, which further increases the risk for caries (Turner & Ship, 2007).

Physical or cognitive impairments that limit the ability to adequately clean the mouth can also increase carious activity (Wyatt & MacEntee, 1997), and in some older adults this activity tends to cause more destruction in a shorter period of time (Wyatt, 2002b). As well, recession of the gingiva can increase with age to expose the roots of the teeth and increase further the risk of caries (Chrysanthakopoulos, 2010). It is important therefore that problems are identified and managed before they deteriorate in later years. Unfortunately older adults may face both physical and economic barriers to accessing dental care due to limited financial resources and medical conditions that limit mobility (Kiyak & Reichmuth, 2005; Rubinstein, 2005). Negative dental experiences in the past and disregard of minor symptoms in old age compound access to care problems even further (McKenzie-Green, Giddings, Buttle, & Tahana, 2009).

Inadequate oral hygiene and lack of professional care are commonly associated with increased oral disease. Older adults, in particular those with physical and/or cognitive impairments, typically have poor oral hygiene and more severe gingivitis (Chalmers, Knute, Carter, & Spencer, 2003; Padilha, Hugo, Hilgert, & Dal Moro 2007; Philip *et al.*, 2011). Periodontitis, which is a more destructive inflammatory disease of the bone around teeth, occurs in about one-in-five of the older population and can also cause tooth loss (Swoboda, Kiyak, Darveau & Persson, 2008). The risk and damage of periodontitis increases substantially in people with diabetes or compromised immune systems due to their inability to mount a strong enough host response to the bacteria (Swoboda *et al.*, 2008). Periodontal pathogens impact not only the mouth but, due to the inflammatory response they elicit, have been linked to cardiovascular disease

(Starkhammar *et al.*, 2008), stroke (Grau *et al.*, 2004), diabetes (Taylor & Borgnakke, 2008), respiratory disease (Azarpazhooh & Leake, 2006), arthritis (Mercado, Marshall, Klestov, & Bartold, 2000) and more recently to cognitive impairment (Noble *et al.*, 2009). Although the pathogenic pathways have yet to be determined, it is likely that efforts to improve oral health will also contribute to overall health (Cullinan, Ford, & Seymour, 2009).

2.8.1 Models of Oral Health

Early models of oral health, such as the one proposed in 1988 by Locker (Figure 1), were adapted from the World Health Organization (WHO), International Classification of Impairments, Disabilities and Handicaps (ICIDH), a conceptual framework used to identify the consequence of disease on body function, activity and social participation (WHO, 1980). Locker's model illustrates oral disease as a linear progression from impairment to handicap. For example, tooth loss (impairment) as a result of caries (disease) leads to difficulty in chewing (physical dysfunction) which can be embarrassing in social situations (psychological dysfunction) and result in avoidance of eating with others (handicap). While this model, like other utilitarian approaches to disease, can help explain the consequences of disease and can be helpful in designing treatment to restore "health", it does not consider the environmental and personal context in which disease occurs, and an individual's ability to cope and adapt to impairment at any given time (MacEntee, 2006a).

Figure 1 Conceptual model for measuring oral health. Adapted from Locker (1988)
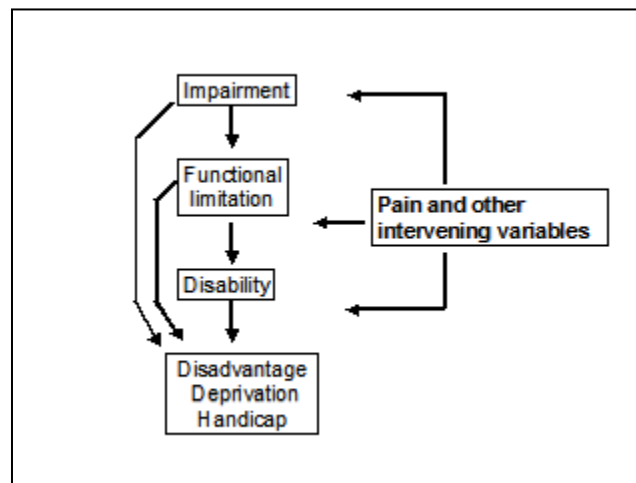
The recognition of health and disease as a dynamic as opposed to a linear

phenomenon with biopsychosocial consequences for the good or the bad, led the WHO

(2001) to replace the ICIDH with the International Classification of Functioning,

Disability and Health (ICF). This new model (Figure 2) did not focus on consequences

of disease, but instead on components of health and their impact on functioning of an

individual in their surrounding environment (WHO, 2001).

Figure 2 The International Classification of Functioning, Disability, and Health (ICF),
            Adapted from WHO (2001).

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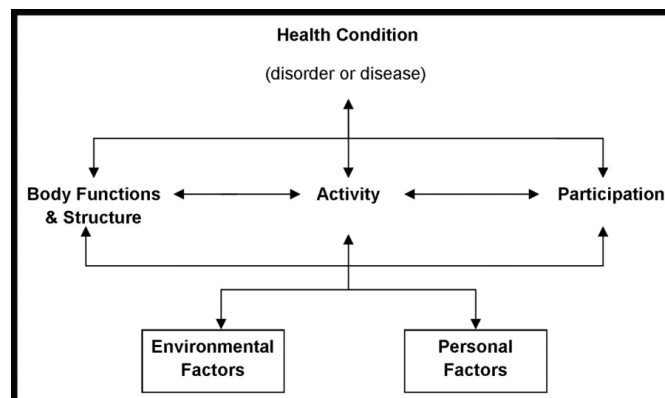
This shift prompted the development of new models of oral health, such as

MacEntee' (2006a) Existential Model of Oral Health (Figure 3), which shows the multi-

directional relationship of factors associated with oral health. This model emerged from

personal interviews with 24 older adults, discussing the significance of the mouth in old

age (MacEntee *et al.*, 1997). Thematic analysis of the narratives revealed three major

factors which formed the inner layer of the model representing the principal components

of oral health: comfort; hygiene; and general health. The outer environmental layer

allows for social and personal context, which may or may not negatively impact the

central functional layer. This new way of conceptualizing oral health demonstrates the

dynamic interplay of body and environment in the function or dysfunction of the mouth.

Most notably, the model allows for the possibility that oral disease does not necessarily

restrict or handicap people who have an ability to adapt to their impairment.

Figure 3 Existential model of oral health. Adapted from MacEntee (2006a).
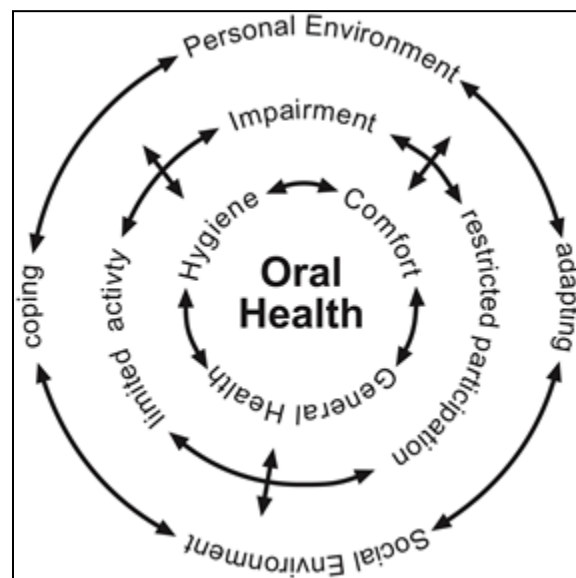
This model was later evaluated by Brondani *et al.* (2007) using focus groups of older adults living in the community. The groups were asked to discuss the relevance of the model and its components to their oral health-related beliefs and experiences. While the participants in general agreed with the model, they also suggested the addition of four dominant themes: diet; economic priorities; personal expectations; and health values and beliefs. They also suggested that to better illustrate the dynamic and overlapping importance of the components, that the model be elliptical instead of circular. The refined model (Figure 4) also uses more positive language, by excluding the terms "restricted" and "limited". To date neither of the two models has been evaluated by elderly people living in LTC facilities.

Figure 4 Refined model of the key components relating to oral health. Adapted from Brondani *et al.* (2007).
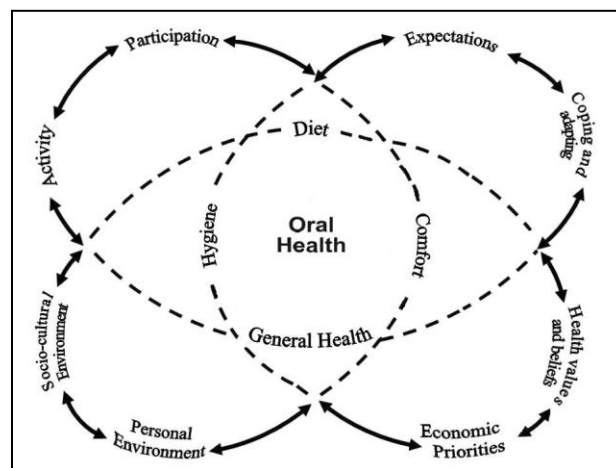
2.8.2 Oral Health in LTC

The focus on prevention and restoration of oral diseases in the past 40 years has resulted in an older population with more of their own teeth than ever before. Not only

are people keeping their teeth longer, they also have expectations regarding continued care and maintenance of their oral health (Brondani *et al.*, 2007). Yet as one becomes frailer and more dependent on others for mouth care, the risk of oral disease increases substantially (Chalmers & Pearson, 2005; MacEntee, 2005a).   Those living in LTC seem to be particularly at risk as numerous studies indicate that the oral health status of residents is poor (Chalmers & Pearson, 2005; Philip, Rogers, Kruger, & Tennant, 2011; Wyatt, 2002b). The caregivers find it challenging to care for the teeth of some residents (Chalmers, Levy, Buckwalter, Ettinger & Kambhu, 1996; Frenkel, Harvey, & Newcombe, 2001), and dental professionals are reluctant and unsure of how to provide appropriate care in the facilities (Bryant, MacEntee, & Browne, 1995; Chalmers *et al.,* 2001; Nitschke, Ilgner, & Muller, 2005; Dharamsi, Jivani, Dean & Wyatt, 2009; Wardh & Sorensen, 2005). Daily mouth care and professional care are important in the maintenance of oral health, regardless of age and living situation, but both are difficult for people who are physically and/or cognitively impaired (MacEntee, Thorne & Kazanjian, 1999). Therefore, caries, periodontal disease, and oral lesions can be even more prevalent among the residents of LTC facilities than among the more independent elderly population (MacEntee, 2005a).

2.9 Oral Health, Body Image and Social Behaviour of Elders

Body image, weight loss, and cosmetics, for many people, are concerns in the quest for eternal youth (Hurd Clarke, 2002; Hurd Clarke & Griffin, 2007), as are the appearance of "nice teeth" and a "nice smile", especially among older women, and it is quite possible that men feel the same (Brondani *et al.*, 2007; Campbell, 2005; Fiske *et*

al., 1998; MacEntee *et al.*, 1997). These findings are not surprising since oral health in western society, regardless of gender, is based on youthful cultural standards where teeth are ideal if they are straight and white. A quick glance at web-sites for dentistry will support the pervasiveness of this ideal (MacEntee, 2005b), but to what extent these concerns persist when elders become dependent on others and institutionalized is unknown. Much of what we do know about the oral health of institutionalized elders comes from quantitative studies that report on disease status or socio-dental indicators that measure the negative effects of oral problems (Brondani & MacEntee, 2007). However self-assessed oral health status can be quite different than normative or physical assessments of the mouth (Lee, Sheih, Yang, Tsai, & Wang, 2007; MacEntee *et al.*, 1991). It is such perceptions and the priority placed on them that appear to influence social behaviour, but we have little understanding of how institutionalization and frailty affects either the assessments or the assignment of oral health priorities. Previous research has shown that tooth loss can impact perceptions of oral health (Fiske *et al.*, 1998; Jones, Orner, Spiro, & Kressin, 2003; MacEntee *et al.*, 1997), as well as produce feelings of fear and anxiety (Friedman, Landesman, & Wexler, 1988). While many of these studies involved older adults, none specifically addressed the impact that tooth loss has on the socialization of elderly people in LTC facilities, nor do we know what other factors influence the perception of oral health and body image. Figure 5 illustrates what is known about the relationship between social interactions, body image and oral health among healthy adults, and poses the unanswered questions about institutionalized elders.

Figure 5 Social interactions, body image and oral health relevant to healthy adults.

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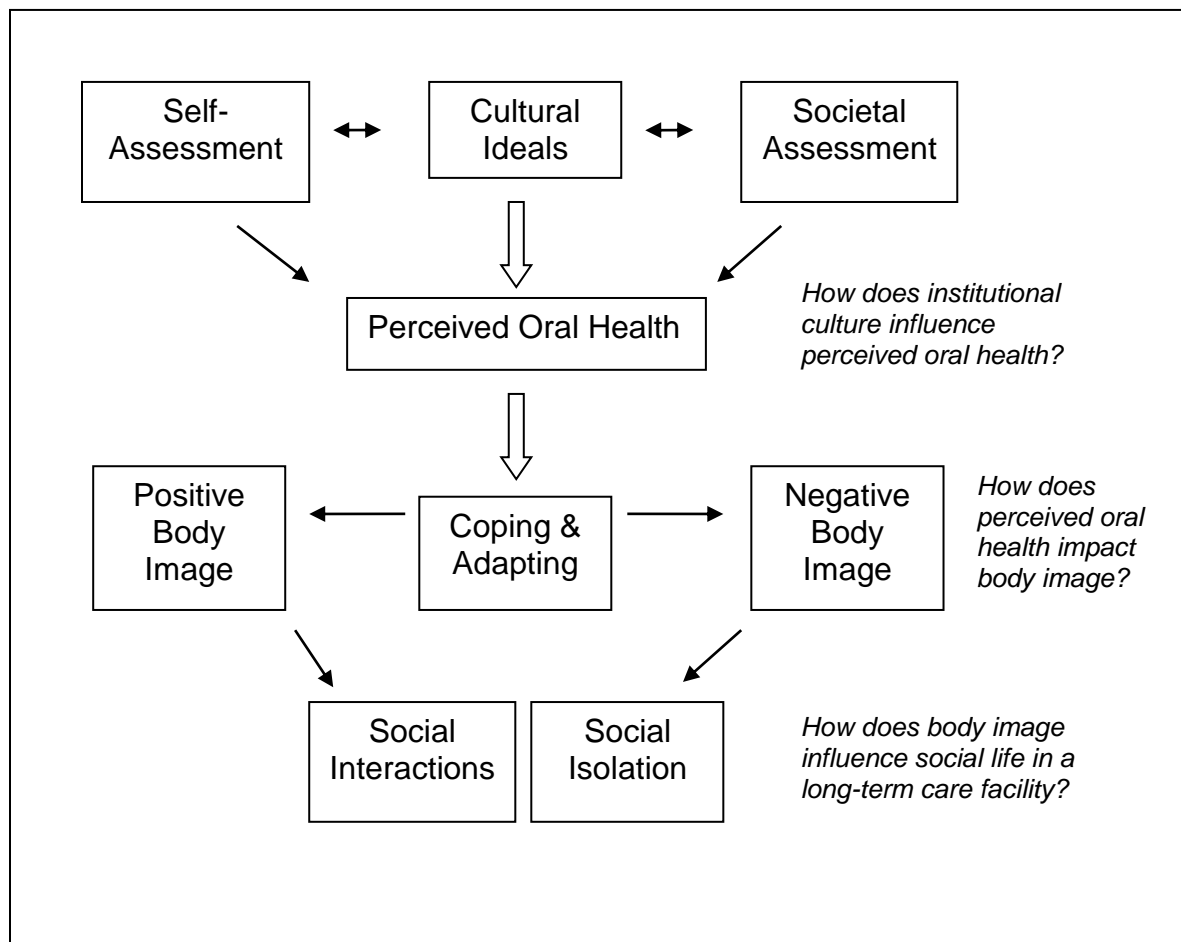
2.10 Summary of the Literature

Social relations are important at all stages of life and may be particularly beneficial to the health and quality of life of frail elders. There are many chronic diseases that influence social behaviour in old age, however, we do not know much about the influence of oral diseases within the cultural and social context of elderly people in LTC. Poor oral health negatively affects the social lives of younger people and independent elders in the community, but with increasing frailty and institutionalization it is quite possible that other concerns take priority. Anxiety about personal appearance persists well into old age, but is influenced strongly by cultural norms and ideals. Therefore the culture of LTC, compounded by increasing disability and dependency, may dampen concerns about personal appearance and social interactions, which could explain in part why oral health and appearance receive limited attention from the nursing staff and the elderly residents. Models of aging, body image, and oral health provide a framework for understanding how conditions of the mouth influence social interactions, but personal and environmental context is prominent within more recent models of oral health, therefore it is not clear if they can be extrapolated to institutionalized elders. More exploration is needed with this specific population to understand the effect of oral health and disease in their lives.

CHAPTER 3: METHODS

No empirically derived information or theory exists to explain how appearance-related concerns and social behaviours of frail elders who live in LTC facilities are influenced by perceived oral health and disease. Therefore, I chose to employ a qualitative method of inquiry to explore the relationships between oral health, body image and social interactions specific to institutionalized elders, and to develop through the inquiry a theoretical model that could accommodate the relationships. I conducted 43 personal, in-depth interviews with 23 institutionalized men and women, aged 58 to 97 years, in eight LTC facilities. The interviews focused on the participants' social behaviours, perceptions of oral health and body image, and on their experience in a LTC facility. I also conducted 24 hours of observation of resident, staff and facility activities.

3.1 Theoretical Foundation

Social interaction within the context of LTC facilities is the central concept underlying my research question; therefore I used a grounded theory approach since it is useful in deriving meaning from social phenomena (Charmaz, 2006; Strauss & Corbin, 1990). Grounded theory was described by Glaser and Strauss (1967) as a systematic way to develop new theory based on data gathered purposefully from individuals who have experienced a particular process or phenomenon. Information derived from interviews, focus groups and/or observations are coded and analyzed to identify themes and categories of information within transcriptions of the interactions. Analysis and data collection occur simultaneously through a constant comparison of information gathered

during one interactive or observational session with information gathered in subsequent sessions. The information is coded to identify concepts that are combined and recombined through this process to form categories that build the theory. Theory development is an abductive process, in which data are gathered and analyzed to help generate hypotheses. These hypotheses are then explored in order to generate an explanation of what is happening. As this explanation or theory begins to emerge, theoretical sampling is used to ensure that specific cases are sought that can further inform the categories of information and expand the theory as it develops. In this way, theory is built from data derived from individuals, not pre-existing knowledge. In essence it enables the development of a general explanation of a social phenomenon derived or "grounded" in information collected from individuals and their environment (Creswell, 2007 p. 63).

