Social interactions, body image and oral health among institutionalised frail elders: an unexplored relationship

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Objectives: This paper draws on theories of ageing, body image and disfigurement, to explore the potential for relationships between oral health, body image and social interactions between institutionalised elders.

Background: Social relationships are important at all stages of life. A positive body image increases confidence in social interactions, which contributes substantially to health, well-being and quality of life. Body image can be negatively impacted by oral conditions, particularly those that are appearance related and do not meet cultural ideals.

Results: Typically, the oral health of frail elders in long-term care facilities is poor, but to what extent poor oral health and dysfunction influence body image, and social behaviours is unclear.

Conclusions: We conclude that there is the potential for poor oral health conditions to contribute negatively to the social well-being in this population, but suggest that it requires further investigation.

Keywords: geriatrics, social interaction, body image, oral health, frail elders, ageing.

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Social isolation is a growing concern in long-term care (LTC) facilities because weak social contacts seem to contribute substantially to the risk of cardiovascular disease, cancer, reduced host resistance and impaired cognition. This risk has been equated to tobacco, hypertension, cholesterol, obesity and physical inactivity, but we have very little empirical information about how it is influenced by impairments and diseases of the mouth. Halitosis, tooth loss, and poor dental aesthetics undoubtedly disturb social interactions between people who live and work independently in society, and resolution of these dental problems can improve social confidence. However, the extent of this influence on frail elders in LTC has received little attention.

Maslow’s hierarchy of need emphasises physiological needs, but Majercsik in his hierarchy of needs for older people places self-actualisation (belief that one has reached their full life potential) and self-esteem (belief in one’s self-worth) is much higher than physical needs. Majercsik’s hierarchy has important implications in the care of elders and particularly relating to dentistry where psychosocial needs are apt to dominate among healthy elders. Therefore, oral health with the role it plays in both the personal and social comforts of older people might contribute substantially to the self-esteem, body image and overall general well-being of frail elders.

Social and emotional isolation

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. Usually, it is measured as the number of social contacts, hours spent alone and the size and type of social networks. Emotional isolation or loneliness is a similar but subjective assessment of social relationships, measured typically on a loneliness scale. The objectivity of social isolation and the subjectivity of loneliness share common personal, social and health-related characteristics, but they are different psychosocial conditions as witnessed frequently in LTC where some elders prefer long periods alone without obvious signs of loneliness.
Social and emotional isolation can have a negative impact on health; however, the process is complex and not well understood, owing to the multiple social variables involved. 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. Social relationships are also strong predictors of mortality that operate independently of gender, ethnicity or other risk factors for diseases and illness. Yet, it remains unclear whether social and emotional isolation cause disease or whether 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.

Much of the interest in social interactions in old age has focused on the measurement of social networks, social support and social participation. There have been very few attempts to explain how conditions of health as opposed to the consequences of disease influence social behaviours. 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. 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. Nonetheless, we do not know how much positive or negative influence oral health or disease imposes on people when they are frail and in LTC.

Social interactions and theories of ageing

A lack of social interactions can be harmful from a biomedical perspective, but from a psychosocial perspective, it is unclear whether self-imposed isolation is a bad thing. This becomes even less clear when you consider the heterogeneity of an elder population. While ageing is inevitable, not everyone experiences it in a negative manner. Rowe and Khan suggest that ageing is either “usual” accompanied by expected age-related losses or “successful” and not encumbered by losses. They suggest usual or successful ageing is dependant not on chronological age, but instead 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 for age-related declines. Therefore, not all elders who have limited social interactions may suffer physiological or psychological consequences of being alone. However, activity theory purports that social engagement is necessary for health and well-being, and continuity theory contends that social behaviour and activities are maintained as we age. Other theories of ageing, such as socio-emotional selectivity, disengagement, and gerotranscendence, contend that reduced or more discretionary social relations and activities are a normal and healthy part of ageing.

The theory of gerotranscendence offers an intriguing explanation for situations where elders find fulfilment and life satisfaction in solitude, reflection and meditation. According to Tornstam, our perspective as we age shifts from an interactive, materialistic and pragmatic view of our role in the world towards a more reflective and spiritual view and normally accompanied by an increase in life satisfaction. Therefore, an elderly person who is reconciled to old age may quite reasonably feel no obligation to socialise or to establish superficial relationships. This shift in perspective abandons “social convictions” for a more contemplative state. Consequently, the imposition of social activities that so often pervades daily life in a LTC facility might indeed impede the development of “gerotranscendence” and reduce life satisfaction. This could explain further why some people with many social contacts are profoundly lonely and unhappy, especially when social engagements are forced and persistently encouraged.

Giles et al. 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 filling emotional experiences. Unfortunately, this quest for intimacy is often thwarted by the physical and cognitive disabilities that lead to placement in an LTC facility.

Despite the differences between the various theories of ageing, they all share the premise that social interactions should be meaningful rather than frivolous if they are to promote health and satisfaction.

Social interactions and body image

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 factors44. Essentially, a positive body image provides confidence to engage in social relations, whilst a negative image decreases the ability and desire to socialise. Until recently, studies of body image have focused primarily on the weight and body shape of young women. 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 by society to a standard deemed ideal for our culture, and through an “internalisation of a cultural standard,” we view these cultural ideals as our own46. Our ability to meet the ideal, therefore, is either a glorious achievement or a shameful 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 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 useful in explaining the influence of depression on men and women of different ages47. Further investigation may also confirm the role of OBC within the cultural context of LTC facilities in relation to oral health.

