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Complete tooth loss as status passage.

Barry J Gibson¹, Phil V Sussex², Ruth P Fitzgerald³, W. Murray Thomson⁴.

1. Unit of Dental Public Health, School of Clinical Dentistry, University of Sheffield, United Kingdom.
2. Department of Oral Health, Nelson Hospital, Nelson, New Zealand.
3. Department of Anthropology, The University of Otago, Dunedin, New Zealand.
4. Sir John Walsh Research Institute, School of Dentistry, The University of Otago, Dunedin, New Zealand.

Abstract

The aim of this paper is to add to the literature on the sociology of oral health and dentistry by presenting the relevance of status passage to the study of complete tooth loss. The paper reports on an analysis of data taken from participants residing in the Nelson region of New Zealand. In total the data include interviews from 20 participants, all of whom had their remaining natural teeth removed prior to 1960. In total, 12 women and eight men were interviewed. All were from a European background with an age range of 71 to 101. Participants were interviewed, following a narrative approach, on the nature of the social factors that resulted in complete tooth loss by starting with their family history and then focusing on the factors and events leading up to their total tooth loss. Data were analysed through the methods and techniques of grounded theory. This paper provides an outline of the importance of scheduling, prescribing, social factors, 'compound awareness contexts' and reversibility to the status passage into complete tooth loss. We conclude by arguing that the theory of status passage may enable a detailed analysis of the time 'space extensionality' of trajectories into complete tooth loss.

Keywords: status passage, complete tooth loss, formal grounded theory, dentistry, reification

Word count 8458

Introduction

Sociological work on oral health and dentistry has tended to focus on producing a 'symptomatology' of the consequences of tooth loss for different groups of people (Berthelot 1991). So, for example, research in Canada has described how adults over the age of 70 evaluated the significance of their oral health in terms of comfort, hygiene and health (MacEntee et al. 1997). More recently, researchers have found that the loss of a single tooth can result in a significant personal trauma, a challenge to one's existence and a case of biographical disruption (Davis et al. 2000). Rousseau et al. (2013), publishing in this journal, found that, for some groups of people, the loss of a single tooth could involve a profound sense of loss, resulting in associated feelings of moral failure. They also found that certain groups of people (middle classes) actively resisted having dentures because they acted as a metaphor for old age. Tooth loss can therefore be traumatic because it can signal a change to an undesirable social status. Yet such associations are by no means universal. For some social groups (some working class people and Mexican American migrants), tooth loss has historically been relatively unproblematic, indeed common (Exley 2009, Gregory et al. 2005, Horton and Barker 2009, 2010, Rousseau et al. 2013). Indeed, at particular points in history, in some parts of the world, the transition to *complete tooth loss* (edentulism) has been considered part of a normal transition in life (Sussex, 2008).

The historic 'epidemic of edentulism' in New Zealand

Conceptually distinct from the more common incremental loss of teeth which tends to occur sporadically through adulthood (Broadbent et al. 2008), edentulism is the state of having lost all of one's natural teeth (Sussex 2008). The transition to edentulism involves an explicit decision to undergo complete removal of the dentition (or what remains of it) in a single operation, known as a "full clearance". That process usually involves the removal of at least some teeth which are still intact and functioning, meaning that the decision to opt for a full clearance is likely to be as much a social decision as it is a clinical one. Thus, the aetiology of edentulism involves both disease-related

and socio-cultural influences (Sanders et al. 2004), and this is reflected in well-documented international variations in the occurrence of this state: different countries have dealt with comparable rates of dental disease in different ways, and the observed variations in edentulism rates represent this. There is a strong influence of social (lay) and professional norms in the occurrence of edentulism. Historically, only Scotland and Australia have had anywhere near New Zealand's edentulism prevalence rates, and countries outside the British Commonwealth had, on average, considerably lower rates. The former experienced marked declines in edentulism during the latter half of the 20th Century, but New Zealand had the highest initial rates and appeared to be the slowest to begin to decline. Edentulism rates have fallen markedly in recent decades, but there has always been a strong association with socio-economic status (SES), whereby edentulism rates among low-SES adults have been found to be considerably higher than among those of higher SES. Indeed, social class differentials have continued to widen as the prevalence of the condition has decreased (Thomson, 2012).