Grounded theory has been adapted in numerous ways since its development. It was adapted initially to develop theory around a core category with multiple sub-categories that identify causal conditions, strategies, intervening conditions and consequences as they relate to the core phenomenon (Strauss & Corbin, 1990). Another approach of Charmaz (2006), does not use strict, systematic coding and categorizing procedures around a core phenomenon, but instead takes a more social constructivist and flexible approach to develop theory. This approach is based on the premise that reality is not pre-existing or singular, but instead developed through interactions with others, resulting in multiple realities depending on the social and historical context. A social constructivist approach places emphasis on the view of the researcher in interpreting

and deriving meaning from participant narratives and actions. The narratives are gathered through open-ended questions that allow participants to discuss issues broadly and how they construct meaning of a situation. The interview is not one-sided with the researcher asking questions and listening for long periods of time to what a participant has to say, but instead is more like a conversation between participant and researcher in the quest for shared understanding. This form of data gathering enables the researcher to uncover complexities of views in the participant's stories, rather than narrow meanings of ideas. With this approach special consideration is given to the importance of culture and context when attempting to understand social phenomena as it allows exploration of larger issues that can contribute to observed differences and distinctions between individuals and situations. Social constructivism is an interpretive approach and therefore the researcher must reflect on personal views, values and beliefs and how they influence their analysis. To ensure that the participant's views remains central during the analysis, their words and phrases are maintained and used to describe emerging themes and categories. In the end, theory development is a collaborative process between researcher and participant that is sensitive to how each derives meaning from the studied experience. This approach, through the use of guidelines, upholds the characteristics and tenets of grounded theory which include the gathering of information rich data, the use of coding to sort and categorize data, memoing as a way of providing meaning to data, a constant comparative analysis of data for emerging themes, and theoretical sampling for cases that further inform categories and the theory as it develops. I drew on Charmaz's approach in this study to develop my theory and conceptual model.

3.2 Recruitment

3.2.1 Facilities

Upon gaining ethical approval for this study from the University of British Columbia (UBC), Behavioural Research Ethics Board (BREB), I contacted eight LTC facilities (Table 1). Six of these were facilities where I had previously provided dental hygiene services, and two were facilities in which I had no prior contact.   I met with the Director of Care or Administrator of each facility to explain the purpose, design and protocols of the study. Each site received a "Facility Approval" form (Appendix A) which identified the investigators, the purpose of the study, methods, confidentiality, compensation, contact information, and the rights of the participants. A copy of the signed form was left with the facility and another submitted to the BREB.   The original form was stored in a locked filing cabinet in the Faculty of Dentistry at the University of British Columbia.

Table 1 LTC Facilities

Facility	Ownership	Number of Residents	Attending Dental Professionals
1	Public	130	Hygienist, denturist
2	Public/Private	100	Hygienist, denturist, dentist
3	Public/Private	148	Hygienist, dentist
4	Public/Private	75	Hygienist, denturist, dentist
5	Public/Private	75	Hygienist, denturist, dentist
6	Public/Private	75	Hygienist, denturist, dentist
7	Public	130	Hygienist, denturist, dentist
8	Public/Private	137	none

3.2.2 Participants

At each facility, personal observation and recommendations from the nursing staff regarding a resident's cognitive ability, level of social engagement and oral conditions were used to identify potential recruits. As the study progressed and the theory developed, additional characteristics were used to identify potential recruits. A "Letter of Introduction" (Appendix B) explaining the study and requesting participation was distributed to potential recruits by the nursing staff asking them to contact me if they wished to participate in the study. I met with residents who wanted to participate and verbally reviewed with them the "Consent Form" (Appendix C) identifying the investigators, the research question, the purpose of the study, how the information would be used, compensation, and phone numbers for more information about the rights of research participants. Potential recruits were then asked to tell me in their own words, their understanding of the purpose and conduct of the study and their role and rights as a research participant, to ensure I was obtaining informed consent. Recruitment continued until my analysis reached saturation, when further interviews failed to contribute new information to my investigation.

3.3 Participant Criteria

I began this study with the knowledge that oral health and disease impact body image and social interactions of adult men and women who live in the community. In my study, I wanted to further this knowledge by exploring the role of frailty and institutionalization. To maximize variation in the sample, I purposefully recruited cognitively alert men and women over 75 years who had lived in a LTC facility for at

least 6 months, and who varied in levels of social engagement and oral health conditions. These criteria were initially established and later modified in order to select particular participants who could help to clarify or modify the theory as it seemed to be developing.

I selected participants who were cognitively alert, with no clinical evidence of chronic confusion or dementia because I wanted to focus on residents who were fully aware of their surrounding and who could explain readily their beliefs and behaviours.

I selected both men and women to explore the diversity that gender might bring to the investigation, since conflicting theories exist on the influence of body image among men and women (Feingold & Mazzella, 1998; Janelli, 1993; Halliwell & Dittmar, 2003). I initially chose to recruit elders who were 75 years and older because they make up the majority of residents in LTC facilities and are more likely to experience increasing frailty. This age was later decreased to 55 to explore how age as opposed to frailty influenced the relationship. The frailty assessment described by Fried *et al.* (2001) was utilized in the identification of frail participants since the facilities were not consistent in their frailty assessment.

My study focused on how perceived oral health promoted or impeded social interaction; therefore I sought information from participants who exhibited varying levels of social engagement. All LTC facilities in this study used the Resident Assessment Index – Minimum Data Set (MDS) with a section on "Psychosocial and Well-Being" that

can be used as an index of social engagement in LTC (Mor, *et al.*, 1995). Nurses

utilized this assessment, which was categorized as minimal, moderate or extensive to

identify potential recruits who exhibited the level of social engagement that I was

seeking at a particular time.

To explore how conditions of the mouth influence perceptions of oral health, body

image and social relations when detectable from a conversational distance, I sought

participants with disorders of the mouth although this was not a requirement for

participation. For example, I sought residents with obviously broken, missing or

decayed teeth, loose or missing dentures, bad breath or inflamed gingiva. Since body

image is a personal construct and an appraised construct of others (Taleporos &

McCabe, 2002), I did not focus on the clinical assessment of oral health solely from a

biological perspective, but instead I looked for oral conditions that were apparent during

social exchanges.

Finally I wanted to speak with residents who had lived in a care facility for at least six

months so that they would have had sufficient time to experience the usual activities

and operational culture of the institution.

Table 2 Participant self-reported characteristics

Characteristics	Participants N=23
Age range (years)	
≤ 75	3
76-84	8
≥85	12
Gender	
Men	7
Women	16
Education	
Post-Secondary	12
High school	11
Marital Status	
Single	3
Married	4
Divorced	8
Widowed	8
Employment[1]	
Professional	7
Trade/Vocational	5
Retail/Clerical	5
Domestic	6
Social Engagement[2]	
Minimal	9
Moderate	6
Extensive	8
Mobility	
Wheelchair	18
Walker	1
Walk without assistance	4
Oral Status	
Teeth	11
Teeth & Dentures	7
Dentures	5
Oral Problems	
Noticeable	9
Non-noticeable	10
No problems	4
Oral Care Dependant	4
Oral Care Independent	19

[1] Self-reported employment
[2] Based on MDS Psychosocial and Well-being Assessment

3.4 Sampling Strategies and Conduct of the Study

A tenet of grounded theory is to recruit a diverse group of participants for maximal variation to ensure that each category of the theory is fully developed (Creswell, 2007). I began with a similar group of four women aged 78 to 89 in one facility, so that as themes and categories began to emerge I could seek specific cases to develop further the emerging theory (Creswell, 2007).

I will explain here how the purposeful sampling in six steps helped me to develop my model and theory.

3.4.1 Step One

The first four interviews revealed that for this group of women the appearance of the mouth was important in social interactions even though each woman had limited social contact. The priority they placed on their appearance was influenced by their general health and social activities within the facility. Consequently, after the initial four interviews, I selected men and women with various levels of social engagement, oral health, and frailty from another facility. The interviews revealed that the culture of the facility and the care received were important influences on how residents interacted socially. They revealed also the following phenomena that influenced their well-being: being able to speak-up; being treated like a child; rules, policies and schedules; loss of dignity; and fear of requesting care. These interviews also indicated that access to overall care influenced the priority of body image and oral health. Follow-up interviews included questions regarding the delivery of care and perceived ability to access care,

which I categorized as "priorities", and helped me to identify additional areas of exploration, such as the impact of frailty rather than age. There were indications also that priorities can change in relation to health.

3.4.2 Step Two

I returned to the first facility to speak with two new residents who were identified by the staff as having recent severe changes in health and frailty to explore how priorities change as life becomes more of a challenge. The man and woman were in wheelchairs and totally dependent on care-givers. They revealed that health, frailty and dependence each influence the priority placed on oral health, but in a very dynamic way. I therefore sought additional participants who were dependent or who had experienced changes in their health or frailty.

3.4.3 Step Three

Two additional facilities were added to select more men to further explore the influence of gender, in addition to residents who were frailer and required total care from care-givers, and residents with obvious oral problems. The category of "perceived access to care" was prominent in the previous few interviews and therefore additional questions were added to the subsequent interviews to gather more information on how the provision of care affected a resident's life. However, unlike the other facilities, all three men and four women identified by the staff as suitable for the study refused to participate.

I attempted to recruit participants in another two facilities where I was not providing service, and again, few of the residents wanted to participate. Among those who did agree, one man and one woman had participated in another health care study, and one woman was a retired university professor. None of them had obvious oral health problems, but were concerned about past problems and how they might affect their oral health in the future. One participant was extremely despondent and noticeably bothered by a recent decline in health and increased frailty which left her totally dependent. The other had also recently become totally dependent except for eating and the other was bed-bound and rarely left his room. My interviews with them expanded on how the "rules" of the institution were significant to their lives and influenced social interactions and the importance of the mouth. A participant's personality and their willingness to complain were also identified in regard to coping, which prompted me to re-read earlier transcripts to seek information I may have previously overlooked about the influence of personality traits, and coping mechanisms. The theme of "growing old and frail", and how that was perceived within institutions also started to emerge with more clarity. A specific case was sought (younger man, 58) to explore how age influenced this concept.

3.4.4 Step Four

One assumption that I was beginning to make at this step was that the importance placed on being clean and appropriately dressed was influenced by the resident's

desire to maintain their sense of identity and to avoid being stereotyped as cognitively impaired and treated like a child. Consequently, I spent time in each facility observing activities and interactions between staff and residents as well as between residents.

3.4.5 Step Five

I was still having difficulty recruiting residents with visibly poor oral health and who were dependant on care staff for their daily care, so I asked a colleague who works in several facilities if she could recommend another facility for my recruitment. And so, with the help of the administrator of a 130 bed facility, we identified one potential participant who was cognitively alert, had obvious mouth-problems, and was dependant on care-staff for daily mouth-care. She requested that the administrator be present for the interview, and it became apparent within a few minutes that she was very uncomfortable, so I stopped the interview.

I began to think that the type of resident that I was currently seeking may not exist or at least in very small numbers. It was also possible that staff were less aware than I expected of the condition of the residents' mouths possibly because they relied on dental professionals (like me) who managed the residents' oral healthcare. Consequently, I went to another facility that, unlike all the others, had no current access to on-site professional dental care. This strategy allowed me to explore the significance that "access to dental professionals" might have. I was hopeful that in a facility without on-site dental care that there may be more potential participants who had obvious oral

problems and who were dependant for their mouth-care. The staff helped me to recruit

another three residents – a man and one woman with obvious mouth-problems, and a

woman who was completely dependent on the staff for her daily oral care.

3.4.6 Step Six

After this, I returned to earlier participants to gather information on the changes they

each experienced since the previous interviews, nine months prior. The participants

provided further insight into how increasing frailty or deteriorating health influenced the

priority of oral health, social relations and the ability to cope with change. After the

eighth follow-up interview I found no new information, and so, after another two

interviews I decided that my data and analysis was saturated, and I had sufficient

information from which to complete and confirm my theory.

3.4.7 Sampling Difficulties

I encountered two major sampling difficulties during the course of this study. The

first was with recruitment of potential participants. This only became apparent once I

started to recruit in facilities where I did not have a regular presence as a dental

hygienist. Older adults can be wary of participating in research for a variety of reasons

(Vivrette, Martin, & Kramer, 2008), and this seemed to be even more problematic when

I was a total stranger. Two men identified as having oral problems did not want to

participate because they said they were busy, one man and one woman declined

participation because they said they didn't trust researchers and three women, politely

said "no thank you" .   Another possible explanation for their lack of interest in speaking with me could have been from embarrassment of their oral conditions and the fear of being judged (Fiske *et al.*, 1998).

In the last facility, where I had not been before, I did not have difficulty recruiting. The staff were extremely helpful in identifying potential participants and introducing me to them, which may have put the elders at ease. As well, this facility did not have a visiting dental professional, and therefore the staff may have been more aware of the resident's oral health status. Lack of access to on-site care could have also resulted in more residents with oral problems (MacEntee *et al.*, 1999).

The second sampling issue I encountered was the difficulty in locating residents with noticeable mouth problems who were cognitively alert. With the additional criteria of a dependency on staff for daily mouth care, it was almost impossible to find suitable participants. This was interesting and unexpected because numerous reports on the oral health status of institutionalized elders, in general, portray the population as having poor oral health (Rejnefelt, Andersson, & Renvert, 2006; Samson, Strand, & Haugejorden, 2008; Wyatt, 2002b). As a practising dental hygienist, I also observed poor oral conditions regularly. However this study did not use the clinical judgement of a dental hygienist or dentist, but instead I looked for oral conditions that were visibly obvious from a conversational distance.   Institutionalized elders are a heterogeneous group (Rowe & Kahn, 1987) and this also is true with regard to oral health status (Ettinger, 2010). The difficulties I experienced trying to recruit cognitively alert residents

with poor oral health seemed to lend further support to the association between impaired cognition and oral disease among older adults (Chalmers, Carter, & Spencer, 2003; Stewart & Hirani, 2007; Wu, Plassman, Crout, & Liang, 2008), and is an important factor to consider in future studies.

3.5 Data Collection

Forty-three, semi-structured, open-ended, personal interviews were conducted with seven men and sixteen women. I attempted to interview each participant on at least two occasions. To this end, ten participants were interviewed twice, five were interviewed three times, and eight were interviewed only once because they moved, were ill or died before the second interview. An interview guide (Appendix D) was used to construct the narratives for analysis and to ensure that I sought information pertinent to the research question.   The questions were developed based on a grounded theory approach so that I could explore my topic as well as the participant's experiences (Charmaz, 2006).   Literature and theoretical studies on social interactions, body image, disfigurement, aging and oral health, as well as my experience of working within LTC settings were drawn upon as I developed the guide for the first interview (Kvale, 1996). New issues that arose during the interviews, such as the participant's perceived ability to receive care, were explored with probing questions and incorporated into future interviews. Questions with structured responses on the background of each participant were posed at the end of the interview to record specific information that was not revealed during the interview. Each interview lasted approximately 30 minutes to two hours depending on each participant's schedule and tolerance. The location of the

interview was determined by each participant, either in their private room or another

private space at the facility. Interviews were tape-recorded and supplemented by field-

notes of non-verbal responses or other events such as interruptions and disturbances

that might have influenced the context or meaning of the interview (Kvale, 1996).

I observed and documented the activities of the staff and residents for at least three

hours in each facility, to add further context to the narratives (Creswell, 2007). In

particular, I was interested in watching how residents spent their time interacting with

each other or engaged in solitary activities. I also documented the design and culture of

each facility, such as provision of care in public spaces, interactions between residents

and staff, interaction between staff and management, and how the staff spent their time.

While some of the observation time focused on my participants, most of my attention

was directed at each facility and its social environment as a whole. Observational

strategies were both passive and interactive, and were documented in field-notes both

during and immediately after each visit to a facility. At each facility I watched and

participated in activities, such as card games and sports, and also spent time in the

dining and sitting rooms and hallways to observe social activities and other interactions.

Out of respect for the resident's privacy, I did not try to observe the provision of care in

private rooms.

I attempted to recruit only residents with whom I had no professional contact as a

dental hygienist, since my professional relationship might disturb the ease of interaction

that I needed to encourage and enable a free and flowing interview (Holloway &

Wheeler, 1995). However, I recognized that my identity as a dental hygienist might also be known to residents with whom I did not have a professional relationship. Therefore I ensured all potential participants that I was there to speak with them as a researcher not as a dental hygienist. The participants were also informed that there were no right or wrong answers, and I encouraged them to discuss freely their thoughts and feelings.

3.6 Iterative Analysis

The names of the facilities and participants were removed from all documents and replaced with a code or pseudonym known only to myself. Data collection and analysis occurred simultaneously. The audio-recording of each interview was listened to numerous times and transcribed *verbatim* by myself. The transcripts were read and re-read to identify emerging themes or categories, and to develop additional questions that would allow me in the next interview to expand or clarify an emerging theme. I wrote personal memos after each interview and during analysis of the texts to document my preliminary thoughts and interpretations of the narrative and how they might assist the analyses. An iterative process of constant comparison was conducted so that I analyzed the information from the interview before I proceeded to the next. These processes required a back and forth approach to gathering and analyzing information, so that each interview could influence the conduct of subsequent interviews (Erlandson, Harris, Skipper, & Allen, 1993).

The software program *NVivo 8* was used throughout the analysis to embed codes and develop categories and subcategories of information. These were then further

elaborated on through subsequent interviews by theoretical sampling of participants who could provide further insight into the context and complexities of the categories as they emerged, hypotheses were formed and theory developed (Creswell, 2007 p. 64). For example, when I heard from one participant that the priority of oral health was influenced by frailty, not age, I recruited a frail but younger participant who might provide further information to verify this possibility. This case was also sought to improve the rigour of my interpretations, since it allowed for a refinement of the emerging theory (Charmaz, 2006, p. 101).

Each participant was offered, but declined, a copy of their transcript selecting instead a verbal summary of my preliminary interpretations and analysis at a follow-up interview. I was able to conduct follow-up interviews with 15 of the participants after the initial analysis to confirm the categories, inferences and conclusions I had made (Bloor, 1997). This also provided participants with an opportunity to identify misinterpretations and to provide additional information. Only one participant corrected an interpretation that I made of one of her comments.

3.7 Reflection

In essence, qualitative research is interpretive and therefore susceptible to the investigators "biases, values and personal background" (Creswell, 2009, p. 177). This necessitated that I identify myself within the inquiry and acknowledge potential influences on my interpretation of the information I gathered. I am a healthy, middle-aged, middle-class, white and female dental hygienist enrolled in a university doctoral

program. These personal attributes not only needed to be acknowledged but also reflected on throughout the study to ensure that the analysis and interpretation was a product of the participant's narratives, and not just my own perceptions. This was particularly important with regard to appearance related concerns among the genders where my own values and beliefs could override the participants'. Being a female exposed to Western ideals of masculinity and femininity had the potential to bias my attention and interpretation both during the interview and the analysis and needed constant reflection throughout the study.

It was also important for me to recognize and reflect on the influence of being a dental hygienist, and the significance my profession places on good oral health. I was aware of my own values and beliefs in this regard and I recognized that my views may be different from those of the elderly participants. Consequently, during the interviews and analysis to ensure that I was not imposing my own views on the participants I had non-dental professionals, with a background in social work and nursing, who were experienced in qualitative research methods, review my coding and analysis to further confirm that my professional background was not overriding the participants' thoughts.

My clinical experience of ten years working as a dental hygienist and educator in LTC facilities gave me comfort and knowledge to communicate effectively with the participants. This was important since an elder's ability to communicate can be hampered by poor or delayed recall of information, speaking difficulties, lack of affect, and sensory difficulties (Hall, Longhurst, & Higginson, 2009). Being able to understand

both their verbal and non-verbal cues, as well as being sensitive to their disabilities during communication helped me conduct the interviews in a respectful way that fostered rapport. It also helped me to more accurately interpret and understand what was being communicated. Having tacit knowledge of the culture of institutions helped me gain access to the participants as well as design questions and observational strategies that were appropriate and not intrusive.

3.8 Rigor

In order to support the auditability of this study, I undertook certain procedures to improve the rigor of the study as well as its credibility. Qualitative research requires extended periods of time in the field in order to immerse oneself in the study so that rich data with heavy description can be gathered (Charmaz, 2006). I spent approximately 25 hours in the facilities observing residents, staff and facility activities, making field notes and writing memos. I also spent nearly 70 hours in personal interviews with the participants. In order to further immerse myself in the data, I personally transcribed each of the interviews. While time consuming, this activity provided me the opportunity to hear over and over the words that were spoken, including tone and inflections of voice. This aided me in understanding the emotions that were also being conveyed.

