Perception of elderly women with depressive symptoms regarding access to oral healthcare in the Family Health Strategy

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Abstract: The Brazilian population is aging and in a feminization process. Among the most prevalent chronic diseases in the elderly, depression directly impacts the perception of oral health, with reflexes on self-image and self-esteem. This descriptive study, with a qualitative approach, aimed to analyze the perception of elderly women with symptoms of depressive disorders at a family health unit, about access and care in oral health and self-perception of oral health and its relationship with quality of life. The study included 20 women aged 60 or over, registered at a family health unit in Ribeirão Preto-SP. Audio-recorded semi-structured interviews were carried out, later transcribed, and analyzed through the Content Analysis technique. The results expressed an important relationship between self-perceived oral health and quality of life, barriers to access to oral health care, the importance of popular knowledge in self-care practices, self-perception of the mouth as part of their general health, and feelings of dissatisfaction and insecurity due to the lack of information, associated with the experience of a mutilating curative model. The importance of actions with an expanded approach and in a multidisciplinary team is emphasized, focusing on integrative care and quality of life for the elderly.

➤ **Keywords:** Aged. Mental health. Health Care Quality. Access and Evaluation. Dental Care.

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Introduction

Brazil has been facing a change in the sociodemographic profile and life expectancy increase scenario includes a population with more elderly women (Miranda; Mendes; Silva, 2017; Rocha *et al*., 2019; Hellwig; Munhoz; Tomasi, 2016), which impacts oral health, as well as income, more presence of toothache, the use of public services, and demand for treatment (Bulgareli *et al*., 2018). Brazilian population aging involves economic and social changes for society as a whole and increasingly demands a multidisciplinary team approach focused on comprehensive care. At this stage of life, the development of chronic diseases - and their sequels - does not necessarily interfere with the life expectancy of individuals, but it can restrict functional and mental capacity during aging (Hellwig; Munhoz; Tomasi, 2016).

Among the diseases associated with aging, common mental disorders stand out, which are considered an important public health problem because they intensify during the aging process and are more likely to be present in women, such as anxiety, insomnia, forgetfulness, and cognitive decline (Silva *et al*., 2018). A population-based study conducted in southern Brazil with elderly people showed that 15.2% of the population studied had some depressive symptom, more present in women, and among those with worse economic status, who did not work, who were physically inactive or had some functional disability, and those with worse self-rated health (Hellwig; Munhoz; Tomasi, 2016). The increase in the number of elderly with depressive disorders demands multidisciplinary teams' interventions, that commit to this population's quality of life, considering it is a multifactorial event that involves the different dimensions of life, including physical, mental, functional, and psychological well-being, and has influences health-disease process, care, decision-making, and the individual's independence to perform activities of daily living (Martins *et al*., 2016).

Elderly people'a oral health is an integral and inseparable part of general health and is directly related to social and economic conditions (Brazil, 2004; Silva; Oliveira, 2018). In the epidemiological survey of oral health conditions in the Brazilian population, SB Brazil 2010 (Brazil, 2012), 46% of the elderly between 65 to 74 years old reported feeling some impact of oral health in daily life, and the main complaint pointed out was difficulty to eat. Also, recently, there has been an increase in research to identify the relationship between oral health and the quality of life of

the elderly, to improve health promotion action plans with multidisciplinary teams (Vargas; Vasconcelos; Ribeiro, 2011; Vasconcelos *et al*., 2012; Bulgareli *et al*., 2018; Ball; Correa; Toassi, 2019; Silva *et al*., 2019).

Regarding oral health and mental disorders, it is known that elderly people with symptoms of depressive disorders have a decline in their general health and oral health, with consequences mainly related to self-image and self-esteem, due to tooth loss, dry mouth, or pain (Vargas; Valencia; Ribeiro, 2011). Oral issues directly affect the individual's general health, with negative impact on quality of life (Bulgareli *et al*., 2018; Silva *et al*., 2019). However, to assess how much oral health interferes with quality of life, biological indices and clinical data are not enough for relevant results, since they do not assess, for example, pain and how much this condition affects daily life (Vargas; Valencia; Ribeiro, 2011). Studies indicate that self-perception of oral health is multifactorial, and should consider sociodemographic characteristics, such as age, race, education levels, and income, as well as self-perception of general health and acquired knowledge (Vasconcelos *et al*., 2012; Ball; Correa; Toassi, 2019). Thus, it is possible to recognize how social, cultural and economic values interfere with their quality of life (Silva; Oliveira, 2018). In this sense, the patient's account becomes a more comprehensive way of assessing the relationships between their health and their quality of life, as well as the associated factors (meanings, reasons, beliefs, values, and attitudes) (Mussolin *et al*., 2020).

