I pledge my honor that this paper represents my own work in accordance with University regulations. /s/ Do-Hyeong Myeong

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"Bad Teeth":

Experience of Bad Dental Hygiene among Working-Age Homeless Men in Trenton

Introduction

"I've never seen a dentist in my whole life," said Jonathan, a 29-year-old black man[1]. Jonathan's history of "bad teeth" began as a child. Because both of his parents have been in prison since he was a year old, he was raised in multiple foster homes. As a result, Jonathan said, he "never got to see the dentist [he] was supposed to as a kid," and is still suffering from dental health conditions so severe that he is in need of surgeries[2]. He believes that bad dental health is one of the primary reasons why he couldn't find a job even with a college degree, clean criminal history, and multiple job experience. Yet he says that it is extremely hard for him to get dental care, or seek support (Jonathan interview).

Jonathan's story allows us to see how dental health impacts a person's life experience and how few support uninsured working-age men has in relation to dental care. In addressing the increasing uninsured population in U.S, Gay Becker has argued that those who are uninsured are no longer the minority population that lies on the margins of the state, but are rather those who "lies at its very heart (299)." So far, much of the literature about the unequal access to dental care focused on children, women, or immigrant workers. While it is true that those populations are among the most vulnerable to dental health – and overall health –

[1] This paper is based on a field visit to UIH Family Partner as part of the Community-Based Learning Initiative project. All the interviews quoted in this paper were conducted on April 17, 2015 at UIH Family Partners office in Trenton, NJ. Anne Woehling, Abigale Gellman, Jake Schade and Linda Song was in the same group as me.

[2] Jonathan never specified the exact conditions he is suffering from; it is possible that he doesn't know, for he has never been to a dentist.

problems, the lack of attention paid to the working-age male population – the non-minority population – poses some problems. To begin with, the lack of attention to adult population neglects the problem that children with bad oral health grows up to be adults with bad oral health (Horton and Barker 212); the problem doesn't simply disappears as the child grows up, but instead become more serious because bad dental health affects the person's chance of employment and blocks upward social mobility (Durham et al 191; Horton and Barker 215). It also underestimates the increasing number of uninsured working-age adult males in the "grey zone" who are neither privately insured nor qualifies for state-funded insurances (Becker 304). Moreover, instead of opening up the discourse on why so few uninsured adults seek dental care, the low visibility obscures the problem and gives off false impression that the problem is insignificant (Becker 317; Horton 295).

In this paper, I would like to observe the concern for the lack of dental health among the unemployed, mostly homeless men between the age of 25 and 50 raised by UIH Family Partners, a nonprofit organization based in Trenton, NJ that focuses on empowering unemployed, non-custodial fathers. Using the accounts of UIH's two staff members and Jonathan, one of their clients, I would like to observe how lack of dental health impacts an indivudual and how the problem is addressed and interpreted within the community. What larger social problems are connected with the issue? What is the UIH's approach to solution, and what other factors should also be considered?

Teeth and Personhood

Sociologist Catherine Exley argues that oral health is crucial to a person's physical and social function (Exley 1094). Medically, mouth is "the boundary between: the internal body and the external sources of pollution (Nettleton 1988: 163)" – thus lack of oral health can result in malnutrition and various infections (Slavkin and Baum 1215-1216). Culturally,

teeth, in particular, has been strongly associated with wealth, and physical strength (Gibson 339-341); Lack of oral health is usually interpreted as a sign of poverty and stigmatize the individual (Horton and Barker, 213-214) – "the appearance of the mouth and the teeth are important to both an individual's perception of self and their social interactions (Exley 1094)."

Jonathan's account shows how bad dental hygiene can affect an individual's self-esteem. He admitted that he feels "uncomfortable" and "less confident" talking to people or smiling because he doesn't want to show people his teeth, especially during job interviews. He said that many of the men at the center shares his opinion, and that the lack of confidence that originates from bad dental health is directly related to the men's unemployment because "the way you look" matters in getting a job, and the men "don't look the way we're supposed to" because of their missing tooth (Jonathan interview).

