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‘I didn’t want to pass that onto my child, being afraid to go to the dentist’:
Making sense of oral health through narratives of connectedness over the life
course

Abstract

While previous sociological research on oral health has identified the relevance of personal relationships, there is more scope to analyse the mouth through a lens of connectedness. Recent qualitative interviews with 43 older people (65+) in England and Scotland found that participants constructed relational narratives to make sense of their oral health practices. By drawing on ideas of family practices, family display and personal life, we illustrate how the mouth can be understood relationally. Participants presented their own embodied experiences as connected to the actions of their parents. Narratives also reflected how, as parents and grandparents themselves, participants tried to shape the experiences of others. In this way, oral health practices were conceptualised as being about family. This can be seen in self-narratives that demonstrated how participants located themselves as embedded in webs of ongoing relationships. We highlight the importance of narrated practices of thinking and feeling, whereby participants imagined doing oral health, and indeed family, in different ways. We thereby demonstrate how oral health practices are constituted through family connectedness and at the same time how these practices contribute to the constitution of family. Policy should therefore pay attention to family relations when promoting improvements in oral health practices. (200 words)

Keywords: Ageing, oral health, embodiment, family, narrative method, connectedness

Words: 7,999

Introduction

In this paper we explore how stories relating to oral health practices emphasise connectedness. We do this by examining how older people made sense of their oral health by identifying links between their own practices and the actions of family members. Looking at how stories are generated '*from and with*' people's bodies (Phoenix, 2011: 112) necessitates paying attention to the lived experiences of relationality that are part of these stories. By analysing participants' narratives, we are able to show how the mouth is conceptualised as connected and relational over the life course. We argue this has implications for how family is conceptualised in oral health policy.

This is important because longitudinal cohort studies have highlighted that the oral health beliefs and practices of parents are central to the oral health practices of children (Broadbent *et al.*, 2006; 2016). Oral health may therefore be read as the result of actions by different generations. Indeed, parents are frequently identified as the most important actor in preventing dental decay (Vermaire *et al.*, 2012). Despite its obvious significance, there has been very little focus on the centrality of intergenerational connectedness in the sociology of oral health and dentistry. To date the focus has been theorising the mouth and oral health in terms of disciplinary power, social systems and biographical disruption (Exley, 2009; Kleinberger and Strickhouser, 2014; Nettleton, 1992; Gregory *et al.*, 2005; Rousseau *et al.*, 2014). There is therefore room to explore experiences of oral health through this lens.

This article employs a sociology of personal life, which situates meaningful aspects of people's lives in a relational context (Smart, 2007) in order to interrogate how oral health practices are constituted. This can be used in conjunction with the idea of family practices (Morgan, 2011) to illuminate how embodied practices foster an idea of family and how this is displayed to others (Finch, 2007; James and Curtis, 2010). Building on this, we follow Smart who argues for a greater focus on thinking, feeling and imagining, the interior processes that are *entwined* with the practices that constitute family (and the non-familial relationships that are part of our personal lives)¹. Smart's 'connectedness thesis'

¹ The central concern of this article is family relationships, particularly the vertical connections between children, parents and grandparents, but we recognise that looking at personal life does not inherently prioritise biological kin or marital bonds (Smart, 2007) and that other relationships, particularly those with friends, are

(2007: 189) has been used to explore family experiences of living with life-threatening illness (Ellis, 2013), narratives of household work practices (Kettle, 2016) and family use of commercial ultrasound (Roberts *et al.*, 2017). These authors have shown how the concepts of memory, biography, embeddedness, relationism and the imaginary (Smart, 2007) can be used to theorise how family is created through social action. This research enables us to ask in what ways do the teeth of older adults continue to embody early family practices? How is family displayed in older people's narrations of their oral health experiences? Before we can answer these questions, we need to consider exactly what we mean by relationality, family practices and displaying family.