A review of the literature on edentulism by Sussex (2008) remains the most comprehensive to date emphasising the importance of both socio-cultural and disease-related influences on its occurrence. In this literature, the key actors in the process appear to be the patient and the dentist; the literature on the subject clearly demonstrating that the former is influenced by lay culture and values (both societal and personal), whereas the latter is influenced more by his/her professional culture and values. An early analysis of US data found that patients' and dentists' values and beliefs were more important than clinical status in determining whether teeth were extracted (Bailit et al. 1987). That particular work concentrated on incremental (rather than total) tooth loss, but the principle also applies to edentulism. In relation to professional norms and values, the extraction-denture culture evident in New Zealand in the early-to-mid-20th century has been attributed partly to the relatively late maturing of dentistry as a profession in that country (Sussex, 2008). It has also been observed that the profession's less-developed sense of autonomy at that time made its members more susceptible to pressure from patients and their families to undertake full clearances

(Sussex et al. 2010). The aim of this paper is to report on the relevance of the grounded theory of status passage to a developing grounded theory study of the social psychological processes associated with complete tooth loss. Before introducing the study, we will briefly introduce the theory of status passage.

Status Passage

In 1971, Glaser and Strauss published "Status Passage" as an example of what they had called 'formal theory'. Although the theory was incomplete, it was developed to expand the scope and applicability of the theory associated with 'rites of passage' (van Gennep 1960). The theory of status passage reflects little of the original structure of 'rites of passage'; gone is the three-stage process of separation, transition and incorporation of the 'passagee' into their new status. Status passage was initially described in relation to whether or not the passage was scheduled, regular and prescriptive. Scheduling involved establishing when the passage would happen, by whom and by whose agency. Regularization referred to the degree of control various agents had over the passage, including who carried out the relevant actions during the passage. Finally, prescription involved providing details of the steps that must be gone through for the passage to take place, including the routine actions that formed part of the status passage (Glaser and Strauss 1971).

Status Passage in the sociology of health and illness

Status passage is now a widely cited textⁱ, the concept has been employed in a large range of studies in health and illness (Chenitz 1983, 1980; Chopko et al. 1986, Evans et al. 1975, Fenwick et al. 2009, Herrington et al. 1986, Howie 1993, Kellehear 1990, Lewis 1999, Newton 2012, Tolhurst and Kingston 2013, Vickers 2010, Wilson 1980). Kingston (2000) focused on falls as accidents leading to a particularly medicalised status passage. Falls, like many status passages, often begin without the 'passagee' being aware that a particular condition that they might have has been progressing. Falls are preventable but the problem is that physicians and the casualty of the fall often do not act to try and prevent the fall. Kingston (2000) argued that failure to act may result from the belief that the

casualty is facing an inevitable decline into old age and that nothing could be done about this.

Expectations concerning the passage into 'old age' therefore related to the temporality of the status passage but they could also act as a precondition for not being able to prevent the fall. Kingston (2000) links status passage to Charmaz' (1987) work on preferred identities arguing that whilst all status passages have temporality they invariably involve something that is important to the 'passagee', usually relating to some form of preferred future identity (Charmaz, 1987, Kingston, 2000).

Timmermans (1996) elaborated how resuscitation technologies used under the conditions of cardiac arrest or medical emergencies could result in a double identity movement. On the one hand this movement suspended multiple social identities (wife, husband, father or mother), whilst on the other, it established multiple medicalised identities as part of a 'resuscitation script'. This script led to the patient becoming established as a 'double ambiguous body-machine' a central point in a 'dense network' (Timmermans, 1996; p. 780). The patient's identity was also expressed in medical terms, being a 'green line on a display' or being in a 'V-fib' state. When the emergency was over the patient's multiple identities were restored and the patient placed back into the community (Timmermans, 1996).