Yet low self-esteem is not the only barriers to the men's employment, nor is the lack of desirable appearance the only explanation for the companies' decisions to not hire the men. Reducing the problem solely to aesthetic and psychological factors blocks us from recognizing real, physical conditions that arises as a result of bad dental health that affect the men's chances of employment.

Bill Davis, Client Service Specialist at UIH who has dealt with homeless men for the past 18 years claims that "one of the biggest barriers to success has been dental." He emphasized that the barriers the men feel are real – that "it's not just their self-esteem imagination." Davis said that he can come up with multiple cases of men who had job interviews but were denied by companies. In many cases, the companies didn't want to hire someone with bad dental health for positions that require direct interaction with customers (Davis interview). This point was further pointed out by Carter Patterson, the center's

Program Manager, who said that bad dental health usually results in bad breath and slurred speech, which directly affects an individual's "marketability as an employee (Patterson interview)."

These accounts all point out that the lack of dental health acts as a barrier to employment in multiple levels. It reduces the men's self-esteem and makes the men physically unsuitable for and aesthetically undesirable for certain jobs. Although not mentioned by any of the interviewees, economic factor might also come into play; since many employers choose not to offer health insurance, let alone dental insurance, to their employees (Becker 304), those employers might be unwilling to hire people who are obviously in need of dental care. There are clear relations between psychological, physical and social conditions caused by bad dental health; teeth thus is an intersection of the mind, the body, and the social self.

A Problem of Tradition?

Both Davis' comment that the lack of dental health is a barrier to success and Patterson's remark that bad dental health affects an individual's "marketability" as an employee shows that how dental health is viewed as an asset for success. It is interesting that this lack of biological asset is never geneticized or biologized; rather, the problem was interpreted as a lack of knowledge on certain techniques and habits. Bill Davis stated that "oral hygiene is not a tradition among poor population." He pointed out that many of the center's clients simply don't know how to take care of their teeth – how to brush their teeth, how often and for how long should they brush it, how to floss, and so on (Davis interview).

It is important to link the organization's attention to dental health to its other efforts and strategies to empower unemployed men. Originally, the UIH's intervention programs to assist its clients focuses on helping the men find a job and gain financial stability. The

programs include education on how to dress for jobs and interviews ("Dressed to Impress"), how to write resumes ("Resume development") and use computers ("Computer literacy training"), and how to manage anger, stress, and time. In other words, the center has focused on educating the men the techniques they didn't learn growing up but are regarded as necessary in job markets – what Phillipe Bourgois would call "cultural capital (Bourgois 142-173)."

The UIH's attention to dental health is therefore notable in a sense that the organization recognizes the biomedical barriers to success as originating from a "tradition" of bad dental hygiene. Just like the men lacked knowledge on skills and behaviors necessary for employment, so did they lack awareness on oral hygiene, and this lack of awareness – a cultural factor – produced a tangible medical condition. Horton and Barker calls this a biocultural embodiment of social inequality (Horton and Barker 207)

Yet in regarding the dental health problem as cultural it is easy to dismiss broader social context and structural issues that shaped the "tradition" of bad oral hygiene. In fact, the dental health problem is nothing but cultural. As in Jonathan's case, in many cases an individual's bad dental hygiene has roots in the lack of dental care as a child, which again could be traced back to parents' absence (incarceration; a social and political problem) or lack of insurance (unemployment or employment that doesn't provide health insurance). Poverty, in most cases, is directly related to bad dental hygiene; Davis identified the issue as that of "poor population," and Jonathan stated that he couldn't afford dental care with his insufficient Medicaid coverage. Race, although implicit, is an issue. 64 percent of the center's clients identify themselves as African-American (UIH Newsletter); African-Americans are twice more likely to be uninsured than their counterparts (Becker 300). In the next section, I would like to discuss some of the structural issues that might also contribute to the issue.