This study aimed to analyze the perception of elderly women with symptoms of depressive disorders in a family health unit, regarding access to oral health care, as well as self-perception of oral health and its relationship with quality of life.

Methodology

This is a descriptive study, theoretically supported by the National Oral Health Policy (Brazil, 2004), with a qualitative methodological approach and the participation of elderly people registered in a Family Health Unit (FHU) in the city of Ribeirão Preto-SP. This unit is a field of teaching and research for undergraduate and graduate students from different areas of health at a public university. It is important to highlight that this FHU is registered in the Ministry of Health with a minimal Family Health Strategy (FHS) team that does not include an oral health team in the models the Ministry of Health proposes (USP, 2020), but counts

with the participation of residents and preceptors of a multiprofessional residency program, that includes oral health professionals.

A total of 50 people aged 60 years or older, registered in the area covered by the FHU, were randomly selected. They were contacted by telephone or in-person and invited to participate. After five attempts, it was not possible to contact 8 participants for one of the following reasons: the telephone number was outdated, they did not accept the call, they were not present at the unit during the research period, and they were not at home for professional or personal reasons. The data was produced by questionnaires and interviews conducted by one of the researchers, a dental surgeon, resident in the same unit, after a pilot interview training. The Informed Consent Form (ICF) was read and signed, followed by data production. First, the Mini-Mental State Examination (MMSE) was applied, as an instrument to assess the degree of cognitive deficit in the elderly (Melo; Barbosa, 2015) and those who did not present a minimum cut-off score were excluded from the study. Until data saturation was reached, 32 elderly men and women were invited to participate, of which 1 did not reach the minimum MMSE score and another 11 did not agree to participate in the research. Next, we applied the Patient Health Questionnaire - Two items (PHQ-2) (Kroenke; Spitzer; Williams, 2003). Those who had a positive score for symptoms of depressive disorders after responding to PHQ-2 (Kroenke; Spitzer; Williams, 2003) were included, that is a score greater than or equal to 3. Data were produced through audio-recorded semi-directed interviews, of approximately 30 minutes, at home or the FHU, according to each participant's choice, at a previously scheduled time, assuring comfort and privacy. A socioeconomic assessment questionnaire was applied to characterize the profile of the elderly population in terms of gender, age, education, income, self-reported diseases, and use of dental services (Brazil, 2012). For the interview, the script included questions about the perception of care and access to dental services in previous experiences and at the time of the interview, self-perception regarding the functionalities related to oral health (talking, smiling, chewing, swallowing) and their interference in quality of life.

The final number of participants formed an intentional sample reached by theoretical saturation. Thus, after reading the interviews, they were finished when the information obtained was already sufficient to bring consensus regarding the topic studied, along with the theoretical contexts involving the research issue and the type

of study (Minayo, 2017; Fontanella *et al*., 2011). In the end, the number of participants interviewed was 20, named "Participant", followed by numbers from 1 to 20.

The interviews were transcribed into a Word (Microsoft Office) file and stored on a drive owned by the researchers. Data analysis began with the contact with the reality to be studied, in the interaction between researcher and participant, during the data production (Preti, 1993). After transcription, the data were systematized and analyzed using the Content Analysis technique (Bardin, 2011) in three stages: 1) Pre-analysis and exploration of the material; 2) Data processing with the construction of thematic categories; and 3) Inference and interpretation of the categories. The data were interpreted and associated with existing studies and the National Oral Health Policy (Brazil, 2004).

The study was approved by the Ethics Committee of the University of São Paulo at Ribeirão Preto School of Dentistry under opinion number 3,150,556.

Results and Discussion

The participants of the research were 20 women, aged between 60 and 84 years (mean of 74 years), 90% white, 35% married and 65% widowed, single or divorced and 20% living alone. They had an average of 6 years of schooling and reported having chronic diseases, 80% hypertension, 60% diabetes mellitus and 11% cancer. All of those who declared family income (50%), had an income of at least two minimum wages. Regarding access to oral health care, 65% of them visited the dentist less than a year ago and, of these, 60% used the public service and 40% the private service.