The theory of status passage is also useful because it adds an important dimension to existing approaches for analysing the impact of chronic illness (Tolhurst and Kingston 2013). So, for example, analyses that adopt the concept of biographical disruption tend to focus on how illness disrupts everyday life, including focusing on how subjective responses to the structural conditions of chronic illness develop. We can see a similar pattern in analyses of tooth loss that have adopted this perspective. Relatively affluent people tended not to expect to lose their teeth and, as a consequence, were very upset when tooth loss occurred. By contrast, those from lower socioeconomic status groups experienced tooth loss as just another event in a long list of problems they had been dealing with (Rousseau et al. 2013). The dental literature on this subject is clear:

whether or not edentulism is deviant depends very much on prevailing social norms. In societies (or societal strata) where edentulous adults are commonly seen, losing all of one's teeth carries little or no social stigma; by contrast, in strata or societies where the retention of teeth is the norm, being edentulous is likely to lead to social marginalisation. So, for example, the prevalence of edentulism among 65-74-year-old Australians in 2004-06 was 20.3% (Slade et al. 2007), whereas in New Zealand, over one third of the same age group were edentulous. While edentulism is falling in both countries, it is falling more quickly in Australia, where all State capitals are now fluoridated and where there is greater State involvement in the provision of routine dental care for low-income adults than in New Zealand. It is also possible that changes in the social influences on tooth retention have been more rapid in Australia.

As we can see, a focus on biographical disruption, while producing an important analysis of the impact of tooth loss on groups of older people, can have the effect of limiting analysis to subjective experience in the face of structural conditions (Tolhurst and Kingston 2013). Tolhurst and Kingston went on to argue that, while biographical disruption is useful, status passage offers a set of concepts that can enable a greater analysis of the extension of illness experience over time and space. Apart from being able to explore the temporal nature of illness trajectories there are other arguments for drawing on status passage. Status passages might be subject to revision and adjustments accompanied by changes in how organizations and social groups encounter the problems associated with them (Glaser and Strauss 1971). These changes might lead to changes in the scheduling, regularization and prescriptive aspects of illness that would not otherwise be explored if we retained a focus on biographical disruption. In what follows, we seek to explore how status passage became relevant to an ongoing grounded theory study of tooth loss.

The study

The data on which this analysis was based were taken from semi-structured interviews with participants aged 75 years or older who were currently residing in the Nelson region of New Zealand

who had had all of their remaining natural teeth removed prior to 1960. Participants were recruited by placing advertisements on the notice boards of 11 retirement villages and Rest Homes, 4 Local Libraries and classified adverts in local newspapers. Not everyone who subsequently contacted the team met the inclusion criteria (aged 75 or over, living in the Nelson region, and had lost or had extracted all of their teeth prior to 1960 while living in New Zealand). Our goal was to conduct 'maximum variation sampling'. Maximum variation sampling seeks to capture the central themes that cut across the phenomena being investigated by sampling participants who are likely to have contrasting experiences (Patton 1990; 2002). We therefore chose participants to maximise the differences between participants in relation to age, the urban/rural mix, the age they had teeth removed and their gender. This approach is in keeping with the grounded theory strategy at the heart of this paper which is based on the constant comparative method (Glaser, 1978). Glaser argued that data analysis involves analysing incident to incident with the goal of establishing 'underlying uniformity' and the 'varying conditions' (Glaser 1978; p. 49). We felt that any underlying uniformities that emerged in such a broad sample would highlight important, shared experiences that would warrant further investigation.

Our strategy mirrors that of Wuest (1995, 1997, 1998) who developed her grounded theory of precarious ordering over a series of ongoing empirical studies. In this paper, we are reporting on the relevance of status passage to the study of tooth loss as part of this investigation. We have previously reported on the salient characteristics that appeared to be driving edentulism in New Zealand at the time. These were divided into influences that were society-wide (universal), recurrent influences affecting a large number of participants (major), or personal factors relevant to a small proportion of individuals (minor) (Sussex et al. 2010).

Participants were recruited and interviewed by Phil Sussex and the data were subsequently transcribed and analysed by Phil Sussex along with the rest of the research team. In total, 12 females and 8 males were interviewed. All were from a European background, with a wide age range of 71 to

101; 11 in total were from rural backgrounds. We chose to involve South Island participants because most of the research team are based there and so it was more convenient. We only had the resources to include 20 participants at this stage of the analysis more participants would be needed in order to develop the theory further. Details of the sample are provided in Table 1.

