

# ORAL HEALTH INFLUENCE ON THE QUALITY OF LIFE OF SCHOOL ADOLESCENTS

*Influência da saúde bucal sobre a qualidade de vida de adolescentes escolares*

*Influencia de la salud bucal en la calidad de vida de escolares adolescentes*

Original Article

## ABSTRACT

**Objective:** To investigate the impact of oral health on the quality of life of school adolescents associating it with sociodemographic conditions. **Methods:** Quantitative cross-sectional field study conducted in 2012 in the city of Sumé, Paraíba, with 184 adolescents aged 15-19 years. The impact was assessed by applying the Oral Health Impact Profile (OHIP-14) to the participants, and data on sociodemographic conditions were obtained through a second questionnaire answered by parents or guardians. The Chi-Square test was used to associate the impact of oral health on quality of life and the study sociodemographic variables, with significant values set at  $p < 0.05$ . **Results:** In general, the impact was considered weak on 167 participants (90.8%). "Physical Pain" was the quality of life domain most affected by oral conditions among those that resulted in intermediate impact (22.8%;  $n=42$ ). Only the variables "Property Situation" and "Accommodation" were associated with the overall impact ( $p < 0.05$ ). The low percentages of strong overall impact (1.1%;  $n=2$ ) were related to adolescents whose mothers had studied only up to primary education or whose families lived on one minimum wage or less. **Conclusions:** It was observed that oral health conditions had a weak negative impact on the quality of life of adolescents. The analysis of the sociodemographic conditions of individuals related to the overall impact of quality of life related to oral health were associated with the variables "Property Situation" and "Accommodation".

**Descriptors:** Adolescent; Quality of Life; Oral Health.

## RESUMO

**Objetivo:** Investigar o impacto da saúde bucal em relação à qualidade de vida de adolescentes escolares, associando-o às condições sociodemográficas. **Métodos:** Estudo de campo transversal e quantitativo desenvolvido em 2012, no município de Sumé-PB, com 184 adolescentes na faixa etária de 15 a 19 anos. Para avaliar o impacto, aplicou-se o questionário Oral Health Impact Profile (OHIP-14) aos participantes, enquanto para a obtenção dos dados referentes às condições sociodemográficas, os pais ou responsáveis responderam a um segundo questionário. Utilizou-se o teste Qui-quadrado para associar o impacto da saúde bucal sobre a qualidade de vida e as variáveis sociodemográficas pesquisadas, sendo considerados significativos com  $p < 0,05$ . **Resultados:** Em geral, o impacto foi considerado fraco em 167 pesquisados (90,8%). "Dor física" foi a dimensão na qualidade de vida mais afetada pelas questões bucais entre aquelas que resultaram em impacto médio (22,8%;  $n=42$ ). Apenas as variáveis "Situação do imóvel" e "Acomodação" associaram-se ao impacto geral ( $p < 0,05$ ). Os reduzidos percentuais de impacto geral forte (1,1%;  $n=2$ ) relacionaram-se aos adolescentes cujas mães só estudaram até o ensino fundamental, ou às famílias que vivem com um salário mínimo ou menos (1,1%). **Conclusão:** Observou-se que as condições de saúde bucal apresentaram um impacto negativo fraco na qualidade de vida dos adolescentes investigados. As análises das condições sociodemográficas dos indivíduos relacionadas ao impacto geral da qualidade de vida relacionada à saúde oral associaram-se as variáveis "Situação do imóvel" e "Acomodação".