Concerns about body image appear to remain relatively stable across the lifespan48, at least until old age when they seem to decrease as Jenny Joseph (1974) impishly declares in her poem “Warning: When I am an old woman I shall wear purple.” However, anxiety about weight can persist into old age49–51, but whether this or other body-concerns persist as we grow frail is unknown. Body odour52,53, disability45,54 and personal grooming55 all influence the body image and social behaviours of adults; however, no attention has been paid to the influence of these social characteristics and related concerns of body image among institutionalised elders. Moreover, problems with mobility, hearing and vision impede social interaction56, so it seems plausible that oral dysfunction could have a similar effect.

**Social interactions and facial disfigurement**

Undoubtedly, facial disfigurement influences social interactions, and the “fear avoidance” model of psycho-social difficulties helps to explain the experiences and behaviours of people who have visible deformities of the mouth and lower face57–59. Apparently, a “phobic anxiety” and the fear of how others will respond to a visible deformity can lead to avoidance of social situations58. Visibly missing teeth can be considered disfiguring by some, although the severity of the response to this varies greatly and unpredictably9. Even relatively minor deformities can have devastating effects on social interactions depending on how the individual conceptualises and copes with the disfigurement15,60.

Halitosis is not physically disfiguring but can disturb body image and self-confidence. Some people have a sense of smell that supports a “body odour image”. Consequently, the “fear of avoidance” model has been employed to explain how people with badly smelling wounds behave and cope in social situations. It is not difficult to believe therefore that halitosis can cause a marked disturbance of body image and social behaviours, although the extent of the disturbance probably depends largely on the social and cultural context in which people live and on their sense of smell52,53.

**Body image, oral health and social behaviour of elders**

Body image, weight loss and the cosmetics for many people are concerns in the quest for eternal youth62,63, as are the appearance of “nice teeth” and a “nice smile”9,15,31, especially among older women, and there is little reason to believe that men feel differently55. These findings are not surprising as oral health in Western society is based also 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. Unfortunately, the oral health among residents of LTC facilities is generally poor64, but to what extent these concerns persist when an elder becomes institutionalised is unknown. Much of what we do know about the oral health of institutionalised elders comes from quantitative studies that report on disease status or socio-dental indicators that measure the negative effects of oral problems65. However, clinical dental status among older adults can differ from ones perception of oral health66. It is such perceptions and their priority that appear to influence social behaviour, but we have little understanding of how institutionalisation affects this. Previous research has shown that tooth loss can impact perceptions of oral health9,15,67, as well as produce feelings of fear and anxiety68. While many of these studies involved older adults, none specifically addressed
the impact that tooth loss may have on socialisation among institutionalised elders. As well we do not know what other factors influence the perception of oral health and body image. Figure 1 depicts a visual representation of what is known about this relationship among younger populations as well as questions that have yet to be answered in regard to institutionalised frail elders.

Future research considerations

Long-term care facilities are meant to bring people together and provide an environment where they can engage in social activities with others. However, even today with great improvements in activity departments, residents spend most of their time alone, sitting in their room. Depending on which theory of ageing prevails, this activity or inactivity can be considered either a healthy response to ageing or a detrimental response to disability. Autonomy and satisfaction with activities contribute to the social engagement of elders living within institutions, but illness and frailty obviously disturb the desire and ability to engage in social relations. However, there are other aspects of life in a LTC facility, such as the cognitive impairment and erratic behaviour of neighbours that can encourage a self-imposed isolation in this social setting. It is possible also that the deteriorating health and frailty of other residents as a consequence of ageing and illness disturb the social environment to the point where a resident prefers to remain alone. As well the facial disfigurement of neighbours as a consequence of stroke and other neurological disorders may make social interactions uncomfortable. Similarly, a disfigured or foul-smelling mouth may cause social withdrawal for good or for bad. The extent of this influence in long-term care and how it can be addressed most effectively warrants more attention than it has received from clinicians or from researchers.

Recently, Eriksen and Dimitrov proposed that research related to oral health needs to move from the biomedical context of function, dysfunction and malfunction to a broader social context. This certainly seems true with regard to frail elders living in LTC facilities. To better understand the relationship between oral health, body image and social interactions between this unique population research needs to address the following gaps in the literature:

1. How does institutionalisation and frailty influence an elder’s desire and ability to socialise?
2. What influences perceptions of oral health and body image among institutionalised frail elders?
3. How are body image and oral health prioritised among institutionalised frail elders in relation to other events and concerns?
4. How do the priorities that institutionalised frail elders place on body image and oral health influence social interactions?
5. How do social interactions that are influenced by body image and perceived oral health impact quality of life among institutionalised, frail elders?

Conclusion

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 how these influences extend into the cultural and social context of elderly people in LTC. Poor oral health negatively affects the social lives of younger people but with increasing frailty, it is quite possible that other concerns take priority. Anxiety about personal appearance persists well into old age but it is influenced strongly by cultural norms and ideals. Therefore, the culture of LTC compounded by increasing disability and dependency is likely to dampen concerns about personal appearance and social interactions, which offers at least some explanation as to why oral health and appearance receive so little attention from the nursing staff and the elderly residents alike in care facilities. More exploration needs to be undertaken with this unique population to better understand the effect that oral health and disease have on the body image and social behaviours and ultimately the quality of life among institutionalised elders.
References


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