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## Perceptions of Two Older Adults Regarding the Factors and Barriers that Influence their Oral Health Care: A Case Study

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### Abstract

This paper presents the results of a case study about the perceptions of oral health care, factors that influenced current oral health, and barriers to dental attention of two older adults; the study was conducted by researchers from a hospital-school of dentistry at a public university in Mexico. Two adults aged 64 and 70 years participated in this study. First, the oral health status was clinically evaluated using the Decayed/Missing/Filled/Teeth (DMFT) Index. A semi-structured interview was then conducted to learn about the perceptions of oral health care. Thematic content analysis was used to explore the data obtained using the ATLAS.ti software 7.0 version. Four main themes and their subthemes were developed. The main finding of the case study was that oral health was directly and strongly associated with the impact that it has on a participant's life, especially in the functional field of chewing. Also, the participants recognized the importance of having good oral health and see it as a necessity for living. Aspects that influenced the current status of oral health were mainly the care received during their childhood, as well as the previous dental beliefs and treatments. Finally, some of the perceived barriers to dental care treatment were lack of time, finances, and education. These findings challenge professionals to be more sensitive to past and current experiences of older adults at the time of receiving dental care. Knowing their perceptions can support health professionals to strengthen patients' commitment to prioritizing oral health care needs.

### Keywords

oral health, perception, older adults, case study

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# Perceptions of Two Older Adults Regarding the Factors and Barriers that Influence their Oral Health Care: A Case Study

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This paper presents the results of a case study about the perceptions of oral health care, factors that influenced current oral health, and barriers to dental attention of two older adults; the study was conducted by researchers from a hospital-school of dentistry at a public university in Mexico. Two adults aged 64 and 70 years participated in this study. First, the oral health status was clinically evaluated using the Decayed/Missing/Filled/Teeth (DMFT) Index. A semi-structured interview was then conducted to learn about the perceptions of oral health care. Thematic content analysis was used to explore the data obtained using the ATLAS.ti software 7.0 version. Four main themes and their subthemes were developed. The main finding of the case study was that oral health was directly and strongly associated with the impact that it has on a participant's life, especially in the functional field of chewing. Also, the participants recognized the importance of having good oral health and see it as a necessity for living. Aspects that influenced the current status of oral health were mainly the care received during their childhood, as well as the previous dental beliefs and treatments. Finally, some of the perceived barriers to dental care treatment were lack of time, finances, and education. These findings challenge professionals to be more sensitive to past and current experiences of older adults at the time of receiving dental care. Knowing their perceptions can support health professionals to strengthen patients' commitment to prioritizing oral health care needs.

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## Introduction

The oral health of the elderly is now recognized as a major public health challenge. Increased life expectancy and an advancing baby boom generation are the double effects that continue to rise the amount of aging population (Maille et al., 2017). Mexico also shows an increase in the population of 60 years and older, which was 9.9% in 2010, and will rise to 21.5% in 2050 (Consejo Nacional de Población [CONAPO], 2012). Oral diseases are mostly irreversible and have a full-term effect. In 2017, as part of the latest report of the Epidemiological Surveillance System of Oral Pathologies (SIVEPAB) in Mexico, it was stated that adults aged 65 to 79 had no functional occlusion with less than 20 teeth, a prevalence of cavities of 98% and the presence of periodontal disease in 35.8% of the population (Secretaría de Salud [SS], 2017).

Oral diseases can trigger chewing, phonation problems, lead to inadequate food selection, and make changes in facial structure that alters integrity and self-esteem, producing psychological and social relationship dysfunctions (Müller et al., 2017). It is important to state that older adults are exposed to the cumulative effects of risk factors and oral diseases throughout life, thus threatening their overall health, quality of life, and well-being (Tsakos,

2011). Oral issues and tooth loss also have a significant negative impact on the well-being and quality of life of people, because they affect people not only functionally, but also psychologically and socially (Gerritsen et al., 2010).

However, it is unusual for older adults to identify oral health conditions as their only health problem, when these issues are advanced, they often cause pain and lead to depression (Chen et al., 2015). People build their perception of health according to what they had lived in the past and the memories they hold onto. In addition, they evaluate health information through the eyes of their personal experience, rejecting any evidence that is not in accordance with their beliefs and values or within their cultural framework (Borreani et al., 2010).