Some elderly women reported using the oral health services offered by the FHU, such as dental care, while others preferred to attend private oral health services, even though they were registered in the FHU, and used other health services offered, such as medical care, care by a multidisciplinary team, and participation in health promotion groups. They use private services due to the delay in access to public secondary care service, such as prosthetic rehabilitation, or because they had a bond with professionals in private care services throughout their lives.

Based on the analysis of the interviews, the results were organized into four thematic categories presented below: Access yesterday and today; The construction of popular knowledge in oral health care; Meanings of the Experiences of the Health-Disease Process; and Food: synonymous of happiness.

Access yesterday and today

The first category is mainly related to the barriers to accessing oral health care. In the following excerpt, the elderly woman talks about her experience of tooth loss when she lived in a rural area.

> And I also lost a lot of teeth too, you know... because... We lived in the countryside and the dentist was far away, so I went to my grandmother's house in (another city) so I could take care of my teeth... you know? (Participant 2).

In addition to geographical barriers, the consultation with the oral health professional (dentist) was influenced by financial aspects and by the experience of a curative model of oral health.

> As a child I never... I went to the dentist when I was 17 years old with all my teeth damaged... they had to remove all my teeth and put on a prosthesis at the age of 17 [...] at that moment it hurt because we didn't go to the dentist... because we lived in a very far place, it was beyond (nearby town)... a farm [...] it was difficult... There was no way a tooth could be treated... (Participant 15).

Based on the participants' experience and their life context, it was possible to identify different barriers to access to services, such as the lack of human resources and the fact that they lived in a rural area. This reality is mainly present in rural populations, where the elderly have difficulties accessing health services due to the need to move, lack of transportation, or long distances to health facilities (Costa *et al*., 2019).

Before the creation of SUS (*Sistema Único de Saúde*, Brazilian Public Health System) and the implementation of actions proposed in the PNSB (*Política Nacional de Saúde Bucal*, Oral Health National Policy), universal access to oral health was considered precarious with few resources allocated to supplies and training of professionals (Brazil, 2004), therefore, it is understood that there is a need for a transition care model for the elderly, people-centered and involving different actors such as caregivers, family members and managers (Nitschke *et al*., 2022). The implementation of the PNSB should, therefore, reorient the oral health care model, developing network, decentralized and priority actions regarding pain, infection, and suffering, to qualify for comprehensive care (Brazil, 2004).

For these elderly women, the unusual toothbrushing culture and difficulties in accessing water were considered barriers to oral health care, especially for those who spend their childhood in rural areas.

> Well, in the beginning, in the old days I didn't use it, right? Hardly anyone brushed their teeth at all... we didn't have toothpaste... We didn't even have a toothbrush, you know? Then (after I got married) it went on like this: we brushed... more or less... because if you look at the water, it was there in the mine... There in the spout [...] (Participant 2).

> On the farm, I brushed only on the spot... In the morning... Because then we'd go to work, you know? I helped my parents and only at night to go to sleep I had (toothbrush and toothpaste)... (Participant 6).

Besides cultural aspects, financial difficulties to access restorative treatments and the hegemony of the mutilating curative model were reported as factors that influenced their choices and that may have repercussions in suffering due to tooth loss.

> Yes... I'd rather took it off... extract... than... than to treat, right? Because it was cheaper... It's where my mouth is missing a lot of teeth... a lot are missing. I'd rather pay to take it off at the time. (Participant 3).

> I had bleeding gums when I was about 17... 18 years... or even less... around 14... My pillow was full of blood in the morning... every day... so... But we didn't have the treatments that we have today... (Participant 19).

In Brazil, despite advances in dentistry, edentulism is still quite prevalent among the elderly, with an average of 29.4 missing teeth in the age group of 65 to 74 years, evidenced by the need and/or use of prostheses for oral rehabilitation in most of the population in this age group (Brazil, 2012). Reports of invasive procedures in services such as dental extraction explain the predominance of the curative care model, in which tooth loss results in psychological discomfort, an important factor that impacts the quality of life of elderly people (Echeverria *et al*., 2019).

Another point raised was the desire to have information about their oral health condition and treatment needs, before the prognosis of the disease "was the worst" and demanded more invasive procedures.

> I would like, so, as I told you, to have someone to guide me. That say, 'Oh, you may have a gum disease, go look for it.' To be led, right? Because we didn't have that much information. Today there's more, right? But at the time, when all started, there wasn't, right? [...] yes, I think you must have it! (Participant 1).