To ensure the trustworthiness of my interpretations, I conducted "member checks" with the participants so that they could confirm or further inform my initial analysis (Charmaz, 2006, p.111). This also enabled me to gain a shared understanding of the participant's thoughts and views beyond what was attained during the interview. To

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ensure that my professional background was not creating bias in my analysis, I also had

other non-dental professionals code my data and review my interpretations. Any

differences were discussed so that a consensus could be reached. The triangulation

between myself, the participant and another professional increased my confidence in

the credibility of my final analysis.

3.9 Introduction to Results

The following three chapters will present my results. These chapters have been

divided to represent the categories and their sub-categories of my findings. I will begin

in Chapter Four with a discussion of how my participants perceived their oral health and

the important influences that lead to their perceptions and impact on social interactions.

Chapter Five focuses on the priority that participants placed on their oral health and the

personal characteristics that contributed to their perceived access to care. Finally,

Chapter Six will discuss the impact of institutionalization and frailty on the perception of

oral health, the priority it had in the participant's lives, their perceived ability to receive

care and the impact on social interactions.

CHAPTER 4: PERCEIVED ORAL HEALTH

In this first chapter of results I will explain how the participants perceived their oral health and the influence it had on their social activities.   In general they considered their oral health as either adequate or less than adequate in the context of four themes: a) comfort; b) cleanliness; c) functionality; and d) how noticeable any problems were. The term noticeable was used as opposed to visible since multiple senses contributed to this theme. Although 19 of the participants identified a problem with teeth or dentures, only 11 of them considered their oral health as inadequate. Here I will explain how the four themes influenced each group of participants.

4.1 Perception of Adequate Oral Health

Twelve of the 23 participants considered their oral health to be adequate (Table 3). This perception was derived from the question: "*How do you feel about your teeth and/or dentures?*" The most common answer among these 12 participants was "*they are fine*", which I inferred and deemed as adequate. There were six men and six women in this group, one wore dentures, six had natural teeth, and five had both dentures and natural teeth, and all but one of them could care for their teeth or dentures without help. Although these 12 considered their oral health to be adequate, eight of them identified a problem with their teeth or denture, and three of them at normal speaking distance had a noticeable problem.

Table 3 Participants with perception of adequate oral health.

Name*	Age	Oral Status	Mobility	Self-Reported Oral Conditions	Noticeable Oral Condition	Investment In Oral Health
Women						
Gerry	88	Dentures	Wheelchair			
Janice	93	Teeth	Wheelchair			Past & present
Kate	83	Teeth & Dentures	Wheelchair	Broken teeth		Past
Olga	87	Teeth	Wheelchair	Gum disease		Past & present
Sara	97	Teeth & Dentures	Walker			Past & present
Tina	94	Teeth & Dentures	Wheelchair	Missing teeth	Yes	
Men						
Ullie	81	Teeth	Wheelchair	Broken teeth	Yes	
Dean	86	Teeth	Walks	Cavities		Past & present
Ed	97	Teeth & Dentures	Wheelchair	Broken teeth		Past & present
Ian	63	Teeth	Wheelchair	Missing teeth		Past
Monty	85	Teeth & Dentures	Wheelchair	Missing teeth	Yes	
Quincy	58	Teeth	Wheelchair			Past & present

* Pseudonyms are used to maintain the anonymity of the participants

4.2 Perception of Inadequate Oral Health

Eleven of the participants (one man and ten women) believed that they had less than adequate oral health (Table 4). Responses to the question about their teeth and dentures were much more varied than the other group and ranged from "*they could be better*"(Irene), to "*they are the worst part of me*" (Alice). Although there was a marked difference in the degree of adequacy of their oral health, their perceptions were still influenced by the comfort, cleanliness, functionality and how noticeable a problem was. Five had natural teeth, two had teeth and dentures, while four had complete dentures. Ten of these participants reported problems with their mouths, six (one man, five women) with noticeable conditions. Seven of them could attend to their own oral care.

Table 4 Participants with perception of less than adequate oral health.

Name*	Age	Oral Status	Mobility	Self-Reported Oral Conditions	Noticeable Oral Condition	Investment In Oral Health
Women						
Irene	89	Teeth & Dentures	Wheelchair	Cavities & broken teeth	Yes	Past
Bonnie	88	Dentures	Walks	Loose denture		Past
Meryl	78	Teeth	Walks	Chipped tooth	Yes	Past & present
Penny	78	Dentures	Wheelchair	Loose denture Bad breath	Yes	Past
Alice	84	Teeth & Dentures	Wheelchair	Missing teeth Bad breath		Past
Betty	89	No Teeth/ Dentures	Wheelchair	Missing teeth Discomfort	Yes	Past
Clare	95	Teeth	Wheelchair	Broken teeth	Yes	
Fran	78	Dentures	Walks	Loose denture		Past
Nora	82	Teeth	Wheelchair	Broken teeth	Yes	Past
Ruth	78	Teeth	Wheelchair	Gum disease	Yes	Past
Men						
Harry	68	Teeth	Wheelchair	Broken teeth	Yes	

* Pseudonyms are used to maintain the anonymity of the participants

4.3 Comfort

A strong influence on the perception of oral health among both groups of participants was whether or not they experienced pain with their teeth or dentures. If they did not have a toothache or other mouth-pain, usually they believed that their mouth did not require professional attention, despite their awareness that there was a problem. Some also used the term comfort in describing the health of their mouth. When I asked what "comfort" meant, they generally made a reference to pain in one way or another, such as Janice's comment: *"I don't have any aches or pains,"* and Ed's comment *"well there is no pain".* Furthermore, among those who believed their oral health was inadequate, the variance in the perception of pain, further promoted the use of a broader term in

relation to the sensation of pain. I therefore inferred that lack of pain along its continuum should be considered and termed "comfort".

Five of the men and one woman from the 12 participants who perceived their oral health to be adequate were aware that they had broken or missing teeth, but without pain they did not give the situation much attention or want treatment. Kate, who wore an upper denture against lower natural teeth, one of which was broken, explained: *"I have a bit [of discomfort] now but not what I would consider dire. . . . If it was hurting that would be dire . . . well one [tooth] is broken . . . [and] once in a while it stings . . . it's a molar, back molar [so I'll] leave it alone."*

Dean, who had almost all of his own teeth, also described how the lack of pain from his two broken and decayed back teeth *"don't bother me".*

Ullie, who also had multiple broken teeth, explained: *"I'm 81 years old . . . and I still got my own teeth (laughing) . . . and I haven't been to the dentist for 15 years, maybe 20 . . . and I don't have any toothaches, I can eat ice cream like anybody else without having it bother my teeth".*

Comfort was also important to Gerry, who wore complete dentures and believed that *"if your teeth don't fit-in properly then that's no good."* In this case, comfort was not associated with lack of pain, but instead with the sensation of a loose denture that moved around a lot and was *"irritating"*.

Among the participants who perceived their oral health to be less than adequate, two women also complained of discomfort with their dentures. Fran, who wore complete dentures for about 50 years said: *"Well they hurt sometimes and that is not good, but . . . most people with dentures… get apprehensive that any of their food hasn't got stuck on their teeth."* The last part of her statement was said with a chuckle to insinuate that others were silly to be more concerned about food sticking to their dentures than about how the dentures fit and feel. Betty, who just received new complete dentures, was also unhappy with their comfort and with their unnatural appearance: *"I don't like them and I'm not comfortable with them especially I don't like their perfection."* Comfort for her meant both the fit and appearance of her dentures. She was the only participant who spoke of comfort in relation to the appearance of teeth or dentures.

The others in this group were reasonably comfortable and had little to say about how their teeth and dentures affected them. Harry with all of his natural teeth broken-off at the gum- line explained how: *" the fact that there was very little pain associated with the whole thing made it not a huge priority.   I know it was pure luck, but still the fact that it didn't blow up on me all the time is big."*

4.4 Function

A view shared by everyone was that the ability to enjoy food was important, and if this was possible, for most of the participants, there was little problem with their oral health. There was a range of chewing ability associated with the enjoyment of food,

and this enjoyment was influenced by their ability to cope and adapt to the dysfunction. For example, it became apparent that for some, a full natural set of teeth or dentures were not required to enjoy food. Kate, for example said, *"I got in the habit one time of eating without [dentures] because food tastes altogether different."*   Others were on a diet that did not require much chewing.   As Betty said, *"I don't eat anything . . . I only have a can of 'Ensure' . . . and a few 'Rice Crispies' in the morning."* Irene, who had both teeth and dentures mentioned that she was on a *"pureed"* diet because of swallowing and gastric reflux problems, and therefore the lack of a fully functioning dentition didn't bother her. Clare with broken natural teeth thought that her teeth worked well because she was on a minced diet and had "*lost most interest in food.*" Even Ed, when he thought about being unable to wear his upper denture said *". . . well I'd have a tough time eating and would have to use liquid foods, but I'd have to get along without it."*

Yet there were others who discussed how oral dysfunction affected their perceptions. The women who complained of poor function and less than adequate oral health all wore complete dentures.   Bonnie had dentures for close to 40 years and now had *"shrinking gums"* complained that her dentures were loose and worried her that they *"could fall out or something"* while she was eating, making mealtime worrisome as opposed to enjoyable. Penny who had her teeth removed and dentures made about two years previously also complained of loose dentures and said, *" they drive me nuts . . . [especially] when food gets in behind."* For her, the poor fit and resultant loss of function made eating less than enjoyable.

There was also the perception that the oral dysfunction could disturb overall health. Fran who had complete dentures all of her adult life stated that:

Function is the most important.   I think the aesthetic beauty is secondary and

for your digestive system if it's not well chewed before you swallow it you're in

trouble so . . . the function of the teeth is more important than the aesthetic, and

by aesthetic I mean the whiteness and how they look.

Olga, at 87 years with nearly all of her own natural teeth also explained that,

". . . without healthy teeth you couldn't chew anymore and that would cause you

intestinal problems."

Harry was unable to chew some foods with his broken teeth, and was considering the possibility of new dentures because, *"it would be nice to eat good food again. It would be nice to eat salads. I can't chew a salad right now . . . it's annoying, it's really annoying.   I had things in here the other day with a nice side salad and I just couldn't [eat it]."*

Even though Harry was able to eat steak with his broken teeth, it was obvious to him that the effort required to eat less dense food was inadequate and reason enough to seek resolution of the problem.

4.5 Noticeability of Oral Conditions

Just as comfort had a large influence on how the participants perceived their oral health, so did the noticeability of a problem. As I explained above, I used the term noticeability as opposed to visibility or appearance, because visual, tactile and olfactory detection of problems were identified by the participants.   The term "tactile" related more to a personal assessment of comfort. Yet visual and olfactory sensations were also important especially since problems could be detected by others, which seemed to cause much of the distress associated with the perception of less than adequate oral health.

While comfort was important with both groups, there was one participant who could tolerate some discomfort if her teeth looked pleasant. Tina who had no lower front teeth said that she did have a *"little plate"* that fits in the space, but it pinches her and she only *"jams it in"* when she is going somewhere important. Although she leaves her denture out to avoid soreness, it was very apparent that she was willing to put up with a bit of discomfort to look good around others.

The issue of noticeability of oral health conditions was evident with all of the participants who believed that their oral health was adequate, but it did not disturb everyone in the same way. Janice, who explained that she had always been very attentive to her mouth and continued to see her dentist annually, believed that mouth-problems, even if not visible, needed attention. When I told her that others said they would not bother about problem teeth if they were not painful or visible, she responded:

"I think that's rot . . . well its nonsense! If it's broke fix it, if it ain't broke then don't fix it." Sara also indicated that she "*wouldn't want a broken tooth and have to eat on it."*

The responses from Janice and Sara were unique among the 12 participants who were happy with the health of their mouth. In part, these views were due to past and current investment in their oral health. My definition of investment was drawn from Cash, Ancis and Stratchan's (1997) description of body image investment of "actions one takes, as a result of one's evaluation in order to enhance, improve or change one's body".   Investment is therefore not just financial, but action oriented. Those who had always taken care of their teeth and dentures daily and visited a dental professional regularly for both preventive and restorative care, I considered to be invested in their oral health. However, previous investment did not always mean that non-visible problems would cause a participant to perceive their oral health as a problem or prompt them to seek care. Quincy, for instance, who saw a dentist regularly and received help from the nursing staff for oral hygiene explained: *"as long as I could eat fine . . . then I don't care."* However when I asked about a broken front tooth, he said "*I want to kinda look normal . . . a broken one would probably bother me psychologically."*

Ed who was also invested in his mouth, both in the past and the present, and who had recently broken a posterior tooth said, *". . . the filling came out and it can't go back in, so I'm just keeping it like that until it begins to hurt."* When I asked Ed how he would feel if he was unable to wear his upper denture in public, he was unconcerned because he had seen people in the dining room eating without their dentures and believed that

"*as a rule, people without an upper denture, they just keep on going.*"   Ullie and Monty had broken and missing front teeth, however, unlike the others, they had not seen a dentist in years and sought dental care mainly for relief of pain. For these men, having a noticeable oral problem was of no concern. Investment not only affected perceived oral health, but also had a strong influence on the priority of oral health and will be discussed further in the next chapter.

Appraisal from others also influenced the participant's perceived oral health. Harry, for example, considered getting his teeth fixed or dentures made not only to eat salads again, but also because he was concerned about the appearance of his mouth and how others judged him: "*I don't spend a lot of time worrying about it . . . I've got a few friends [who have] false teeth, and they're on you all the time [to] go and get [dentures]*".

While friends were considered judgemental about appearance, family were perceived as less threatening. Betty, who recently had all of her teeth removed and didn't have dentures yet explained:

I don't mind looking as I am in front of my husband or son, but people from outside; I don't want them to come inside. I don't have teeth.   I know I am talking pretty much [normally], but it is not easy to talk without teeth. Your tongue is trying to make-up for the fact that there is a space there and everything doesn't come out for you the way you intended. So yes, I am troubled when people come [to see me].

About two months later, Betty received dentures, but complained how she was not pleased with them. When I asked her how she was adjusting to her new dentures she replied:

> Not at all well, mainly because I think of where I am, and I'd rather have not tried to bother. I'd rather manage without them. I don't eat anything anyway . . . so I don't need [them] to eat and I certainly don't like them. They are nothing like my own teeth. I hate the perfection, ridiculous. . . . I really do think that the age of the person should be considered when they are made. . . . I can't think that anybody is so stupid as to like having perfect teeth.

When I probed further, Betty explained:

> Other people can do what they like, but personally I don't like perfect teeth. I think they look stupid in an old face . . . my own teeth [were] arranged according to my face. Today the teeth they make for people are stupid. There isn't any likelihood that they would have been like that if they were left alone. . . . Everyone smiles today and you look at them and you think surely those aren't natural; no one has teeth like that.

Betty's comment about the *"stupid"* perfection of the appearance of her dentures was unusual. However, Fran, who is Betty's friend, told me that Betty's family had a big influence on how Betty felt about her dentures:

> A few days ago [she] got new dentures and she had lipstick on with these dentures and I said 'my goodness you look, they look beautiful.' And she said

'well my husband said there was something wrong with them, that [I] looked all teeth now.' I said 'that's because they're all nice and white and clean . . . it's taken years off you, you know,' cause she had no teeth before. And now she's got these, and she said 'does it?' I said 'yeah and you tell your husband [he] better watch out'. And she's always smiling . . . they're very beautiful teeth that she has now, and the enamel, and the way they've arranged them, and on her appearance. It looks so nice.

Obviously the comments made by Betty's husband did influence how she felt about the dentures. Furthermore, Betty was willing to put up with discomfort to appease others. She told me that in addition to being unhappy with how the dentures looked, they also did not fit well. When I asked her why she continued to wear them, she replied: "*Because people expect me to . . . but there is nothing about them that makes me want to wear them.*"

Alice was also concerned about how she would be judged, and indicated that she didn't want to offend others with a mouth that was imperfect:

I mean my whole ensemble [of teeth and denture] looks better when they are together than when [my denture] is over there and I am here. Of course I've only got 2 or 3 [teeth] showing here. . . . If [the dentures] weren't in I feel that I shouldn't have exposed other people to this odd mouth with 2 or 3 teeth.

Not only did Alice want to avoid offending others without dentures, she was also concerned about her breath: *"Oh my friend phoned me recently and she didn't say hello or anything, she just said 'you've got bad breath and your teeth don't fit'."* Alice elaborated on how this influenced her:

I don't feel very good about my teeth [or] my mouth; always having a terrible

taste. No I don't feel good about my teeth, that's true. They have always been

the worst part of me . . . anyway, no I don't feel good about my teeth . . .

mainly it's because my mouth never feels clean to me now and my teeth feel

fuzzy.

4.6 Cleanliness

Alice's comment about the cleanliness of her teeth was a common theme with both groups of participants. A clean mouth was considered healthy and a belief shared by everyone. Ullie who had many broken and missing teeth said:

Well I think I've always understood that not having a clean mouth can lead to all

kinds of bad things- infections and whatever, none of which can be good for

you. So you're better off if you look after them than you are if you don't. If

you're determined not to look after yourself, the fact that the care staff would do

that is a nice bonus.

Cleanliness was something that was important not only in the mouth but generally. Janice explained: *". . . as long as I'm clean I don't really care. I try to shower every day and brush my teeth three times a day and change my nightie every day."* When I asked

her what it would be like if she didn't feel clean, she replied: *"It would never happen. It is something I picked up as a baby. My mother bathed me every day."* This is also why she brushed her teeth every day and believed that *"the secret to keeping your teeth is cleaning them."* This was a fair assumption on her part, given that she was 93 years of age and had all of her natural teeth except for one removed in her 20's "*for no good reason*". Although Janice was quite frail and spent most of her time in bed, she was able to clean her teeth. When I asked her what it might be like when she is no longer able to do this, she replied, *"Don't leave me around that long"*. She went on to describe that it would make her feel dirty and even though she didn't leave her room often, she believed that people would not like to visit her because, *"you don't like to talk to somebody with yellow teeth and terrible breath."*

Janice was not the only participant who talked about tooth colour in relation to oral hygiene and health. It was a common statement made by nearly everyone. Dean, with most of his natural teeth, when I asked him what clean and healthy teeth look like, told me: "... *they'd be white; well you see the ads on the television."* The "yellowing" of teeth and dentures was a general concern; even if they believed that they were healthy. Everyone but Betty wanted whiter teeth.

Olga could still brush her own teeth, but she too was concerned about the color because as she said, "*I have always had these yellow teeth, but I wish they could be whiter . . . because whiter teeth are nicer. It looks as though I don't take care of them."*

The participants believed that neglect and a dirty mouth causes bad breath, although none of the participants who perceived their oral health as adequate believed that they had bad breath, or as Dean said, *"nobody has complained yet."* The ability to care for their own teeth and dentures gave them the sense that they had control over mouth-odour and was the reason why Ian brushed and used a mouth rinse daily, because, as he explained: *"you know you want to be pleasant, you want to smell pleasant."*

The fact that nobody had complained about Dean's breath led him to believe there were no real problems in his mouth, even though he had two teeth currently being tended to by his dentist. Those who felt that they had a clean mouth had little concern about bad breath, but they would want something done if it did occur, as Fran explained sternly: *"Well I'd get rid of it first off. If I found I had [bad breath] I'd get rid of it, I really would. I can still think that way and do it . . . you have to keep yourself clean."*

Among those who perceived their oral health as inadequate, the fear of bad breath was much more of a problem. For Pearl, who wore complete dentures, bad breath was the *"bane of her existence"* and the reason that she sucked on mints all day. Harry was also quite concerned about his breath, especially when he had to speak to others, and he explained:

I get a sense that [bad breath] is there all the time, that it's just kinda hiding.
Like [I] don't do a lot to breathe out hard or else people are going to start falling
down (laughs). . . . That was one of the things that I was worried about when

you asked to come in here today. You know, I know what you're going to see, I

just don't know what you're going to smell, and I didn't want you to buckle and

faint.