The perception of the oral health of older adults, as well as the use of dental services may be influenced by age, sex, educational level, socioeconomic status, lifestyles, attitudes towards health, cultural values, previous experiences, social support, and beliefs that pain and some disabilities are associated with age (Araújo et al., 2015). The results of epidemiological oral health investigations are invaluable; however, they remain quite general and deterministic. There is also very little mid-range theory about oral health throughout life. A solution to this problem is to adopt qualitative techniques to explore course of life from the view of those who experience good and poor oral health (Gibson et al., 2019).

Prior studies about oral health perception have mostly concentrated on children, adolescents, parents (especially groups focused on mothers), nurses, caregivers or health professionals (Filipponi et al., 2016; Momeni et al., 2017). However, less information is available in relation to perception of oral health in the older adult population. These studies have emanated mainly from institutionalized, dependent adults and from non-Latin American countries. Also, the principal data collection was made by focus group sessions and in-depth interviews (Araújo et al., 2015; Horn et al., 2018; McKenzie-Green et al., 2009). To the best of our knowledge, this is the first study of its kind in older adults, following the qualitative methodology we utilized, in Mexico.

In the discipline of phenomenology, experiences include thoughts, memories, perceptions, feelings, and imagination, each evolving intentionally, as the individual centers on a specific thing or event (Crotty, 1996). Phenomenology has been used in multiple disciplines to describe how, within a certain environment, something happens in a particular point of view. It is highly practical and useful in the comprehending of the background against which the input is perceived and interpreted (MacKinnon, 1993). Phenomenology in health care attends to the perception of individuals regarding their experience of the illness from within, and it is an experience of continuing transformation which impacts all dimensions of life. These experiences include bodily alienation, social changes, disrupted experience of space and time, frustration and challenges in self-identity and integrity (Toombs, 2001).

The results of qualitative health research give health professionals a deeper understanding of health, disease, and well-being experiences and an appreciation of the contextual factors that influence how health services are provided, received, and experienced (Luciani et al., 2019). In this context, we found it important through a qualitative method, to know and better understand the perception of two older adults and those factors and barriers that influenced their oral health.

Although epidemiological studies in oral health are necessary, goals and priorities in this area cannot be achieved solely on the basis of this information. Adapting specific practices and services to meet the needs of older adults will only work if they are developed in conjunction with understanding how older adults perceive and evaluate their own oral health, because their perceptions may condition them to seek dental care and improve adherence to healthy behaviors.

Our approach to this area began with recognizing our own preconceptions, knowledge, attitudes, and beliefs about experiences in oral health care of older adults. I (Dinorah) was

working on my master's degree thesis in gerontology with my thesis director (Dr. Irma). The thesis was about an educational program in oral health and hygiene for older adults, where knowledge, attitudes, and oral hygiene were evaluated through a survey which used quantitative methodology. The next semester, I chose to take the subject "Qualitative Techniques," as part of my training in the master's degree program, and I was immediately fascinated by the class and the scope qualitative methods cover.

During the same semester for another subject, "Gerontological Practices," I had to put into practice what I learned the previous semesters, so I wanted to use qualitative methodology and together, Dr. Irma and I, concluded this topic would be good to explore through qualitative technique, to have a better vision of what older adults perceived. As dentists and masters in Gerontology, we are aware of the role oral health plays in the aging process, and we know that it is critical to study health issues from all possible aspects. We started to consider the importance of the mouth to the individual and the social and psychological implications that come with it. Furthermore, we considered the inequalities and complications older adults face in accessing oral health services.

At that point, our interest directed us to use the qualitative approach to gain insight about older adults' interpretations, an aspect of knowledge that is unachievable by using experimental research methods. We believe that gerontologists, based on the results of this type of qualitative study, will be better able understand how the oral health of the elderly is developed through the course of life, and then help gerontologists develop better models of care not only for this age group, but also for generations of children and young adults, who will eventually have similar experiences through the course of their lives.

## **Methods**

A case study was conducted in a hospital-school of dentistry at a public university in Guadalajara, Jalisco, Mexico during the months of October-November 2018. According to Yin (2018) a case study is an empirical source that helps to investigate a contemporary phenomenon within its real-life context, with the understanding that the boundaries between the phenomenon and the context may not be clearly evident at all. A case study addresses the complexity and uniqueness of a simple case, comprehending its activity within important circumstances (Stake, 1995). The aim of the study was to explore the oral health care perception in older adults, so we decided to choose this approach, to fulfill our inquiry.