<Insert Table 1 about here>

Participants were interviewed through a narrative approach by focusing on their family history and social disadvantage, and the factors and events leading up to their dental clearance. Other factors that were explored included the role of those involved in the decision to have a dental clearance, gender, dental anxiety and oral health beliefs. This approach is similar in tone to that of Charmaz (1990), who elicited narrative data in her grounded theory work on chronic illness. Data analyses then focused on the 'remembered reasons' for having teeth extracted, in keeping with the value of biographical narratives for representing a sense of order in historical life events. In supplementing the analysis of the interviews, consideration was also given to 'data slices' taken from the published literature on professional and lay dental cultures in the early-to-mid-twentieth century (Gibson and Hartman, 2014). This enabled us to check the context and make interpretations which were informed by the professional and lay culture of the times. We are aware, however, that these data cover a very long time span and as such should be interpreted with caution. The resulting analysis should therefore not be considered definitive and the theory itself remains open for revision (Glaser 1978).

Data analysis

Data were analysed using the methods and techniques of grounded theory (Glaser and Strauss 1967, Glaser 1978, Gibson and Hartman 2014, Strauss and Corbin 1990). Our analysis initially involved axial coding before moving on to more substantive theoretical coding. The findings of the axial coding are published elsewhere (Sussex et al. 2010). Following this stage of analysis, it became apparent that the formal theory of status passage was relevant to explanations of tooth loss. We paid particular

attention to the position of the narrator in the accounts by looking at how they used “I”, “we” and “they” and looked to see if “we” was directed to general assumptions about what was normal at the time. Likewise we also looked for the position of the participant within these narratives of complete tooth loss in the same way that others have done in relation to grounded theory studies of chronic illness (Charmaz, 1990). So, for example, we looked to see how the events in their narratives about complete tooth loss were positioned in relation to other events in their biography and then to see what this told us about the general status of complete tooth loss. In addition, we explored in detail the role of other agents in this process and were mindful that as part of a biographical narrative that individuals would be positioning themselves within particular life events (Riessman, 1990, Charmaz, 1990). The remainder of this paper seeks to elaborate on this analysis.

Complete Tooth loss as a non-scheduled status passage

The central problem being discussed in this study was the events that resulted in participants having all of their teeth removed and replaced with a denture (Figure 1). In the narratives, the denture was presented as a *natural solution* to failing or unreliable teeth. We suggest that complete tooth loss can be interpreted as a ‘non-scheduled status passage’ that becomes increasingly ‘scheduled’, culminating in a series of appointments to have teeth extracted and a denture fitted. Tooth loss typically ended in two status outcomes, becoming edentulous on the one hand and becoming a denture wearer on the other.

<Insert Figure 1 about here>

The status passage into complete tooth loss often began with either a closed awareness context or a suspicion awareness context, usually as a result of suffering from the effects of incipient disease, discoloration in the teeth, pain and the mouth becoming increasingly unreliable. Subsequent to experiencing these effects, ‘passagees’ became aware of the deterioration of their teeth. The change from a closed or suspicion awareness context to an open awareness context was typically facilitated by interactions with dental professionals. For those who became edentulous at a young age, the

status passage usually happened with the collusion of family members. Whilst this might seem unsurprising, it is important to understand that the process was neither inevitable nor natural. As we shall see, some members of the same family would have their teeth saved whereas others would be selected to have their teeth removed. How this happened provides us with interesting insights into the kinds of awareness that surround tooth loss, including the social material factors that shape a patient's trajectory into complete tooth loss. In what follows, we go through the central features of the status passage into complete tooth loss whilst focusing on the social and material factors that shape it. After this, we will discuss the problem of awareness contexts in relation to complete tooth loss before going on to make more general reflections on the reversibility of the status passage. Finally, we will outline how complete tooth loss as a status passage combined with other status passages.

The Unreliable Mouth

A key precondition to the trajectory into complete tooth loss was the emerging unreliability of the mouth and teeth. Teeth and gums became increasingly problematic and discoloured, and operated as a site of pain. Under these conditions, the work of the dentist, embodied in extractions and the making of a denture, appeared as the 'natural' solution to these problems. An important dimension running through these narratives of complete tooth loss was therefore the degree to which 'naturalisation' and 'denaturalisation' processes affected the changing status of the patient's teeth and the dentist's work. Accompanying these processes were additional processes associated with the relationships between the person going through the status passage and others such as the dentist and the patient's immediate family.