**Descritores:** Adolescente; Qualidade de Vida; Saúde Bucal.

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## RESUMEN

**Objetivo:** Investigar el impacto de la salud bucal respecto la calidad de vida de escolares adolescentes y su asociación con las condiciones sociodemográficas. **Métodos:** Estudio de campo transversal y cuantitativo desarrollado en 2012 en el municipio de Sumé-PB con 184 adolescentes entre 15 y 19 años. Se aplicó el cuestionario Oral Health Impact Profile (OHIP-14) a los participantes para evaluar el impacto de la salud bucal mientras los padres o responsables contestaron un segundo cuestionario para la obtención de los datos de las condiciones sociodemográficas. Se utilizó la prueba Chi-cuadrado para la asociación del impacto de la salud bucal en la calidad de vida y las variables sociodemográficas investigadas, considerándose significativo el  $p < 0,05$ . **Resultados:** En general, el impacto fue considerado débil en 167 investigados (90,8%). “Dolor físico” fue la dimensión más afectada de la calidad de vida por cuestiones bucales entre las que resultaron en impacto medio (22,8%;  $n=42$ ). Solamente las variables “Situación del inmueble” y “Acomodación” se asociaron al impacto general ( $p < 0,05$ ). Los reducidos porcentuales de impacto general fuerte (1,1%;  $n=2$ ) se relacionaron con los adolescentes cuyas madres estudiaron hasta la enseñanza fundamental o con las familias que viven con un sueldo mínimo o menos (1,1%). **Conclusión:** Se observó que las condiciones de salud bucal presentaron un impacto negativo débil en la calidad de vida de los adolescentes investigados. Los análisis de las condiciones sociodemográficas de los individuos relacionados al impacto general de la calidad de vida relacionada con la salud oral se asociaron con las variables “Situación del inmueble” y “Acomodación”.

**Descriptor:** Adolescente; Calidad de vida; Salud Bucal.

## INTRODUCTION

Childhood and adolescence are life cycle stages marked by serious tensions, as they represent periods when the individual is growing and developing physically and intellectually. The World Health Organization (WHO) defines the chronological limits of adolescents between 10 and 19 years. However, under Brazilian law, the Statute of the Child and Adolescent considers a child the individual up to 12 incomplete years of age, and adolescents those between 12 and 18 years of age<sup>(1)</sup>.

In a broader sense, adolescence is a stage of development characterized by life conflicts, discoveries and intensity. In this context of urgency and intensity, it is common for young people to neglect self-care measures, and such personal neglect is recognized by adolescents as a cause of their dental problems<sup>(2)</sup>. Therefore, it is a period considered risky in relation to oral health diseases due to poor control of biofilm and reduced care concerning toothbrushing. In addition, in this stage of life, parents

do not delegate oral health care tasks for their children, and these tend to not accept the interference of family in daily hygiene practices<sup>(3)</sup>. A considerable percentage of adolescents reported they do not need to be reminded by their parents to brush their teeth<sup>(4)</sup>.

Assessing the behavior of adolescents as well as the changes in their lives and social and educational changes requires the assessments to be done in schools, given that educational institutions hold the majority of adolescents and young individuals of the community and represent a space for socialization, education and information<sup>(5)</sup>.

Oral health is important in various scenarios of adolescents' life. Factors such as personal appearance, sexuality, employment and health, in general, motivate them to take care of their oral health<sup>(6)</sup>. Therefore, the social dimensions of oral health and the real impact of injuries on the quality of life of individuals should be considered<sup>(7)</sup>.

The analysis of sociodemographic factors becomes relevant as oral health conditions are influenced not only by behavioral habits, but also by social issues. The prevalence and incidence of tooth decay are strongly associated with individuals belonging to the most deprived social classes, whose parents have low education level<sup>(8,9)</sup>; additionally, oral hygiene habits are also influenced by socioeconomic level<sup>(4)</sup>. Critical social conditions in the early stages of life may predispose individuals to a dental condition that, in turn, can have a negative impact on quality of life in adolescence. In addition, given that oral health also involves emotional, aesthetic and social aspects, it is necessary to assess the impact of oral health conditions of these young people on their quality of life<sup>(10)</sup>.

Given the vulnerabilities to which this population is exposed, adolescent health must be considered in a holistic manner, and not focused on the biomedical model that fragments the individual, focusing only on the disease. Therefore, the *Estratégia Saúde da Família – ESF* (Family Health Strategy), through oral health actions, should meet this expanded prerogative of care, representing a breakthrough for the health promotion of this population. However, the programmed or systematized actions have not been targeted to adolescents yet, which constitutes one of the challenges for oral health in Brazil<sup>(11)</sup>.

Given that, the school is an essential scenario in the context of oral health promotion, enabling self-care to be encouraged and reflecting the improvement of oral health conditions and habits at individual, family and collective levels, especially with the training and joint planning of activities between the school staff and health professionals<sup>(12)</sup>.

The importance of the present research, developed in a small municipality in the semi-arid region of Northeastern

Brazil, focuses on the acquisition of data reflecting the wants and needs of the study population. Given the above, the aim of this study was to investigate the impact of oral health on the quality of life of school adolescents associating it with sociodemographic conditions.