In this study two older adults participated. First, a 64-year-old female, whom we will name Rosa to keep her confidentiality. She is an older adult, widowed with two children, who no longer live with her, but who visit her frequently with her grandchildren. Rosa went to the dental clinics of this school-hospital in the company of a friend; she is excited, but at the same time she is a little nervous about the diagnosis they will give her. She tells us that she has always been a housewife; she didn't go to college, because she had to start working to help with expenses at home. Her life, in her words, has been focused on taking care of the home and her family. A few years ago, her husband was sick, and she had to take care of him, which affected her physically and mentally, deteriorating her health and mood. She recently began to have discomfort in her teeth, so she decided to come and get dental attention.

Our second participant is a 70-year-old male, whom we will name José. He is retired and has been married for 42 years, during which he had three daughters. The eldest of them is the one who accompanied him to the school-hospital. José describes himself as a hard-working man, whom, from a very young age, made a living doing any kind of informal work. He has been a security guard, packer, house painter, carpenter, mason, and welder, having up to three jobs per day. During one of his jobs in which he performed heavy maneuvers, he suffered an accident to his face, which knocked him on his front teeth. And from there he showed a decline

in his oral health, which already had a negative record throughout his life, starting at his childhood. Thanks to his daughter's emotional and economic support and interest, Joseph went to the dental clinics to have total prosthetics performed so that he could recover his teeth.

The selection of participants was by sampling for convenience, as it was intended to know the perception of two older adults who presented different oral conditions from each other. Some other inclusion criteria were being an older adult, attending for dental attention at the dental school-hospital, and agreeing to be part of the study.

As part of the ethical considerations, the research proposal was submitted to the Institute Review Board from the Master in Gerontology Academic Committee. The proposal project was approved on the basis of the recommendations of the experts. Afterward, the research purpose was explained to the participants, in order for them to understand the information and have the right of freedom to decide whether to participate or decline. They were approached individually and given an appropriate time to address any concern. Anonymity and confidentiality were guaranteed by not revealing their real names or identity in the data collection, analysis, and study findings. The names presented in the next content were changed to protect the identity of the participants. An informed consent was signed after, in which participants agreed to have an oral examination and the semi-structural interview recorded for further transcription and analysis.

The data was obtained at two different times. First, we both evaluated the oral health status clinically with the DMFT Index, following the recommendations for the procedure, examination area and infection control given by the World Health Organization on the *Oral Health Surveys Basics Methods, Fifth Edition Manual* (World Health Organization [WHO], 2013). The DMFT index is extensively used in dentistry, it describes the situation of dental and oral health status among the population (Babaei et al., 2017).

The instruments we required to examine the oral health were: Plane mouth mirrors, explorers and tweezers, rubber gloves, paper hand towels, protection glasses, and face masks. We took assessment of oral health status into account since we wanted to have participants who presented very different oral conditions from each other. José, for his part, had no teeth in his mouth and Rosa, presented most of her teeth, which had dental restorations and only needed some molars in the back of her jaw, which were the ones she came to replace, since she was ashamed to be without them.

Subsequently, a semi-structured interview was conducted, with the aim of exploring the perception of oral health care in older adults. In a qualitative interview, the investigator creates the questions based on their understanding of the issue and knowledge of the field (Percy et al., 2015). The semi-structured interview offers grand potential to attend the complexity of a topic in need of contextualization. It addresses themes related to the phenomenon in question, while leaving space for the participants to submit new significance to the study focus (Galletta & Cross, 2013).

We created the interview questions in order to bring answers that were relevant to the study and would generate important information in response to the research question. Then, a pilot test was conducted to see the result of the semi-structured interview. A pilot study refers to a small version of the main research, in which pre-testing includes different methods applied in the investigation. The importance of the pilot study lies in the potential practical issues that can be identified (Baker, 1999). The conclusion of the pilot test was that the semi-structured interview needed little changes to achieve the aim of the research, given that not much information was obtained, we reformulated a part of the questions and added some others. In order to assure the interview met the adequate criteria, the “new version” of the semi-structured interview was reviewed by two qualitative investigators and professors who had long trajectories in the research field.