Theoretical background

When looking at individual's *accounts* of embodied experiences over the life course, we can draw on an understanding of the narrated self as relational, connected and embedded (Mason, 2004). Smart stresses the active nature of relationality as a constant process, as people exist within 'intentional, thoughtful networks which they actively sustain, maintain or allow to atrophy' (2007: 48). What happens within individual families, and the responsibilities between people, develop over time through a process of negotiation (Finch and Mason, 1993). Developing a relational sociology of oral health would therefore involve further work drawing on personal narratives of lived experiences (Rousseau *et al.*, 2014; Gregory *et al.* 2005).

Involvement in maintaining the oral health of others would be an example of a family practice (Morgan, 2011). Practices are a way in which a sense of family is achieved. This approach emphasises active, everyday, regular and fluid aspects of family, and how particular practices are understood as being about family 'at least for the time that these practices are being followed' (Morgan, 2011: 10). Meaning is constituted and reconstituted through practices, and family itself is an ongoing process (family is what we *do*, and not simply what we *are*). Such practices are assemblages of thinking and feeling, as well as doing (Smart, 2007). A lens of connectedness, applied to practices within the realm of the personal, is orientated to different aspects of social life than a gaze focused on individualised

also important.

actors (Mason, 2004).

Practices are patterned, interdependent forms of action organised around shared, practical understanding (Bourdieu, 1977; Schatzki, 2008; Schatzki *et al.*, 2001). For example, research on the practice of eating emphasises its repetitive and collective nature (Warde, 2016). While practices may become ‘automatic’ over time, reflecting on these everyday actions brings into focus how they are sustained. With family practices, the shared meanings of family are conveyed to others, both those who are involved in particular practices, and to relevant audiences who are not (Finch, 2007). This notion of display emphasises that various activities can be understood as being about family, framed in terms of parental responsibility or care, and helps us understand how family relationships are shown to work over time (Dermott and Seymour, 2011).

Attending to the relationality of the narrated subject (Somers, 1994), avoids assumptions about what lies “‘beneath” or “‘behind” or outside narrative’ (Doucet and Mauthner, 2008: 404). As Mason (2004) shows, narratives of residential histories are characterised by contextuality, contingency and relationality. Multi-layered narratives show how the self, who has lived in different places, is constituted relationally. James and Curtis (2010) situate practices of display in a wider cultural context which shapes what it means to do family *properly*. They argue that the telling of family stories works as a *cultural* level of meaning; stories told in relation to ‘other’ families reflect and reconstitute discourses of what family should be.

Families and relational narratives in oral health and dentistry

Parents’ actions are significant for children’s oral health. Parents may express different ideas and engage (or not engage) in various practices to prevent oral disease in their children (Collins *et al.*, 2016; Daly *et al.*, 2010; Duijster *et al.*, 2014; Lenčová *et al.*, 2008). Families are also a key site for enduring food practices which may not comply with the dietary advice provided by dentists (Backett-Milburn *et al.*, 2010; Curtis *et al.*, 2009; Petrunoff *et al.*, 2014). This is particularly relevant to mothers who are constituted through dental discourses of maternal responsibility (Nettleton, 1991), although it is not clear how this is experienced in relation to a more coherent understanding of self

across the life course.

Dimensions of connectedness are drawn on in accounts of anticipating future experiences when deciding to seek emergency dental care (Anderson and Thomas, 2003) and biographical explanations for a fear of dentists (Slack-Smith *et al.*, 2009). Furthermore, the idea of relational narratives (Mason, 2004) is useful for considering how decisions are framed with reference to others; people may explain their decisions to pay, or not to pay, for dental implant treatment whilst alluding to ‘family money’ (Exley *et al.*, 2012).

In the case of experiences in older age, previous research on the relevance of biography has been limited (MacEntee *et al.*, 1997), although the connection of personal and family stories is acknowledged (McKenzie-Green *et al.*, 2009). Family members have played a key role in the decision to remove teeth (Davis *et al.*, 2000; Gibson *et al.*, 2017). Gibson *et al.* (2017) theorise complete tooth loss in New Zealand as a status passage, with family members as agents who can initiate the status passage, or shape how it takes place. Other research suggests that some older people accounted for the decision to have all their teeth removed with reference to family members (Donnelly *et al.*, 2015)).