## METHODS

This is a quantitative cross-sectional field study carried out between February and November 2012 in the municipality of Sumé, PB, in the middle region of Borborema and micro-region of Western Cariri. This municipality has an area of 838,058 Km<sup>2</sup> and a population of 16,060 inhabitants according to data from the last population count<sup>(13)</sup>; therefore, it is characterized as a small municipality in the semi-arid region of Northeastern Brazil.

The population consisted of adolescents aged 15-19 years enrolled in primary and secondary education in public schools. With regard to determining the sample size, it was considered a finite population of 571 adolescents, acceptable error of 5.0%, confidence level of 95% and prevalence of 50.0%. To determine the adolescents who would comprise the sample, we carried out systematic random or probability sampling. Thus, the initial sample consisted of 230 adolescents and the final sample included 184.

To do so, we requested education authorities to provide a list of adolescents regularly enrolled in schools containing their dates of birth. After obtaining the lists of students per class, we organized one single list per school, including only individuals aged 15-19 years. After that, the lists of the institutions were turned into one single list. For selecting the adolescents assigned to participate in the study, we opted for a sampling interval through drawing in order to define the random start.

As inclusion criteria we considered adolescents aged 15-19 years regularly enrolled in the educational institutions selected, whose parents or guardians signed the Free Informed Consent Form (IC) authorizing their voluntary participation in the research and the Informed Assent Form (IA) in case the adolescent was under the age of 18 years. Following the Brazilian Ethics Resolution, we requested a term of approval from education authorities, so that they could authorize the research and be aware of their co-responsibilities towards the research subjects.

Data were collected by a single trained researcher using as collection instruments two questionnaires targeted to adolescents and their parents.

To assess the impact of oral health conditions on the quality of life of adolescents, we applied to study participants the questionnaire Oral Health Impact Profile (OHIP-14)

validated in Portuguese<sup>(14)</sup> and used as a tool to check adolescents' experiences in the last 12 months, according to recommended method<sup>(15)</sup>. The OHIP-14, with 14 questions, enabled to assess the following parameters or dimensions of quality of life: functional limitation, physical pain, psychological discomfort, physical disability, psychological disability, social disability and social disadvantage. The response options varied on a scale ranging 0-4, where: 0 (never), 1 (rarely), 2 (sometimes), 3 (almost always) and 4 (always). The total indices obtained were calculated based on the sum of the response codes multiplied by the weight of the questions. The lower the value obtained (minimum = zero), the lower the negative impact of oral health on the adolescent's quality of life. In contrast, the maximum (maximum = 28) value represented a greater negative impact of oral health conditions on quality of life of individuals. Therefore, the overall impact was classified as: weak, when the indices obtained ranged from 0 to 9; medium, between 10 and 18; and strong, between 19 and 28. The assessment of the impact by domain or dimension followed the methodology used in another study<sup>(15)</sup>: weak ( $\leq 1.33$ ), medium ( $1.33 < x < 2.67$ ) and strong ( $\geq 2.67$ ).

After the draw, the adolescent participant responded to the printed version of OHIP-14 questionnaire in the school environment reserved for the research. Noteworthy, after the researcher provided instructions for filling in the questionnaire, the completed questionnaire was deposited by the adolescent in a file folder along with other questionnaires in order to avoid identification of the individual and ensure the confidentiality of information, since they did not contain data on personal information. There was not a determined time for completion of the instrument.

To obtain the data on the sociodemographic situation, such as family income, maternal or paternal education and property situation, a second sociodemographic questionnaire based on a collection instrument published in the scientific literature<sup>(16)</sup> was sent, along with the IC and IA forms, to the parents or guardians on the day before the application of the questionnaires to the adolescents.

Data were entered and analyzed using the Statistical Program for Social Sciences, version 20.0 (SPSS for Windows, SPSS, Inc., Chicago, IL, USA) using descriptive statistics for data analysis and results. For quantitative and frequency data obtained from the questionnaires, the chi-squared test was used to associate the impact of oral health on quality of life with sociodemographic variables, with  $p < 0.05$  considered significant.

The present study was approved by the Human Research Ethics Committee of the *Faculdades Integradas de Patos – FIP* (Integrated College of Patos) under protocol No. 167/2011, following the requirements of Resolution 466/12 of the National Health Council<sup>(17)</sup>.