Thematic content analysis was used to explore the data obtained. This method allowed us to identify, organize, analyze in detail, and provide patterns or topics from a careful reading of the information obtained; thus, we could infer results that promoted the proper understanding and interpretation of the study phenomenon (Braun & Clarke, 2006). This form of analysis permitted us to develop visual networks and conceptual connections through careful deliberation of the information at multiple levels (Fereday & Muir-Cochrane, 2008; Northcutt & McCoy, 2004).

Data analysis began with the transcription of the semi-structured interviews in MS Word documents, which took approximately seven hours each. After, the documents were transported to the ATLAS.ti software 7.0 version for its analysis and codifying (Muhr, 2019). Codifying is the process to apply and reapply codes to qualitative data, which permits to group, segregate and link information in order to unify meaning and explanation (Grbich, 2007). The transcript was reviewed and through constant data mining, the initial codes were developed. After the review, some of the codes were relabeled and subsumed by other codes. As Saldaña (2013) mentions, qualitative research demands meticulous attention to language and a deep reflection on the emergent patterns and sense of human experience, so to code correctly the first time is rare.

Constructing categories is the essence feature of qualitative content analysis. A category is a group of data that shares a commonality, which must be exhaustive and mutually exclusive. This means no information should fit between two categories or fall in more than one (Krippendorff, 1980). The categories were created contrasting the various codes based on the similarities and differences. A theme is defined as a recurring regularity created within categories or cutting across categories (Polit & Hungler, 1999). Themes are described as links of meaning that recur in domain after domain (Baxter, 1991). The themes were constructed by comparing the categories with each other and formulating the latent content.

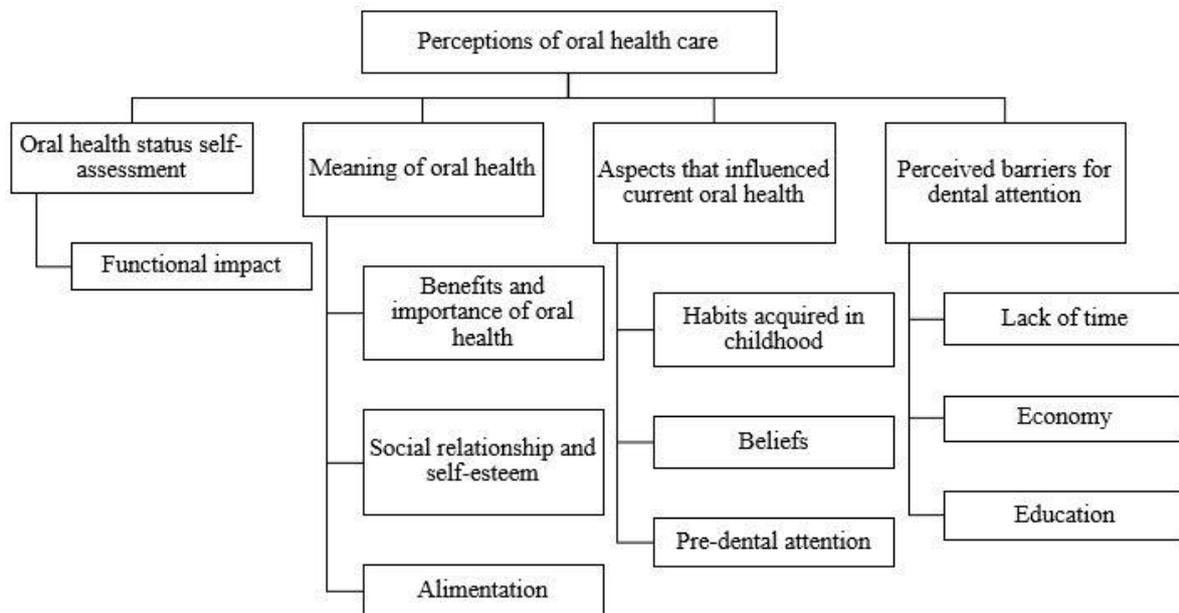
## **Results**

The registered DMFT was 14 (female) and 28 (male), which indicates that the older adults present regular and bad oral health, respectively. The maximum level of schooling achieved during the study was the incomplete primary for both.