Individual oral health experiences are thus shaped by the actions of other people in the past, or the potential impact of actions on others in the future. Our work demonstrates that the mouth is relationally constituted through ‘mouth talk’ (XXXX, Forthcoming) embedded and practiced within family relationships. There has been limited focus on what oral health can tell us about family relationships, and the extent to which oral health practices can be understood as being *about* family. Furthermore, by mapping the practices of thinking and feeling about oral health, and the dimensions of connectedness involved, it is possible to develop a more in-depth understanding of *how* the mouth is constituted relationally. Therefore, we would argue, the sociology of oral health would benefit from further engagement with theories of relationality, family practices and family display.

Methods

The research was based in two UK cities: Edinburgh (Scotland) and Sheffield (in the north of England). Both cities are considered to provide a representative cross-section of the UK population;

Sheffield was also chosen for reasons of convenience and Edinburgh was chosen because of the historically high levels of edentulousness in Scotland. Participants aged 65 and over were recruited through social clubs and lunch groups, residential homes, local newsletters targeted at older people and the University of the Third Age (U3A) movement. The research aimed to recruit a broad range of older people and recruitment took place in demographically-varied areas, where the researcher spent time discussing oral health and dentistry with many older people who chose not to take part in the research. Recruitment was most successful among older people involved in the U3A movement.

The convenience sample (n=43) comprised 15 men and 28 women aged between 65 and 91, all of whom were White British and retired. Thirty-three participants were recruited from Sheffield and 10 were recruited from Edinburgh. Together, participants reflected different levels of education and a range of occupations. Occupations prior to retirement were classified according to the Office for National Statistics Standard Occupational Classification (ONS, 2010). There were relatively high numbers of individuals with further or higher education who had been employed in a professional or managerial role, and thus we defined the sample as predominantly middle-class. However, several participants who had been employed in professional roles highlighted a disadvantaged background, which became part of their personal narrative of accessing the social world of dentistry (XXXX, 2018). In-depth, audio-recorded interviews were undertaken with all participants; 34 in the participant's home, and the rest in cafes or university buildings. Interviews lasted on average 50 minutes, were transcribed verbatim by an external company, and then checked and anonymised by the interviewer and sent to participants for comment. All interviews were conducted by the same member of the project team. The project received ethical approval from the lead institution. Before the interview, each person was given an information sheet and had the opportunity to ask questions. The interviewer obtained written consent from all participants, and emphasised that their involvement was voluntary and they could withdraw at any time. All names in this article are pseudonyms.

The project was advertised as aiming to learn more about what older people think about their oral health by talking about experiences to do with the mouth and teeth over time. Participants were encouraged to start with their early encounters and move through the life-course, prompted by a topic

guide. Stories were generated in response to questions such as ‘could you tell me more about [x]’, where [x] was an incident such as a restoration or a particular encounter with a dentist. Topics covered in the interviews included looking after teeth, going to the dentist and everyday experiences involving the mouth, as well as how participants had felt about their teeth over the life course. Exploring the significance of the mouth in older age through a narrative approach allowed participants to tell stories that added background to, and detailed the specificities of each account. Recollections of dental treatment across the life course may be subject to recall bias. However, what is important for this study is the way that particular incidents are interpreted from the position of the present.

Analysis of the data took place alongside fieldwork. A ‘realist tale’ approach was taken to the analysis of interview data, attending to the content of stories and how they were told in the interview context (Phoenix *et al.*, 2010). Transcripts were read several times by one member of the research team and analytical notes were written to identify emerging themes and reflect on how narratives were used (Riessman, 2008). Analysis was therefore able to focus on the capacities of stories, and the work they did in the setting of the interview (Frank, 2010). Transcripts were then coded thematically using computer assisted qualitative data analysis software (NVivo 10), in order to compare how participants spoke about experiences relating to their mouths and teeth across the sample. These themes were discussed and refined by the research team in regular meetings over the course of the project. In this paper, we focus in detail on a number of narratives in order to illustrate how oral health practices can be understood through the lens of connectedness. These narratives reflect the significance of family relationships to the constitution of oral health and dentistry. This writing choice allows us to start a discussion about the relevance of relationality to the sociology of oral health.

The role of parents in participants’ narratives

According to participants, parents played an important role in dental encounters, influencing whether they went for regular dental check-ups or underwent recommended treatments.