Scheduling, prescribing and the social factors involved in complete tooth loss

Scheduling and prescribing in status passage refer to the agents that impact on the passage either by initiating or shaping the pace of it. The narratives provided by Betty and Helen reveal the agents who had control over their status passages. Betty (aged 80) was 18 when all of her upper teeth were

cleared and 25 when the remaining lower teeth were removed. The decision was scheduled for her by her dentist with the direct support of her family. She was expecting to lose teeth because she was pregnant. Part of the decision to opt for the complete removal of her teeth was based on a concern that “the gums at that stage (had) a bit of inflammation” (Interview Betty, Age 80, p. 5) and concern that she might get an infection. The prescription of the dentist was paramount in her initiation into the status passage to complete tooth loss:

“I think we abided by what we were told those days and didn’t question it. There was no talk then of such a thing as having one capped or anything and I don’t remember any real discussion, there could have been with my mother I suppose but I don’t recall questioning, he advised me to have them out...” (Interview Betty, Age 80, p. 5).

Betty’s family history also played an important part in this process. A relative had died during pregnancy as a result of having an abscess and it was decided not to take any risks. Family history could also play a role in other ways. Olivia had her teeth removed in 1935 at the age of 15 on the prescription of her mother.

“I was very meek when I was young. My sister who kept her own teeth was very um, definite about what she wanted and she would argue with mother, an awful lot... She went to um, she went to college in Wellington, because she wanted to so she did. When it came to my turn “ No, college ruined Kate’s you are not going too”, but I really think there was more behind it than that because she found I was useful and um, then when it came to going to the Dentist, she rang the Dentist and said extract all the teeth that need attention, I've just spent 28 pounds on Kate’s and I'm not going to spend it on yours.” (Interview Olivia, page 2)

Olivia went on to talk about the time when her sister came to visit the family

“to make things worse my sister had got off the train when she came home and she said keep your lips together when you smile dear.... Ha ha and that affected my smile for a long time, cause I thought about that...keep your lips together when you smile dear.” (Interview Olivia, page 4)

This case illustrates a very important point. In 1935, complete tooth loss was not inevitable; the process could be reversed or avoided altogether. Here, two sisters from the same family had very different experiences. One retained her teeth the other had hers removed. Olivia’s parents remained the principal agents and they could have enabled the reversibility of the status passage if they had been willing to pay for the treatment. Olivia clearly felt however that this was not the case and was suspicious that her mother had other reasons for not saving her teeth. This brings us to our next point. An important aspect of the status passage was the role dental professionals played in the process. Dentists in New Zealand at the time were willing agents in scheduling complete tooth loss this willingness combined with dominant ‘ideologies’ of disease (Sussex et al. 2010) to make tooth loss appear inevitable.

“Well.. the teeth were in a shocking state. There was holes everywhere. So one of the first things I did when I got down to Wellington ...he examined my teeth and he said, oh he said You’ve got a whole lot, the whole lot’ll have to come out. I said, Why? He said you’ve got pyorrhea. I’d never heard of pyorrhea.” (Interview Michael, 96, page 5)

‘Pyorrhea’ is a condition of the teeth where the level of infection gets so bad that pus oozes out from underneath the gum margin. ‘Pyorrhea’ was tied to understandings of gum disease at the time. Such gum disease was perceived as inevitable to the point that any bleeding (very common) was viewed as the first stage of an inexorable decline into the loss of the supporting tissues of the teeth. These professional factors combined in complex ways with universal factors (the lay culture of edentulism, widespread patterns of disease and patterns of dental care utilisation) and major

personal influences such as poverty and family history (Figure 1). In the example above, Michael had been living in conditions of severe economic and material deprivation. This led to the destruction of his dentition so that the dentist had to remove his teeth. There is a sense of mystery in his account revealing the fact that the status of our teeth and their trajectory towards destruction can be 'masked' (Glaser and Strauss, 1964). This brings us to the problem of awareness contexts and the trajectory into complete tooth loss.

