

## Self-perception of teeth loss of the aged \*

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### ABSTRACT

The objective of this work was to analyze the perceptions of a group of the aged regarding teeth loss. A qualitative study was conducted using the Discourse of the Collective Subject as a methodological technique for ordering the data. The analysis of the interviews and the construction of the Discourse of the Collective Subject disclosed information on the thoughts and values associated with the loss of teeth within this group. The main results suggest that the lack of teeth caused functional and psychological problems, but that these appeared to be offset by solving the aesthetic problem. The justifications disclosed by the collective subject for edentulous predominantly reflect the healthcare model, which focuses on surgical, restorative and rehabilitation procedures, to the detriment of preventive actions and the promotion of health. Thus, the development of initiatives in the field of education and prevention regarding oral health is essential, emphasizing actions that target integral attention to the aged, detaching the social dimension of the illnesses, as well as the role of the State as supplier of health and quality of life to all citizens.

**Keywords:** aging. oral health. self-perception.

### Introduction

A growing number of the aged in the population has provoked a significant increase of studies that are proposed to investigate the phenomena that surround the human aging.

In the area of the health, this process has provoked a discussion about the re-organization of the attention to the aged, aiming at the qualification of the care in the diverse areas of knowledge.

In Brazil, the last epidemiological survey shows that the aged group of 65 to 74 years already lost 93% of his teeth (Health Ministry, 2004). This reveals the precariousness of the oral health in the Brazilian aged population and denounces the absence of cares to these individuals during their life.

In the Dentistry, the worry with the aged resides in the fact that, among others, the chew capacity is connected to the nutritional condition and this, to the general health of the individuals, which has repercussions in their quality of life. Although the dental aesthetic is important, the oral cavity should be sight in his fullness, therefore by means of it the social integration exists of the individual (Brunetti & Montenegro, 2002).

In the area of health education it has been being stress the articulation between the technical and the common knowledge for enabling the communities and the own individual to know and control the factors that affect

and determine their health. The self-diagnoses and the self-care boost the health actions development to the aged, therefore the dental mutilation produce incapacities that are not always perceived like relevant functional problems (Freire Jr. & Tavares, 2005; Narvai & Antunes, 2003).

The objective of this work was to identify and analyze the individual perceptions about the teeth loss, as a way of increasing the knowledge and qualifying the actions and the service provided for the old people.

## **Methodology**

The approach for data collection started from a qualitative cut. The population was composed by an age group of sixty years or more, of both the sexes, that participated in an event of health and leisure for the third age, in the Federal University of Santa Maria.

The data were obtained by individual interviews with two questions: "Have you ever lost any tooth?" and "what does losing your tooth mean?". The individual had freedom of speaking about the subject and relate his history.

Starting from the perspective of a qualitative study, the sampling followed inherent criteria to this kind of inquiry, considering sufficient the number of interviews when were observed recurrence and exhaustion of the categories in the talks of the individuals (Bosi & Mercado, 2004).

It has been realized 23 interviews. The talks were recorded and transcribed literally by the researchers. For the talks analysis the methodological approach was The Discourse of the Collective Subject (Lefèvre et al., 2000).

Each interview was analyzed individually after successive readings, collecting the expressions-key and the respective central idea. Right away, the thematic categories considered more significant were pointed out. The synthesis of the talks of the individuals represents the talk of the collective subject for each thematic category.

According to the ethical criteria, the participation of the individuals was voluntary, after the reading and explanation of the objectives of the study, and followed by the signature of the term of consent informed. The research project (Nº 015770) was submitted and approved by Committee of Ethics in Research of the CCS/UFSM.

## **Results and Discussion**

The population studied was constituted by functionally independent aged and active participants of third age groups, retirees, predominantly of the female sex and with ages varying between 55 and 84 years. Preliminary data of an oral health survey, 87% of the aged uses some kind of dental prosthesis (Unfer, 2004).

The thoughts and the values associated to the loss of teeth by the aged were organized according to two main themes: the central ideas that compose them and the Discourse of the Collective Subject.

