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A Descriptive Phenomenological Study of Body Art Patients and Their
Health Care Experience

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A Dissertation Submitted to The Graduate School at the
University of Missouri-St. Louis
in partial fulfillment of the requirements for the degree
Doctor of Philosophy in Nursing

May 2020

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Abstract

This study aimed to update dated research by exploring the relationships between patients with body art (tattoos and body piercings) and their interaction with health care providers. This creates a current description of the body art patient's health care experience. Previous research indicates that body art has been associated with risk taking and deviant behaviors and these behaviors have been used to justify why people with body art are negatively perceived. If the presence of body art and the associated behavior are viewed as a threat to normalcy, then Stangor and Crandall's theory (2000) suggests that stigma may surround the body art population. Health care providers may have developed attitudes perceived by this population if stigma does exist. A descriptive phenomenological methodology was used to explore the perception of the lived experience of the body art patient. Participants who had body art and who had interactions with the health care providers were interviewed using open-ended semi-structured questions. To ensure trustworthiness the interviews were analyzed using Colaizzi's (1978) method. Interviews occurred with 12 participants, with two overarching themes and three essences within each theme discovered. All described their tattoos as a deeply personal artistic representation of who they are and all shared they felt stigma, the two overarching themes. Even though health care access and quality were not affected, several participants stated having negative experiences with health care providers that they perceived were related to their body art. The findings suggest that the body art patient's health care experience may be enhanced with provider recognition that an individual's body art is both deeply meaningful and an important form of identity.

Chapter 1

Introduction

The presence of body art is increasing in society (2010 Pew Research report: U.S. Census Bureau, 2010). Therefore, the chances of health care providers encountering patients with body art are quite high. While individuals acquire body art for various reasons, the co-presence of tattoos and/or body piercings has been associated with high-risk health behavior and/or deviant behavior (Carroll, Riffenburgh, Roberts, & Myhre, 2002). This behavior has been cited to explain why tattooed and pierced persons are negatively perceived by people including health care providers (Stuppy, Armstrong, & Casals-Ariet, 1998).

The associated negative perceptions toward people with body art is explained by Stangor and Crandall's (2000) theory of stigma etiology. Their theory is based on a perceived threat to society's normalcy, which in regard to the body art population is the general presence of a tattoo or piercing and the associated risk taking and deviant behaviors presented in the literature. This deviance from normalcy causes society to group those with body art together as a sub culture. This in turn, causes stigmatized beliefs and attitudes on a societal level to ensue. This consensual sharing of stigmatization leads to those outside a stigmatized group to develop opinions and behaviors that reflect societal beliefs, and stigmatization of certain populations becomes a cultural norm. Therefore, based on Stangor and Crandall's theory stigma may surround the body art population on a societal level. Thus, society, including health care providers, may have developed attitudes and behaviors toward the body art population that reflect the associated stigma.

Because of the possible associated stigma surrounding body art, it is essential to recognize the experiences of those with body art in the clinical setting and their interactions with health care providers. If people with body art perceive negative attitudes from health care providers the patient-provider relationship may suffer, perceptions of care could be hindered, and health outcomes could suffer. First encounter with a patient is crucial, and that first encounter can directly influence the development of a therapeutic relationship (Stuppy et al., 1998). Consequently, if perceived stigma exists a quality therapeutic relationship may not develop, and patients may not be receptive to needed education, counseling, or other health care needs.

If people with body art feel they are negatively perceived and have associated perceptions of stigmatization, this may affect their health care decisions and be reflected in their health care experience. As stated previously patient relationships may deteriorate due to those harmful perceptions, and in turn people with body art may be untrusting of the health care system. Indeed a recent systematic review of implicit bias found patients who perceive they are the target of health care providers' stigmatization are less likely to adhere to treatment (Hall et al., 2015), for example, seeking appropriate, timely care when experiencing symptoms of infection. In another example, Armstrong, Koch, Saunders, Roberts, and Owen (2007) found that people with body piercing complications return to their piercing studio rather than to a main stream health care provider for nonjudgmental care. Historically, the body art population has sought health related information from unqualified personal due to their perceived treatment within the health care system. This presents a problem for the current state of health care, and the number of adults that now have body art.