Awareness contexts and the status passage into complete tooth loss

The theory of status passage focuses on the degree to which 'passagees' are the authors of their trajectory; they can be aware of their status passage and play a part in it or they might go through the status passage without being aware of what is happening to them. Glaser and Strauss (1971) argued that status passages can happen under the conditions of a 'closed awareness' context with writers like Richard Ekins (1997) later adding the social structural context of 'masked awareness'. The accounts of complete tooth loss in this study suggest that there are numerous factors that could 'mask' the reasons for complete tooth loss. In some instances the accounts revealed a degree of 'confusion' about why things happened the way they did. This suggests to us that there may be a class of awareness context that combines one or more awareness contexts as dimensions within the same social-psychological space. We will call such 'types' of context 'compound awareness contexts'. In this study, one form of compound awareness context was characterised by a degree of 'confusion'. Participants knew they were going to lose their teeth and so were openly aware that they would. At the same time, however, they often did not understand why. Important reasons for their tooth loss were hidden from viewⁱⁱ. This contrasts with another form of compound awareness context, 'suspicion awareness', whereby key aspects of the underlying reasons for tooth loss were suspected but never confirmed (see the case of Olivia). This suggests that, in some situations, the awareness context may not be completely masked but, in others, the masking process may be

successful. This brings us to the underlying processes that served to 'mask' aspects of the status passage into complete tooth loss.

Time and again in these data, the status passage into complete tooth loss was 'masked', appearing as a 'thing in itself'; as a 'natural' event (Lukacs, 1971, Taussig, 1980). We would like to suggest, following Taussig that the signs and symptoms of oral disease "*are not 'things-in-themselves', are not only biological and physical, but are also signs of social relations disguised as natural things*" (Taussig, 1980; p. 3). The data indicate that this process was supported by both external and internal factors associated with the consultation with the dentist. External factors include particular professional ideologies; taking the example of Betty above, we can see that underpinning her account was the predominant professional belief that an infection in her tooth could lead to an infection elsewhere in her body. This is of course the theory of focal infection, which had some influence at the time in New Zealand (Sussex, 2008). What is clear from these data is that universal factors (lay culture, theories of disease and widespread disease patterns), and proximal factors (poverty, family history and organisation etc.) could all combine to make the transition into complete tooth loss seem inevitable. We also suggest that, within the relationship between health care professional and patient, there were denaturalisation and naturalisation processes associated with reification that also served to mask awareness. All of these factors combined to make the status passage seem inevitable. Yet the status passage, as we have already seen, was not as inevitable as it might seem.

Reversibility and the status passage into complete tooth loss

Most of the data presented thus far indicate that transitions into complete tooth loss were inevitable. By contrast, status passages into complete tooth loss were reversible. They were reversible because they could be avoided and they were reversible because the lost teeth could be replaced by a denture. Having a denture and therefore reversing the loss of teeth was seen as a

normal process in these data. Liam had all his teeth extracted in 1951 by a dental surgeon called Mr Peters.

“My mother always saw that we cleaned our teeth and because of the economic situation we had very little lollies and virtually no soft drinks so I guess our situation was average for children of that era. ...I was married in May 1951 and decided to have all my teeth extracted prior to our wedding so that I would have dentures fitted in plenty of time before the big day. Now I can remember telling Mr Peters of my decision and he tried very very hard to talk me out of it and I can still remember it. I was sitting in the chair and told him I want them out and he said ‘well now you go away and think about it’. And he had an upstairs surgery and I got down the bottom of the stairs and I said to myself, this is no good so I just went straight up again and said to him, I’ve made up my mind so that he could see that I was pretty determined and I stuck to my decision.... I don’t really regret my decision.” (Interview Liam, 79, p. 2)

Although Liam eventually had a total of 30 teeth removed, his account of the decision to have them removed is presented as being in the face of professional resistance. Liam was clearly the principal author of his status passage which happened in a very different historical period to the others in this study. In Liam’s account, as with many other accounts, getting a denture appeared to act as a positive achievement. Unreliable, discoloured teeth were replaced with a more reliable and better looking denture. The denture itself acted as a mask and at the same time provided some degree of reversibility for the condition of complete tooth loss. The status passage into complete tooth loss often combined with other status passages, leading to multiplicity in status passage.