My mother nevertheless was very good at always taking us to the dentist so we went regularly in spite of our fears and trepidation. (Gladys, 79, retired nurse)

We used to have the dentist come to school every so often and check your teeth. And then, if you had to have anything done, you'd have to go to the clinic and have it done. And very rarely did my mother take us, because I think my mother still had that terrible experience with her. (Sandra, 67, retired secretary)

For Sandra, this meant that she did not always receive the required treatment. She spoke about how her mother's fear of dentistry was 'passed on', in the same way as other personal characteristics (Nordqvist, 2014). Sandra's own biography included this family story of her mother's 'terrible' dental encounter (see below). She suggests her oral health practices as a teenager were shaped by this:

I was so frightened that rather than have a filling I said "Take it out". And I kept saying, each time when he said, "I'll fill it in," "No, no, take it out".

This changed as she got older, when she no longer felt afraid of going to the dentist, and Sandra narrated a story of 'growing up' that involved a different way of thinking:

I just got over it and talked myself round, and looked at it in a more logical manner, really, which you do when you get older. Because as a child, you don't reason. And then, when you get older, you start to reason it through. And also, I realised I didn't want to pass that on to my child, being afraid to go to the dentist.

Personal thoughts and feelings about dentistry could be interpreted as practices that were also about family, for instance changing one's thinking in order to be a better parent.

Other stories included parents acting to achieve better oral health for their children. William (69), a retired business manager, recalled his protruding front teeth as a child. He went to a 'special unit', which required his mother collecting him from school, and got an orthodontic appliance. Reflecting on this, he mentioned his parents being 'thankful' he went, and when asked, he remembered them referring to this treatment specifically in later life:

"It's a good job- do you remember we took you down to that place? They did a good job down there. They did a good job down there. It was so good that that was available."

In William's account, family is displayed to those involved in the practice, communicating meaning and framing practices in a particular way. Such narratives suggested that parents were invested in their children's longer term oral health, and importantly, that they had the financial resources to make this happen.

The way in which parents were seen to invest or not invest in children's oral health can be illustrated by comparing the narratives of two working-class participants, Beryl (82), a retired home help, and Ted (71), a retired postman. Both referred to the expense of toothpaste when they were children, and indicated a normative understanding of it being something that many people did not use. However, Beryl constructed a narrative that positioned her family as different from a generalised '*they*' who '*didn't bother much about the teeth*'. She talked about how her mother encouraged her to brush her teeth and bought her tooth powder, at a time when '*not a lot of people*' took care of their teeth. Beryl also recalled a friend whose mother would not buy her tooth powder, and who cleaned her teeth with green Fairy soap. Within her narrative, she used this example to illustrate how she felt fortunate compared to her contemporaries. Throughout her interview, Beryl returned to her mother's role and commented '*I owe it to my mum, actually, having good teeth*'.

In contrast, Ted repeated that his mother '*could have done a bit more*' when he was younger. Nevertheless, he emphasised the difficult situation she was in with seven children and an alcoholic husband, and recognised '*she couldn't be behind me every time to tell me to brush your teeth and wash your mouth out and all this and that*'. While Beryl remembered her mother checking if she had cleaned her teeth, Ted exhibited the potential for ambivalence. He interpreted a lack of action by his mother as having played a part in shaping his oral health. Nevertheless, he also recalled that she tried to offer a solution (cleaning his teeth with salt) and suggested '*did what she could*' for him. Beryl's narrative constituted a family that '*worked*' (Finch, 2007) through the oppositional display of other people (James and Curtis, 2010), and specifically her friend. In contrast, Ted reflected on his oral health from the position of the present, acknowledging the wider context in which his mother '*did what she could*'.