Among both groups, cleanliness, was considered an indication of both physical and mental function and when Sara talked about residents who were dirty and smelled, she said, *". . . well I used to think that they were sloppy, but I don't think that anymore. . . I think they are having a hard time . . . just like me."* Fran elaborated:

You have to look at the person… and see what they are capable of doing and

not doing. I mean most of them don't want to be smelly because they were

brought-up quite different, and maybe they're in a position where they can't help

it anymore.

It became clear during several interviews that the participants emphasized a clean mouth because it was something that they could manage. For example, Tina said: *". . . you can't help [broken teeth] you know. Whereas the other [oral hygiene] is something that you can control."*

Among those who believed that their oral health was adequate, all but one could attend to their own oral hygiene, which seemed to give a sense of personal control and independence. When I asked Kate to tell me what it might be like not to be able to take care of her teeth she replied, *"It's gonna be hell because I'm very independent and to take everything away from me, it's gonna be hard to handle."*

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Among those who believed they had less than adequate oral health, four were unable to care for their mouths and it seemed to be a strong influence on both their perceptions as well as their social relations as Ruth explained: "*Oh I don't feel my teeth are ever clean and I don't want to smile, let alone laugh.*" She went on to tell me that she has *"never had pearly white teeth but they sure were a hell of a lot better than they are now"*. However, despite the importance she gave to the appearance of her teeth, she complained that:

I got lazy. I got very, very lazy. And I think 'Ruth you have still got all your own teeth for God's sake keep them'. [But]I can't brush my teeth like I used to, and I can't even put toothpaste on a brush by myself. [It] takes two hands to do everything . . . if [the staff] got time, they load up my toothbrush because they know I can't do it . . . [and] once I get the brush in there I can manage with one hand.

Like Ruth, Nora who was also dependent for her daily mouth care, complained: *"I don't know if I ever felt they were brushed properly."* However, Nora was quite ill and her oral condition did not affect her social relations.

4.7 Social Impact of Perceived Oral Health

Most participants indicated that they would be bothered during social interactions if they had a noticeable mouth problem. Bonnie said that if she didn't have her dentures in her mouth, that she *"would never leave her room."* Meryl said she *"wouldn't smile,"*

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and Tina would avoid people all together because she would be *"terrified of walking out into a group of people and having bad breath."*

Others were unsure of how it would affect them, such as Fran who pointed out *"if you haven't been there then how would you know."* However, among those who had reached that point and did have oral problems, only a few indicated that it disrupted their social relations, and this revolved around the "noticeability" of the condition to others. In speaking with Ed about how poor oral health would affect social well-being, he said, *"there's people living in here that don't enjoy life at all . . . it's not to do with their teeth mind you, they just don't enjoy life".* Harry, near the end of our interview, explained this relationship further:

> *If you can find out from the patients why [oral health] is important to them in the*
> *first place, then you will probably have lots of information that would replace what*
> *lots of people think is important. . . . People do need reasons for being*
> *passionate about something and I don't see a lot of it about teeth or the lack*
> *thereof even.*

It was obvious that Harry believed that concerns about the mouth were much less of a concern among residents and staff than other aspects of living in the care facility, and his comment stressed the importance of exploring with residents their priorities of oral health, instead of relying on preconceived thoughts.

Comfort, function, noticeability and cleanliness all played a role in how the participants perceived their oral health. The extent to which they were bothered about mouth-problems varied. These issues will be the focus of the next chapter, which will explain how the elders prioritize oral health in the midst of other problems they have.

CHAPTER 5:   PRIORITIES OF ORAL HEALTH

The previous chapter explained how the participants perceived their oral health. While some were content with their teeth and dentures, others had a much more negative view, but the degree to which this view influenced their overall well-being varied. Multiple factors emerged during the interviews that contributed to the importance or priority that oral health and disease had in the participants' life. These factors were largely related to investment in oral health, socioeconomic status, current health status, support systems and perceived access to care.   This chapter will focus on how these factors influenced the participants to help explain how oral health was prioritized.

5.1 Investment in Oral Health

Why some participants were bothered by the less than ideal condition of their mouth in part related to how invested they were previously in their oral health. Participants who had always taken care of their teeth or dentures and attended a dental professional regularly wished to continue and when problems arose they wanted to have them addressed. Among the participants who believed that their oral health was inadequate, all but two of them had been quite invested in their mouths as evidenced by their past dental history, and were bothered by the current state of their oral health. This was certainly the case with Nora who had always seen a dentist regularly, but was experiencing problems with her teeth. She explained: *"Well, I don't want to lose all my teeth, that's for sure. I was willing to pay a fair amount, you know, to get my teeth*

tended to properly [right now] . . . I think they need cleaning, and could to do with a little whitening."

Those currently invested in their oral health had problems addressed when they became apparent, but remained concerned about the future. Meryl had almost all of her teeth, brushed them twice daily and saw her dentist regularly. She was bothered by a small chip on her front tooth, and was going to make an appointment with her dentist. When I asked her how she would feel if that was not possible or if things got worse, she very sternly said, *"off with your head".* I probed further what it would be like if she lost some teeth to which she replied: *"I would hate that. I would absolutely hate that. I do think about that sometimes when I am down in the dumps . . . and dread the thought of having dentures."*

While those who were currently invested in their oral health placed priority on its maintenance, there were participants for whom oral health was and never had been important.   Harry, for example, during our first interview reflected back to a recent stay in the hospital when the care-staff brushed his teeth:

> *They never miss a day doing it. Getting me up in the morning and they'd be in there, right in there, right now working on your teeth, every day **. . .** yeah I did [appreciate the care] I remember thinking so many times, I wonder if my mother and father had done that then [would I] be in this mess. They didn't and I didn't, so here I am.*

It was also apparent that there were also participants who were not invested in their mouths because they really didn't care one way or the other. Gerry made it clear that she didn't give much thought at all to her mouth. She had dentures for most of her adult life and was able to care for them easily because she soaked them daily in a denture cleaner. They fit well, caused her no discomfort, cost nothing and she was not too concerned about not having them in the future, nor did she see any reason to have them checked regularly by a dental professional.

Other participants made it perfectly clear how important their oral health was and how this importance had not changed at all now that they were frail and institutionalized. Janice, for example, had gone to the dentist regularly and did so annually. When I ask her to tell me if she had noticed any change in her teeth since she moved to the facility, she stated: *"they've gotten five years older".* When I asked her about any change in their importance she replied sternly: *"What do you mean by importance? They are always important."* Janice was able to brush and floss her teeth, and rinse when she felt they needed cleaning. Although she said she did not want to think about not being able to do so in the future, she employed a private nurse and appeared confident that when the time came that she could no longer care for her teeth, her nurse would attend to them.

5.2 Socio-Economic Status

Janice, an affluent and highly educated woman, was in a financial position to hire private nursing care which maintained her priority on oral health. Her nurse gave her a

sponge bath every day and took her for a shower almost every other day. Janice had no fear that she would not be able to receive daily oral care and this allowed her to remain confident that she would avoid oral problems.   The same was true of Olga, another affluent and highly educated woman who also had a private nurse.   Among the 23 participants, seven of them (four men and three women) were quite affluent. All had at least an undergraduate degree and had been professionally employed. When it came to discussing the priority of oral health it was apparent that being able to afford needed care, whether it was professional dental care or daily oral care from a private nurse, their financial position reduced barriers. They were also thankful for the amount of investment that they had made in their mouths. Olga, when she discussed the financial investment she had made in her teeth, said:

I am very glad I had [my teeth] done 10 years ago 'cause my old teeth were terrible, like quicksand that were breaking . . . so I'm glad that I had that. I was at that time reluctant 'cause I didn't want to spend $6000, but I am glad that my husband insisted.

5.2.1   Dental Insurance

Aside from personal wealth and the ability to hire private nursing care, having dental insurance was also an important influence on the priority that participants placed on oral health. Quincy had multiple sclerosis and for many years was on disability insurance, which covered the cost of dental care. When discussing why he was so invested in his oral health he informed me that: *"Not only do I have my dental insurance but . . . I'm*

also a dependant under my wife's [insurance] so I am pretty much [taken care of]." I

selected Quincy for this study to offer the perspective on the priority of oral health from

a frail, but younger, institutionalized person. He was 58, had been living in a care

facility for the past eight years and had gone from being able to walk and do most things

for himself to a quadriplegic who was bed-bound.   He was the most dependant

participant in my study and one of the most invested in his oral health. He continued to

go to his dentist and dental hygienist every three months for examinations and

cleanings, and had a fluoride gel applied to his teeth every evening. The nursing staff

also brushed his teeth at least once a day with an electric toothbrush. From his

perspective, his teeth were well taken care of and remained a priority in his life.

However he did worry about his ability to have them maintained at the facility. Due to

the amount of care that Quincy required now that he was totally dependent, the facility

administrator suggested that he hire a personal attendant to help with his care, to which

he quite angrily responded:

> *Why should I spend all my money on something when you have lots of people*
>
> *here' . . . [it's] reasonable that they should be doing the dental care. It's not*
>
> *reasonable for me to hire somebody to do that.   I think that is part of their*
>
> *responsibility running a facility like this . . . I think that dental is a big deal in a*
>
> *place like this, and there are lots of people here who have very bad teeth, and it*
>
> *would be wise to do preventative things to stop it from happening.*

While Quincy had the finances through his dental insurance to cover the costs of his

professional dental care, he did worry that at some point he would have to pay someone

to come do his daily care, which he did not think he would be able to afford. This concerned him because, as he said:

I think that the dental thing deserves a lot of priority, not cosmetically, but so that people can eat and don't . . . medically need things, and that kind of stuff. So yeah I think it can be paid more attention, than what it gets in most nursing homes.

Other participants with dental insurance seemed to do what they could within their means. Irene, who had a dental plan and believed that she needed "*a lot of work done,*" because of broken and missing teeth, explained that:

I want to [have my teeth fixed] if [my insurance company] will help me. They are very good, but I don't think [the social worker] heard back from them yet . . . I can't foot that kind of bill you know, but if they would help me then sure lets go ahead.

Kate, a retired healthcare worker, who always had a good dental plan and was able to get the dental care she required, explained how her financial position and dental insurance influenced the priority she placed on her oral health:

Well I couldn't care less whether I keep 'em or loose 'em for the simple reason [that] they don't cost me anything. If the dentist wants to fill 'em, or whatever, it doesn't cost me anything, so it doesn't matter. If it was costing me a lot that I couldn't afford, I'd have 'em yanked.

Both Irene and Kate would not be able to afford care unless it was covered by their insurance. While Kate would remove her teeth if she could not afford to have them restored, Irene and others in a similar financial situation wanted to leave things as they were. Even though they both had dental insurance, if the care they required was not covered by their plan, the priority they placed on their oral health diminished.

There were other participants, such as Tina, who never had insurance or the financial ability to get the dental care she wanted, and as she said:

I've never had much time or money to do much with [my teeth] . . . of course you have to have the money to do what you want or you can't do it. [If cost wasn't an issue] I would have gotten quite a bit of work done; [you] opened a sore subject there.

The priority that Tina placed on her teeth at the time of the interviews was that it *"sits about half way 'cause if I get a toothache I'm gonna have to get it out*."

Pain also influenced the priority of Monty who never had the money to do much with his teeth and only sought care when his broken teeth became painful. Monty was the least affluent of all the participants and for a time was homeless before he moved into the care facility. His teeth were in poor condition and, as he said, *"I never had the money to do anything, but now it's gotta be done".* He was in pain and received emergency dental insurance through social assistance to have his painful teeth removed and a denture made. He was still missing his lower front teeth, but since they

were missing for a long time, and social assistance would not provide dental benefits in the absence of pain, he did not think it was a priority to replace them, nor could he afford to do so.

Alice also did not have much money to spend on oral care over her lifetime. She was a single mother of five children, and although she had a university degree, for most of her life had struggled financially. Upon moving to the facility, her children paid for her care, including dentistry. She had her teeth cleaned every four to six months at the facility, and went to the dentist for fillings when needed. However, by the end of the study she was much less interested in having her teeth tended to because she said that *"it cost too much and I would rather spend my money [on wine, because] . . . it gives me pleasure".*

5.3 Current Health Status

As a participant's general health deteriorated, there seemed to be a point where their oral health assumed a much lower priority, even if they were able to afford care. Alice could walk and leave the facility whenever she wanted at the beginning of my study. Within four months she was experiencing problems with continence, was unable to dress herself because of a painful shoulder and was depressed about her increasing dependency. It seemed that the priority she placed on oral care was changing.

Deteriorating physical function caused another participant, Ruth, to re-examine the importance of certain aspects of her life, including oral care. She had always prided

herself on her appearance, but was now quite distressed since a stroke left her confined to a wheelchair and dependant for almost everything. In speaking about how her current condition impacted her, she stated:

I felt so terrible.   I mean I've always prided myself on standing tall and dressing as good as I could on my budget, looking half decent and now I don't give a care what I look like . . . you know I am a grown woman and haven't got a shred of independence left.   I don't quite know how to overcome that . . . the clothes I wore, and keeping my figure. Like I say I was tall and slender and keeping my hair looking nice. Now I just don't' give a damn about any of it . . . I can't be bothered to even brush [my teeth] most days now.

In probing further how her deteriorating health influenced the priority and importance of her teeth, she told me:

Well I used to go every 6 months cause I had tartar build-up, so I used to go to the hygienist, it was either 3 or 6 months. I never minded going and then I went into a nursing home and the only way I could get to see a dentist was to go out to UBC . . . I had to get one tooth pulled and a lot of gum-line cavities. I simply can't be bothered with any of these things anymore.

Even though Ruth had the financial means to obtain professional dental care, her poor health made it impossible to attend her own dentist. Being forced to have treatment in a geriatric dental clinic compounded the problem as it reinforced the limitations she experienced with declining health.

One participant also had some expectations about how health would impact the priority of oral health. Tina, who still considered herself relatively well, told me that if her health declined: *"I am sure . . . if you would feel so miserable, you wouldn't feel like… fixing [your teeth] up or whatever you had to do."*

Nora, who had been quite ill, explained how this affected the priority she placed on her oral health:

There was one period when I heard that I might die so I was very worried and didn't really know about that cause.   I didn't know why, I didn't realize I was so ill. . . I wasn't too worried about my teeth and now I've lost a couple and that concerns me.

Since her recovery, the desire to have her mouth restored was quite evident:

I've been thinking about my teeth, you know. I'm running my tongue on all my teeth . . . they need to be cleaned and they need some kind of attention. I'm aware of it. They don't look very smooth or clean anymore . . . and I don't know why there are so many teeth missing.

Nora had been so ill she was not even aware that her teeth had been breaking off. However, once she started feeling better the health of her mouth was once again a priority, so much so that she even wanted her teeth whitened because the color also bothered her.

5.4 Reduced Access to Professional Oral Care

Access to professional oral care was affected by both physical and financial constraints. For physical reasons, and the use of a wheelchair the majority of participants could no longer leave the facility to visit a dentist. If care could not be provided at the facility the priority was much less because access was very difficult. Ian, who had been quite invested in his mouth in the past, now placed little emphasis on it because as he said, *". . . it's hard for me to go to the dental office and all that stuff."* Ian was a teacher before his cerebral palsy became more pronounced. As his condition progressed it became much more difficult to get around. At the time of the interviews he was in a wheelchair because his condition had deteriorated. He explained:

Oh I don't think [I want dental work done] now . . . it's hard for me to go to the dentist's office and all that stuff. So for me I think I will just leave things the way it is . . . I've had quite a bit of dentistry done so I think I will just leave it the way it is.

Ullie experienced similar difficulty accessing care. He had recently fallen off a ladder, was in a wheelchair and found it difficult to get to outside appointments. When we talked about his teeth he said, *". . . the one side here you may have noticed has broken off so I've been wanting to go and get that done, but now when I got hurt, I imagine I'll just live with it."* When I asked him if the priority of getting his teeth fixed would change if the dentist came to him, he remained concerned about cost, although physical access was no longer an issue;

Yeah [on-site dental care] probably would [help], but then again it would depend on the cost too. As I say, I am not that flush with dollars so if I could get an estimate and maybe do a little over-time, and then that costs money too, and if you have to have someone come here then you might as well get enough [teeth] done so that you're done with it for a while. But otherwise I don't think I'll worry about it unless somebody is coming here for more than me, then they could give me an opinion or a quote as you call it. So other than that we'll leave it alone.

Ullie was well aware that the cost of having someone come to him at the facility was much greater than if he could go to a dental office. However he would need assistance to get there and did not have any. In general, lack of outside support affected the perceived ability to access professional oral care, which in turn influenced the priority of the mouth. All of the facilities were visited by a dental hygienist and a denturist. A dentist also came to the facilities to provide dental exams and extract teeth, but residents had to seek care outside of the facility for fillings or other dental treatment. This was not an issue for those who could walk or who had a private nurse or family and friends, but for the others the difficulty of accessing dentistry decreased the priority that they placed on their mouths. For example, Betty, who could not walk, described how she felt when she decided to have all her teeth removed.

I just thought about it [and] made the decision that I would have them all out at one time, because I couldn't have [my son] coming and getting me. He has his own busy life and you have to have someone to take you for each tooth, so I decided to have them all out at once. . . . There is only one [dentist], who comes

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to these places, and he did it on the bed, and I found nothing wrong with him, but

I found a reaction to having them all taken out at once; [it] was difficult.

Tina was hesitant about requesting help to go to the dentist because: ". . . *like my*

own daughter . . . they make me feel bad because I can't do it myself."

Others, like Tina, just lost the desire to access dental care if they had nobody to

help them. For participants who were in wheelchairs, on-site comprehensive dental

care might have made a difference in their desire to have dental care done. However

there were others who didn't feel that on-site comprehensive care would make any

difference at all. Other aspects of life took priority. As well, the participants without

dental problems believed they only required daily mouth-care.

5.5 Perceived Access to Care

The participant's perceived ability to receive daily needed care also influenced the

priority of oral health, especially among those who were more dependent. While all the

men and a few women were comfortable asking for help, others tended to take what

they could get. Their ability to request help was partly a result of their personality and

their perceived ability to speak up and be heard. However, participants who were more

dependent also had to set priorities when it came to their care, due to perceived

consequences.

Residents who could no longer care for their teeth and dentures also lost interest in the health of their mouths. Even though cleanliness was important to everyone, those who could no longer clean themselves relied on the nursing staff to provide the care. Participants, who viewed their oral health as adequate, tended to believe that someone would help if necessary. When I asked them to tell me about requesting help from the staff, I heard positive things from those who were content with their oral health, such as:

They don't mind you know. Like I say to them often, I say 'do you mind doing this thing' [cleaning me] 'No,' they don't. (Ed)

The care staff here is marvellous; there is nothing that they wouldn't do for you. All you have to do is ask. Well for me anyway. (Kate)

5.5.1 Requesting Care

The ability to request care emerged as a strong influence on the priority that was placed on oral health. The care received was impacted to some extent by a participant's personality and willingness to speak-up. Ian explained: *"I have a way of talking to people to make them understand that I need something. I am very verbal, which helps",* whereas Alice believed:

It's a great survival course [in] old age homes . . . you learn to be pretty tough and you learn to establish how you want to be treated, which you really have to do, because you know if you're a wimp you'll be treated like a wimp.