Complete tooth loss and multiplicity in status passage

As we have seen, Liam entered into complete tooth loss in advance of getting married. Marriage as another status passage could therefore support the decision to initiate complete tooth loss. Liam

was not alone however Queenie had her teeth removed in preparation for her marriage. Her main reason for this was not dental disease but the way her teeth looked she indicated six times that she had her teeth extracted because they were 'bucked'. She opened her interview by stating:

"I was born in Invercargill in 1930. I went to primary school and technical college. When I got my second lot of teeth, one of my front teeth were bucked and I had teeth crowding so I had some of my teeth taken out to allow for expansion, but the tooth still stayed out as bucked and when I was in my late teens I wasn't very happy with it and so when I was 22 I decided to have all my teeth removed and got false teeth." (Interview Queenie, 75, Page 1)

Queenie kept coming back to her 'bucked' teeth throughout the interview making it clear that it was how her tooth stuck out that gradually became more and more of a problem for her. She indicated that her teeth were not in bad condition but that it was this 'bucked' tooth that was upsetting her so much. She went on to state that:

"I wasn't happy with it and I suppose it was cosmetic, more than anything and we were getting married when I finished my nursing training. So I decided to get them out before we got married and I went to the dentist and said to him about it and he didn't hesitate and said yes right make an appointment and took them all out.

All of them?

All of them, so there was no say, or you know, try or anything. There was no Orthodontic treatment those days." (Interview Queenie, 75, Page 1-2)

Her teeth were 'bucked' and it was because of this she was embarrassed. She had her teeth removed one month before her wedding to her husband. She stated that:

"Ivan he already had his false teeth. So we both had false teeth when we got married." (Interview Queenie, 75, Page 7)

In this example the passage into complete tooth loss was supported by the status passage into married life. Although Queenie was clearly upset by her 'bucked teeth' they had to be sorted out by the time of her wedding. This was because she was embarrassed and the wedding was a good

reason to sort out her embarrassment. We also feel, however, that there is a kind of symmetry in her narrative. Behind the last statement she indicates that having her teeth out *made her like her husband who also had dentures* therefore indicating a desire for intimacyⁱⁱⁱ. Liam's mother was European and was responsible for his relatively good oral health. We later hear that his mother and father had got divorced but that he had remained with his mother and his father moved away. His decision to have his teeth removed gives the sense that in doing so he was more like his father who had entered into the status passage some years earlier. Olivia's passage into complete tooth loss marked her out as the sibling who would stay at home in contrast to her sister who had caused a lot of trouble and had left home. Olivia eventually grew to resent this and ran away to her Uncle's house in the South Island of New Zealand, never returning to live with her mother. Each of these examples indicates how *these narratives of complete tooth loss* build connections between multiple status passages that the 'passagees' were undertaking at the same time. This suggests that the status passage into complete tooth loss gains some of its meaning from its placement alongside other life events.

Glaser and Strauss (1971) discussed the multiple aspects of different status passages, arguing that as 'passagees' encountered various social institutions, this led them to deal with multiple different trajectories at once. They did not, however, discuss the social conditions that resulted in this complexity, the extent to which this might be a central feature of modern life or that some status passages could derive their meaning from their combination with other status passages.

We argue that the association of multiple status passages can be 'encoded' (Douglas 1975). In the same way that different meals in the day and different parts of different meals derive their meaning from their position in a series, complete tooth loss as a status passage can derive its meaning from its position in a series of other status passages. Following Douglas (1975), we investigated the rank order of status passages. In many of our narratives we found that the passage into complete tooth loss occurred *before* other status passages. Olivia's mother initiated Olivia's status passage, the idea

behind this was that Olivia would become the stay-at-home child and contribute to the household economy, the removal of her teeth being presented as a precondition for this happening.

In other narratives, the status passage into complete tooth loss came after a long account about how someone's material circumstances had changed, how they had suffered from extreme poverty and how these conditions led to the experience of pain and eventually complete tooth loss. In the passage to complete tooth loss, the mouth and teeth came to occupy a lower rank than other categories such as survival, pain and poverty. Contrast this with the status of the denture and we begin to see that unreliable teeth were juxtaposed against a more valued technological solution. Finally, we can contrast this with the position that the status passage into complete tooth loss occupies within current discourses of prevention and we begin to see that, for some groups, complete tooth loss is now a passage to be avoided at all costs. Accompanying this change is a change in the rank order of teeth and dentures. Teeth have become highly valued whereas dentures are now denigrated.