Addiction and Community

As discussed in the previous section, lack of dental health among unemployed working-age men can be traced back to many social factors. Race, poverty, unstable employment, homelessness and incarceration are among some of those factors (Becker 300-304; Gilbert et al 1850-1859).

In this section, I would like to focus specifically on two factors; substance addiction and the lack of community support. According to Patterson, about 40 percent of the UIH clients have a history of addiction problems, and all of those people are suffering from significant dental health problems (Patterson interview). There is a proven direct correlation between dental diseases and addiction to substances such as alcohol, tobacco, methamphetamine and heroine (Robbins 920-921, 927). Substance addiction further detriments the men's dental health because it not only directly causes medical conditions but also deprives the men of their ability to seek help[3] and stigmatize[4] them (Robbins 927-928).

Although there is a widely known and proven correlation between bad oral health and substance addiction (Robbins 920-921), none of the interviewees brought up the factor until asked. Perhaps because the connection was too obvious; or perhaps because substance addiction has been traditionally viewed as a personal problem, not a systemic one. Davis implied that both bad dental health and addiction are conditions that the men don't want to talk about (Davis interview). Yet closer examination of the interviews with UIH staff members suggest that the factor of substance addiction is related to a larger social

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[3] "You're not brushing your teeth. You are drinking all of these really toxic concoctions… cheap stuff." Patterson said, explaining that when intoxicated the men lack basic ability to take care of their dental health.

[4] Patterson acknowledged that one of the reasons why employers are reluctant to hire someone with bad dental health is because people generally associate bad dental health with substance addiction, and that no one is willing to hire an alcoholic or a drug addict.

phenomenon – the disintegration of community.

Patterson pointed out that local business owners take advantage of the center's clients with history of alcohol addiction. "The liquor store opens at 7:30 [a.m]." Patterson said, "That's a problem. It's open seven days a week, you know. Dude. Wait until it's three [p.m]. But you're opening at 7:30. It's right around the corner. And they [the clients] are right out there, and the business owners, [they] see these guys, they're unclean, they're shaking, they have red eyes, and they are waiting at the door for the liquor store to open. Do you [the business owners] feel bad about this? No, you don't. You're just thinking about making money (Patterson interview)."

Later, as we left the building, we also heard from Everett, our driver, that most of the men roaming the building were drug dealers trying to sell heroine to the homeless men at UIH center (Barber interview). [5] It was clear that the members of the local community – either shop owners or drug dealers – were taking advantage of the center's clients, rather than providing support.

Lack of community support was also visible from another aspect: the unwillingness of local dentists to tend to uninsured patients. There was a dental clinic right downstairs from the UIH office. We asked Patterson whether the dentist downstairs worked with the center, and Patterson said no. According to him, there are only two dentists around the area who are willing to see uninsured patients; the waiting list are six months long, and often those dentists provide only minimal care, such as brief teeth cleaning (Patterson interview). Later, Davis added that "it is extremely hard to find a pro bono dentist." He blamed the high cost of dental

[5] Everett, a long-time resident of Trenton, told us that he was a former drug dealer. Before going sober, he had a history of methamphetamine addiction, and he sold heroine and methamphetamine for multiple years in Trenton and Princeton. Although the information cannot be verified, I chose to believe his knowledge as a former drug dealer – if not, at least his knowledge as a local community member.

schools for making dentists unwilling to treat unprofitable patients (Davis interview). While Davis does point out a valid point – the systemic problem with the dental schools that leads those professionals to seek profits – there are also broader, policy-level issues related to the dentists' unwillingness to see uninsured patients. Horton and Barker has pointed out that "pressures of time and patients may lead even the best-intentioned providers to deliver disparate care (Horton and Barker 207)" – that even when the dentists do tend to uninsured patients, they end up limiting the number of uninsured patients they see in a month and economizing the time spent with the patients, which results in "assembly-line cares" that favors quick and easy treatments over restoring the patient's dental health (Becker 307-310; Durham et al 191-196; Horton 296; Horton and Barker 207-209). Without addressing those systemic problems, it would be very difficult to come up with an effective solution.