The analysis of the data revealed four main categories: oral health status self-assessment, meaning of oral health, aspects that influenced current oral health and perceived barriers for dental attention. The diagram presented by Figure 1 was created in order to show how the themes were organized. This scheme is a summary and a practical way for the reader can see the themes and each of the subthemes that derive from them. We thought it appropriate to show scheme before each one was developed and exemplified, as a way of introduction. These kinds of schemes are a great help to keep work organized, serve as visual support, and also guide the reader.

**Figure 1**

*Perceptions of oral health care in older adults at a dental hospital-school of a public university in Guadalajara, Jalisco, Mexico, 2018.*



### Oral Health Status Self-Assessment

This was the first theme that emerged. The self-evaluation of their own oral health was a complex task to achieve for the older adults, as it was not easy for them to accept and recognize they were not in a healthy status. They initially tried to lessen the problem, but at the end they accepted the magnitude of it. Both cases recognized their oral health was not good due to the conditions they presented, and they knew the consequences of being in that status; that is the principal reason why they decided to seek dental care. Rosa pointed out:

I consider it bad. Although I've seen that a lot of people of my age has fewer teeth than me, so I'm not that bad if I compare myself with them, but I do think I'm not healthy at all because of how I feel about myself.

A justification of this kind is somehow part of the inevitable social comparison that can be expressed at any age. Through such observation, a level of such fulfillment seemed evident, demonstrating how people cope to social influence and psychological pressure.

**Functional Impact.** This subtheme revealed the perception of oral health for older adults is the main issue directly linked to the influence oral health has on their daily lives, especially with alimentation and communication, a task they see as being the most affected by their oral health. Here is what Rosa shared with us:

It bothers me to have been so long like this, I don't like it, it's very frustrating to want to eat well and not be able to eat, I feel embarrassed that I have gaps on my mouth, also I feel like I can't make myself understood when I talk.

More than represent a pleasure, eating represents pain and suffering due to the conditions they have. Thus, maintenance of health is an important factor in seeking dental attention. Self-

perception is a combination of different concepts, as we can see, which goes further than only how people value or feel about themselves. It involves the functional aspect of the person, the conditions that might help them to their self-care, within the social and familiar environment.

### **Meaning of Oral Health**

The second theme revealed by the analysis was meaning of oral health. Both subjects linked it as a fundamental need because it allows them to perform different activities. They mentioned teeth play a very important role in their lives. Three subcategories were then developed: benefits and importance of oral health, social relationship and self-esteem, and alimentation.

**Benefits and Importance of Oral Health.** Older adults stated caring of teeth is important for health and its benefits include avoiding expensive treatments, if good prevention is done. José shared this reflection:

It is a very important thing, because if one takes care of on time, then you avoid going so often to the dentist, although it is recommended that one go at least once a year, but maybe we wouldn't go every time and we wouldn't spend much either.

And Rosa stated:

It's a health benefit, having cavities can bring you infection and there are even people who have lost their lives for it and it also has to do with digestion, to chew well.

At this sense, they are aware of the importance of avoiding bad oral health and the consequences that it can carry on, like the outline Rosa shared. It was impressive to hear that statement because many people do not even know how bad a cavity could end. Having healthy teeth was interpreted as a double benefit: staying away of the risk it can develop and the money savings.

**Social Relationship and Self-Esteem.** They stated the ability to continue to relate to others and not to lose contact with society was important to them. In addition, they recognized maintaining a healthy oral state can change the way they relate to their environment. Keeping an image that pleases themselves and others is important, as negative self-image can lead to social isolation, low self-esteem and even depression. When we were interviewing them, they seemed a little ashamed when talking by covering their mouth. About this subtheme José commented:

It is going to be a very good change and a good thing for me, something positive, so, when I get my dental prosthesis I'm going to talk more with people, I'm going to try to eat properly...I have retired a little, right now precisely because I... I feel ashamed, to be seen like this, but so with my relatives not, it is normal, I am already used to being like this with them, but I am ashamed to dialogue with friendships and that affects me.

The relationship that oral health and self-esteem keep is undeniable. The mouth plays an important role in communication. This connection is why self-confidence, self-liking, and self-

competence can be affected when oral health is not good. Being unhealthy is a limitation that contributes negatively to their quality of life, especially with the sensation of feeling separated from society, which in consequence affect how they enjoy old age and their well-being.