Problem

Prior research conducted by Armstrong, Roberts, Owen, and Koch (2004a; 2004b), King and Vidourek (2013), and Koch, Roberts, Armstrong, and Owen (2010) concluded that people with body art are at an increased risk to participate in sexual promiscuity, alcohol use, and drug use, and because of these behaviors negative perceptions surround this population. Furthermore, research conducted by Totten, Lipscomb, and Jones (2009) and Caroni and Grossman (2012), found that the number of tattoos and piercings a person has negatively effects how he or she is perceived by others. Research completed by Dean in 2010 and 2011 targeting service workers also indicated that having tattoos was related to negative perceptions of service.

What the research does not address is if these negative perceptions develop into stigmatization of this population, and to what effect this stigmatization, or perceived stigmatization, has on health care. This perceived stigmatization could affect health care access and quality, but this needs to be researched. No research has been conducted concerning the variables associated with body art and stigma. Does location, visibility, or amount of body art change perceptions? Does the meaning behind or type of artwork alter opinions? Do these characteristics have an effect on perceived stigma and health care treatment? Answers to these questions may ensure access to quality healthcare for individuals with body art. Lastly, if the dated research still holds true and this patient population is more prone to deviant and risk taking behaviors, people with body art maybe more likely to need health care services.

Current research of the body art population is lacking. The vast majority of body art research was conducted in the late 1990s and early 2000s. With the absence of recent

research on this phenomenon, further studies regarding tattoos and body piercings need to be done to establish a current understanding of this population. Of note, the changes that have occurred with body art since the 2000s have caused body art to become more main stream in society. There are now reality TV shows based on tattoos (Weinstock, Hersh & Richter, 2012) and it is not uncommon to see prevalent athletes displaying body art on and off the playing field. By investigating how patients with body art describe their art and their health care experience, clarity surrounding this population can begin to be achieved.

Purpose

The overall purpose of qualitative research is to achieve an understanding of how people make sense out of their lives (Merriam, 2009). Qualitative research is more involved in describing the process of achieving meaning, and describing how people interpret what they experience, rather than empirical outcomes (Merriam, 2009). The research question being presented in this proposal is directed toward how people interpret their experiences, how they construct their worldviews, and what meaning they attribute to those experiences, which is the principal goal of qualitative research (Merriam, 2009). Doing qualitative research in body art would help shed some new light on dated findings and open the door for a fresh understanding. Body art is very humanistic in nature, no one piece of artwork is the same, nor is the rationale for obtaining one. Thus, the interpretation of how it is perceived by others and the participant perspectives are highly subjective. The qualitative research process allows for various avenues to be explored through the lived experiences of the presented population to achieve an understanding for the whole (Streubert & Carpenter, 2011).

When looking at the research question the best fit to explore the answers is a descriptive phenomenological methodology. Phenomenology focuses on the lived experience itself and how that experience is transformed into consciousness. The purpose of descriptive phenomenology is to describe this particular phenomenon, or appearance of it, through the lived experience of the participant (Streubert & Carpenter, 2011; Merriam, 2009). The methodology allows the researcher to represent the body art patients' lived experiences in health care.

Descriptive phenomenology directly explores the current experiences of those who have body art by addressing it as a part of their daily lives. Descriptive phenomenology stimulates the perception of the lived experience while emphasizing the richness, breadth, and depth of those experiences (Spiegelberg, 1975). This stimulation allows for a free look into the experiences of people with body art with no underlying assumptions. Through this methodology descriptions surrounding perceptions, body art characteristics, traits of the participants, and health care experiences can take shape. This approach also provides direction for further research studies by proposing new insights in this under-researched phenomenon.

Research Question

The purpose of this study is to explore the relationships between patients with body art (tattoos and body piercings) and their interactions with health care providers, and to uncover the meaning in the experiences of people with body art in the health care setting. The research question to tackle the presented problem and achieve the study purpose is: "How do individuals describe the relationship between body art and their health care experience?"

Definition of Terms

There are many types of body art, including branding, dermals, tattoos, and body piercings (Armstrong, 1991). The most common forms of body art, tattoos and body piercings, are the focus of this study. *Tattooing* is defined as an “invasive procedure where an artist uses an electrically powered, vertically vibrating instrument to inject tattoo pigment 50 to 30,000 times a minute into the dermis at a depth of 1/64th inch to 1/16th of an inch” to create various designs (Armstrong, Owen, Roberts, & Koch, 2002a, p. 23). *Body piercing* is described as the penetration of jewelry into foreign openings of the body such as eyebrows, lips, tongues, nose, navels, nipples and genitals (Armstrong, Ekmark, & Brooks, 1995). For the sake of this study the reference to *body art* refers to tattoos and body piercings only.