Personal narratives invoked decisions made by others, which impacted on the mouth and teeth. Decayed, filled and missing teeth, or dentures, can be read as the result of poor oral care. Older people's embodied narratives described not attending the dentist or poor brushing habits with reference to their parents, and specifically their mothers. In these cases participants implicitly drew on an idea of maternal responsibility for family health, which has also been identified in relation to healthy eating (Curtis *et al.*, 2009; Gregory, 2005; Parsons, 2016). Nettleton (1991) has highlighted the different ways in which mothers are conceptualised in dental discourse. Her interviews with mothers highlight a felt sense of responsibility for children's oral health, and this still appears to be the case (Marshman *et al.*, 2016). Sylvia (68, retired midwife) recalls her mother '*never ever taught us to clean our teeth*' and she only cleaned her teeth before they went to the dentist. The turning point in her story was a school assembly when the headmaster referred to cleaning teeth twice a day. Sylvia explained that although she then started to look after her teeth, '*that was that*'; she presented the state of her teeth (which were extensively filled) as having been shaped by the decisions of her mother.

In these interviews, the mouth is understood as relationally constituted. Oral health in older age is shaped by the action and inaction of others, as well as through an individual's own oral health practices. Following Smart (2007), accounts of how a person thinks and feels about their mouth can also be relational; for some of the participants quoted above this included feeling happy (William) or ashamed (Sylvia). Eileen (70), a retired counsellor, summed up how she felt about her teeth in relation to her biography:

I have had lots of work done on my teeth and it's been gruesome at times. But I have no regrets at all and I'm really pleased. And I think it's probably because of my background and I'd seen my parents with their [false] teeth and also for me how important my teeth are.

In Eileen's account, her approach to looking after her teeth and undergoing dental work is contingent on a number of factors (Mason, 2004). She saw her mouth at seventy as partly shaped by the practices of her parents, and requiring '*gruesome*' work. From a narrative perspective, there was the potential to tell a tragic story about a lack of parental care resulting in extensive restorative work that left her

feeling unhappy. However, she was able to draw a more positive conclusion about her feelings in which she emphasised what she had achieved for herself, and for her daughter and grandchildren (see below). Analysing this interconnectedness allows us to further understand the significance of oral health to one's sense of self.

Displaying family through oral health practices with children

Participants indicated a view that they could affect the oral health practices of others, and highlighted how they had facilitated their children's oral health:

There was quite a push when I was pregnant. I had to take fluoride tablets and this was meant to strengthen the baby's teeth which worked in a way because my daughter has got the strongest teeth you've ever seen. (Yvonne, 66, retired radiographer)

Even then, this is obviously 30 odd years ago, I think people were aware that drinks like Coca-Cola [...] were loaded with sugar and that they weren't good for you. And we never had such things in the house. (Roy, 67, retired engineer)

Current oral health policy suggests parents should reduce children's consumption of sugar, supervise the brushing of teeth twice a day until the age of 7 and take children to the dentist on a regular basis (Public Health England, 2017). Research with parents living in deprived areas has identified barriers to complying with toothbrushing advice (Marinho *et al.*, 2003; Marshman *et al.*, 2016). As grandparents provide more childcare (Wellard, 2011), it may be important to determine their involvement in children's oral health. Young children cared for in informal childcare (the majority of which is provided by grandparents) are more likely to be overweight than those cared for by a parent, and health promotion may need to be targeted at grandparents (Pearce *et al.*, 2010).

Participants also spoke about how they worked to make the practice of going to the dentist less unpleasant for their children:

I used to take them with me and the dentist that I had then was a bit of a friend, family friend actually and he used to let the kids ride up and down, so they got used to it. (Rose, 80, retired)

support worker)

One participant recalled how, as a parent, she acted in a particular way during a painful dental encounter so as not to worry her children:

I always remember sitting in the chair thinking “I can't, I can't make a noise”, because I'd have been saying, “Stop, stop, you can't do anymore. You give me the gas”. But I thought...the kids were all sitting in a row, you know. I thought, “Oh I can't”. (Josephine, 79, retired college lecturer)

These accounts suggest a view that children may take forward parts of the past, and frame their own encounters in relation to those of others. Rose and Josephine implicitly recognised the potential for narratives of being scared of the dentist to refer to the actions of one's mother, as was the case for Sandra (see above), and described acting to avoid this happening. Participants indicated how they thought their children and grandchildren might have interpreted their actions. Although we cannot know if the children in question would have reflected on certain incidents in the same way, participants acknowledge their *potential* to play a part in the biographies of others, as they identified the role of parents in their own stories.