The literature shows that social factors such as housing conditions, geographic location, social interaction, access to basic sanitation, and health information are important for oral health (Costa *et al*., 2019). Travassos and Castro (2009) explain that access barriers mark social inequalities both in the access and the use of health

services. For these authors, the absence of health professionals is one of the main barriers to access, but they also highlight other obstacles, such as geographical, related to home location; financial, linked to access to goods and services; organizational; informational, regarding access to information; and cultural, referring to values and beliefs. In addition, barriers related to the type of health services offered also contribute to or hinder the access to services.

It is also possible to observe that the relationship with the professional who provided the healthcare was based on the service provided and not on the relationship between patient and professional or on the exchange of knowledge in the health-disease process. Thus, acknowledging access barriers, including communication and bonding between professional and patient, are important aspects the intention is to expand the clinic beyond oral health, and rescue biopsychosocial needs.

The construction of popular knowledge in oral health care

The second theme concerns the use of home remedies and oral hygiene habits, built from popular knowledge. For Holanda *et al*. (2020), the work of the multidisciplinary team in the FHU consists of redirecting health practices when it is guided by the valorization of popular health education. This position enhances movements of autonomy to construct knowledge collectively in the community. In view of the difficult access to oral health services, the use of medicinal plants, teas and herbs as home remedies for pain relief is observed among the elderly women.

> [...] If you had a toothache, they would give you a tea... something there and they told you to gargle with potato leaves... with a TEA... And with that I grew up at that pace... (then) I lost all my teeth... (Participant 9).

> [...] we used to make a mouthwash with a home remedy, we even did a lot of mouthwash, when it was swollen, with sweet potato leaf (Participant 15).

Based on these reports, it can be thought that clinical-restorative procedures in dental treatment are not the only alternative to deal with the health-disease process. Popular knowledge, i.e., beliefs and values passed down between generations in families, show the strength of the user's autonomy and the appreciation of their knowledge in health care. In Brazil, due to the influence of indigenous, African and European cultures, the use of medicinal plants is a common primary care practice in populations and is characterized by coming from popular knowledge and tradition (Zeni *et al*., 2017).

To expand the articulation with the community and its knowledge, the National Health Promotion Policy (Brazil, 2010) proposes networking, so that health actions planning is more linked to the perceived needs and experiences of the population in the different territories, promoting quality of life and reducing vulnerabilities and risks to health, increasing the autonomy and co-responsibility of the subjects.

The construction of health habits, with reference to family tradition, were reported by the interviewees, such as the participation and vigilance of parents in oral health care.

> Look, actually, we didn't do anything because we didn't have any encouragement from our father or mother... (Participant 5).

> At night he finished eating, we brush our teeth that my mother forced, you knowright? So, my mom... But she was very strict, you know. (Participant 18).

The perception of the elderly women reveals the family and cultural values built since childhood, which make up factors that can influence hygiene habits, the cariogenic diet, or the development of caries in childhood, with consequences for the oral health of their children (Carmo *et al*., 2023). According to the participants, the oral health experience reported had repercussions on the habits and parenting and shows differences in access between the generations.

> My children were little... We took them (to the dentist). (Participant 2).

> I took both. Because what I had gone through with my teeth, I didn't want them to go through... And he's got ALL his teeth... He has them and so does the other one... Because I always took both to the university, you know? (place where they had dental care). (Participant 7).

The health promotion actions proposed in the PNSB, in this sense, should contribute to the autonomy of citizens through approaches to risk factors, or simultaneous protection, both for diseases of the oral cavity and for other diseases (Brazil, 2004). The studies by Quintela *et al*. (2019) and Dutra, Bossato and Oliveira (2017) point to the importance of valuing autonomy, valuing the individual's potential, and empowering the user by sharing knowledge between professional and patient, so that neither party is seen as holding knowledge.

As a result of early tooth loss, many elderly women reported having removable dental prostheses, as well as how the take care of them in their daily routine. As found in the literature, the participants reported the habit of performing oral and prosthesis

hygiene mechanically, that is, with the use of a toothbrush, and knowledge about the importance of removing them to sleep (Oliveira *et al*., 2018; Falcão *et al*., 2019).

> [...] I take off my false teeth and wash them all... then I brush the ones at the bottom, everything... and put it back in my mouth... (Participant 17).