**Alimentation.** They identified it as a fundamental need, which is impacted by not being in good condition, such as not having all your teeth. It affects what they eat, because they deprive themselves of some food and the process of mastication is not well realized, so they do not get all the nutrients from the food. Here is what Rosa opines about this topic:

It is necessary for me to have my teeth in good status so I can be able to eat healthy, all the things I used to ate before, I ate hard and soft things, and since I no longer have my dental prosthesis it is very uncomfortable to eat and right now my diet is nothing but very soft and liquid things and of course it is not the same.

Participants perceive the mouth as crucial for their survival and pointed to the relation the mouth has with the rest of the body. The mouth represented the key in mastication and staying nourished. They perfectly pointed out the link between oral health and overall health.

### **Aspects that Influenced Current Oral Health**

This was the third theme derived from the analysis. The subjects expressed through different anecdotes, which they felt may have affected or benefited, as the case may be, in their current oral health. Most of these were found to be related to the stage of their childhood. It was a very personal moment listening to them, remembering all their experiences from when they were little. Three subcategories were identified: habits acquired in childhood, beliefs, and pre-dental attention.

**Habits Acquired in Childhood.** Both participants stated they were instilled in how to perform their oral hygiene as children by a maternal figure who mainly cared about keeping their mouth in good condition. These health lessons acquired during childhood can be reflected as habits in their adulthood. José shared how it was for him during his childhood:

My mother would tell us do it like this, as she performs a little acting of how to brush our teeth, every day when we get up, we would go to the bathroom, wash our mouth and all that. After that, she used to give us some liquid to take and then rinse, but daily she told us to do this, do that. She was telling us how to brush up and down, to the left and right and all that.

The initial experiences during their childhood were the key that shaped the attitudes and feelings towards oral health. We can state how parents, especially their mothers, played an important role of authority in taking them to the dentist and also by impacting their oral health habits.

**Beliefs.** This was an important category for us to develop, because there are a lot of myths people believe, because they see them on T.V. or because a close relative tells them. The fact is sometimes they grow with this wrong information and continue that cycle by sharing this data to their family or friends. At their age, that the process of aging is thought to be a contributing factor to for the deterioration of the oral health, like the tooth loss or the

accumulation of plaque, which they assume is something “normal.” Here is an example of José’s reflection:

I was fine with my teeth and everything, but somehow I started to losing them. I think it is because I’m old. You know what they say that age has a lot to do with getting ugly teeth.

This statement relates to the feeling that passive loss of teeth is comprehended by older adults as a sense of something inevitable, like the end of life. This image is the result of the social construction of old age in terms of physical deterioration, which society has built. The image of an older adult without teeth has been stereotyped. This image is internalized since childhood, so people get used to it. If we do not change this social construction, then oral health will continue to deteriorate, and there will be no scope that changes that constructed image. In addition, they attributed confidence properties to oral health to the fact that people have teeth. This was the first time that we heard something like that, but somehow, we can relate to the next paragraph. What Rosa shared with us was totally unexpected:

My mom always told us to my siblings and me, that people who didn't have teeth, weren't people to be trusted, because if they had let so much time go by to neglect their own health until the point that they lose their teeth, they couldn't be trusted in anything else and I always have that on mind.

The complexity in the construction of lifestyles is given by multiple factors such as education, family characteristics, childhood, economy, and socio-cultural environment. The professionals who assist this specific population have a mayor task and will need to confront ethic challenges, beliefs, different realities, and the constant transformation of the importance people give to health care.

**Pre-Dental Attention.** On the other hand, they also attributed some of the current oral status to the treatments received during their youth, which they stated may not have been the most appropriate. We consider here two different situations that might be the reason why the dental procedure did not result well. First, it could be that the dentist did not proceed with a correct treatment because it was not their specialty. Or that the patient did not take care of their teeth in an appropriate way by following all the precautions, care, and recommendations given by the dentist. Both circumstances are very common in dental area. José shared the experience of getting dental attention during his adulthood:

I went to the dentist because I had an accident and they put me crowns on my frontal teeth, after that I started to feel pain and I even had pus. So, I blame on that, who knows, then my teeth started to fall so I don't know what else it could had happened.

The outcome of this kind of bad experience can lead to a strong dislike of dentists and dental procedures. People may feel doubtful or insecure about oral health practitioners and lose comprehension of the importance in seeking prevention measures. The lack of transparency in dental services is related to not seeking care in later years.