Body Surface Area (BSA) of tattoos refers to the Wallace rule of nines (see Figure 1), which is the standardized method used to quickly assess how much body surface area has been burned on a person (Hettiaratchy & Papini, 2004). The Wallace rule of nines allows you to estimate the amount of burned body surface area on an adult by using multiples of nine (Hettiaratchy & Papini, 2004). While this has never been applied to tattoos it is the only reference available to estimate coverage of body surface. For the sake of this study *BSA of tattoos* will be estimated using the Wallace rules of nines. By applying this principle to tattoos, one can approximate the body surface area on an adult that is coated in tattoos. Using this tool allows for control of the amount of tattoos while trying to maintain the four or more tattoo findings of the Koch et al. 2010 study. Participants will have to have at least 9% visible body coverage with tattoos to participate, and/or at least seven piercings that are not located in the earlobes.

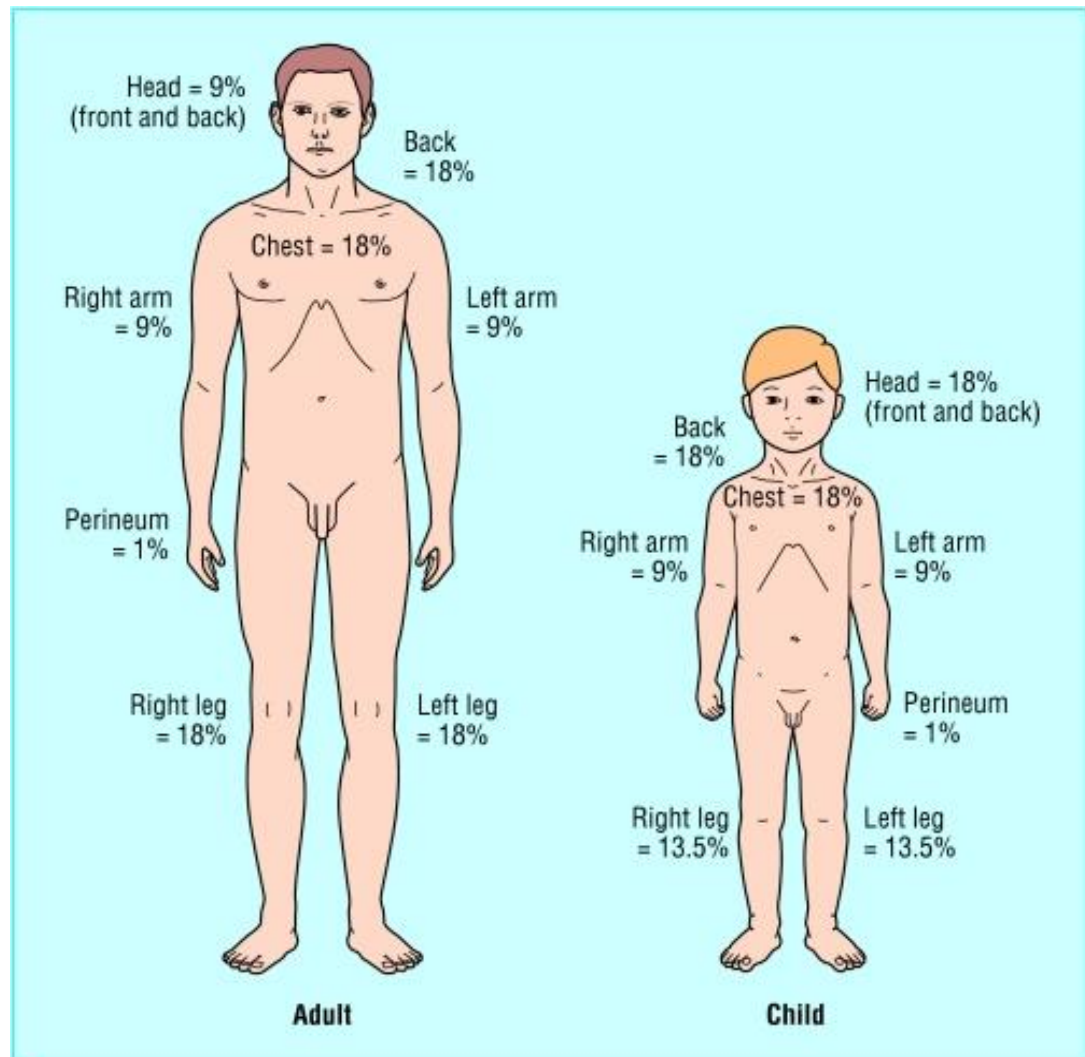
Figure 1. Wallace Rule of Nines

Figure 1. Wallace rule of nines provides an efficient and quick way estimating medium to large burns in adults. The body is divided into areas of 9%, and the total burn area can be calculated. It is not accurate in children. Using Wallace's rule one can estimate the surface area of tattoos. The study will not be done on children. Child diagram provided for reference only. Adapted from "Initial management of a major burn: II—assessment and resuscitation," by S. Hettiaratchy and R. Papini, 2004, *BMJ: British Medical Journal*, 329, p. 101. Copyright 2004 by the British Medical Association.

The research study done by Koch et al. in 2010 found that those with seven or more piercings (excluding earlobes) had a stark difference in deviant behaviors from those with one to three piercings. The same study found significant differences in level of deviance if four or more tattoos was present verse just one tattoo.

Significance

The United States has seen significant growth in body art. In 1992, Anderson estimated that in 1990 only 3% of the United States population had tattoos. However, in 2010 Pew Research report, *Millennials: A Portrait of Generation Next*, found that 38% of Millennials (people born between the years 1981-1991) have at least one tattoo, which according to the 2010 census bureau, is approximately 5% of the total United States population, and a 2% increase with just the millennial generation added. This does not consider the 32% of Gen Xers (people born between the years 1965-1980) that have a tattoo, the 15% of Baby Boomers (people born between the years 1946-1964) and the 6% of Silents (people born between the years 1928-1945) having a tattoo (Pew Research report, 2010). Once those generations are added the total percent of those tattooed in the United States is approximately 16.2%, which is more than a 10% increase in 20 years (U.S. Census Bureau, 2010).