Thus, it is possible to observe suffering pain, and anguish in the past led them to search for alternatives for care, such as home remedies, and to protect their children, constructing their popular knowledge in oral health care, which contributed to changes in habits between generations.

Meaning of health-disease experiences

In the third category, self-perception of oral health led the participants to express various feelings, representing their experiences and emotions concerning what they experienced in the health-disease process. In addition to the dissatisfaction with the losses suffered, the elderly women expressed anguish and dissatisfaction with their history and desires for changes, such as, for example, a woman who regretted that she no longer had her natural teeth.

> So, I'd like to have had a treatment, that I didn't have to take them off even though... I don't feel anything... But having our teeth is different to have a bridge... Something like that, you know? (Participant 18).

In this context, their experiences of health and disease were marked by insecurities and fear in the face of the curative oral health model. And the fear of these elderly women is shown to be something real that interferes with self-care in oral health. These aspects are confirmed in the literature, as fear of the dentist is more prevalent among women and fear affects choices about dental care (Silveira *et al*., 2021; Alenezi; Aldokhayel, 2022). Thus, their anxieties once again pointed that access to information barriers are essential for safe decision-making about their own health, in addition to the expectation about access to specialized treatment.

> I was scared to death... they put it... wow... that little engine... but as I went... I suffered... but I went... But I suffered... until today, you know? (Participant 18).

> But if I'm sure (that it would work because of my age) I would do an implant, yes! If it's all true what they say, right? That there's no longer a problem of food under the tooth, these things... (Participant 1).

> The best option would be a full denture, right? There is the possibility of having the implant, right? Functionally it's also better, there's more freedom, you know?" (Participant 12).

> Even if I could use it on top and bottom, thinking about making an implant, but it's very expensive, I would like to make an implant, it would be fixed, right? (Participant 20).

The oral health care model provided by the PNSB focuses on comprehensive care, so that there is the progressive incorporation of actions to promote, protect and recover oral health, at all levels of care, and these elderly women aim for and expect all complete actions to improve their quality of life.

Food: synonym of happiness

In the fourth category, the participants indicated that they believe in the direct relationship between the health of the gastrointestinal tract and chewing functionality and pointed to the relationship between food and quality of life.

> It's in the stomach mainly... that swallows everything whole... Sometimes your stomach hurts... sometimes it makes you feel nauseous... I believe it's because the missing teeth, right? (Participant 4).

> Yes, a healthy mouth is important to have good health, my body... not having a tooth that hurts, for example… (Participant 14).

Most of the participants reported some alteration in oral health functionalities, mainly related to chewing difficulty and aesthetic loss.

> Because today it's like this: 'oh, you can't eat anything too hard; meat', the other day I said to a dentist of health the insurance, I said: 'Oh, my teeth don't cut meat anymore... I have to cut it with the knife (into small pieces) if not... I can't.' [...] It never looked like my previous teeth, which were wide in the front... It's never been the same, right? [...] For example, I'm going to take a picture, right? Take a picture, if I'm going to smile like everyone else smiles, there's a taller tooth... another lower one here that wasn't the height of the prosthesis. I don't even feel like smiling in the photo. (Participant 1).

When reflecting on the meaning of quality of life, the participants reported on financial conditions and the relationship with food and the feeling of happiness.

> So, quality of life for me is eating well, eating well [...] It's eating well, being happy; (Participant 3).

> And my stuff was like this... To have my teeth, right? To eat... to smile... to be happier than I already am... I think that what is missing for my happiness is the lack of my teeth... (Participant 4).

> Oh, I don't know, I think quality of life for me is ... (I say it like this) eat what you can eat, right? That poor people can't afford it, but I think that's what quality of life is all about, eating well, eating well, eating at the right time; (Participant 5).

It is possible to notice a strong relationship between good nutrition and happiness, from access to food to the possibility of chewing and smiling, being happy. The mouth is then understood as a fundamental part of being in the world. Based on the functional aspect of the mouth as a key component, these elderly women were able to recover the idea of the oral area (Botazzo, 2006), that is, the dimension of oral health and the relationship between the mouth and its social function to survive, live and coexist. According to Botazzo (2006), this concept refers to the mouth relating to the world in its different sociological and psychological aspects and producing subjectivities. In this sense, oral health professionals should connect with this dimension to recognize their co-responsibility in restoring the lost dignity of these elderly women who want to eat and smile again.