Discussion

The aim of this paper is to contribute to the developing literature on the sociology of oral health and health care by reporting on the relevance of status passage to complete tooth loss. The theory of status passage offers an explanation of the dynamics underlying accounts of complete tooth loss from New Zealand referring to the early to mid-period of the last century. The theory strikes us as a rich vein of thought that may well help to promote a greater sensitivity to the 'time space extensionality' of complete tooth loss (Tolhurst and Kingston 2013). It also reveals how the mouth can be a site of social conflict (Horton and Barker 2010, 2009, Nations et al. 2002). The relevance of status passage demonstrates the central importance of prescription, control and scheduling in complete tooth loss; the role of dental professionals and family members being particularly important. Likewise, the ability of individuals to resist the status passage into complete tooth loss was also important. Paying particular attention to who had control of the passage says a lot about

the social position of someone entering it and more significantly about their relationship to the institution of dentistry. This approach lends further support to the claim that the mouth can be conceptualised as a site where structural conditions are 'played out' (Nations et al. 2002). The judgements dental professionals made about patients, especially in relation to where they were on their trajectory into complete tooth loss seemed crucial. The similarities between these judgements and those made by doctors in relation to the inevitability of falls in older age are striking (Kingston 2000).

The theory presented here also demonstrates the relevance of a 'confused awareness context' to the status passage into complete tooth loss. While patients will always be aware that they are going to lose all of their remaining teeth, they may not know 'why' this is happening. So, while complete tooth loss was something that happened to them, it was also something that was loaded with multiple meanings derived from their existence as daughters, partners-to-be or as someone experiencing extreme poverty. We argue, however, that this is also a particular feature of the kind of data we are using to explore complete tooth loss. An important feature of narrative data is the search for meaning, for reasons why something happened (Frank 1997). In our data, we encounter the experience of complete tooth loss re-embedded within personal history, presented as something that 'just happened'; as a social phenomenon. This indicates the relevance of reification to these encounters.

A central component of the descriptions of the encounters when teeth were removed is the presentation of our participants' teeth as objects out there in the world; this hints at the distinction between fact and value and 'immediate from ultimate causes' (Taussig, 1980; p. 4). As Taussig has argued, our specifically modern problem is that our bodies are experienced as things, and at the same time they beg questions concerning the social significance of disease and our subsequent experience of treatment. Many of these narratives beg such questions. Participants' teeth oscillate from being a thing to being part of personal history. Taussig (1980) followed Sontag (1978) when he

argued that, while the symptoms and signs of disease have a material quality, they are also social as well as physical and biological facts. He also argued that the purely instrumental relationship between doctors and patients led to a masking process that in turn contributed to the alienation of the patient.

Exploring complete tooth loss as status passage also highlights how different status passages interact and support each other. These interactions can lead to teeth and dentures taking on different value. Moving to college away from home meant teeth had greater value than dentures whereas staying at home meant teeth were less important, less reliable and the denture more valuable because it prevented further cost. In this respect, as patients encountered different aspects of social structure over the life course, the status of their teeth changed.

These narratives also demonstrate that status passage is more than simply a change in the status of someone from one point to another. Accompanying these changes are changes in the status of the body, embedded as it is within social and structural processes. The theory actively supports accounts of tooth loss that see this phenomenon as something that is 'narrated' in the face of structural conditions (Rousseau et al. 2013). Tooth loss can appear as natural as gender, poverty and family relationships and, as such, warrants further detailed investigation.

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ⁱ Over 700 citations to the original text can be found on Google Scholar.

ⁱⁱ It is important to realise that the concept of compound awareness contexts are partially a product of the type of data involved in this study. Rather than directly corresponding to the actual behaviours that happened at the time that produced edentulism, these data represent the 'given reasons' for agreeing to tooth extraction and are therefore part of a process of 'making sense' of previous events. So the awareness contexts that we are describing could be as much to do with the process of reflection as it might be to do with actual events. We would however still contend that the category of a compound awareness context remains 'logically' justifiable. The very idea of prescriber and prescriptive processes entails contexts were various dimensions of awareness could be combined. We would therefore argue that both confused and suspicion awareness contexts are types of compound awareness contexts and that the overall class is worthy of further investigation.

ⁱⁱⁱ Our use of the term 'intimacy' here refers to the same sense of Niklas Luhmann in 'Love as Passion'. Here intimacy refers to the sharing of the world view of the other, becoming both the same and cherishing differences at the same time. Time and again in our data teeth were removed at the same time as weddings. Not just to look better on the big day as is the case for Queenie but also to be with the other person and be like them.