Dental Myth, Fallacies and Misconceptions and its Association with Socio-Dental Impact Locus of Control Scale

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ABSTRACT

Introduction: It is important to know about the myths and misconceptions, especially in India, where general and oral health is embroiled in various myths and ritualistic practices.

Objectives: The purpose of this study is aimed at assessing the prevalence of dental myth and utilizes socio-dental impact locus of control scale (SILOC) health model, as the theoretical framework to understand the dental myth and belief and possible reasons for noncompliance with recommended health action.

Materials and Methods: A cross-sectional study was conducted by the out-patients attending dental institute, in Bengaluru city. A total of 150 individuals were included, data were collected using a pretested and validated three-part questionnaire including demographic data, questions regarding dental myth, and seven items SILOC. Data obtained were statistically analyzed using descriptive statistics, t-test, and spearman’s rank correlation.

Results: Almost all the participant believed in one or more dental myth. About 71.3% of the participant had high (≥11) SILOC scores. Statistically significant difference (P < 0.001) was found between mean SILOC scores and gender with males having a lower mean score (14.94) as compared to females (18.62). When SILOC scores and myth scores were compared against socioeconomic status, it showed statistically significant difference (P < 0.001), between them. The SILOC scores highly correlated with myth scores.

Conclusion: Various dental myth and false perception still lurk in the minds of the population, to discourage the unhealthy practices; we the health professionals have to provide intensive health education and promote the adoption of healthy practices. It would be prudent to familiarize professionals to understand these myths and beliefs as they act as barriers toward seeking treatment.

Key words: Culture, Gender, Internal-external control, Oral health, Social class

INTRODUCTION

Oral health means much more than healthy teeth. Despite remarkable worldwide progress in the field of diagnostics, curative and preventive health, there are people still living in isolation far away from civilization with their traditional values, customs, beliefs, and myth intact. Cultural forces bind people and also profoundly shape their lives. Culture has its own influence on health and sickness and that is greatly depicted by the values, beliefs, knowledge, and practices shared by the people.¹ Good oral health is a major resource for social-economic and personal development of individuals. It is observed that some individuals who never had oral health symptoms but still go for care while others, in spite of the presence of symptoms, do not seek dental care. Beliefs and values within the general population associated with these behaviors are not well-understood.² Myths are defined as stories shared by a group of people, which are part of
their cultural identity, having a strong influence in seeking treatment during illness. In scientific terms myth is referred to as extensive and unquestioned false perspective. The concept of dental myth usually emerges from false traditional beliefs and non-scientific knowledge. These myths are further firmly fixed in the psyche of future generation over a space of time, and thus guide the patients in the wrong protocol which can lead to difficulty for dentist to provide satisfying treatment.3,4

Individual beliefs and values about maintaining or regaining health as illustrated by one’s behavior falls under the theoretical domain of locus of control (LOC) (Rotter, 1954). LOC has long been related to physical and psychosocial outcomes, as well as with preventive behavior. Scales with some success have been developed and utilized to measure both physical and psychosocial development.

However, oral health outcomes have been given the least attention. One reason for the same is the scarcity of adequate measures that assess LOC and its effect on oral health behavior. The most recognized multidimensional health locus of control scale utilized to measure general health (Wallston et al., 1978); this scale was not recommended by its authors for use with other more specific health conditions such as oral health behavior. An LOC scale specific to oral health may be useful for many oral health providers and oral health educators. Building on the existing, but limited empirical foundation may contribute to a better understanding of oral health seeking behavior; whether a matter of belief in random chance, one’s own internal beliefs, or through belief in powerful others outside of one’s self.5

Many researchers have used the basic LOC scales but found the scales needed to be modified to measure specific diseases or conditions. The disadvantage using multidimensional scales is, they take more time to administer, provide more in depth assessment and are difficult to score in a clinical setting. Hence in the present study, a socio-dental impacts LOC scale (SILOC) developed by Acharaya et al., is used. This scale is short, easily adaptable to different populations and age groups, the scale combines the advantages of the one-dimensional and multidimensional scales by including three subcategories of internal, powerful others, and chance on a one-dimensional scale. Several studies suggested that people’s general health beliefs were inherent to their culture and played a key role in influencing their health care seeking and health behaviors. Therefore, any health intervention must consider, an understanding of culture, tradition, beliefs, and patterns of family interactions.5

On exploration, it was found that not many studies had been done, and not much data is available related to this subject. There have been no studies reported in the literature on the relationship between SILOC and dental myth, therefore if the association is understood, health professionals can be made more aware of the circumstances and can plan health education intervention programs that might lead to the adoption of particular LOC belief which may aid in improving the overall oral health of the community.