### **Theme 1: Justifications for the teeth loss**

#### **Central Idea 1: absence or difficulty in accessing dental services**

*Living in the field, seventy years ago, you picture how this world was, the life sixty years ago. I lived outside the city, I lived on countryside, was not well-educated, did not do dental treatment. I put hot gray to relieve the pain. It had destroyed teeth. Today someone has tooth destroyed because he/she wants, therefore when I was young, there was not the facility that has today, already have resources that replace the teeth, or replace the aesthetics. In that time, the resources were not available. The problem is the financial situation. We're going, going, and they go spoiling. Lastly, the people finishes removing what remain and puts a dentures. In part, it was negligence of mine. A little bit*

*careless. I feared for going to the dentist, felling the anesthesia, felling the extraction and having hemorrhage. And then I became careless, letting pass, letting pass...*

Considering the access as any situation that permits and facilitates the entrance of an individual to a health service, it is perceived that, for the aged, there is a set of situations that block or do not make easy the utilization of oral health services. Among them are the cultural, economic and social difficulties. Not all of the patients arrive to the third age with financial conditions to deal with the costs of the dental treatment, mainly the prosthetics treatment. Align with this situation is the need of displacements and the help of another people (Narvai & Antunes, 2003; Brunetti & Montenegro, 2002). Besides, although deficit of services exist to the aged, many of them do not seek public services, because they are discouraged by the delay and by the quality of the services (Jitomirski, 2000). In these places, the aged constitute a group of smaller priority.

### **Central Idea 2: unknowing about the causes and the control of the oral illnesses**

*I was 10, 13, 14 years old, did not think of dentist, did not know either what was a dentist, I was bred like this, or brushed the teeth. My mother brushed the teeth with gray, she did not know toothpaste. My gum inflamed and my teeth loosened. Sometimes, I removed with the hand. Until today I don't know the reason, only I know that it loosened. Perhaps the problem is the pyorrhea that loosens the teeth. I had to extract, I was obliged, it was very bad because I had good teeth, healthy teeth, news, with all the age that I had. I felt a lot of pain. One of the teeth bursts here in top, left a hole for outside. I got it to fill, but afterwards it was not possible to fill, then I asked to remove everything, the good ones and the bad ones.*

The manifestations of the aged in this study reflect the results of the epidemiological surveys in the aged and adult population, showing up to high predominance of dental caries, periodontal illnesses and edentulous. The prevention in dentistry had its implementation initiated in the 1970s, but with emphasis on the school population. So far, the cares for the aged have not been contemplated properly in the programs of oral health.

For Jitomirski (2000), the health services must and can include the protection to the oral health of aged on its normal activities. The educational actions should be intensified, providing specific orientation, emphasizing the adoption of compatible behaviors with a good health and stimulating that the aged carry out the self-examination. The self-diagnoses of oral problems can represent the possibility of enlargement of the cover of the preventive systems, of recuperation and of maintenance of the health.

Shankai (2000) affirms that the incorporation of habits and ways of healthy life requires the aged having some knowledge of their problems for adopting this incorporation. Thus, it is necessary to provide the information and the basic orientation so that the health need perceptions are real and are transformed in personal attitudes and claims for governmental measures for the protection of the oral health.

### **Central Idea 3: consequences of the model of attention in oral health**

*A little bit one of the epoch. Because, in my epoch, if a tooth spoiled, instead of the dentists fill, they immediately pulled it out. And then... it was lost. We became sad. Perhaps it is because of a terrible pain in the nerve triplet. It had nothing with the tooth and some dentists would not want to pull out the tooth. As I did not get better of that symptom I went to SESC. They advised me that there I could have my teeth removed, and then I had three teeth removed.*

Brunetti & Montenegro (2002) affirm that, in the past, the interventions in fractured teeth or with mobility involved extraction and placement of partial prosthesis, evolving up to placement of a total prosthesis. The high predominance of edentulous in Brazil reflects a surgical-restorative attention model. Mainly in public services, the extractions are the only form of service offered.

In that context, without a preventive and conservative approach, the interventions evolve from successive restorations, exodontias, placement of partial prosthesis to placement of total prosthesis.