Women were less likely to speak-up for themselves, as Clare complained: *"What can I do? I can't stand up and fight 'em"*, because, as Betty elaborated, *"I can't bear to have things that are troublesome to other people."* Indeed, Betty's timid personality inhibited her from complaining to the denturist or the staff about her dentures. She explained further in another context that: *"I always liked to be independent and I can't be anymore and that's hard, very hard, because if you see any resistance in anyone you ask, you don't ever want to have to ask again".* Betty, already had a sense of being a burden to her family, and was now hesitant to ask for help.

5.5.2 Prioritizing Care Requests

It was apparent that as an elder became frailer or more dependent, the care they requested was selected. For those who had not previously invested in their oral health, it received little priority. Harry, who spent much of his time observing life around him, described why residents learn to prioritize care requests.

[Residents] would say, 'I gotta go [to the bathroom]' and [the staff] would say 'you got your pad on so just go ahead.' No 80 year old, or any year old wants to poop in their pants and then go and lie in it for the next two hours. . . .'What you're saying to me when you say that is that it's ok for me to just lie in my own shit for a couple of hours because you don't like cleaning it up. Well I really mind lying in it because you couldn't be bothered to take me to the bathroom right now'.

It was apparent from speaking with Harry and others that when care was requested it might not be provided, or at least in a timely manner. Participants, who experienced this response from caregivers, were reluctant to request other care, such as daily mouth care. Although Harry had no problem requesting care, he explained how he prioritized his requests:

Things that are just annoyances, I have to just ignore them like they didn't

occur. If I react the wrong way, then what's it going to do for me? If I get pissed

off or say something without thinking my way through it, I could wind up with it

being a lot worse than it started out to be. Basically at the end of the day, I

started it and finished it too.   [It's not worth it] having a bad reaction to

something that is not important in the overall scheme of things.

Tina had similar observations:

Well the [care staff] look after . . . the most basic things 'cause [residents] all

have to go to the bathroom and most of them can't help themselves. So this is

part of it, and some of the [care staff] are so good, knowing when to do it and

when to ask, and others they . . . just hide them in a corner until they get time

to do it . . . [or] keep them out of sight for a few minutes until they got time.

That's a big deal.

When I asked Tina what it was like to observe that behaviour, and how she dealt with it, she responded:

It's something that you get used to living in a place like this. You know what's

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happening; you know where it is happening, and how it is happening. . . . You

just close your mind to it and not worry over something happening or somebody

gets yelled at . . . well if it was a very big thing there would be a lot of, can I say

bitching . . . kinda a controversy anyway.

Tina went on to describe how different residents coped in these circumstances:

Well it would depend on which residents. I mean some of them are right up there

with wealth, and speak what they think. Others are sort of the cowering type.

5.5.3 Consequences of Requesting Care

All of the participants, both those who felt comfortable requesting care and those

who did not, suggested that "consequences" needed to be considered before care were

requested. This further suggested that care needed to be prioritized because as Tina

said:

I guess we all shouldn't complain. . . . I think we all could complain before, but

now we shouldn't, because I think it is a little bit too touchy. You know if they

[facility administrators/owners] say it is not worth it for the bits and pieces that

they get out of it, they might just shut it down, you know, and sell us all to

somebody else.

This comment made it very clear that there were participants frightened by this

possibility, especially those who were not financially stable or who had no outside

support.   It was easy for me, even as a dental hygienist, to begin to understand that

the priority of one's oral health was much less than the risk of being *"sold"* to someone

else or not having anywhere to live and receive care. This seemed to be a reality for the

majority of the participants. They had reached a level of frailty where there was

nowhere else to live. Olga had resided in a care facility for almost two years, was

financially well off, and had good family support. She explained that not even that

would alleviate some of her fear that she and others had regarding their living situation:

I think the worst is that there is no home anymore. And most families, I would

judge the same; the husband and wife, and the children are still school age.

There is somebody looking after the children. It is not the older children now,

and there is no room for the old people in these homes. Not by carelessness,

but by fact . . . I have seen it in myself when I wanted to stay at home by myself.

I dropped dishes . . . I could not walk anymore, so my son said 'this is enough

you must go to a home.' And I realized it was the best way out. And if rooms

are kept as nice as this one, I think people find it quite pleasant.

The facility Olga lived in was nice and clean and had pleasant staff, which seemed to

make it easier for her to adapt to her living situation.   She realized that it was the best

for her and her family. However, not all participants adjusted well to living in a care

facility and their increasing frailty or deteriorating health. The next chapter will focus on

how institutionalization and frailty further influenced the priority placed on oral health

and body image and how all of these factors impact social behaviours and social well-

being.

CHAPTER 6: FRAILTY AND INSTITUTIONALIZATION

In this final chapter of findings, I will add context to the priority of oral health and its impact on social interactions by discussing the influence of frailty and institutionalization. I will explain how frailty and institutionalization influenced the ability and desire to socialize among the residents I interviewed. I will discuss also how frailty was conceptualized by the participants in relation to age, the impact of increased dependency, the experience of witnessing declines in others at the facility, and the coping mechanisms that they employed. Next I will focus on how social opportunities and living with cognitively impaired residents influenced the participants' desire to interact within the institutions. Finally, I will discuss how elders experienced and coped with being institutionalized and how the coping strategies either facilitated or impeded meaningful social relations. My research question was based on the original belief that all of these factors had the potential to change the priority that oral health had in a participant's life and consequently their social interactions.

6.1 Frailty

6.1.1 Old Age

The 10 participants over 75 years of age, in general, thought of frailty as an inevitable consequence of aging. How they experienced growing old and frail had a direct influence on their social relations. Clare, who was in a wheelchair and totally dependent, discussed how being old and frail, influenced her social activities:

When you're 95 what point is there? If you can't get around and you can't stand

up and all that sort of thing, what is there to do. I'd be much happier conked out.

. . . I think people think I am probably antisocial.

For Betty, growing old and frailer also influenced her desire to socialize, and as she

said:

I didn't expect to be useless at the age of 88, and I didn't expect to have no teeth

and not able to control most things. . . . I don't feel well either so it's not

conducive to being interested in much. . . . I think that, when you have lost the

ability to do things for yourself, life is not very pleasant.

Ruth also discussed how increasing frailty after a stroke influenced her desire to

socialize:

I was diagnosed with scleroderma . . . and that's why I needed the walker,

because I couldn't walk without it.   I'd give my eye teeth to have that back now

and get rid of this wheelchair. . . I feel so ashamed in it and embarrassed . . . the

stroke hit my muscles in my throat, so I can't eat very well. I choke and cough,

and I find it horribly embarrassing when I am out or even in here. . . . I feel like a

very crippled old lady, which was never me, active and involved in everything.

6.1.2 Dependency

Increasing frailty for most of the participants meant that they were now more dependent on the care staff.   Dependency increased the perception of being a burden, and as Betty indicated, had consequences on social activities with family:

You know whatever [I] do it's troublesome to my family, particularly to my husband and son. . . . I won't go [out with them] because it's too much trouble, because I have to get this [wheelchair] into a vehicle . . . and that means trouble for both husband and son. So no I don't [go out].

Dependency also influenced relationships with the nursing staff. Even though most of the participants recognized that they were in a care facility because they needed help, it was hard not to notice that some of them, such as Betty, felt as though they were a burden: "*I have never been a person who expected people to do things for me so I find it very difficult now to ask someone to take me to the bathroom*".

This sense of burden and dependence on both family and caregivers disrupted meaningful relationships with the people that they preferred to socialize within the facilities. This preference was due to the difficulties they experienced in socializing with other residents, especially those that were declining or who had cognitive impairments.

6.1.3 Decline in Others

Institutionalized elders not only suffer a decline in their own abilities, but also witness decline of others. This created a sense of dread among participants such as Fran who explained:

I have been here a length of time and to see them going down and sort of going into their own little world, it is sad, it's the saddest part. You think of all the education and talent they had as teachers, nurses or just the working person. Like that concert pianist . . . she used to be interesting to talk to and now she doesn't talk hardly to anybody. Yes that is one very hard step dear, to see them going down and down and then they're gone.

Experiencing decline made social interactions difficult and evident as Fran elaborated on her reluctance to socialize with other residents:

A lot of them have different things you know. I like to talk to Robert . . . and I like naughty Annie . . . Doris, and a few of the others . . . but they've all died. (said very quietly) You can get too close to them. Like Pamela . . . we just clicked right away, and we had three months. I used to go see her in her room . . . she was in the bathroom door [the other day], and I was in my room sitting in the chair, and she waved at me, and half an hour later she was dead.

This experience of losing someone close was not unique to Fran. Others discussed the difficulties they had with loss of friends or acquaintances at the facility, and how it was just easier to not become involved socially with others.

6.1.4 Coping and Adapting

Participants differed in the way they adapted to and coped with frailty. One method of coping was by reflecting on life and expressing gratitude for the life they had, and recognized that this frail stage was only a small part of who they are. The ability to reflect positively on life seemed to help cope with their increasing frailty, and adapt to institutional life:

My husband and I [had] very, very full and happy lives.   I think I have been to almost everywhere in the world except Russia. . . . So that really is my life until I ended up here. . . . I may not like it but I accept it. (Betty)

However this was not always the case. In fact three of the woman had what one of them described as a *"rough and tumble life",* and did not seem to be dealing with their current situation very positively, and in general described their current situation as *"terrible"*.

Others, particularly the men, held out hope that they would be able to return to their previous lives, as Ullie described:

I'd like to go to the rehab once more [to see] whether I'm ever going to be able to use crutches, and well if I can't, then I gotta resign myself that I'm gonna be here for the rest of my life, which is not going to be that easy for me to take, but if you have to, you have to, I guess. I've often thought of getting a wagon or caravan

with a lift on the back. And then I thought I could probably get the hand controls

and drive myself, but [my daughters] are all saying no, no it's better [here]. Well I

say 'it's not up to you if I want to do it I'll do it.' At the moment I'm just still trying

to adapt to this [place] . . . as I say it's not what you call the end of the world. It's

comfortable and if you have to live this life, the rest of your life, you can resign

yourself to do it without getting all upset about it or whatever. Like I say, you do

miss things. Like I used to go goose hunting in the fall and fish, but you've done

a lot of it in your life and I guess you just have to say to yourself 'that's it, you've

done all this', and resign yourself to do what you have to do here and make a

new life out of it . . . that's what I'll do. . . . I'm not going to run across the road. I

really feel that if I got the right therapy, there is no reason why I couldn't stand up

and what have you.

 Another way of coping with increasing frailty was to withdraw. Clare told me: **"***I like*

being flat on my bed sleeping quite a lot of the time. . . . As soon as I go back to my

bedroom they take me from [my wheelchair] to my bed and I dream the afternoon

away."

    Yet, withdrawal from social relations was sometimes not desirable, but beyond a

participant's control. For example, Quincy told me: *"I don't see other people very much*

anymore because I don't even go out to the dining table, because they feed me in here

because it is more work to get me to go out there than it is to just feed me in here."

Quincy, although he was only 58 years old, experienced the greatest degree of frailty, but also expressed a great desire to remain social. However, his current state of health prevented him from interacting with other residents. He feared further decline and told me about a request he made:

Recently I was in the hospital with an infection. . . I told the anaesthesiologist, 'before we do this I want you to know I am a DNR. I have had a full and exciting life and I've done everything that I wanted to do. I don't want suicide or anything like that, but if something does happen, you know that it doesn't work out quite right, let me go . . . if my brain goes without oxygen, then let it go cause I don't want to be like some of these people I've seen with strokes, and they can't talk and they can't use parts of their body and stuff.'*

The fear of increasing frailty, and the wish for death was not unique to Quincy. Seven of the participants spoke about similar wishes, much like the remarks from Betty and Clare:

I hope a time comes when you can press a button, when you can no longer do things for yourself, and that will be it, instead of caring for them and keeping them alive when they're useless. It's such a waste; waste of energy for everybody, because if someone isn't enjoying it . . . you wouldn't let an animal live so why let people . . . [Old people] they don't fit [in]. . . . I think it is quite ridiculous to keep

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* Do Not Resuscitate.

people who are not happy like me alive no matter what they serve; no purpose

except a nuisance most of them [and] most of them don't enjoy it. (Betty)

I used to [socialize, but] not since I've been sort of wheel-bound . . . and then I

had a couple of falls that have left me a bit wonky in the head I think. However

(said quite seriously) life goes on unfortunately . . . I would be happier dead to be

perfectly honest . . . everybody knows I'd rather not be alive and they quite

agree; I mean my family people. What's the point . . . being fed or having your

food brought to you, the care you receive bathing and cleaning . . . oh well I've

got no alternative . . . well I mean it isn't OK, but there is no alternative. I

wouldn't want anybody to go on living like this to over a hundred. (Clare)

Even though seven of the participants spoke of their wish for death, this was

troubling for Betty, who thought that she would miss being able to see the blue sky and

the flowers, whilst Ed commented that, *"I sometimes think that I'd end it, but that'd be*

silly 'cause if I reach to be 100, then I'd get a letter from the Queen."

6.1.5 Shifting Priorities

Increasing frailty and thoughts of impending death affected how appearance was

viewed.   When I asked Clare to tell me how important her appearance was to her, she

responded:

Not at all. I never wanted to top myself out . . . I used to when I first came here, now I don't.   I suppose, I don't give a damn now . . . if I could walk and do normal things it would be different, but all you can do is push yourself forwards and backwards in a chair (chuckling) and I now I am just about complete. Well I would have been quite happy to wake-up dead the next day anytime.

Clare also pointed out that in regard to her teeth: *"Well if I'm going to conk out tomorrow I don't care if [my teeth] are cared for or not (chuckling).   I don't want to be drilled and plumbed and all that sort of thing."*   Tina added that the value of appearance and teeth were also influenced by age: "*I don't think [nice teeth] is quite as valuable now. . . . After this many years it's not that important. I find people don't usually look at your face or stare at your face when you are my age, whereas when you're younger they study your face".*

When I spoke with Alice about her appearance, she said, ". . . *when you think you might be dead tomorrow, it removes some of the worry."* Alice also explained how increasing frailty and the inability to care for her teeth made her feel:

Well if I can't look after my mouth, then I probably can't look after anything.   I mean I don't think it goes partial, thing to thing . . . I'd probably want to be smothered if I had a stroke and had to lie around like a vegetable, no matter what my teeth are doing or my eyes are doing or hair, I'd like to be smothered.

Alice went on to explain that when you have nothing left to live for, then death seems to be the best option:

I was in one [care facility] and they didn't understand my personality. In fact [the administrator] told me 'I'm gonna lock you in a padded room and you can't have any paintings or anything . . . I can do it and I will do it,' and I said 'ok'. I made a little plan checked it all out really well. I got a nice purple plastic bag, put it over my head and killed myself. I had it tightly like this, [how she had her hands on the bag] and all I could think of is, it's working, it's working, it's working, and for some reason someone came in who never did at that time and apparently I was blue and they took me to the hospital… I just had nothing to live for in that regard.   [My daughter] had gone to France and [my son] never visited me, I mean it was just dismal.   I didn't like the people, and the food was horrible, and I simply had nothing to live for. It was self-indulgent, but it helped get me out of that place and into this one where they let me be myself sort of.

Alice was much happier in the new facility where she could be herself. In fact, all the participants had positive things to say about the facility that they were living in; however, their comments were often contradicted by negative stories of institutional life.

6.2 Institutionalization

6.2.1 Becoming Institutionalized

Moving to a LTC facility was not normally a choice made by the participants but by family and doctors. This created a sense of helplessness and loss of control. For Bea, this also resulted in animosity towards her family and a breakdown in family relationships, since she felt as though she had been tossed aside:

I have felt a couple of times quite lonely and depressed . . . you know not so much sorry for myself, just depressed and wondering why am I here. I mean I know why they put me here, my daughter-in-law put me here. . . . Quite frankly they don't want to be bothered with me, period.   I mean, I said that and you can't love everybody, you can't you know, they don't like me . . . the only thing I resent is they're living in my house, one of my houses I had.   I had property and they never asked if they could live in my house and I resent them, because I feel well, they're living in the lap of luxury, they have a lovely home to live in and here I am. You know that is my only resentment.

The move to a care facility was not always a negative experience. Olga, for example, explained how she believed that it was the best place for her. She was involved in the decision to move and continued to receive love and support from their family:

My husband died in 1999, and I stayed at home for another year, then after a year my son . . . persuaded me . . . to be nearer to him. He is a good son and comes here every evening to visit me because he lives near here. And his son

and daughter of course are grown so they look quite well after me. My daughter-

in-law is a doctor and a psychiatrist . . . my son suggested I stay in their home,

but they aren't at home, so we thought about where I now live. I have an

individual room I enjoy a lot and am really quite glad to be here because as I get

older I find it necessary to have more rest, so this is the right fit.

Moving to a LTC facility was also seen as a way to simplify life. Ed and his wife

moved into a facility when he could no longer walk and care for his wife with Alzheimer's

disease. It was clear that Ed thought there were definite benefits to where he lived now:

Well I joined this outfit about a year ago. I came here, and it costs about $1100 a

month, but I can't complain. They do everything; your laundry, and all your

meals, and the dining room, and all this sort of stuff, and they take care of my

apartment here, and the girls are good that serve.

6.2.2 Tensions of Institutional Culture

All of the participants had good things to say about the facility where they lived,

however they also seemed to experience tensions when it came to institutionalization.

Many discussed their dislike of having to live in a care facility; however they also

expressed appreciation for the care they received:

It's not that I am not grateful. This is the best place I could be.   I just wish I was

not in one necessarily. (Alice)

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I am [happy living here] now. I wasn't at first, but I am now. . . . I didn't like losing

. . . my friends, but they come into see me now. . . . I know now that having all

this help is wonderful and it is so reasonable. (Sara)

[Living here] is certainly a lot better than what I would have if I were on my own.

. . you know if I had some family at home that would be different, but there's got

to be [someone there]. (Tina)

As I explored these tensions with the residents, it became apparent that there were contributing factors that revolved around institutional policies, loss of autonomy, care-givers and lack of dignity.

6.2.2.1 Policies

Tensions from the policies, rules and schedules of each facility emerged clearly from the interviews, although not necessarily of sufficient concern to precipitate complaints to the administrators. Ullie, for instance, who expressed both his likes and dislikes quite freely during the interview, explained:

They have their rules of course and they want to put you to bed at a certain time,

they want to shower you on a certain day, bath you on a certain day. So you

have to cooperate otherwise it's - well I don't like to argue with people… In that

way I find it quite comfortable.

There was awareness also that the staff carried a heavy workload, and there were numerous references to the schedules and time-constraints of the staff. Betty, who was sympathetic to the time-constraints placed on the staff, described why:

Mary in the next bed . . . talks about how we are paying for [care].   I say to her 'that hasn't got anything to do with it, [the care-aide is] only allowed so much time with each person … and I know that because I have asked them, and I don't know whether its eight or ten minutes to do the ordinary thing, because they've got others to [care for]. But Mary thinks they are there because she pays them and they should do it.

All of the participants indicated that cleanliness was a high priority, and they were deeply disturbed by regulations that allowed only one bath or shower per week. The policy in most of the facilities required only that each resident be washed with a hand towel every day, but, as Dean complained:

I miss not having a bath . . . I find one shower a week not enough. I just don't feel comfortable.   I do a lot of walking, perspiring and used to do a lot of work in the garden . . . I tried to get a second [bath] a week, but the policy, they can't change it.   I guess there is just one [staff member] to do it.