The purpose of this current study is aimed at assessing the prevalence of dental myth among the population and to determine the association of SILOC scale with the dental myth.

**MATERIALS AND METHODS**

The present study was a “cross-sectional study” conducted to assess the prevalence of dental myth and to determine the association of SILOC scale with the dental myth among the outpatients attending dental institute.

**Study Population**

The study was conducted by the outpatient in the age of 20-60 years visiting Mathrusri Ramabai Ambedkar Dental College and Hospital in Bengaluru city. All the patients attending the outpatient department (OPD) and who voluntarily agree to participate were included in the study. Confidentiality of the identity of a person was maintained.

**Sampling Technique**

Sampling: The sample size was calculated based on the number of out-patients visiting dental institute.

Sample size was calculated using the following formula:

\[ n = \frac{[\text{DEFF} \times N \times (1-p)]}{[d^2/2 \times (1+\frac{1-p}{N-1})] + p^2} \]

The sample size calculated with confidence level 95% was 132

Assuming 10% nonresponse rate sample size was rounded off to 150

Data was collected over a period of 2-month from March 2015 to June 2015

Ethical clearance was obtained from the institutional review board.

**Inclusion Criteria**

- Patients attending dental OPD in the age group of 20-60 years.

**Exclusion Criteria**

- People who refused to participate in the study
- People who could not comprehend the questions of the study despite the assistance.

**Collection of Data**

**Questionnaire**

A questionnaire was developed to assess the prevalence of dental myth among the population and to determine the association of SILOC scale with the dental myth. All the questions were given alternative choices to help the respondents to make quick decisions, and respondents were asked to tick the most appropriate answer from the given list of answers.

Before the questionnaire was definitely established, the questions were pretested in a pilot study on 20 patients, to assess their ability to understand it. The questionnaire appeared to be easily understood and was finalized with no modification.

Its respective psychometric properties were assessed as follows. Content validity was assessed by a panel of ten experts made up of staff members of all the departments of Mathrusri Ramabai Ambedkar Dental College and hospital, Bengaluru. The purpose was to depict those items with a high degree of agreement among experts Aiken’s V index was used to quantify the concordance between experts for each item and the values higher than 0.85 were always obtained. Cronbach alpha was 0.74 indicating good reliability.

Permission was obtained from the institution authorities to administer the questionnaire to the patients. The objective of the study was explained to all who participated in the study
and also informed consent was obtained from all them. The completed questionnaire was collected back in 10-15 min by the investigator and checked for completeness. Any incomplete forms were asked to be completed.

The questionnaire was divided into three parts:
Section 1: Contained questions on personal data that recorded name, age, gender, occupation, religion, and monthly income. The revised Kuppuswamy Scale was used to assess the socioeconomic status (SES). This most widely used Indian scale divides the population into 5 categories ranging from 1; the highest SES group to 5; the lowest, based on their educational level, occupation and income.
Section 2: Consisted of 16 close-ended questions regarding dental myth. The questions 1-5 were based on myth regarding dental caries. The questions 6-9 were about myths regarding tobacco and oral cancer. The questions 10-16 were related to dental problem and treatment related dental myth.
Section 3: Consisted of seven item SILOC scale. The first two items of the scale evaluates the level of the individual’s ownership regarding his or her oral health status; items three and four, evaluates for the impairment caused by dental caries or missing teeth or periodontal disease, item five, evaluates for the oral activity limitation, and items six and seven evaluates for the restriction in participation and interaction with the society due to poor oral health. The responses for the items were in the Likert format (1-5) with the lower scores signifying “internality” and the higher scores pointing to an “external” LOC. The scoring ranged from 7 to 35. The interquartile range for the SILOC scores was used to classify the population into low, moderate and high LOC groups.

For further statistical analysis, responses to the questions were recorded as correct or incorrect and each of the correct answers was given a score of 1 and the wrong answer score of 0 for the questions regarding dental myth.

Statistical Analysis
Data from the returned questionnaire; were encoded and statistical analysis was performed using the software statistical package for social sciences (IBM SPSS version 21). Descriptive statistics, included percentages, frequencies, and t-test, and Chi-square were used to find out significant differences $P < 0.05$. A scatter plot was used to visualize the relationship between dental myth and SILOC.

RESULTS
The present study was a cross-sectional design, using structured questionnaire; the study was conducted to assess the prevalence of dental myth and to determine the association of SILOC scale with dental myth among the outpatients attending the dental institute.