## **Theme 2: Consequences of the teeth loss**

### **Central idea 1: influence in the health**

*I would like to have all my teeth, it is very sad, immensely sad, lose the teeth, I lost much in health. Nothing is like natural tooth, it is comfortable, I think it is a treasure. Natural teeth signify health. I had marvelous teeth, pretty denture. I have just six natural teeth, then there are those gaps, it confuses. When I have a tooth extracted, I say: - I'm going to stay with a tooth to less. The ones who have the good teeth should take care of them; later you will miss them. The absence of tooth could become a headache, any thing to health.*

In the definition of oral health raised by the I National Conference of Oral Health, in the same year of the VIII National Conference of Health, we will see that it is inseparable and integral part of the general health. For the aged population, signifies adequate psychological and biological conditions, so that the individuals have functional chewing, swallowing and phonetics, besides exercising their self-esteem and the social relationship by means of the aesthetic, without inhibition or constraint contributing, in this way, for the general health. Having difficulties in some of those functions or state, we will be faced with a chart of incapacity, which can attack the individuals in many ways (Narvai & Antunes, 2003).

In this study, the aged seem to recognize that the presence of the natural teeth determines or collaborates for the health, although is not clear for them, what forms the discomfort perceived by the loss of teeth can alter the health.

### **Central idea 2: damage to the chewing**

*I think that changes a lot. We do not eat right, cannot feed correctly. If I had my teeth, I could eat a corn cob. It is impossible even for eating meat. The people think it is funny that I cut it with the fork... I have to cut the meat in little pieces. I cannot catch an apple or bread and give it a pleasant bite. I have to catch a knife and cut in pieces. I liked very much eating sugar cane, but now I am not able to do that, the people cannot eat anything that holds tight. The prosthesis is another one thing. It is not like the teeth of the people. The people have not the force in the teeth for the cut because the false teeth are never firmly in the mouth. The prosthesis wears away and does not cut very. It is sickening for chewing; there are many things that people cannot eat with those teeth because it slips. Then, sometimes, I eat very fast. There is nothing better than chew with the natural teeth.*

The aged perceive that to chew is not carried out with naturalness and comfort, and need to select the kind of food or the form of consuming it, by means of strategies that facilitate the consumption.

The loss of teeth and the diminution of the salivate stream in the aged diminish the capacity of chewing and swallowing adequately the food, compromising their general health and the welfare. The change from a healthy diet to a diet with predominance of carbohydrates and food less consistent cannot contain the adequate nutrients to the biological needs, causing apathetic and anemic states in more susceptible persons. Besides, this kind of food can cause atrophy in the musculature chewing, with repercussion on the facial aesthetics and on the self-esteem of the aged (Brunetti & Montenegro, 2002).

Not even the replacement of the teeth by prosthesis confers the comfort and the necessary naturalness for an adequate feeding. In that sense, it is important a biological oriented prosthetic treatment, adequate to the real needs of the aged, providing the comfort and the necessary security for the chewing. Also it is necessary to orient the prosthesis users about the periodic controls that should be carried out by the dentist. The misadaptation of the bases is common due to the bone reabsorption, and the loss of the facial height can be a consequence of the abrasion of the artificial teeth.

### **Central Idea 3: problems in the phonetics**

*I have a problem, difficulty for speaking, talking. It is difficult.*

Although it is known that the dental losses contribute for increasing the difficulty of phonetics, in this study, only three individuals related to feel difficulties in this function, what was verified also in the study of Narvai & Antunes (2003).

#### **Central Idea 4: psychological problems**

*I do not think it is comfortable to be with the teeth that are not mine. The people do not feel the same person. It is starting for the hygiene. Many times one has to leave the table and arrive in the toilet and brush their teeth and artificial denture. For me, it is difficult, I do not feel well, I become embarrassed of brushing the prosthesis. That constrains me a lot. It does not matter to me if the others are there, I do not know if they are looking at me or not, but I always hope do not meet anybody in the toilet when I remove my little toothbrush.*

In the population studied, the presence of prosthesis is a common situation. In case of the removable denture, the oral hygiene requires to remove the prosthesis for the adequate cleaning. That can generate constraint to the users, mainly when there is not privacy in the place. As Wolf (1998) said in their study, even in extreme situations, as grave illnesses or in surgeries, "staying without the prosthesis provokes sensations of humiliation, shame and feelings of lack of protection".