In addition to tattoos, the Pew Research report (2010) also concluded growth in body piercings. Twenty-three percent of Millennials say they have a piercing in a place other than an earlobe, while only 9% of Gen Xers have a piercing somewhere other than an earlobe. With tattoos and body piercings now being a standard activity among adults it is necessary to look to the science to corroborate with current practice applications, and

to further the growth of nursing practice. This, in turn, leads to the improvement of overall health care.

By taking the common concepts found in literature and applying them to current theoretical approaches, one can determine that the body art population is a sub-culture that participates in risk taking and deviant behaviors, and because of this has associated negative perceptions that lead to stigmatization on a societal level. Furthermore, there is evidence to support that an increase in negative perceptions correlates to the amount of body art present. These theoretical insights lead one to question if stigma surrounds the body art population due to their sub-culture identification, motivators, and associated behaviors, and does this stigmatization compare to the amount of artwork?

Based on Stangor and Crandall's (2000) theory of stigma development beliefs and attitudes toward a stigmatized group may develop on a societal level once consensual sharing of information regarding a stigmatized group occurs. Consensual sharing purely means that over time the associated beliefs and attitudes surrounding a particular stigmatized population becomes a societal norm through the everyday sharing of information, and thus stereotyping ensues. This consensual sharing of beliefs happens because society views something as a threat to normalcy (Stangor & Crandall, 2000). As a result, routine social sharing of this perceived threat on a societal level ensues and consensual sharing of beliefs occurs. Once consensual sharing happens the beliefs associated with a stigmatized population are considered a cultural norm. This normalization of stigmatization can cause the development of implicit bias in society. Implicit bias causes the development of unconscious thoughts and feelings that are

difficult for someone to acknowledge and control (Hall et al., 2015). However, these unconscious thoughts and feelings may be perceived by the stigmatized population.

Taking this into account if stigma is indeed present with the body art population on a societal level implicit biases may be present in society and may be perceived by the body art population. This possibility remains true for body art patients seeking health care. Health care providers may exhibit these unconscious behaviors without even knowing it and patients with body art may perceive these behaviors, and this in turn, may affect the health care experience.