Section 1
Demographic details (Table 1)
A total of 150 adults aged 20-60 years attending Mathrusri Ramabai Ambedkar dental hospital OPD were approached to participate in the study. The participants had a mean age of 35.4 years, with about 50.7% of the participant in the age group 20-40 years of age (Figure 1). Among 150 participants, 76 (50.7%) were males, and 74 (49.3%) were females (Figure 2). The majority of participants were from the lower middle-class category of SES 73 (48.7%) (Figure 3).

Table 1: Demographic characteristics
<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency (n (%))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>29 (19.3)</td>
</tr>
<tr>
<td>26-40</td>
<td>76 (50.7)</td>
</tr>
<tr>
<td>&gt;40</td>
<td>45 (30.0)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>76 (50.7)</td>
</tr>
<tr>
<td>Female</td>
<td>74 (49.3)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Semi-skilled worker</td>
<td>10 (6.7)</td>
</tr>
<tr>
<td>Skilled worker</td>
<td>41 (27.3)</td>
</tr>
<tr>
<td>Clerical, shop owner, farmer</td>
<td>25 (16.7)</td>
</tr>
<tr>
<td>Semi profession</td>
<td>22 (14.7)</td>
</tr>
<tr>
<td>Profession</td>
<td>49 (32.7)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Primary school certificate</td>
<td>11 (7.3)</td>
</tr>
<tr>
<td>Middle school certificate</td>
<td>40 (26.7)</td>
</tr>
<tr>
<td>High school certificate</td>
<td>49 (32.7)</td>
</tr>
<tr>
<td>Intermediate o post high school</td>
<td>9 (6.0)</td>
</tr>
<tr>
<td>Graduate or post graduate</td>
<td>18 (12.0)</td>
</tr>
<tr>
<td>Honors</td>
<td>23 (15.3)</td>
</tr>
<tr>
<td>Income: (In rupees)</td>
<td></td>
</tr>
<tr>
<td>&lt;1600</td>
<td>3 (2)</td>
</tr>
<tr>
<td>4810-8009</td>
<td>10 (6.7)</td>
</tr>
<tr>
<td>8010-12019</td>
<td>41 (27.3)</td>
</tr>
<tr>
<td>12020-16019</td>
<td>47 (31.3)</td>
</tr>
<tr>
<td>16020-32049</td>
<td>49 (32.7)</td>
</tr>
<tr>
<td>SES</td>
<td></td>
</tr>
<tr>
<td>Upper</td>
<td>31 (20.7)</td>
</tr>
<tr>
<td>Upper middle</td>
<td>18 (12.0)</td>
</tr>
<tr>
<td>Lower middle</td>
<td>73 (48.7)</td>
</tr>
<tr>
<td>Upper lower</td>
<td>26 (17.3)</td>
</tr>
<tr>
<td>Lower</td>
<td>2 (1.3)</td>
</tr>
</tbody>
</table>

SES: Socioeconomic status

Figure 1: Age distribution

Section 2
Responses for questions regarding dental myth
Table 2 shows the descriptive for questions under the domain "myths related to dental decay, tobacco and oral cancer, dental problems, and treatment related myth."
About 55 (36.3%) of the participants had a myth that dental decay occurs because their teeth are soft, 88 (58.7%) of the participants believed that decay in milk teeth need not be treated as they are going to fall anyways and 81 (54%) of the participants had misconception that placing cloves on the carious tooth relieves pain. 74 (49.3%) of the participants responded that they would prefer to undergo extraction when in pain rather than saving it. The majority of the participants 105 (70%) had wrong belief that swelling caused by painful tooth should be fomented with hot water.

Myth related to tobacco and oral cancer
Almost 117 (78%) of the participants were aware that chewing of pan is not good for oral health, almost 124 (82.7%) participant disagreed that only aged people suffer from oral cancer. About 40 (26.7%) participant believed that chewing of paan improves bowel movement after heavy meal. Chewing betel nut quid with slaked lime prevents gum problem was believed by 45 (30%) of the participants.

Myth related to dental problems and treatment
Most participants 105 (70%) had a notion that all dental treatments are painful. About 105 (70%) of the participants believed that it is not important to visit a dentist unless in pain. About 100 (66.7%) believed that tooth once treated will not require any further treatment in future. More than half of the participants believed that professional cleaning by a dentist causes loosening of teeth. About 95 (63.3%) had an opinion that bleeding while brushing is a normal phenomenon.

Almost all the participant believed in one or more dental myth.

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### Section 3

**Seven item SILOC score**

SILOC scale consisted of seven items (Table 3) shows the descriptive for questions under the domain for SILOC. The responses were in the Likert format (1-5); the scoring ranged from 7 to 35. SILOC scores were classified based on their score into low (≤7), moderate (8-10), and high (≥11) and the proportion
of participants in these groups were 28 (18.7%), 15 (10%), and 107 (71.3%), respectively, (Table 4 and Figure 4).