## RESULTS

Of the total of 230 individuals who comprised the initial sample of this study, a total of 184 adolescents remained. The sample loss percentage represented 20% and included those who refused to participate and others who were absent at the time of data collection. Therefore, 184 participants represented the final sample, with ages ranging from 15-19 years, with a mean of 15.8 years ( $\pm 1.02$ ) (Table I).

Regarding gender, there was a higher frequency of female adolescents (57.1%;  $n=105$ ) and 42.9% ( $n=79$ ) of male adolescents.

The percentages of weak overall impact prevail over the medium to strong overall impact in all sociodemographic variables assessed – 90.8% ( $n=167$ ); 8.2% ( $n=15$ ) and 1% ( $n=02$ ), respectively. The strong overall impact – 100% ( $n=02$ ) – negatively influences the quality of life of adolescents and is related to mothers who only studied up to primary school and families living with one minimum wage or less (Table II).

Table II shows that the variables “Accommodation” ( $p=0.000$ ) and “Property Situation” ( $p=0.025$ ) showed a statistically significant association in relation to the overall impact of oral health on quality of life.

The results related to sociodemographic variables showed considerable percentages of parents who have little education, i.e., the majority of mothers (59.8%;  $n=110$ ) and fathers (63%;  $n=116$ ) only studied up to primary school. Furthermore, the number of parents who attended school totaled 19.6% ( $n=36$ ) (Table II).

The chi-squared statistical test was applied to the individual analysis of the associations between the

sociodemographic variables assessed and the dimensions or domains of the OHIP-14. Thus, the variables “Property Situation”, “Dwelling Location” “Accommodation” and “Maternal Education” showed statistically significant associations with some dimensions of the OHIP-14: “Property Situation” showed statistical association with “Social Disadvantage” (OHIP 13 and 14) ( $p=0.010$ ); “Dwelling Location” with “Physical Pain” (OHIP 3 and 4) ( $p=0.010$ ); “Accommodation” was statistically associated with the domains “Function limitation” (OHIP 1 and 2) ( $p=0.001$ ), “Psychological Discomfort” (OHIP 5 and 6) ( $p=0.001$ ) and “Physical Disability” (OHIP 7 and 8) ( $p=0.001$ ). As to maternal education, the analysis by dimension showed statistical significance ( $p=0.004$ ) in “Functional Limitation” (OHIP 1 and 2) – problems related to the pronunciation of words and taste of food because of dental problems.

The other variables did not show significant values, such as “Number of Residents” ( $p=0.159$ ), “Total Rooms” ( $p=0.639$ ), “Monthly Household Income” ( $p=0.765$ ) and “Paternal Education” ( $p=0.791$ ).

In general, the negative impact of oral health conditions on quality of life of the adolescents assessed is weak. However, when analyzing the impact of oral health-related quality of life (OHRQoL) by dimension, it was observed that all dimensions or domains showed percentages of strong impact, although the values were considerably lower. Among all dimensions, it was observed that “Social Disadvantage”, “Psychological Discomfort” and “Psychological Disability” obtained the highest percentage of strong impact (3.3%), while “Physical Pain” was the domain with the highest medium impact (22.8%), as shown in Table III.

Table I - Distribution of adolescents according to age and institution. Sumé, PB, 2012.

Age (years)	Institution A		Institution B		Institution C		Total	
	n	%	n	%	n	%	n	%
15	34	18.5	13	7.1	44	23.9	91	49.5
16	25	13.6	03	1.6	19	10.3	47	25.6
17	15	8.1	01	0.5	15	8.1	31	16.8
18	08	4.3	00	00	04	2.2	12	6.5
19	01	0.5	00	00	02	1.1	03	1.6
Total	83	45	17	9.2	84	45.6	184	100

Table II - Association between the impact of oral health conditions on quality of life and sociodemographic factors assessed. Sumé, PB, 2012.