Giving the Men a Chance: Towards a Comprehensive and Effective Solution

Patterson said that the UIH plans to promote dental health for its clients through two different approaches; prevention and intervention. The center would educate its clients and possibly local youth population about dental hygiene in order to promote awareness, and would secure funding and seek partnerships with dental care providers to provide its clients with dental care when needed. Patterson said that he intends the two programs to be complemented by other programs the center has been offering so far – for example, counseling services and addiction recovery programs – in order to address self-esteem issues that result from bad dental hygiene and addiction problems that directly impact an individual's dental health (Patterson interview).

While I believe that the UIH's plan is probably the most plausible one within the current health care system and an effective one that considers multiple factors leading to and resulting from the lack of dental health, one thing to keep in mind is that all of the approaches

above ultimately aim to increase the men's marketability as an employee. Because the mission of UIH is to guide "men at risk" toward self-sufficiency, the center's primary interest in dental health arises from the negative influence of bad dental hygiene on their client's employment chance, and their ultimate goal is to help the men find employment through dental health interventions. Yet this implies that once employed, the men would gain access to dental care, while in reality many employers do not provide health care benefits and even if the benefits are provided, they disappear when they lose their job – studies show that those who lose health care benefit as a result of job loss find additional difficulties in getting health care (Becker 304, 307; Horton 295; Quinn et al 177-178). While employment could temporarily help the men afford dental care, without a stable dental insurance plan, the solution would be only temporary. The unstable and unequal access dental care even for the employed population is definitely something to consider.

I also believe that the UIH should gradually attempt to challenge the notion that working-age male population is responsible for their own health. Becker argues that staying healthy became "a private obligation, and the vehicles that help to maintain health, such as health insurance, also become the responsibility of the individual (Becker 314)." Yet this notion should be challenged, because shifting employment model from full-time jobs to temporary jobs and contract work has made health care – not to mention dental care – unaffordable even to the working population (Horton 295) and because there certainly are structural issues beyond an individual's responsibility that affects his dental health.

One way to challenge the individual obligation to dental health is to emphasize the role of community engagement in interventions. Patterson did mention that one of the center's long-term goals is to get a city-level advocacy that prevents the liquor stores from opening in the early morning, which would give the clients a "few hours of sobriety" to

recover from their addiction problem and take care of their health (Patterson interview). In addition to this, getting local dental care providers to engage in the dental health intervention program is crucial. Glassman et al has argued that partnerships between dentists and nonprofit organizations are the most optimal way to promote dental health in a community (Glassman et al 468-469); even something as simple as regular dental checkup or guaranteed recall visit to the dentist after a treatment drastically decreases the likelihood of dental diseases and increases awareness on dental hygiene (Durham et al 196).

Conclusion

So far, we have observed how bad dental health influences an individual's life experience in physical, psychological, and social level, and how factors such as poverty, incarceration, substance addition and lack of community support further contribute to an individual's lack of dental health. In order to effectively address the problem, cooperation from community members, especially local dental care providers, are crucial; engagement from community members would help create a more supportive environment for the men and at the same time help challenge the notion that maintaining health is a personal responsibility.

Above all, more visibility on the dental health crisis among working-age male population is needed. Because of their assumed status as a non-minority, able-bodied men between the age 25 and 50 get very little attention in discourses on health care disparity; yet we have seen that those men are as vulnerable to dental health problems as any other minority groups, and that bad dental health actually harms the men's body, soul, and social self. There needs to be an awareness that in an era of economic instability and privatized medical insurances, dental care disparity is no longer the problem solely belonging to children, women, and immigrants but also to the wider population; that men, too, need attention and help.

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