While some participants described practices that resulted in 'strong' or 'lovely' teeth, others displayed family through reports of dealing with oral health problems. Valerie recalled that her dentist told her daughter and grandchildren ““You've got your grandmother's teeth””, referring to their thin enamel. Valerie reflected on this:

It's not because she hasn't looked after them, she has. She obviously has been born with that. [...] I think sometimes you have to make the best of what you've got. If you got teeth that are prone to getting the cavity, you just have to make sure you look after them, if not it gets worse. [...] She goes regularly and she has them done and looked after and you wouldn't know.

While her account emphasised the inherited physiological characteristics that make her daughter more

prone to fillings, she also talked about her daughter's approach to life and the oral health practices that have allowed her to overcome this. The themes of 'getting on with it' and 'taking responsibility' emerged from this interview, in relation to her daughter and herself (for example, Valerie talks about engaging in intensive oral health practices to maintain her teeth). In displaying a particular approach to oral health across generations within this family, Valerie presents her daughter as embedded in a network of relationships where looking after teeth is prioritised.

Although some older people outlined continued practices across generations, others spoke about oral health practices that reflected different ways of doing family. In the rest of this paper, we demonstrate how participants reflected on this, focusing on how practices of thinking, feeling and doing are narrated.

Doing family differently through oral health practices

When reflecting on the role of their parents or guardians, several participants, who had children themselves, drew on the realm of the imaginary to suggest what they would have done differently. Sandra recalled how her grandmother told her the story of what had happened to her mother:

My grandmother told me that she took my mother to have an extraction as a child. And my mother was literally screaming her head off in the chair. And my grandmother was in the waiting room. I mean, these days, as a mother, I would have gone through. [...] I wouldn't have put up with that. I'd have gone through and said, "What is happening here? Can you stop what you're doing? If it's upsetting my child, I don't want this."

Sandra was narrating this story second-hand, but also making it clear how the audience should interpret this by pointing to the moments when she would have acted differently, noting that she would have 'gone through' and 'wouldn't have put up with that'.

Similarly, Ted (71), who no longer went to the dentist following his experiences as a teenager, felt that his parents could have taken him to a better dentist:

You all used to look at that door, you know, you could hear the drill going or people talking.

[...] *I never took my kids to a dentist like that [...] If I'd have been a father then, I wouldn't have taken them to that dentist. I would have tried to go on private.*

For Ted, a 'nice' dentist meant visiting a surgery where one felt at ease and with 'clean and sparkling' facilities. He explained that, unlike his parents, he would have found a better dentist for *his* children, and that this would have been worth paying for (it is notable that Ted stressed this point, as elsewhere in his interview he indicated an aversion to spending money unnecessarily).

Through these imagined narratives of doing things differently, Sandra and Ted illustrated their values as parents. This involved "doing family things" in a way that would be acceptable by others, reflecting wider cultural norms and mores (James and Curtis, 2010: 1166). Oppositional stories about problematic practices of others can be used to establish 'this is *not* how 'my family' behaves' (Finch, 2007: 78), even if such stories are about previous generations of one's own family. Displaying family is about displaying oneself as a mother, father, grandparent etc., acting according to a set of ideals and thus another way of maintaining a moral identity through oral health practices (XXXX, Forthcoming).

Several participants, particularly those who had oral health problems, told stories of acting to achieve generational change by doing family in a different way. Eileen (70) spoke about a lack of knowledge in her family when she was growing up, suggesting that: '*For the first good few years of my life they [her teeth] probably weren't cared for as they should have been by dentists, by my parents, or me knowing what to do*' She recalled often not having money to buy toothpaste, and eating a diet that wasn't 'balanced'. She also remembered different practices of dental attendance, with relatives only going for severe pain rather than check-ups. However, Eileen explained how she tried to initiate generational change, demonstrating an awareness of idealised oral health care for children. This involved encouraging her daughter to develop good oral health practices through brushing teeth together, and providing 'tasty' toothpaste and a 'fun' toothbrush. Eileen displayed herself as mother and grandmother in opposition to her own parents: '*I instilled that into my daughter, and my grandsons have regular check-ups. So it's about thinking differently, isn't it?*'. Some participants identified a clear role for themselves in a project of achieving good oral health across generations.