Sociodemographic variable	Overall impact						Total		p-value
	Weak		Medium		Strong		n	%	
	n	%	n	%	n	%			
<b>Property Situation</b>									
Homeownership	129	70.1	13	7.1	01	0.5	143	77.7	0.025*
Residential financing	07	3.8	00	00	01	0.5	08	4.3	
Rental housing	22	12	00	00	00	00	22	12	
Tranferred property	09	05	02	1.1	00	00	11	06	
<b>Dwelling location</b>									
Rural area	49	26.6	08	4.3	01	0.5	58	31.5	0.136
Urban area	118	64.1	07	3.8	01	0.5	126	68.5	
<b>Number of residentes</b>									
1-3 people	30	16.3	03	1.6	01	0.5	34	18.4	0.159
4-5 people	108	58.6	06	3.2	01	0.5	115	62.5	
More than 5 people	29	15.7	06	3.2	00	00	35	19	
<b>Total rooms</b>									
1-3	38	20.6	04	2.2	00	00	42	22.8	0.639
4-5	66	35.9	08	4.3	01	0.5	75	40.8	
More than 5	63	34.2	03	1.6	01	0.5	67	36.4	
<b>Accommodation</b>									
Sufficient	146	79.3	10	5.4	00	00	156	84.8	0.000*
Insufficient	21	11.4	05	2.7	02	1.1	28	15.2	
<b>Monthly income</b>									
1 wage or less	116	63	13	7.1	02	1.1	131	71.2	0.765
2-3 wages	40	21.7	01	0.5	00	00	41	22.3	
4 or more wages	01	0.5	00	00	00	00	01	0.5	
Other	10	5.4	01	0.5	00	00	11	06	
<b>Maternal education</b>									
None	13	7.1	01	0.5	00	00	14	7.6	0.977
Primary	98	53.3	10	5.4	02	1.1	110	59.8	
Secondary	44	23.9	03	1.6	00	00	47	25.5	
Incomplete higher education	07	3.8	01	0.5	00	00	08	4.3	
Undergraduate	05	2.7	00	00	00	00	05	2.7	
<b>Paternal education</b>									
None	31	16.8	04	2.2	01	0.5	36	19.6	0.791
Primary	107	58.1	08	4.3	01	0.5	116	63	
Secondary	26	14.1	03	1.6	00	00	29	15.8	
Incomplete higher education	01	0.5	00	00	00	00	01	0.5	
Undergraduate	02	1.1	00	00	00	00	02	00	

\*Chi-squared

Table III - Distribution of participants according to the impact of oral health conditions on quality of life (OHIP-14), by dimension, of students aged 15-19 years of the three places assessed. Sumé, PB, 2012.

OHIP-14 dimension	Weak		Medium		Strong		Total	
	n	%	n	%	n	%	n	%
Functional limitation	167	90.8	13	7.1	04	2.2	184	100
Physical pain	137	74.5	42	22.8	05	2.7	184	100
Psychological discomfort	158	85.9	20	10.9	06	3.3	184	100
Physical disability	156	84.8	23	12.5	05	2.7	184	100
Psychological disability	157	85.3	21	11.4	06	3.3	184	100
Social disability	174	94.6	07	3.8	03	1.6	184	100
Social disadvantage	163	88.6	15	8.1	06	3.3	184	100
Overall impact	167	90.8	15	8.1	02	1.1	184	100

## DISCUSSION

Quality of life can be defined as the individual's perception of their position in life in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns<sup>(18)</sup>. The high quality of life, with regard to the physical and mental aspects, was confirmed among adolescents who had better conditions of income, did not consume alcoholic beverages and tobacco, did regular physical activity, and did not perform labor activities in this stage of life<sup>(19)</sup>.

In the dental field, the repercussions of changes in the mouth can interfere with physical and psychosocial well-being of individuals<sup>(20,21)</sup>. Oral aspects such as malocclusion, trauma, decay and dental erosion have an impact on the quality of life of adolescents<sup>(22)</sup>. Furthermore, periodontal diseases have the worst prevalent impacts on most severely affected patients<sup>(23)</sup>. Studies show that adolescents with higher rates of decayed teeth or periodontal problems present greater negative impact on the performance of their daily activities. On the other hand, these studies have shown an inverse correlation between the highest average of healthy teeth and the impact<sup>(13,24)</sup>. In the present study, the mean age of individuals was 15.8 years ( $\pm 1.02$ ). Other studies conducted with adolescents showed similar OHRQoL means: 16.1 ( $\pm 0.90$ )<sup>(20)</sup>; 13.58 years ( $\pm 1.4$ )<sup>(25)</sup>; (15.2 years and 14.9 years)<sup>(26)</sup>. Obtaining information related to the age of adolescents is important, since statistically significant differences were found by analyzing the pattern of oral hygiene and the impact on quality of life of adolescents aged 16-21 years compared to younger adolescents (12-15 years)<sup>(26)</sup>.