Mean SILOC scores and mean myth scores were compared against gender, we found statistically significant difference ($P < 0.001$), between mean SILOC scores and gender, with males having a lower mean score (14.94) as compared to females (18.62) (Table 5). There was no statistically significant difference found between myth scores and gender.

When SILOC scores and myth scores were compared against SES, it showed statistically significant difference ($P < 0.001$), between them (Tables 6 and 7).

On comparing mean SILOC Scores with mean myth scores using $t$-test, they were found to be significantly associated with each other ($P < 0.001$) (Table 8).

Spearman’s rank correlation coefficient was used to correlate SILOC scores with dental myth scores; it was seen that those with higher SILOC scores had significantly higher myth scores (Figure 5).

**DISCUSSION**

India, a developing country faces many challenges in rendering oral health needs. There is a very strong influence of the various myths on health seeking behavior in Indian population consisting of people from different cultural backgrounds. Myths are part and parcel of everyone’s lives. Myths are a roadblock for access to better oral health among the population.
Table 6: Association of SILOC scores with SES of the study population

<table>
<thead>
<tr>
<th>SILOC scores</th>
<th>Upper class</th>
<th>Upper middle class</th>
<th>Lower middle class</th>
<th>Upper Lower class</th>
<th>Lower class</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>24</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Medium</td>
<td>3</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>13</td>
<td>61</td>
<td>25</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>18</td>
<td>72</td>
<td>26</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

P<0.05: Significant, *Denotes Chi-square, SILOC: Socio-dental impact locus of control scale, SES: Socioeconomic status

Table 7: Association of dental myth scores with SES of the study population

<table>
<thead>
<tr>
<th>Myth scores</th>
<th>Upper class</th>
<th>Upper middle class</th>
<th>Lower middle class</th>
<th>Upper Lower class</th>
<th>Lower class</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (&lt;8)</td>
<td>29</td>
<td>17</td>
<td>22</td>
<td>2</td>
<td>0</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>High (&gt;8)</td>
<td>2</td>
<td>1</td>
<td>50</td>
<td>24</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>18</td>
<td>72</td>
<td>26</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

P<0.05: Significant, *Denotes Chi-square, SES: Socioeconomic status

Table 8: Comparison of mean myth and mean SILOC score

<table>
<thead>
<tr>
<th>Mean Scores</th>
<th>Means±SD</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean myth score</td>
<td>8.25±3.60</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Mean SILOC score</td>
<td>16.76±7.04</td>
<td></td>
</tr>
</tbody>
</table>

P<0.05: Significant, *Denotes t-test, SILOC: Socio-dental impact locus of control scale, SD: Standard deviation

As systems are becoming more entangled and people’s expectations of health-care are increasing with great flair. Understanding the myths and misconceptions about oral diseases is of prime importance in providing excellent care and health education to both patients and healthy individuals, as the high prevalence of these myths will further prevent such population from obtaining proper dental care even if it could be made available to them.

Myths are usually passed on from one generation to the next and can be prevalent in a population due to a variety of reasons such as poor education, cultural beliefs, and social misconceptions. It is very difficult to break this chain as it is deep-seated in the society. Hence, it is important to know about these myths and misconceptions.6,7

Especially in India, where general and oral health is embedded in various myths and ritualistic practices. It would be prudent to familiarize professionals to understand these myths and practices to assist the people, to attain behavioral modifications. Unfortunately, little epidemiological data is available for India. Some common myths regarding oral health prevail in the populations which may act as barriers toward seeking treatment and have an unscientific base and can prove to be harmful to health and also life threatening. Inadequate knowledge of the etiology, course, and outcome of disorders and disease states makes it difficult to initiate health behavioral changes.8

In the present study, a SILOC developed by S. Acharya et al., is used, the possible advantages of the SILOC scale is that it can be adapted for use in different age groups and cultures by modifying the responses. For example, in this study, for “powerful others,” the “family, friends and dentist” were included as people who would wield a powerful influence on their lives. “Family” was an umbrella term which included parents, grandparents, siblings and other relatives. The reason for this was that the extended family occupies a central position in Asian societies by providing material, moral and emotional sustenance and supports to all its members. Hence, the role of the family influence on individual attitudes cannot be overestimated. Similarly, for “Chance” LOC, the responses were “fate” and/or “God.” India is well known for its concept of “Karma” which instills a fatalistic attitude toward life. An individual who has an external LOC would blame his or her fate or God for their oral problems. This scenario would be same in most Asian cultures.9