Participants also reported how their mouths and teeth could be viewed by grandchildren. They recalled incidents when a grandchild commented on ‘dirty’ or ‘yellow’ teeth, or noticed the movement of a denture. Such incidents could be used as an opportunity to convey knowledge and try to instil particular values (Warren and Clarke, 2009). Betty’s grandchildren accidentally saw her without her teeth when they were six years old. She was clear this was not something done deliberately, recognising it could ‘frighten’ children. Nevertheless, in keeping with her project of achieving good oral health for the next generations in her family, she explained how she was able to position herself as a warning of the consequences of poor oral health practices:

I always said, “If you want no teeth like me, just carry on not cleaning them.” And that used to happen a lot in the house and their hygiene was perfect. And they’ve all got lovely pearlies now. (Betty, 70, retired cook)

This contrasted with a lack of help she received as a child. She recalled being told “‘*You’re a naughty girl*’” for refusing to go to the dentist, and imagined how she may have done things differently if there had been ‘*people behind me talking about what effects would happen to me*’. However, turning her own experiences into a lesson for others allowed Betty to reframe her ‘*regret*’ at losing her own teeth into part of a different, more positive, story.

Three quarters of participants were grandparents, and many spoke about being actively involved in their grandchildren’s oral health practices. This included help with brushing teeth as part of childcare and taking a grandchild to the dentist as well as providing food (the provision of treats has been explored elsewhere (Petrunoff *et al.*, 2014)). Grandparents also saw themselves as passing on knowledge and values on the basis of their own experiences, although we cannot know how these were interpreted. As grandparents are increasingly involved in childcare (Wellard, 2011), further research into the extent to which grandparent/grandchild relationships shape oral health practices would be useful.

Recognition of the work done by stories (Frank, 2010) flags the temporal aspect of displaying family. Eileen contrasted the lack of care she received as a child with her own approach as a mother,

facilitating good oral health practices for the next generation. This positioned the family she grew up in as failing to meet understanding of ‘what family is and should be’ (James and Curtis, 2010). When these comparisons are made across time, it is important to understand doing family as an ongoing process and to recognise the relevance of shifting discourses. What it means to do family at any particular historical time is shaped by different discourses of what parenting *should be*. Angela (70, retired journalist) suggested her mother would have seen it as ‘mollycoddling’ to go to the dentist with her teenage daughter (and therefore it was appropriate that Angela went to get her teeth extracted on her own). However, as a mother herself, Angela frames this as a generational difference that reflects changing ideas of parenting: *‘I can’t imagine me sending my 16-year-old daughter on a bus to have two teeth out on her own, but that was a different generation’*. Thus participants challenged the idea that ‘mollycoddling’ would be inappropriate, and illustrated how they were actively involved in achieving good oral health for subsequent generations.

Participants also acted to facilitate independence by encouraging teenage children to take responsibility for their own oral health care, and particularly decisions regarding orthodontic appliances. Yvonne (66, retired radiographer) explained that her 13-year-old son was offered different treatments, and that she let him choose. She recounted how he chose the less invasive treatment, but later in life questioned his parents:

He came back to us and said, “Why didn’t I have this other orthodontic treatment that they’re now telling me I could’ve had?” And I said, “Well, it was your choice.” [...] And I didn’t want him to feel we’d made him have this.

Emphasising to her son that this was his choice shows how being a parent involved not ‘imposing’ a treatment on her child. This can be understood as a part of a process of preparing children for adulthood in a way that reflects the values associated with individualisation (Beck and Beck-Gernsheim, 2002). Adulthood is associated with taking personal responsibility; ‘childish dependency on parental care is expected to give way at a certain age to independent adulthood’ (Hockey and James, 2003: 167). Part of being a parent is acting to facilitate these values in their children (Kettle,

2016). However, as Yvonne acknowledged her son questioned this later in life, and had to ‘*come to terms*’ with the appearance of his teeth. Thus these interviews demonstrate the potential for different interpretations of what doing family *should* involve. As oral health policy identifies a role for parents and guardians, it is important to consider the degree to which children and young people are expected to take responsibility for their oral health within families.