Others, like Tina, complained even more strongly: *"I don't know any woman who wants to go without a bath for one week. I was quite horrified that we were only going to get it once a week."* However, Olga could hire a private attendant to help her overcome this problem: *"I find it most important [to get] washed every day.*

Phoebe [her personal nurse] washes me when she is here … everyone gets one bath [but] I happen to have two because Phoebe takes me, and this is necessary." Others, less affluent than Olga, if they did not have a personal attendant managed to adjusted to the weekly bathing policy, as Nora explained:

I thought 'My God, a bath once a week'. But I seem to manage with it all right. . . I don't think I smell and they wash under my arms, at least I think they sometimes do . . . so I don't smell . . . and I feel better when I'm clean . . . doesn't everybody?

6.2.2.2 Loss of Autonomy

The indignity of bathing only once a week paled by comparison to the loss of autonomy associated with incontinence and "hygienic" pads. Clare described graphically how she came to terms with this:

I've always got pads on so I automatically pee and poo poo, and they come and change that, and put a new one on, and away they go. . . . To begin with, I thought it was absolutely foul . . . In the hospital they gave you the bedpan, but they don't give you that here. They don't approve of that, so what can I do . . . you lie in your own filth, but then they come and take the dirty pad off, put a clean one on, and away they go again. . . . The routine is exactly the same for everyone . . . it's not very comfortable, but you've got to wait your turn until somebody comes and puts you out of your misery. And well now - be perfectly

honest - can you smell me at the moment, because I am sitting on a dirty pad

now.

Tina described her experience with this loss of control and why she reluctantly came

to accept it:

See they don't have enough nurses to get you up to go to the toilet, so, you

know, you have to put up with something . . . it was hard . . . and yet my daughter

explained it and another lady who worked in the hospital who said 'you know they

wouldn't have enough people to get you up,' and I said 'couldn't we have a bed

pan?' Well, (chuckles uncomfortably) I've got them the odd time, but not very

often. Well now I'm used to it, but I try to go and sit on the toilet and get rid of all

of my water, so it doesn't bother me too much.

Harry, who held a much more adversarial view of the relationship between the

residents and the staff, explained how he believes the residents must deal with their

loss of autonomy:

There's a sense of hopelessness that occurs . . . [when residents] can't do what

they want anymore. . . . If you listen to a conversation between residents and

staff around here, you know, the residents are never right and their opinions are

not worth anything . . . The staff just prefers that [residents] don't voice them. . . .

They certainly don't give [them] much credence no matter what they say. The

staff never agrees with the patient EVER! … Regardless of it, it's 'no that's not

the way, that's not the way it is, no that didn't happen, no we don't do that'.

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There's just that adversarial position. It's kind of a power trip as much as anything. The residents don't have any power and they're not happy about that 'cause they pay the bills you know, and it's not cheap. It costs a lot of money here you know, and it's like all day long, stand up, sit down, turn around, do this, do that, do the other thing, kind of like you're being treated like you are 2 not 92. And that's annoying . . . it shouldn't be, I mean if they made it to 92, then they should have learned that you have to accept things and no matter what life gives you, you have to go with it sometimes, whether you like it or not. . . . There is no reason to start a fight with the staff every night of your life just because you don't agree with them, and they don't agree with you. So it's better for everyone if you just get along. So that's what we gotta do.

Or, as Quincy remarked, "*you get a lot more done with honey than with vinegar, so it is a fine [line] between 'when do I complain?' and 'when do I keep my mouth shut and just accept certain things?*"

The problems of autonomy extended also to the therapies imposed on residents. Kate was particularly incensed by her physiotherapist, but was able to retain some of her autonomy:

I get dizzy and my legs start shaking and I don't want to fall down and break something. So I've had an argument with our physiotherapist [who said] 'you should walk, you should walk more'. Well, God damn it, they're my legs and I

know if I can stand up or not, and I told her 'get off my back', so she left me

alone.

Meryl, on the other hand, felt that there was inadequate attention, especially when it came to her emotional needs:

I will be asking [the doctor] something and he has his hand on the door as if he is

ready to go . . . so it doesn't take many incidents like that for me to think what I

have to say is not very important. People see the doctor because they have a

broken leg or something, but he doesn't give a darn about my broken heart I am

sure.

6.2.2.3 Care-givers

Two types of caregivers were identified: those who offered care with sympathy, and those who were more task orientated and generally unsympathetic to the residents, as explained by Tina:

There are people built for this type of work and others who shouldn't be in it. The

ones that are built for it, they love their people and look after them well, and

share them with their other friends. And others that can't be bothered, just get it

done and get away . . . but I would say that there are some made for this type of

work, and then there are others [who] once in a while you want to tell; 'Why don't

you go and get a job that you like?'   You know, because they certainly don't like

this one.

Harry echoed this description with the remark that: "*if you don't like being in service to people, then maybe you're in the wrong business*". Kate complained that it was difficult to ask for help from someone who was uncaring because, as she explained, *"I'm not asking you 'cause I can, I'm asking you because I can't [do something]."* Others, like Tina, reasoned along similar lines that it was not easy for some of the participants to ask for help, either because they were afraid to do so, or thought that they would not receive it.

Betty had the same concern but presented it more in the context of personal shame than fear:

I have this real bad pain and a bowel movement…like I say I am so ashamed when I have to tell the caregiver, whoever she might be, that there's a problem… and she says 'AGAIN!' As if I enjoyed it... however I can understand what she feels... I'm ashamed that it's happened; I'm ashamed that they have to clean it up.

Betty went on to discuss how hard it was after such a response from a caregiver to feel comfortable asking for care again.

6.2.2.4 Dignity

Maintaining personal dignity in the absence of privacy was a recurrent challenge described in many of the interviews, and described graphically by Harry:

One of the girls . . . had me up in the [transport] sling yesterday . . . while she is wheeling me up the hallway, and I thought 'well we're going to Harry's dignity room now.' (laughs) . . . You're just sort of three quarters naked from head to toe with your privates hanging out and you're being walked up and down the hallway and you go 'how did this happen, that could have been avoided'. . . . Fortunately [the hallway] wasn't filled with little old women like it normally would be at that time of day or we'd of had them running up and down the hallway screaming… I don't think your average person likes the idea of walking, being carried or whatever in front of the general public, naked or half naked, no matter what the reason is. They keep you a little vulnerable at that point… I don't know what you'd be afraid of, so it's not really straight up fear. There's just something not quite right about this situation . . . I'm hanging four and a half feet up in the air, going at whatever speed up and down the hallway. It is a little unseemly, I don't know how else to express it.

Alice, who lived at the same facility, shared her experience where, "*people are dragged down the hall in a lift with their diaper sort of hanging down, and you know dignity, kind of, is gone*".

On numerous occasions, I also observed residents wheeled down the hallway, half-dressed, or wrapped in sheet on their bath-day, or left sitting on the toilet naked with the door ajar, as a staff member sprayed an air freshener with no apparent sensitivity to privacy or dignity. The absence of privacy infiltrated all aspects of institutional life, even

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as I conducted the interviews, whether in a private room or a private area of the facility, we were always interrupted without warning or apology at some point or other by staff members.

Another challenge to a participant's dignity was the stigmatization or stereotyping that they had to endure. All of the participants were fully aware and clearly understood what was going on around them, which was a problem when it came to maintaining a sense of identity.   The institutional culture in all of the facilities seemed to inhibit the staff from interacting respectfully on a personal level with residents, almost to the point of disregarding the presence of the residents. Alice explained:

If your relative is with you, they talk to the relative and they say 'well she has the odd back ache and etc. etc.' and when they do that to me I say, 'look I am here, so talk to me.' . . . I find it insulting; they talk above you like you are a mute, deaf and dumb… They think we're all retarded and about to wet our pants at any moment and not having a brain in our head. . . . It is true that there is such a stereotype about old age . . . they talk to you like you are a child; 'oh that was so clever of you to tie your shoe like that, good boy.' (laughing) 'Oh mister so and so you're being so good today.' You know, I mean, I guess it's nicer than being awful. What is that word; patronizing.

Kate offered further explanation of how the dignity and loss of identity among residents of a nursing home are challenged:

I think that some people think that when you are in a rest home you are fed and

that's about it; you're not cared for, where it is altogether different. I think that's

what they think, we are, what would you call it, outcasts or whatever. You know

we have no brains or something to keep up with.

6.2.3 Social Opportunities

The extent to which social interactions were influenced by the culture of the

institution seemed extensive. Most activities included all the residents. While facilities

did cater to those who were less frail and alert, most of the available activities were not

considered worthwhile, and described as *"meaningless"* or *"childlike"*, which is why

some chose not to participate, such as Bonnie who said, *"I don't participate in many of*

the programs here, they don't appeal to me...I'm not a word game lover. I don't play

games . . . which I find are stupid".

When I asked the participants what types of activities they liked, the opportunity to

leave the facility for various reasons was discussed:

Of course I like to go out . . . you know I'm a fairly social animal. (Ian)

Many patients here have somebody who can take them out for a walk. I went this

morning to our favourite corner. (Olga)

I go home and our friends are there of course...we read the paper, and we talk, and we visit, and they come here too. (Gerry)

Meryl, who previously lived in an assisted living facility, explained the importance of being able to go out:

I spent three weeks or something in Toronto, and it was in a rooming house, and I came and went as I pleased, and I got to know the names of the streets, and the people, and nice residences. But here there is none of that. You can't. You just learn breakfast, lunch and dinner, and that is where you get your association.

Meryl went on to tell me how this affected her social life:

Well I can't go out, so I can't go shopping with somebody or to the mall or something. There doesn't seem like there are any outlets or something, so I just stick to myself and you know what, it kind of scares me because I am getting to kind of like it. I don't know whether it is good or bad, nobody has ever asked me if it is good or bad, you know we have never talked about it.   I just know that I can't go out alone you know all the regulations.

For others, like Fran, going out was a way to connect with others, and retain some sense of herself, by doing things that she had always enjoyed:

I like that contact, outside contact, cause I still got a few plates that aren't cracked yet (laughing). So I like to go out and see, and sometimes I guess you

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call it cabin fever... I like just going out for a little while, for a cup of coffee; watch

the kids playing in the mall.

I heard on numerous occasions that activities that were more stimulating and enjoyable than currently available were wanted, such as Ruth who said, *"Give me something where I have to use my brain because that is one thing that wasn't affected by the stroke. My mind is still very cognitive. I am very much with it."*

They were clear regarding the types of activities that they wanted and enjoyed, however when this was impossible, solitary-type activities were sought.

6.2.4 Solitude

Elders living in the community may have limited social opportunities because they are isolated, but for the most part they are not forced to partake in activities that they do not find meaningful. Nor do they have to socialize with those who they do not like or with whom they cannot relate. They have some autonomy in how they spend their time and with whom. Institutions provide residents with social opportunities that they might not get living in the community; however these opportunities are not always valued. When I made the statement; *"Places like this bring people together so that they are not isolated at home, so they have people to socialize with. What do you think of that?"* Harry, one of the more outspoken residents said:

I think it's bullshit! They're on me in here day after day after day to go to the

dining room and have lunch, and I say, 'I'll sit in my room and have lunch . . .

don't worry I'm not going stir crazy or anything, just get off my case. I like the

people in my room. If we decide to stay here and have lunch together, then what

do you care?' I don't understand it.

Meryl also commented:

I must say that if the purpose of a residence like this is to bring people together,

which it maybe is, I don't think I belong here. I would be just as happy in a little

sweet place by myself on the hill. I am not a good socialiser.

Alice, who eats all her meals in her room, did so because of the experiences she had

in the dining room:

It doesn't do me any good to get attached to breakfast, lunch and dinner with my

dinner mates; heads on the table, and not speaking, or being fed with a spoon

(said with disgust). It does nothing to cheer me up, I can tell you. . . . One fellow I

ate with started this bad cough and I thought 'God I am fed up with this place'.

He put his head down and died; that was his death rattle, on the table across

from me . . . that's when I started eating in my room.

Alice also told me:

I actually enjoy my own company which is lucky because I am alone all the time.

. . . I mean it, I enjoy my own company now . . . being alone is not a threat, living

alone is. . . . I figure I live alone here, but I can call on a person or talk to a

person.

Harry, who enjoyed both his solitude and spending times with friends, believed that the care-staff did not recognize the need of some residents for autonomy over their activities, social relations and their preference for solitude:

Well I get the regular kind of answer; 'it's not good for you to be in your room like

that all the time.' What a stupid thing to say 'it's not good for you.' Or you ask to

make a phone call at 8:30 at night, and you know the answer is 'no', 'cause they

say 'it's too late or it's too early'. But if you ask them the real question; 'it's too

late for whom? It's not too late for the person I'm phoning, it's not too late for me,

and so what is it too late for - you? Does it interrupt your shift or what? Or you

just don't want to do it right now, because personally I don't give a shit if you

want to do it now or not. If you don't, then go away and I'll do it myself, but you

can't answer me that it's too late because you don't even know what you mean

by that. You just spouted out an answer that is meaningless.

Alice, in a similar vein, complained that:

Somebody told me that I should eat with people that improve my social skills, oh

yeah (laughing) . . . it would just teach me more bad words to yell at people,

which I don't do really very often. . . . They keep telling me, the care- aides,

because they don't want to bring me my food; [they say] 'its good exercise to go

up there,' and it's this and that.

Having input to social activities was as important to some as was the choice to live in solitude. Kate, for example, liked activities but found it intolerable when she and others were treated badly by the staff:

I don't participate in any activities here at all!   I just can't stand the coordinator . .

. she's the boss and if you want something or suggest something [she says] 'no,

no, no, no, no,' that's not the way she wants it and you can't talk to her, so to

heck with it. . . . I've put ideas in her head and you know she never says 'well

that's a good idea, I'll think about.' It is just a straight 'no!'

Kate was an outgoing person, who enjoyed the company of others, but not having any autonomy or decision making with regard to social activities encouraged her to spend much of her time alone.

6.2.5 Living with Cognitively Impaired Residents

Living with residents who were cognitively impaired was another major aggravation in an institution and one of the main deterrents to social interaction for all of the participants. Ullie explained:

I don't know why I feel there's me and there's them . . . I am still very much me,

and all the rest are them, and I don't really identify with them out there. [Keeping

to myself] might be a protection. You know I like to protect myself. Last night we

had an hour of bowling; nine people on each side so you only get to bowl twice.

It is kind of boring but it is something to do. There are a lot of people, what you call absent-minded and they are told to throw the ball and they stand there and look at it.

Avoidance of cognitively impaired neighbours was a common way of dealing with this aggravation, as Fran explained:

Dementia patients and what's that other disease of the mind, Alzheimer's . . . they can be disturbing, trying to deal with them sometimes, or the ones that hallucinate. But what can you do honey? You have to seek your own little refuge; mine is to beat it outside (laughing) and just see and sit down quietly.

However, it seemed that sometimes it was impossible to escape, which resulted in frustration and anger, as I heard from Harry:

I have trouble with one guy in here he goes up and down the hall in here and he wants to be in my room all the time. He thinks he lives there, he wants to live there, and he just won't stay out of there. There's nothing you can do, you can take him and walk him down the hall, take him to his own room, put him in his own bed, it doesn't matter and now I've got his wife showing up too. Every time I take my head off the pillow and open my eyes there is Alex staring down at me and I just want to scream at him some days; he doesn't know what is going on, he's just trying to get through the day and night and I'm getting mad at him.

Frustration and anger was even more pronounced when a participant had to share a room with others, as Betty explained:

It's very difficult to live in a place where your mind is more or less like it has always been. I was always very bright and intelligent and understanding about the candle things, but in here it is difficult, really difficult to live with people who are living in some other, wherever they are. One talks only about her mother and what she cooks for her . . . and the other doesn't speak at all. There isn't anyone to talk to who is, you know, physically handicapped. . . . I suppose I have no patience.

Nearly all the participants, in one way or another, tried to distance themselves from most of the other residents and focused on relationships with staff and visitors:

[I socialize] with not the resident, [but] with their family or friends 'cause there is no one really to talk to in here. (Kate)

My friends that I have made here, they have all died on me every one of them. But I'm good friends with their daughters, and they come in and see me and send me cards from where they are. (Fran)

All my friends are more from the outside because, I'm not criticizing, I know what's going on, but when you want to make a conversation and they're way out in left field I can't handle it. Most of my friends are family and friends that come to visit. (Sara)

Tina expressed annoyance at the way others with dementia are treated by some of the staff, which prompted her to keep even more distance between herself and residents who were demented:

Sometimes [the staff] get quite annoyed . . . they get picking on one of the guys here because he yells at them, and they laugh. To me I don't think that's funny. They are nice girls, they don't mean any harm, they just think that it is fun, but basically them teasing him about what he wears and how he wears it [isn't funny]. . . . I hate it when I see somebody laughing at somebody else or teasing them about something. I think it is a very mean thing to do.

The experience of being stereotyped as *"someone from a nursing home"* with cognitive impairments was also mentioned by Kate when she told me about a recent visit to her dentist. The dentist was not only surprised that she still had some of her teeth, but also that she was dressed nicely and her finger nails were painted. Kate was quite an outspoken woman and said she *"set them straight"*, about the diversity of people who live in LTC facilities and the care they receive, however it was apparent by the way she recalled the incident that it was still troubling to have to deal with the stereotype.

6.2.6 Threat of Appraisal

Social interactions with family, friends and staff, while enjoyable, did pose a threat when it came to a participant's appearance. Most of the residents in the facility were deemed incapable of judging a participant's appearance, but not so with the staff and outsiders. For example, Alice told me:

I tidy up my room . . . I always try to wear my best stuff when [my family] come because they are the most important people in my life. Who else is there to care what I am wearing? Well I do [and] when Penny, my eccentric friend, comes then I go all out . . . [and the music therapist] of course, I have to get dressed up . . . I try my best [to look good] every time I go out.

Fran also thought it was important to look good in the facility, and when I asked *"why"*, she explained that it is *"out of respect"* for the people you are with. Dean also thought it was important for him to at least have clean and matching socks when we conducted our interview because he thought I *"might appreciate it."*

Harry viewed appearance quite differently:

My own take on that, is that most of [the residents] don't particularly care. I'm sure they do, but they don't seem to. I don't see it in the way they look from day to day, and I don't see it in the way they dress, and I don't mean in the clothes they wear, but in the way they wear their clothes. I don't see any efforts here to look better. I think they do appreciate the fact that people shave them and do their teeth every day, and all that. I think that is appreciated by most people.
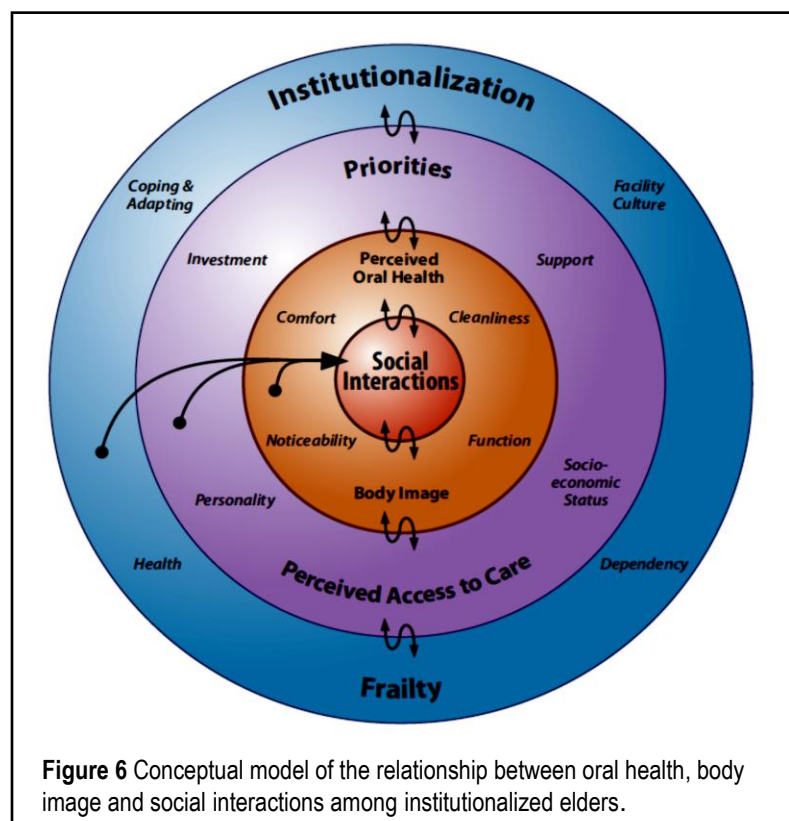
Harry, on a subsequent interview, clarified that this observation related to residents in general, including those who were cognitively impaired.