The results of the current study in context to myth regarding dental caries showed that more than 50% of the participants believed that decay in milk teeth need not be treated as they are going to fall off anyways and it is in accordance with the finding of Vignesh et al., and Khan et al. These findings reveal that the masses are still not aware about the importance of primary/milk teeth, the importance of milk teeth should be communicated to masses as they are vital for masticatory function, aesthetics, for maintenance of space for the erupting permanent teeth, and aids in development of jaws.10,11

The majority of the participants responded that they place clove on the decayed tooth to get rid of pain. As we know a toothache is a dreadful thing, unfortunately, they have a nasty habit of striking in the night, thanks to changes in blood flow, and when the dentist’s office is closed. Cloves are a spice hailing from India and Indonesia, used to warm mulled drinks and chai. Traditionally been thought to cure toothache and this old wives’ tale has scientific merit. Cloves contain eugenol, a phenyl propene that is used commonly in medicine and dentistry as a local antiseptic and anesthetic. Chewing on cloves can serve to numb and clean the affected area. We should also keep in mind, that cloves numb toothaches but aren’t a replacement for treatment.10,11

Almost half of the participant responded that they prefer undergoing extraction when in pain rather than saving it. This may be because people have inadequate knowledge about treatment modalities in saving a tooth, or they feel once the tooth is infected and is painful it’s better to knock out the teeth at one shot rather than undergoing multiple sitting of root canal treatment which is also more expensive.3
The majority of the participant had wrong belief that swelling caused by painful tooth should be fomented with hot water. In reality fomentation done for reducing the pain associated with a decayed tooth may not worsen the pain at times, but it may lead to cellulitis in some cases.12

Most participants had a notion that all dental treatment are painful; these findings are in accordance with the findings of study done by Khan et al.13 About 70% of the participant believed that it is not important to visit a dentist unless in pain. Pain is the symptom which occurs only in the final stages of dental caries and providing treatment at this phase is far more expensive; these findings reveal that the participant had very poor knowledge about prevention of dental diseases. More than half of the participants believed that professional cleaning by a dentist causes loosening of teeth, the results are in line with the findings of study done by Vignesh et al.9 In fact in reality, it is recommended to get professional cleaning done every 6 months to maintain proper oral hygiene. The majority of the participant had an opinion that bleeding while brushing is a normal phenomenon which in reality is the early sign of gum problem and if adequate measures taken at this time to maintain proper oral hygiene it can prevent further progression of disease and morbidity. Most of the participants believed in the myth that extraction of upper jaw teeth affects eye vision. This is a misconception inherited due to false exaggerated information promulgated by those who had previous personal negative dental experiences.13 Vision is not affected in any way by undertaking treatment of the upper teeth including its extraction.

In the current study, one positive finding was that most of the participants were aware about the adverse effect of pan chewing.

Mean SILOC scores and mean Myth scores when compared against gender statistically significant difference was found between mean SILOC scores and gender, with males having lower mean score as compared to females. These findings are not in accordance with the study was done by Acharaya et al. High SILOC scores signifying externality, the reason behind this may be women have strong faith in god and in god’s action; religious faith attenuates the women’s fear and reduces their perceived threat of the disease. Fatalism has been defined as the perception that individuals have the limited influence to change the course of the disease, to detect it early or to prevent it. It is the belief that an individual’s health is beyond their control and that survival is based on luck, fate, and destiny. Fatalistic attitudes may lead to a lack of participation. Faith as a facilitating factor can be encouraged and supported by the health care system if health promotion messages are tailored to appeal the masses. Fatalism, along with fear, is a perception that is formed for a long-time through one’s sociocultural context and it is too difficult to uproot, one possible way to counteract fatalism is by providing knowledge, By doing that, we will “plant the seeds” for future efforts.14-16

In the present, the mean SILOC scores were significantly higher among those who had higher myth score, with positive correlation seen between SILOC scores and myth scores. Previous research has shown that an external LOC was associated with poorer oral health indicators.

Irrespective of the area of residence (whether residing in urban or rural areas) every one of us, have our own beliefs and practices concerning health and disease.17

Limitations of Our Study
Data reported in this study cannot be generalized to the entire Indian population since the study was conducted in urban setting. Exploration of research, to know other myths prevailing in the society is necessary. Furthermore, quantitative and qualitative research studies on a larger sample and for a longer period are essential to circumvent the limitations of the current study, and more research is needed to validate the results of this study.

CONCLUSION
The study population has considerable belief in myth and higher SILOC scores, pointing to an “external” LOC.

REFERENCES

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