Regarding gender, this study found a higher percentage of female individuals (57.1%), unlike a study that found a figure of 55.42% of male adolescents<sup>(25)</sup>.

The data from the present study regarding the association between sociodemographic variables and the overall impact revealed that "Property Situation" and "Accommodation" showed statistical significance. It was noted that for most adolescents, the type of accommodation was considered sufficient ( $n=156$ ; 84.8%), associated with the highest percentage (79.3%) of weak impact on this variable. Although the variable "Monthly Household Income" was not associated with the impact in the present research, another study<sup>(27)</sup> proves the association between a higher prevalence of toothache – a condition that causes impacts such as decreased sleep, failure to perform daily activities, dietary restrictions, and decreased work performance – in adolescents belonging to families with income of up to two minimum wages<sup>(27)</sup>.

A worrying statistic revealed in this study showed the percentage of fathers and mothers with low educational

level: 63% and 59.8%, respectively. With regard to paternal education, it was also found that 19.6% of fathers were illiterate. As to maternal education, the analysis by dimension showed a statistically significant association with "Functional Limitation" (problems related to the pronunciation of words and taste of food because of dental problems). The highest medium and strong values for this domain have been linked to the fact that mothers have studied only up to primary school, corroborating a study that also linked the impact to the low educational level of parents of adolescent students<sup>(26)</sup>. Unlike the present study, the level of education and occupation of family members of Greek adolescents showed no correlation with the OHIP-14 or its dimensions<sup>(20)</sup>.

Although the weak overall impact has prevailed in the present study, demonstrating that the oral health of the individuals assessed has little negative influence on their quality of life, there are adolescents who need more attention, which is justified by the reports that have shown strong overall impact. Given the percentage of young people who presented weak overall impact (90.8%), there is – possibly in the location researched – the development of preventive and educational actions in oral health, as well as dental treatment, covering effectively most school adolescents.

Similar research also found a considerable weak overall impact (87.57%)<sup>(13)</sup>. However, another study, which used different measuring instruments, found, as in the present research, more favorable percentages, i.e., the oral health-related quality of life (OHRQoL) was good for 60.06% of the adolescents; weak for 22.6%, and medium for 17.34%. It is noticed that in the OHRQoL scale the weak condition is intermediate<sup>(25)</sup>.

Comparing the aspects of quality of life most affected by oral problems, this study found the following dimensions: "Physical Pain" (OHIP 3 and 4) – referring to the question about having felt pain or discomfort because of dental problems, with 22.8% of medium impact; "Psychological Discomfort" (OHIP 5 and 6), "Psychological Disability" (OHIP 9 and 10) and "Social Disadvantage" (OHIP 13 and 14) – referring to less chances in life and inability to act because of dental problems, with 3.3% of strong impact, corroborating the results in which "Physical Pain" and "Psychological Disability" were the most frequent manifestations of negative impact on quality of life<sup>(13)</sup>.

In the present research, the findings that show a low parental education corroborate another study<sup>(28)</sup> in which parents were mostly cited (78.40%) by adolescents as responsible for transmitting knowledge and hygienic practices, such as teaching to brush their teeth. It is evident, therefore, that the oral health of adolescents can be a good

indicator of their overall health and is directly influenced by the family education<sup>(28)</sup>.

Motivation and oral health education are powerful tools that, when used in a pleasant and attractive way to transmit information, show to be effective in promoting health. In addition, the inclusion of adolescents in preventive programs tailored to them within the ESF, with oral health actions and a careful, judicious and sensitive approach by the dentist-surgeon can help them reach adulthood in a healthy way<sup>(29)</sup>.

One limitation of the present study is the fact that it has not proposed a clinical examination for assessing oral conditions. Thus, the sample may have been made up of adolescents with or without caries experience. In this context, more worrying findings could have been identified if the impact of oral health on quality of life was associated with young people with past or current caries experience. Given that, there is a need for further studies targeted at young Brazilians in different regions with larger samples, which can be representative of the population of adolescents in the country.

## CONCLUSION

It was observed that oral health conditions had a weak negative impact on the quality of life of the adolescents assessed.

“Psychological discomfort”, “Psychological disability” and “Social disadvantage” were the aspects of quality of life most affected by oral problems observed in a minority of young people who presented a strong impact on these dimensions.

The analysis of the sociodemographic conditions of individuals related to the overall impact of oral health-related quality of life were associated with the variables “Property situation” and “Accommodation”.

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