#### **Central Idea 5: aesthetics implications**

*If my tooth breaks I panic, I go to find a dentist, and I do any thing. I think it is horrible the person without tooth or toothless. It is an unpleasant thing. I take care of my teeth! The two dentures are false. Once I had a tooth broken, I was crazy, despaired, where find a dentist, it was Saturday. In another day, I said to my daughter: - I am going out, if I find a dentist that puts that tooth back in the denture I'll come back home, otherwise, I do not come back, I am going to do any thing, I do not come back without a tooth. Because to me the main thing in a person is the face! I have already changed two times, not, three times. Once I had a prosthesis fitted. My cousin and goddaughter did it. It was horrible, I felt horrible! A week afterwards, I had another one fitted. I already have it 6, 8 years. I don't know... I think that it does not imply anything, no problem, even though that they are situated at the side, well behind, they do not are frontal teeth, nobody notes.*

The concern with the replacement of the teeth lost is bigger when the aesthetics is involved and minor when the re-establishment of the dental function is necessary. In the last oral health survey of the Brazilian population, it was verified that the use of upper prosthesis exceeded the use of lower prosthesis, and one of the reasons can be explained by the aesthetics factor that involves the loss of upper frontal teeth (Health Ministry, 2003).

The self-esteem is related to an imposed ideal standard by the social demands. So the expression: "*the main thing in the person is the face*" reveals the importance of the image for the desirable standards from the society (Wolf, 1998).

#### **Central Idea 6: problems caused by the prosthesis**

*People say that it is horrible to accustom with the lower prosthesis, this is way I am enduring. Right now, I had these tooth fitted, but I am not used to them very well, they are different, they are accentuated, it hurts. My jaw is prominent, it is not the same thing it used to be. Next year I am going to have another new prosthesis. From time to time, falls the pivot, then I run to the dentist and he puts it back again. It disturbs a little, the upper not so much, but I cannot sleep with the lower prosthesis.*

The possibility of maladjustment of the removable prosthesis, because of the bone reabsorption or of the erosion of the artificial teeth can cause several problems. The adaptation of the lower prosthesis is always more critical, therefore the index of bone reabsorption in the lower arcade is bigger than in the upper one. The absence of accompaniment and control of the adaptation can cause the appearance of lesions in the oral

mucous membrane and problems in the neuromuscular system, increasing the incidence of not-using, specially the lower removable prosthesis (Brunetti & Montenegro, 2002).

### **Central Idea 7: compensation by the use of prosthesis**

*It did not change because I had to use artificial, false teeth. I had to put pivot. I don't know if they still use. It felt strange the prosthesis, but now I am accustomed, now it is good, it is as it was before, I accustomed quickly, I find that it is the same thing. My prosthesis is very good because it was well made. The dentist extracted the teeth and already put the prosthesis. That tired me, mistreated me a lot but now I don't know if I have prosthesis. I am very well, better than with the teeth that I had. For me it is like natural tooth, mainly the upper, not the lower. At least, the people are not toothless.*

For many elders, the access possibility to the use of a prosthesis looks to exceed the difficulties with the dental extractions and the compromise of the oral functions. The use of artificial teeth or prosthetic device is capable of improve the self-esteem and the relationships, since the individual expectations are fulfilled. (Narvai & Antunes, 2003; Wolf, 1998).

### **Final Considerations**

The utilization of the qualitative methodology for the apprehension of the perceptions of the aged about the oral problems, visualized by means of the Discourse of the Collective Subject, permitted to know prominent aspects that should be considered in projects and programs developed for this population.

It perceives that the collective subject does not look to have knowledge of the causes of the oral illnesses and the forms of prevent and control its manifestations, before being necessary intervene by means of surgical procedures, restoratives or rehabilitators.

It stand out the need of making aware the aged about the importance of periodic revisions for the evaluation of the prosthesis regarding the aspects of stability and retention and by the possibility that the prosthesis bad-adapted will generate damage in hard and soft tissues of the oral cavity.

On the other hand, the users of bad-adapted prosthesis or people that have not replaced artificially their teeth lost may be compromising their general health by the loss of the chewing efficiency, besides putting in risk, also, the nutritional quality of their diet.

Equally, it is necessary take into consideration the psychological factors that involve the individuals that lost his teeth, giving attention to the social and psychological damages that this situation involves and are not always verbalized clearly to the health professionals. It is indispensable the development of initiatives in the field of the education and prevention in oral health, emphasizing behaviors for self-exam, control of carious, gingival and periodontal lesions and prosthesis maintenance.

It is important, still, show up the social dimension of the illnesses and the role of the State as a health supplier, providing quality of life to all citizens.

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