It was clear from all of the interviews that frailty and institutionalization posed challenges to meaningful social interactions, and overwhelmed any concerns about oral health. The participants, especially those with increasing frailty, found it difficult to engage physically in social activities, and found some satisfaction in solitude. Moreover, solitude was also a protective coping strategy for residents who could no longer tolerate loosing friends or witness the decline of others. Solitude was also preferred over meaningless social activities and engagement with cognitively impaired residents. Consequently, the participants tended to socialize with staff, family and outside friends. While this socialization was enjoyable, it also posed a threat to a participants' sense of self due to stereotyping and concerns about appearance, and even the appearance of the teeth and mouth.

6.3 Conceptual Model

My findings led to the development of a conceptual model (Figure 6) to help explain the relationships between oral health, body image and social interactions. The model has three dynamic layers that influence the central phenomenon of social interactions. The first layer nearest the centre contains the personal factors (comfort, cleanliness etc.) contributing to the formation of perceived oral health and body image. The next layer contains the priorities and perceptions of access to care that help to maintain the personal factors of the inner layer, and in turn these are influenced by the outer layer of physical and cognitive frailty within the institutional environment. The double-sided arrows crossing the boundaries between layers represent the dynamic relationships whereby the various phenomena and personal circumstances could either positively or negatively influence social interactions. For example, a resident who felt dependent and a burden on care-

Figure 6 Conceptual model of the relationship between oral health, body image and social interactions among institutionalized elders.

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staff might be reluctant to ask for help with oral hygiene, and as a consequence feel embarrassed and unwilling to socialize with others. Of course, the financial means to hire a personal care-giver, as in the case of some of the participants, removes this concern and so help to foster an active social life. In this way, the model allows for individual outcomes to vary with context, personal factors and perceptions.

CHAPTER 7: DISCUSSION

This study was undertaken due to an encounter I had as a dental hygienist with an elderly woman in a LTC facility. The woman had not spoken during the previous three years, which was attributed to increasing frailty, as she was withdrawing slowly from social encounters and communicated solely by nodding in response to questions. After her oral hygiene improved, she began to speak quite unexpectedly because she no longer believed she had bad breath. Further discussions with the woman, her family and staff revealed that the woman had been very proud of her appearance but had become quite distressed as she became frailer and the health of her mouth deteriorated. Her improved oral hygiene appeared to have revitalized her self-confidence and willingness to communicate. A search of the literature failed to provide any substantive evidence that poor oral health disturbs the social behaviour of institutionalized elders.   Consequently, I conducted this study to explore how oral health might influence social interactions of elders in LTC facilities in order to better understand why the woman started to speak, despite broken and missing teeth, when she perceived that her breath improved.

My study explored relationships between oral health, body image and social interactions among seven men and sixteen women living in eight LTC facilities in British Columbia. In this final chapter, I discuss my findings and the model I generated to explain the relationships.   The findings are in accord with the existing literature related to perceived oral health, body image, institutionalization and frailty among elders. I will

also discuss the broader implications of the study, its limitations and the possibilities for further investigations.

The relationships of perceived oral health, body image and social interactions were complex and dynamic. Perceived oral health and body image among the participants were considered either adequate or less than adequate, and it was influenced by their perceived comfort, cleanliness, function, and noticeability of the conditions of the mouth. The extent to which social interactions were impacted by these factors was dependent on the priority that they placed on body image and oral health in life generally, and their perceived ability to access care to maintain or improve their oral health. Institutionalization and frailty further influenced their priorities and perceptions about care, which in turn was dependent on how they coped with and adapted to their health, dependency and the culture of the facility where they lived.

In general, social interactions within institutions were difficult, and as I heard, went far beyond concerns of the mouth. The cognitive impairment of other residents presented challenges to meaningful social relations. Activities and social opportunities were limited and often had little resemblance to a participant's previous interests. The rules and policies of the institution accentuated the loss of control felt by the participants, requiring them to develop coping strategies dependent on individual personalities, support systems, financial resources and how they had dealt with challenges in the past. Frailty, dependency and health concerns were significant influences within their relationships. When they felt unwell or were adjusting to

increased frailty and loss of independence, concerns about the mouth were minimal. Yet, this was very dynamic, and as frailty or health improved, so did the priority given to concerns about appearance and oral health, especially if it had been important previously.

7.1 Perceived Oral Health

About half of the participants considered their oral health to be adequate and described it as either "*fine*" or "*not a problem*", which is similar to the responses recorded from other groups of elderly people also living in institutional care (Finkleman *et al.*, 2010; MacEntee *et al.*, 1991) or independently in the community (Brondani *et al*, 2007; MacEntee *et al.*, 1997).   Among elders in LTC, Finkleman *et al.*, (2010) found also that comfort was typically synonymous with the absence of pain, but unlike my findings, they reported that discomfort also related to temperature extremes, metallic taste, gagging, loose fillings, dry mouth and a burning sensation of the tongue. In addition, they performed oral examinations, took photographs of the mouth and used a structured questionnaire to gather data. The focus they placed on the clinical aspects of oral health and their use of questions quite specific to dental care probably contributed to the various factors they identified relative to the comfort of their subjects. They also found that although lack of pain was important, there were different levels of pain, most likely attributable to individual tolerance levels. Hence, comfort was considered a more representative description than lack of pain. Comfort, including comfort in personal appearance, has also been described by MacEntee *et al.* (1997), and more recently McKenzie-Green *et al.*, (2009) in relation to oral health in groups of community dwelling

elders. I heard a concern about appearance from only one participant in my interviews, and in general, concerns about personal appearance revolved mainly around the noticeability of an oral problem.

MacEntee *et al.* (1997) found also that the enjoyment of food related to comfort, whereas, Brondani *et al.* (2007) found that diet was a separate theme contributing to the oral health of elders. This was discussed also by my participants, but I did not identify it as a separate theme. However, I considered food and diet to be a dimension of function because most references were made about the chewing ability in relation to enjoying food and obtaining an acceptable diet. Due to the importance that elders place generally on function in later life (Reboussin *et al.*, 2000), and how they cope and adapt to declines, the category of function seems more appropriate. The ability of the participants to enjoy food and still consider their oral health adequate in the absence of a full functioning dentition was enhanced by the variety of food textures and alternatives offered in a LTC facility, as well as the acceptability of such alternatives while eating in the presence of others (Kayser-Jones, 2002).

Previous studies have identified general health as an influence on oral health, but the participants in this study, for the most part, related health to the importance or priority that their mouth had in life, not just its perceived adequacy. Their health, especially when dire, dominated everything to the point that the mouth was not even considered. MacEntee *et al.* (1991) in a survey of institutional elders concluded also that ill health contributed to a widespread lack of concern about the mouth among their

respondents, many of whom were very frail. Yet health and lack of oral concern may not be just related to later life. Gregory *et al.* (2005) also described how the relevance of oral health even among younger adults is influenced by changes in general health and other life circumstances that could shift the margin of importance at any given time.

7.2 Perceptions of Body Image

Body image and appearance-related concerns also were influenced by comfort, cleanliness, function and noticeability. The participants tried to present themselves as cognitively alert, so cleanliness, pleasant smells and appropriate dressing were central to their appearance and to their avoidance of being stereotyped as cognitively impaired or overly dependent. Similarly, self-care helped to avoid stereotyping. All of these concerns and anxieties reflected on their sense of self, and although less important within the facility than in the community, family, staff and visitors did impose an emphasis on personal appearance that sustained their anxieties about body image even when challenged by other priorities. Additionally, most of the participants were sensitive to how their functional disabilities portrayed to others an undesirable image of incompetence. The ability to stand, walk or even roll over in bed contributed to their evaluation of who they were and how they were perceived. Like Reboussin *et al.* (2000), I found that concerns about function superseded those about personal appearance. Furthermore, as functional abilities declined, the participants placed more emphasis on wearing clean, comfortable clothes and indicated that their greatest priority around body image was to be clean and not smell which is similar to observations made by Isaksson (2002), who found that bodily secretions are generally considered dirty and

offensive. As the participants in this study grew more dependent, it was almost

impossible for them to avoid the feeling of embarrassment and disgust when unclean.

At first I found it somewhat perplexing that concerns about weight, grey hair, and

wrinkles where minimal in the institutions, which contrasts with the concerns of

community dwelling older women who quite frequently are anxious about weight gain,

and signs of aging (Hurd Clarke & Griffin, 2007), and older men who worry about

muscle loss (Baker & Gringart, 2009). Pruis & Janowsky (2010) suggest that body

dissatisfaction and anxieties about weight gain is a reflection among older women of

their life-long battle with their weight and societal pressures to be thin. Within the

unique culture of a LTC facility, the pressure to achieve the thin ideal was almost non-

existent among the women, indicating that societal pressures to achieve typical ideals of

femininity do not necessarily persist in institutional life. The reduced preoccupation with

muscularity and lack of body dissatisfaction among the men also differed from reports of

community dwelling older men, probably as a response to their functional decline and

resignation to their aging bodies in the context of living in an institution. Although,

difficult to understand at first, it became quite apparent in later interviews that the

concern over an aging appearance was far less troublesome than other aspects of life.

7.3 Perceived Oral Health and Body Image

The impact of perceived oral health on body image was quite varied and negatively

affected the women more so than the men, probably due to the emphasis that many

societies place on a woman's appearance even in later years (Baker & Gringart, 2009).

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However, the limited number of men or the relatively few women who had noticeable mouth-problems in the study might have contributed to the observed gender differences in relation to poor oral health.

The noticeability of a mouth-problem strongly influenced how participants considered their oral health. Out of sight, out of mind was the prevailing influence in the cultural context of long-term care - if it was not apparent to others it was not a problem, and it had no impact on body image, which corresponds with the findings of Taleporos & McCabe (2002) who also found that feedback from others about one's disability contributed to one's perception of body image. Yet their study showed also that over time people tended to adjust to their disability so that concerns about body image became less troublesome. Similarly, the participants in this study may have learned to cope and adapt to their oral problems and to lessen their concerns about how the problems appeared to others. However, body image was about more than the appearance of their broken and missing teeth, and clearly involved worries about mouth-odours. This led me to consider the impact on body image as "noticeability" of the problem as opposed to the visual detection.

Eli *et al.* (2001) identified "bad breath" as a "body odour image" shaped by both self-perception and the appraisal of others. Most of the participants were concerned about and ashamed of "bad breath" or a noticeably dirty mouth in their social encounters, possibly because bad smells from the body can foreshadow poor health and even death, (Piggin, 2003; Curtis & Biran, 2001) or at best social and moral irresponsibility

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(Low, 2006). The thoughts and emotions that odour evokes is culturally bound (Curtis & Biran, 2001) and unpleasant body odours within western culture is very objectionable. Within the culture of a LTC facility, where unpleasant odours proliferate, relations between nurses and residents, as well as care-giving practices can be negatively influenced by the disgust and contempt that offensive body odours tend to evoke (Van Dongen, 2001). Frail and dependent residents rely on their care-givers to be clean and free of unpleasant smells, including bad breath, which was considered by many as an indicator of mental and physical competence. The feeling generally was that residents with such impairments were shunned, left out of conversations, laughed at, and subjected to other social indignities.

The residents associated a healthy mouth with "*white teeth*", and discoloured teeth did disturb body image; all but one of the participants expressed a desire for whiter teeth, and was worried that their teeth relayed an undesirable image of old age. Ironically, when one of the women (Betty) received new dentures with "*perfect straight white teeth*" she was very disturbed because she no longer looked like herself, and she believed that others would know that she wore dentures, which in Western society today, are still equated with ageism and poverty (Fiske *et al.*, 1998).

Multiple reports have described the oral health of residents in LTC as poor and inadequate by both dental and medical professionals (MacEntee *et al.,* 1999; MacEntee, 2006b; Wyatt, 2002). Others have suggested that social interactions can be disturbed by oral problems due to changes in personal appearance (Locker, 2007;

Mollaoglu & Alpar, 2005), although this depends on what elderly people consider as problems (MacEntee *et al.*, 1991; Mojon & MacEntee, 1992). The concept of what constitutes a problem may explain why some of the participants still considered their oral health to be adequate, despite clearly noticeable problems. Differences in findings between my study and that of Mollaoglu & Alpar (2005) may also be attributable to the quantitative methods they used to determine that a good dentition improves social interactions. Quantitative methods, including questionnaires are unable to explore in detail why social relations suffer because of mouth concerns (Locker, 2007). Nonetheless, it appears that the social impact of poor oral health among younger populations or among elders living in the community is projected onto elders in LTC. Even though body image and social relations can be negatively impacted by poor oral health among other groups (Kiyak, 2000a; MacEntee *et al.*, 1997), body image is a construct of both personal and observer appraisal. Therefore, fitting in from a body image and oral health perspective is also dependent on culture and can be different in an institution. I found that a unique influence within LTC was the presence of residents with cognitive impairments who were perceived as unable to offer an appraisal or at least one that was of any consequence to the elder. However, I also found that staff and visitors were perceived as judgemental, and therefore affected the priority the elders had of their appearance and oral health. In general I found that it was the priority placed on oral health and body image that ultimately influenced social relations.

7.4 Priority of Oral Health

The influence of perceived oral health and body image on social interactions was much more complex than the mere presence or perception of an oral problem, and was dependent on a variety of personal factors. During the first few interviews it was apparent that participants had very little concern about the mouth, and preferred to dwell on other aspects of life. Their inability to access care forced many of them to develop coping strategies influenced by their socio-economic status, oral health investment, individual personalities, and support systems.

7.4.1 Socio-Economic Status

Perceptions about access to care involved overall care, professional oral care and daily mouth care, so that the priority of oral health was influenced to a great extent by their perceived ability to access each of these. Residents who could pay for professional care placed a higher priority on the health of their mouth, which is reasonable since cost is a significant barrier to oral care at any age (Kiyak & Reichmuth, 2005). Financial ability either directly or with help from dental insurance strongly influenced the priority placed on oral care so that participants without financial reserves usually wanted to leave things as they were or have their natural teeth removed. Similar to findings from Manski *et al.* (2002) I didn't find that dental insurance always positively influenced the priority of oral health and access to care, when need supersedes coverage. Yet, a number of participants felt that they did not require professional oral care if they could eat comfortably, looked normally, and were free of

pain and bad breath. For them, daily mouth-care was sufficient. The more affluent

participants were able to hire a personal attendant to tend to this care, while the others

depended on the nursing staff.

7.4.2 Investment

One factor that strongly contributed to the priority of oral health was prior investment

in oral healthcare. As mentioned previously, investment was not just monetary, but also

included the amount of time and energy given to self-care and visiting a dentist. Those

who had invested effort into their oral health in the past tended to care for the

investment as they grew frail, at least until they were overcome by more pressing

problems. Indeed, there were participants who lost interest in their daily oral care even

when offered freely, because they also worried about access to overall daily care in the

midst of deteriorating living conditions and frailty. In this way, it appeared that for some

participants, their sense of control and self-efficacy over daily care was low, contributing

to the feeling of futility in their ability to maintain their oral health. This was much more

apparent and troublesome especially among the women, who when compared to men,

seem to have invested more into oral healthcare.

7.4.3 Personality

Schedules, rules and policies dominated institutional life, and everyone had to adapt

in a unique way to cope. Some challenged the staff and management to get what they

wanted, while others resigned themselves to what they could get without causing

trouble, or as Kahn (1999) suggests, to "make the best of it". However, I noticed a burden of withdrawal or introversion that seemed to disturb the women more than the men, possibly because, as social exchange theory proposes, they were unable to contribute equally to relationships (Blau, 1986). Similar behaviour has been described as a way in which people who are extremely frail cope with their inability to reciprocate the care they receive. They simply stop asking for help, as a way to improve the unpleasant situation they believe they have caused (Beel-Bates, Ingersoll-Dayton, Nelson, 2008). I heard repeatedly from women how they didn't want to be *"troublesome"* or to *"rock the boat"*, and preferred to *"keep their mouth shut."* However the men and a few of the women routinely asked for care. "*Speaking up*" was how they received the care that they wanted or needed, and this was a reflection of their personality. Yet, Weirsma (2010) found that care-staff frequently consider this behaviour as "difficult", "resistive", or "aggressive", and that both the staff and residents know how it can lead to unpleasant repercussions. Consequently, they found that in some facilities, fear and sedative medications were used to create a more compliant, submissive, or, as I heard, "*vulnerable*" resident. It was clear that the care sought by the residents, even among the more outspoken, was guided by the perceived consequences of making requests, and how it would affect other aspects of their institutional life. Many of them didn't like to voice their opinions or ask for care because in the past they were ignored or made to feel bad. According to Weirsma (2010), this tactic is used by some members of the nursing staff to enforce institutional schedules and routines, and particularly when associated with tasks, such as daily mouth care, which some of the staff feel is a "disgusting" job (Connell, McConnell & Francis, 2002).

7.4.4 Support

Despite the fact that care-givers may consider mouth care as disgusting, having a clean mouth was valued and a priority because being clean, in general, was the participants' number one concern.   Nearly all of the participants could attend to their own oral hygiene and were uneasy about the thought of not being able to continue to do so. They were less concerned if they could afford additional help or felt supported by their families and staff. Others just simply lost interest in their mouth and got more depressed generally as they became more dependent on the support of others for routine daily care.

Access to professional dental care outside the facility also required support from friends and family, consequently some residents did not bother seeking this care. Disinterest in seeking dental care can also be due to withdrawal, resignation and low expectations of having a need met (Walters, Iliffe, & Orrell, 2001). This is particularly true when there is disconnect between what health care professionals and elders believe constitutes an actual unmet need (Drennan *et al.*, 2007). This is similar to MacEntee's (1991) suggestion that not all oral problems of institutionalized elders are a "problem" that they consider requires attention.   Exley (2009) recommends that the social impact of oral health is more comprehensible when dental professionals understand how people experience and perceive oral health, how experiences are influenced and changed by overall health, and how oral health is prioritized within other aspects of health.   The participants, for the most part, indicated that the mouth in social interactions may not be a particular problem relative to the other priorities. Yet this was

a very individual perception. Therefore, to help them receive the oral care that they

want, a supportive dental community, sensitive to the unique needs of this population is

needed.

7.5 Frailty, Institutionalization and Social Interactions

The perception of oral health and the priority it received was overwhelmed by the

frailty of the participants and their life in the institution.