> Lately I've been talking, I'm embarrassed to talk to the person because I feel like my mouth is bitter. So, as I feel the mouth bitter, I think I have bad breath. So, I try not to be around people or talk because I'm terrified of this bad breath thing! My grandson, he's very close to me, a lot! He keeps saying to me, 'Grandma, did you brush your teeth?' I said, 'I brushed them.' Is he feeling something that he says that to me? Because if you look at it, I don't have a tooth in the back, I only have it here in the front. So in a restaurant it's hard, I don't even like to go out because of it. [...] Sometimes I stop going out because of it. My husband says 'Let's go to such and such a place', I don't eat. I don't tell them, but I don't because of that. (Participant 3).

Silva *et al*. (2019) pointed out an important association between oral health variables and depressive symptoms in the elderly population, in which a strong prevalence of depressive symptoms was observed with the need for oral rehabilitation, aiming precisely to bring back the chewing function and pleasure in eating. Thus, the lack of teeth, or even the changes perceived in the oral health functionalities of the participants, directly reflects on the feelings of self-care and social interaction, an important point for self-esteem and quality of life of the elderly.

Given oral health self-perception, we suggest that dental treatment of the oral health team, especially in oral rehabilitation, should consider not only technical aspects but also the patient's perception of their image and the need to work as a team with a focus on the expanded clinic, to promote full individual-centered care.

Conclusion

This study shows an important relationship between self-perception of oral health and its relationship with quality of life, emphasizing that individuals bring

with them the consequences of both their previous and recent experiences. In the population studied, we can observe barriers that prevent access to healthcare, the importance of popular knowledge, self-perception of the mouth as part of their general health, feelings of dissatisfaction and insecurity in the face of the lack of information and access to specialties, associated with the experience of a mutilating curative model in oral health.

The oral health care offered to these elderly women presented aesthetic and functional aspects that influenced their social life, and they reported having sequelae in their self-esteem and in the relationship with their health and the oral health professional. It is emphasized that the construction of the professional-patient bond and relationship should be based on dialogue and the joint construction of solutions according to each social context, favoring the patient's autonomy in making choices about their health condition. Based on the perceptions of these elderly women, we expect to contribute to the development of promotion, prevention, and recovery health actions with an expanded approach, and in a multidisciplinary team, focusing on elderly women's comprehensive care and quality of life[1].

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Note

[1] M. de Matos and S. F. Mestriner: study conception and design, data analysis and interpretation; writing of the article, relevant critical review of the intellectual content, final approval of the version to be published, responsible for all aspects of the work ensuring the accuracy and integrity of any part of the work. L. P. de M. Lago and A. F. Bulgarelli: data analysis and interpretation; writing of the article, relevant critical review of the intellectual content, final approval of the version to be published, responsible for all aspects of the work ensuring the accuracy and integrity of any part of the work.

Resumo

Percepção de idosas com sintomas depressivos sobre acesso e cuidado em saúde bucal na Estratégia de Saúde da Família

A população brasileira está envelhecendo em um processo de feminização. Dentre as doenças crônicas mais prevalentes em idosos, a depressão impacta diretamente na percepção de saúde bucal. Este estudo descritivo, com abordagem qualitativa, teve como objetivo analisar a percepção de idosas com sintomas de transtornos depressivos de uma unidade de saúde da família, sobre o acesso e cuidado em saúde bucal e autopercepção de saúde bucal e sua relação com a qualidade de vida. Participaram do estudo 20 idosas com 60 anos ou mais, cadastradas em uma unidade de saúde da família. Foram realizadas entrevistas semidirigidas audiogravadas, posteriormente transcritas e analisadas pela técnica da Análise de Conteúdo. Os resultados expressaram uma importante relação entre a autopercepção de saúde bucal e a qualidade de vida, barreiras de acesso ao cuidado em saúde bucal, a importância do saber popular nas práticas de autocuidado, a autopercepção da boca como parte de sua saúde geral e sentimentos de insatisfação e insegurança diante da falta de informação, associados à vivência de um modelo curativista mutilador. Enfatiza-se a importância de abordagem ampliada e em equipe multiprofissional com foco no cuidado integral e qualidade de vida das idosas.

➤ **Palavras-chave:** Idoso. Saúde Mental. Qualidade. Acesso e Avaliação da Assistência à Saúde. Assistência Odontológica.