Conclusion

In this article, we have considered how a person’s embodied experiences over the life course can be interpreted as interconnected and relational, using the example of the mouth and teeth. We have highlighted that oral health can be conceptualised within ongoing family relationships, and say something about how people do, and can imagine doing family. The narrative accounts of older people, while telling their own stories, can also illustrate “this is my family and it works” (Finch, 2007: 70). Other stories question the actions of parents, reflecting changing understandings of what family *should* be (James and Curtis, 2010). Analysing accounts of oral health practices through a lens of connectedness (Smart, 2007) offers a way to theorise oral health as a family practice (Morgan, 2011).

Considering how participants constructed their own mouths and teeth as relational through ‘mouth talk’ (XXXX, Forthcoming), we have shown how individual embodied experiences could be reframed. We have shown how narratives of oral health point to the contextuality, contingency and relationality of how oral health is experienced over the life course, as in the case of residential histories (Mason, 2004). As lives are linked to those of others (Bengtson *et al.*, 2002; Elder, 1994; Smart, 2007), so the actions of another can impact on a person’s oral health. This was a concern for participants with children and grandchildren, who recognised their potential to shape the oral health of the next generation. Oral health practices are therefore constituted through family connectedness. They also simultaneously contribute to the constitution of family. This might help to explain why these relationships are found to be important determinants of oral health outcomes (Broadbent *et al.*, 2016, 2006).

Oral health practices are also one way in which a relational sense of self is constituted. What we have shown is that these practices are sustained and developed relationally over the life course. Participants displayed family through accounts of oral health practices over time (Finch, 2007). Some illustrated a family that ‘works’, and emphasised continued practices. In other cases, participants set themselves up in opposition to their parents, making different choices and acting according to different values. As James and Curtis (2010) found, participants drew on cultural ideas of what it means to be a ‘good’ parent. Participants engaged in practices to encourage their children and grandchildren towards good oral health care. These various relational narratives explained participants' oral health practices, and how they saw their role in relation to children and grandchildren. Further work is needed to connect these narratives to actual oral health practices in order to inform policy in this area.

Of course, there are limitations to the study. As might be expected in a sample of people aged 65-91, women outnumbered men. The sample was also uniformly white and predominantly middle-class, although the examples included in this article reflect a range of educational and occupational backgrounds. A more diverse group across class, ethnicity and location might have generated different perspectives. Further work in different communities would help to strengthen and refine our understanding of the relevance of connectedness to personal narratives of oral health. In this paper, we have focused on relational aspects of oral health narratives, and thus the families of participants play a key part. However, as participants’ relatives were not part of the research, we are not able to consider the potentially competing narratives of different family members. We would suggest further intergenerational research on oral health practices to explore the significance of family relationships over the life course. Although all interviews could be read through the lens of connectedness, family relationships were not always the focus (see XXXX, 2018; XXXX, Forthcoming). We have selected narratives in order to show how connectedness can work as an analytical tool. Nevertheless, it is important not to overstate the personal significance of family relationships. Additional research to develop a typology of intergenerational relationships with respect to oral health would be useful. In relation to this, there is scope to develop a more nuanced understanding of parental responsibility for children’s oral health. Although our research identified an implicit understanding of maternal

responsibility for children's oral health (in keeping with Nettleton (1991)), some participants did recall involved fathers, or noted an active role as fathers and grandfathers. We suggest further exploration of the significance of gender to family practices of oral health, particularly as the composition of families continues to change.

This research demonstrates the relevance of connectedness for older people putting together the picture of their oral health experiences over the life course. Participants in this study drew on memories and imaginings to construct their own oral health biographies, reflected on their embeddedness within webs of relationships, and displayed family practices of oral health. By focusing on how family is displayed as well as enacted through narratives of oral health practices (including thinking and feeling, as well as doing), we have highlighted the everyday significance of connectedness for making sense of embodied experiences across the life course. Future oral health policy should therefore pay close attention to family relationships when seeking to promote improvements in oral health practices.

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