## Perceived Barriers for Dental Attention

The two participants reported difficulty in accessing oral health services or maintaining good care during some time in their lives. The main barriers they manifested were classified under three subcategories: lack of time, economy, and education. From our experience in dental practice, we agree these three factors are the most common when getting dental attention. So often, when a patient goes to the dentist the first time, and we ask them why they have not come before, their response is the same: no time because of their jobs, other activities like housekeeping, and taking care of family or kids. They have also expressed they cannot take free day from work, and, when they do, they prefer to do other things they consider more important. For older adults, this situation is more complex. Due to their socioeconomic status, they can hardly pay for fundamental things like food or medicine for their chronic conditions.

**Lack of Time.** As they expressed, time issues were the main cause perceived as a barrier to receive dental attention. These included excessive workload and extra activities, such as acting as an informal caregiver. For José was impossible to make some extra time:

I used to have two jobs. I worked from 5 in the morning and then went out until the other day in the afternoon, so I worked 22 hours a day. I didn't have much time to do anything else. I just wanted to go home eat, rest, and be with my family.

We talk about what we have seen in our population. Some of the older adults have to get up to three jobs because they do not have a pension, so there is no time left for their self-care. For this reason, the socio-economic conditions, the cultural context, and the previous experiences of illness, are important factors which directly affect the self-care. The situation for Rosa was really different, but the result was the same:

There was a time when I was careless with myself because my husband got really sick, so I was only looking after him and because of that I stopped taking care of myself, and that's when I started having problems with my teeth. I really had no time and energies left for me.

Also, on the Mexican culture, is very common for women to take care of their relatives, even when they are children themselves, and it continues when they get older. They watch for their parents or other members of the family. The cost of caring for others are a reduction of free time, social life, and self-care, which in consequence improves stress and physical and mental fatigue. Being a caregiver involves difficult aspects, such as constant worry and even harder, dealing with the ever-changing moods of the assisted person.

**Economy.** Not having the necessary resources at different stages of their life was other reason for not attending the dentist. This negatively impacted their oral health with bad consequences. Access to oral health when you have been careless can cost a lot, because there is so much work to do. José shared the obstacles he encountered:

Well look, mmm... in my house when we had cavities and then it started to hurt, my parents took us to see the dentist and they removed our teeth because it was cheaper that way... So when I talked with my mom her answer was that there was no money and that later I would get another tooth, the permanent teeth, so

there was no other choice...Well, right now with the pension, I have some money, but my daughter is helping me with a part to put my teeth back.

As we stated before, the price of dental attention plays a part of the frustration, skepticism, and anger that the participants experienced. They see the affordability of oral health services as a challenge. Social network and the ability to receive help from others, family or friends, in order to satisfy personal needs or goals plays an important role at this age.

**Education.** Despite being aware of the importance of going to the dentist and letting more time go by without going to receive care can be detrimental to their health, participants stated sometimes they simply do not do it. In this case education plays a large role. José shared with us:

It also has a lot to do with education, because, although sometimes we already know that we have a cavity, but it doesn't hurt, we are calm and don't pay attention to it, but then when it hurts and pain gets insupportable, then we immediately go. Lack of time, the cost of the treatment and everything doesn't become a barrier to go, because the only thing you want is to get rid of the pain, no matter what it takes.

Rosa commented:

You leave dental attention for later and time passes by and when you realize it, is because the situation is very advanced and getting worst. For one thing or another there have always been other needs before going to the dentist, like eating, pay bills, family and somehow you make carelessness.

With the statements of both participants, we conclude that pain can be a potential stimulus for visiting the dentist. The self-value of oral health coupled with the poor evolution of knowledge over the years, play a negative motivation to engage in health-seeking behavior, attitude and compromise.

## **Discussion**

Among the main findings, our participants' oral health is poor and impacts on their daily life. Other studies have reported similar findings. In Cambodia, older adults identified they had oral health problems and affirmed the impact of poor oral health function on nutrition and health (Horn et al., 2018). Unfortunately, poor oral health is a very common in older adults, resulting in issues such as tooth loss, hyposalivation, swallowing problems, among others. As a result, the prevalence of edentulism in people aged 65 to 74 in countries of higher and middle income, is still high (Kossioni, 2018).