7.5.1 Frailty and Social Interactions

Institutional life is distressing and even more so as frailty increases. Although LTC

facilities bring people together they do not always promote social interactions, nor was

this always perceived as a beneficial goal.   Nursing home residents can spend a large

part of their time doing nothing (Gottesman & Bourestom, 1974; Harper-Ice, 2002). I

heard about the physical and psychological difficulties of engaging in social relations,

and the despondency and depression caused by forced engagements. At this time of

life with increasing frailty, I heard how many residents preferred to be alone, which

according to the theory of gerotranscendence and socioemotional selectivity might be a

normal response to frailty (Carstensen, 1992; Tornstam, 1997).   The negative health

effects of social disengagement indicate that interactions should be encouraged to

promote well-being and help prevent further decline in functional ability (Buchman *et al.*,

2009). Social activities have even been suggested as a way to delay the onset and

progression of cognitive decline (Ybarra *et al.*, 2008). Yet, retreat from superficial social

relations also preserves energy for meaningful interactions that may impart greater

benefit to overall well-being, especially in the very old or frail, who can be drained by social activities (Carstensen, 1992; Lockenhoff & Carstensen, 2004).   Frail residents valued their time with family and friends and did not want to waste it on frivolous interactions, especially with others who were cognitively impaired. They valued their autonomy over social relations and were bothered when it was challenged.   Solitary activities were also enjoyable and important to some, and distressing also when they were unavailable. Men in particular benefit psychologically from the self-direction derived from solitary activities that give personal meanings to the individual (Lennartsson & Silverstein, 2001; Rowe & Kahn, 1998; Agahi, 2008). Recently, Ranzijn (2010) suggested that the focus on "active ageing" signified by physical health, independence and productivity can be difficult to achieve for many people and lead to a sense of failure, especially among oppressed or marginalized groups who are frail and inactive. Furthermore, Adams (2011) concluded from a review of the literature on social and leisure activity in later life that choice, meaning and perceived quality of activity rather than the type or frequency of an activity give optimal health benefits. The participants of this study seemed to support these conclusions in that they, especially when frail, preferred to rest. They also valued the ability to pursue activities and social engagements that brought meaning to life. However, they sought support and encouragement for the right to spend time alone or with others as they wished. They acknowledged that visible problems around the mouth impeded their desire to interact with others, although the significance of oral impediments diminished as frailty increased.

7.5.2 Institutionalization and Social Interactions

The inability to spend time as they wanted was not just related to a resident's frailty, but also to the institution itself. The culture of the facility, including the physical space, the type of residents, caregivers, management, and organizational philosophy, had the potential to either promote or inhibit social interactions. The ability to cope and adapt to the culture of the institution was central to this influence and for the most part revolved around attempts to maintain personal identity in the midst of so much conformity.

7.5.2.1 Cognitively Impaired Residents and Meaningful Social Opportunities

Living and socializing with others who were cognitively impaired was not enjoyable, and many did what they could to distance themselves by leaving the facility or staying in their room. However, avoidance was not always possible. Keating *et al.* (2001) also found that frail people preferred to partake in activities away from residents who showed signs of dementia, and they sought private spaces for solitary pursuits. Goffman's (1961) description of "institutions" still pervaded the facilities I attended. People lived together under the control of management where rules and schedules dictated daily activities to meet institutional rather than individual needs, and the residents were aware of the stereotyping and stigmatization that occurs. They discussed dehumanizing situations similar to those described by others where each resident is seen as part of a homogeneous group of frail, dependent and socially withdrawn individuals (Hubbard *et al.*, 2003; Dobbs *et al.*, 2008).

The facilities reinforced this stereotyping by offering activities that involved everybody no matter how cognitively impaired. Very few activities provided mental stimulation, and even fewer of them were previously enjoyed by the residents. The more alert residents complained about the lack of intellectual stimulation and the affront to their personal identity and self-respect, which is similar to the observations made by Wiersma (2007) in her ethnographic study of elders' adaptation to living in LTC. Noticeable oral conditions could also contribute to stereotyping and diminish the desire to socialize, but much less so among residents who are cognitively impaired.

7.5.2.2 Coping and Adapting

Everyone discussed the need to cope and adapt to living in an institution. Being forced to witness physical and cognitive declines was troubling and decreased the desire to socialize, and precipitated a fear of further dependency and death. The participants were weary of forging new relations following the death of family, friends or other residents, so they tended to restrict their social interactions to family members and staff who were healthy. Nonetheless, the limited opportunities for meaningful social relations with healthy people caused them to value their solitude, which for some like Alice was a "safe" time void of negativity. Continuity theory and activity theory consider this type of reclusive behaviour unhealthy and detracting from quality of life (Atchley, 1971; Lemon *et al.*, 1961). However, I was told that being alone watching television, reading, listening to music, and reflecting in solitude were comforting activities, suggesting that they were explained better by theories of disengagement and

gerotranscendence (Cummings & Henry 1961; Tornstam, 1997) in which solitary leisure is associated with promoting health and longevity (Lennartsson & Silverstein, 2001).

I believe that the choice of social interaction or solitude is dependent on each individual and the context in which they live. Furthermore, the rationalizing of forced social engagement for health and longevity may be futile among those who are happy with the life they have lived and have come to terms with the mortality (Scocco, Fantoni, Rappattoni, de Girolamo, & Pavan, 2009). In a similar vein, the focus of dental professionals on the social repercussions of a clinically apparent oral problem is not likely to change a resident's priority of oral health when they are generally unhappy with other aspects of their life. Although some residents will choose to isolate themselves because of a noticeably unpleasant mouth, overall the condition might not disturb their general well-being if they prefer to be alone anyway rather than engage in social activities that seem meaningless. This is not to say that social activity should not be promoted and that oral health be ignored, but instead, a resident's personal, social, psychological and environmental situation needs careful consideration.

7.6 Implications

I explored the associations between perceived oral health, body image and social interactions among a purposeful selection of cognitively intact elderly people in several LTC facilities. The participants thought that social relations could be disrupted by noticeable problems with their teeth or dentures, yet I found little evidence that the disruption increased frailty or illness or impeded social life within the institutions I visited.

Social isolation and disengagement was more related to having limited meaningful social opportunities and declining health than concerns of the mouth. Long-term care facilities would benefit from a better understanding of how each of their residents prefers to spend their time and support them in achieving the social relations they desire. Individualized activity or social engagements that impart meaning in a resident's life should be identified and provided if well-being and quality of life is to be realized (Gaugler & Kane, 2005; Shura, Siders, & Dannefer, 2011).

I found also that the priority given to mouth-concerns was impacted by numerous personal and environmental aspects of a resident's life, not just the presence of a mouth or denture problem. To help residents obtain adequate oral health, dental professionals need to relate clinical observations to the expectations of the residents. Consideration of the multiple challenges that institutional life and frailty pose is essential to gaining the interest and cooperation of the residents and the care-givers. The concept of "adequate oral health" needs further development and clarification to reflect the concerns of people who are frail and dependent, what they want from a useful oral healthcare service, and how they might receive care without feeling they are a burden on their families or on the staff who attend to their needs.

Finally, and perhaps most importantly, this study demonstrated how the residents wanted carers with a better understanding of how the mouth can affect psychosocial health. A clean mouth helps residents, especially those who are cognitively aware and

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dependent, to avoid being adversely stereotyped and to uphold their dignity with or without social interactions.

7.7 Limitations and Future Directions

My study was designed to explain how the mouth affects the social interactions of elders in LTC. The research method I used gave me insight into the relationship between oral health and social interaction, at least within this selection of cognitively aware, frail residents. My findings should have implications for similar groups of elders elsewhere, although I recognize that the next generation of elderly people might have quite different concerns, expectations and needs. The priorities given to healthcare generally, and especially to the cosmetic aspects of the mouth and teeth is likely to change with the current emphasis on personal appearance among baby-boomers. A past investment in oral health appears to have a strong influence on these relationships, and the oral health-related investments made by young adults today is very different from those made by many of the elders I interviewed. The number of younger elders seeking dental care within the community has also increased as of late (Waldman & Truhlar, 2010) and is likely to increase further in the future. Among this new cohort of elders, concerns about less than ideal oral health may impact social relations differently, since the norm for oral health may change when the majority of residents in LTC have their teeth and expect to keep them (Brondani *et al.*, 2007). In the near future it may no longer be socially acceptable within the culture of LTC to have unattractive teeth or dentures, a dirty mouth or bad breath. Nonetheless, the model of the relationship between oral health, body image and social interactions that emerged contains several

interactions and relationships that are likely to be sustained. For example, financial limitations will likely continue to negatively impact access to care, just as comfort will remain a prominent factor in the evaluation of oral health.   Yet the model has not been formally evaluated and will need further testing to confirm its usefulness among a larger, more diverse sample of institutionalized elders.

My sample of participants was entirely of European descent which is a serious limitation to a more general understanding of these relationships. Oral health and body image are culturally bound so people from different cultural backgrounds are apt to have different values and beliefs about oral health and appearance.   Aging is also experienced differently among some ethnic groups. Clearly these types of matters need additional investigation in our multicultural communities.

A further limitation in regards to the population is the cognitive status of the participants. While it is possible to successfully conduct interviews with the cognitively impaired by providing a "safe context", with special attention to the establishment of rapport and trust over a period of time (Hellstrom, Nolan, Nordenfelt & Lundh, 2007), I chose to first focus on the cognitively aware in order to develop a model that could be used in the future with different groups. Although the cognitively impaired were not the focus of this study, they deserve attention in the future, because as a group, they may experience this relationship differently, and also because make up a large percentage of LTC facility's population.

Finally, the people I was able to recruit for my study are likely to be more concerned about their oral health, appearance and social lives than many others in LTC, simply because they agreed to participate. There were some residents with obvious oral problems who declined participation for reasons that were not clear possibly because they were bothered by their mouth-problems and were embarrassed or fearful of interacting with someone who might raise their concerns even further. It is also possible that my professional role previously as a dental hygienist posed a threat to their personal comfort or to their financial concerns. In this context I might well have been perceived by many as someone who would offer a negative appraisal of a noticeable oral problem. On the other hand, perhaps many of them simply did not want to be bothered by discussions of oral health, personal appearance and social interactions that played little part in their current priorities for well-being and contentment.

7.8 Conclusions

I can conclude from my research question "*how are social interactions influenced by perceived oral health and body image in elderly people who live in long-term care facilities*" that the living conditions, health and frailty, perceptions about oral health and access to care, along with the relative priority and investment given to oral health, all influence social interactions. They contribute in a complex and dynamic way to the ongoing shifts in personal experiences that are part of the social and psychological environment of life in a LTC facility compounded by the fears of increasing frailty. While it is possible for social interactions among residents to be negatively impacted by oral health, multiple other factors also influence social relations and can be equally if not

more disturbing than problems with one's teeth or dentures.

Being frail and dependent diminishes both the ability and desire to engage in social activities. Also, the social opportunities available for cognitively aware residents can be minimal, further decreasing the desire to participate. Yet residents still enjoy time with family, friends and staff. During these interactions it is important for most elders to present themselves in a manner that maintains their identity and dignity to counter the ongoing negative stereotyping of ageism. Generally, this is accomplished by being clean, nicely smelling and appropriately dressed. When this is not attainable some people become deeply distressed and seek the safety of solitude, whilst others go about their daily affairs without apparent thought to their personal appearance. Apathy for appearance is influenced by an inability to do something about it, and especially when care is difficult to obtain without embarrassment or harassment. When care is unattainable due to institutional culture, lack of finances or support, the priority placed on outward appearances decreases.

Most oral conditions have the potential to alter body image, but they must be noticeable to others (or at least perceived to be noticeable), either by sight or smell before they threaten social interactions, through alterations in body image and personal identity.   Alterations are unique to each person and the context in which they live. Within the context of frailty and institutionalization the priority of oral health has the potential to be less of a problem due to more pressing life challenges. Overall, I found

that it was this priority placed on oral health and appearance amidst other personal and

environmental concerns that ultimately influenced social relations.

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APPENDIX A: FACILITY APPROVAL

September 16, 2008

FACILITY APPROVAL FORM

Title: Exploring the relationship between social interactions, body image and oral health among frail elders living in Residential Care.

Principal Investigator: Dr. Michael MacEntee, Faculty of Dentistry, University of British Columbia.

Co - Investigator: Ms. Leeann Donnelly, PhD student, Faculty of Dentistry, University of British Columbia.

Purpose:

The purpose of this study is to gain insight into the possible influence oral health may have on social interactions and body image of frail elders living in residential care facilities.

Study Procedure:

This study will involve tape-recorded, face-to-face interviews conducted by the co-investigator as part of the research for her doctoral dissertation. The interviews will be non-structured to allow participants to discuss their thoughts about poor oral health such as bad breath and broken or missing teeth, body image and the influences that they may have in regard to social interactions. The interviews will take approximately one hour each and will be conducted in a private location at the facility chosen by the participant and at their convenience.

Confidentiality:

The identity of the participants and the facility will be held in the strictest confidence by the investigators, and will not be revealed except by a code known only to the investigators. Information gathered will be stored securely in a locked filing cabinet or on a password secured computer in the Faculty of Dentistry at the University of British Columbia.

Remuneration and Compensation:

Each participant will receive a small gift (*e.g.* toothbrush and other dental supplies) and a thank you card for their participation in this study. The facility will receive one in-service for staff entitled "Daily Oral Care for Older Adults".

Participation:

Your participation in this study is voluntary and you are free to withdraw from the study at any time without providing any explanation. If you decide to withdraw you will still receive the in-service for staff and any residents who participate will receive their small gift.

Contact for Information about the Study:

Ms. Leeann Donnelly

University of British Columbia

Faculty of Dentistry

Department of Oral Health Sciences

2199 Wesbrook Mall

Vancouver, BC, V6T 1Z3

Dr. Michael MacEntee

University of British Columbia

Faculty of Dentistry

Department of Oral Health Sciences

2199 Wesbrook Mall

Vancouver, BC, V6T 1Z3

Contact for Concerns about the Rights of Research Participants;

If you have any concerns about the treatment or your rights as a research participant you

may contact the Research Subject Information Line in the UBC Office of Research Services

at (604) 822-8598.

AUTHORIZATION

I,_____ , have read and decided to participate in the

study described above. My signature indicates that I give permission for the information

gathered in this study to be used without identifying me or this facility in research

articles/journals/books, and/or teaching materials. Additionally, my signature indicates that I

have received a copy of this consent.

Signature_____

Date_____

Printed Name of Participant _____

APPENDIX B: LETTER OF INTRODUCTION

September 16, 2008

WOULD YOU LIKE TO PARTICIPATE IN A RESEARCH STUDY?

Title of the study:

Exploring the relationship between social interactions, body image and oral health among frail elders living in Residential Care.

Principal Investigator: Dr. Michael MacEntee, Professor, Faculty of Dentistry, University of British Columbia.

Co – Investigator: Ms. Leeann Donnelly, PhD candidate, Faculty of Dentistry, University of British Columbia.

What is the purpose of the research study?

We want to know about the influence that the mouth might have on how older people feel about their appearance and ability to interact with others.

Who do we want to talk to?

Women and men older than 65 years who have lived in a residential care facility for more than 6 months and who speak English comfortably.

What will you do?

Participate in a private and confidential interview that will last about one hour on 2 occasions with Leeann Donnelly;

What will we talk about?

How older people feel about their appearance and their ability to interact with others.

Where and when will the interviews take place?

The interviews will take place here at the facility in a private location that you choose on a day and at a time that best suits you.

Who can you contact for more information or to participate in the study?

If you wish to participate in this study, have any questions or require any further information in regard to this study please contact Ms. Leeann Donnelly or return this letter with your intent as indicated below in the self-addressed stamped envelope provided.

I would like to speak with Ms. Leeann Donnelly about this study.

Name:_____

The best time to contact me is_____

APPENDIX C: PARTICIPANT CONSENT

September 16, 2008

PARTICIPANT CONSENT FORM

Title: Exploring the relationship between social interactions, body image and oral health among elders living in Residential Care.

Principal Investigator: Dr. Michael MacEntee, Faculty of Dentistry, University of British Columbia.

Co – Investigator: Ms. Leeann Donnelly, PhD student, Faculty of Dentistry, University of British Columbia.

Purpose:

The purpose of this study is to gain insight into the possible influence oral health may have on social interactions and body image of elders living in residential care facilities. The research will form part of the co-investigators doctoral dissertation.

Study Procedure:

We would like to interview approximately 30 elders living in residential care facilities. The interviews will be open-ended and conducted by the co-investigator on two separate occasions to allow the participant to respond comfortably and without undue direction. Each interview will last about one hour in a private location within the facility at the convenience of the participant. The interviews will be tape-recorded so that they can be analyzed carefully and accurately. The interviews will focus on the participant's experiences and concerns regarding their oral health and dental status, with particular

attention to the influence that the mouth and teeth might have on the participant's social interactions and personal appearance.

Confidentiality:

The identity of the participants will be held in the strictest confidence by the investigators, and will not be revealed except by a code known only to the investigators. Information gathered will be stored securely in a locked filing cabinet or on a password secured computer in the Faculty of Dentistry at the University of British Columbia for 5 years. After 5 years all documents will be shredded, computer files deleted and audio-tape recordings de-magnetized.

Remuneration and Compensation:

Each participant will receive a small gift as a token of appreciation for helping with this study.

Participation:

Participation in this study is voluntary and participants are free to withdraw from the study at any time without providing any explanation for doing so.

Contact for Information about the Study:

If you have any questions or require any further information in regard to this study you can contact:

 Ms. Leeann Donnelly

University of British Columbia

Faculty of Dentistry

Department of Oral Health Sciences

2199 Wesbrook Mall

Vancouver, BC, V6T 1Z3

 Dr. Michael MacEntee

University of British Columbia

Faculty of Dentistry

Department of Oral Health Sciences

2199 Wesbrook Mall

Vancouver, BC, V6T 1Z3

Contact for Concerns about the Rights of Research Participants:

If you have any concerns about the treatment or your rights as a research participant

you may contact the Research Subject Information Line in the UBC Office of Research

Services at (604) 822-8598.

AUTHORIZATION

I, _____, have read, understand and have decided

to participate in the study described above. My signature indicates that I give

permission for the information gathered in this study to be used without identifying me or

this facility in research articles/journals/books, and/or teaching materials. Additionally,

my signature indicates that I have received a copy of this consent.

Signature _____   Date_____

Printed Name of Participant _____

APPENDIX D: INTERVIEW GUIDE

Interview Guide
 Tell me about some of the things that you like to do and why?
Has this changed since you moved here? Why? How does that make you feel?
Can you tell me how do you feel about your appearance?
What influences these feelings?
Has this changed since you moved here? Why? How does that make you feel?
How important is it for you to look good here at the facility? How about when
friends and relatives visit? How about when you have to leave the facility?
How do you feel about your teeth, dentures…?
What influences these feelings?
 Has this changed since you moved here? Why? How does that make you feel?
How do you feel about the appearance of your teeth or dentures?
What influences these feelings?
Has this changed since you moved here? Why? How does that make you feel?
Is there anything that I didn't ask you about your social life, your appearance or your
mouth that you would like to tell me about?
Follow-up Interview Questions
How do you feel about your mouth now? Why?
What impact has this had on their social behaviours or other aspects of their life?
Who takes care of your mouth now?
What is it like to have someone else care for your mouth now?
How are you coping with increased dependence or frailty?
How do you prioritize oral health now? Why?
How do you perceive your access to care? Why?

**Demographics of Residents – to be sought during interview, formally and
informally.**

Age
Ethnicity
Country of origin, years spent in Canada
Family history- parents, siblings
Marital history/status
Children
Education history
Work history
Religious affiliation
Health conditions