Older adults in our study expressed the mainly affected capacity is the functional, because it is related to the chewing process and, therefore, nutrition. This coincides with Petersen et al. (2010) who expressed extensive tooth loss reduces chewing performance and affects food choice; for example, edentulous people tend to avoid dietary fiber and prefer foods rich in saturated fats and cholesterols. Our participants also linked the meaning of oral health with different aspects. They expressed that oral health for prevention is important because it helps to save money. This is consistent with Pourat et al. (2018) which demonstrated savings in dental treatment costs are achieved by using preventive measurements.

Another meaning our older adults attributed to oral health was focused more on the social aspect, mainly to communicate with others and be active within a society. They reaffirm the importance of oral health in a functional aspect, and they link the mouth with the rest of the body. Participants showed keeping their teeth is related to appearance, good health, and improved self-esteem. This is consistent with Bitencourt et al. (2019) who showed older adults consider oral health a necessity and an important part of overall health, mainly because of the impact it can have on their daily lives while performing activities such as eating, talking, and smiling. This also has to do with the physical aspect, which can lead them to social isolation and impact on their self-esteem. This finding agrees with Dhama et al. (2017) who concluded a great number of the elderly population are suffering from psychosocial functions. They felt sad about the condition of their mouth, dissatisfied with their own impression, and avoid social contacts because of the teeth missing.

For our participants, some of the aspects that influenced their current oral health state were evoked more towards their pre-dental visits, behavior, and habits of care received during their childhood, specifically the attention given and received by the maternal figure and beliefs surrounding oral health care. As in McKenzie-Green et al. (2009), our findings emphasize the good or bad behavior and habits people may have acquired during their childhood have an impact on their adult stage. Another study concluded oral health status in the older adults is the cumulative result of oral health attitude, diseases, and their treatments during their course of life (Issrani et al., 2012). Moreover, there is a tendency to associate having no teeth as an expected feature during the ageing process. This is called “culture of edentulism” where the loss of all teeth is seen as a normal aspect of daily life, because of the high number of people that are being affected by this circumstance in this age group (Bitencourt et al., 2019).

Lack of time attributed to different issues such as work and family care and has a negative impact on older adults in being able to access to dental services. They also reported that the treatment, despite being carried out in a public institution, is sometimes expensive for them and greatly influences the employment situation they are going through. This disagrees with the results of Mago (2016) where the difficulties for accessing to health services were lack of information, mental or physical disabilities, alcohol abuse and lack of knowledge. We attribute this difference to socioeconomic status, level of schooling, culture, and sex.

The economic factor was identified as another barrier, because through their life course they have been through financial deficiencies. National data reported that poverty is a condition that in 2014 affected 43.7% of older adults in Mexico and has a greater presence in women of this age group (Secretaría de Desarrollo Social [SEDESOL], 2017). In México, the older adult population is the most unprotected, because they do not have social security, it isn't economically active, and its health condition poses a complicated scheme, which encompasses chronic degenerative diseases, limitations for the realization of day-to-day activities, and disabilities (De la Fuente-Hernández et al., 2010).

The educational part plays an important role in the oral health care of older adults. The lack of preventive measures throughout life and the little knowledge of oral health care and their consequences, are factors that are reflected directly in their oral health, as reported by our participants. Oral health education is a recent discipline of research that has been considered an important mediator between socioeconomic factors and oral health outcomes (Tenani et al., 2019). Similar research showed that in terms of dental care, income, education, the right type of treatment, and the perception of need for treatment, are associated with reduced access to health services (De Oliveira et al., 2013). For our participants, pain and suffering, are potential stimulus for seeking dental attention. This is consistent with the findings of Wallace et al. (2012) who stated people with low incomes tend to go to the dentist only when an emergency occurs.

## Practical Implications and Limitations

Our study contributed by adding individual perceptions of oral health in older adults. These findings challenge health professionals to be more sensitive to past and current experiences of older adults at the time of dental care. How they are treated can make a difference to self-esteem and can challenge or support their commitment to prioritizing oral health care needs, which are not always met. Furthermore, these findings suggest the perceived oral health by older adults, may be a critical measure in odontology due to the evident and strong relation between dental attendance and the relation of sociodemographic characteristics.

We identified our sample size as a study limitation. For some it could be considered a quite small sample size to include only two older adults, but, in contrast, we believe this limitation also allowed and helped us to investigate this theme in a deep and valuable way. Future research might include a larger sample size, in order to complement and enrich the findings from this study.

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