How stigma develops and is traversed through societal norms, and thus allows the development of these unconscious attitudes, is important to acknowledge when looking at how people with body art perceive their health care experience. Negative perceptions about people with body art may contribute to disparities in health and health care, due to stigmatization perceived from the patient. This has already been found with race as Hall et al. (2015) found in their systematic review on racial and ethnic implicit bias in health care. Researching the health care experience of someone with body art would contribute to answering the previous stated question, "How do individuals describe the relationship between body art and their health care experience?" and help address the gaps in knowledge that currently exist. It also establishes clarity regarding if stigma on a societal level surrounds this culture as the combination of current theories suggest.

The literature suggests that negative perceptions surround the body art population, but what we do not know currently is if these negative perceptions effect health care. If people with body art feel they are negatively perceived and have associated perceptions of stigmatization this may be reflected in their health care experience, and in turn, the

therapeutic patient relationship may suffer due to those perceptions. Again, the Hall et al. (2015) review found across 15 studies that patients who perceive they are the target of health care providers' stigmatization are less likely to adhere to treatment. Spector (1991) suggests that when health care providers become sensitized to their own bias they may become more accepting of client differences. Using this principle, once health care providers are able to understand the health care experience of people with body art they are able to see how they are perceived through the eyes of a body art patient and recognize their own possible bias. Awareness of the perceptions of the body art population allows health care providers to evaluate their own attitudes and possible implicit bias and allows them to work towards becoming more accepting of client differences due to this realization.

Researching the health care experience of those with body art provides guidelines for current practice applications, and a foundation for future inquiries. The growth in body art in the past few years speaks to the complexity of the phenomenon. Further research from the perspective of the body art population provides a contemporary description for scholars as well as helps determine how people with body art view their health care experiences and the traits associated with those perceptions. In turn, a possible connection can be established regarding perceived perceptions and the effects on health care. New research would help validate if prior characteristics of this population still hold true, if perceived stigma surrounds this population, what (if any) traits contribute to perceived stigma, and whether these influences have an effect on health care.

Assumptions

What is known about the body art population is that body art has been associated with risk taking and deviant behaviors, and people who have body art are perceived negatively by society. What is known about perceived stigmatization from the Hall et al. (2015) review regarding racial implicit bias is that perceived stigmatization has a negative effect on health care outcomes. It can be inferred from the Stangor and Crandall's (2000) theory of stigma development that once consensual sharing occurs on a societal level, biased feelings toward stigmatized populations may develop. Thus, the body art population may perceive stigmatization from society. This normalization in society may cause the development of unconscious thoughts and feelings that are difficult for someone to acknowledge and control (Hall et al., 2015). By taking this into account, and if stigma is indeed present with the body art population, health care providers may exhibit these unconscious behaviors without even knowing it and patients can then perceive those behaviors.

Limitations. In general, qualitative research can be seen as subjective and based on the researcher's descriptions and explanations. The argument can be made that the researcher's personal views may affect the understanding and interpretation of the data collected. That is why the researcher used methodological techniques such as bracketing, which is when the researcher identifies and temporarily sets aside assumptions, and journaling throughout the study to help control bias and presumptions (Wertz et al., 2011). Acknowledging that there is always bias present, and that this bias affects interpretation is an integral part of the descriptive phenomenological research process

(Streubert & Carpenter, 2011). Colaizzi's (1978) methods of data analysis were also used to ensure rigor and validity in the data evaluation process.

In qualitative research there is no result verification by study replication. Since the format of qualitative research is subjective no two studies are the same. The same study design could produce very different results, so the argument can be made that findings from qualitative studies cannot be generalized to larger populations. This is why it is important to provide a clear description of the context, selection and characteristics of the participants, data collection, and the data analysis process (Elo & Kyngas, 2007). This allows for transferability of the study and helps provide rigor and trustworthiness of the findings (Elo & Kyngas, 2007).

Qualitative research has its own challenges, but the actual study itself had limitations. Finding compatible research subjects was a daunting task. First, subjects meeting the strict body art requirements needed to be located. Once those subjects were located an evaluation of their health care exposure was done to determine that they met the criteria of appropriate health care experiences. It was difficult to find body art participants that meet both the amount of body art requirements and health care experience requirements.

Not only was it difficult to find qualified participants, but it was difficult to find qualified participants willing to describe their experiences to an unknown researcher. Talking about personal experiences with a novice researcher is asking a great deal of any candidate. Ascertaining a sufficient population of subjects to interview to provide trustworthiness and transferability to the study is difficult in any qualitative study, but the

added requirements needed for this particular study and the personal subject matter being illustrated presented additional difficulties.

Conclusion

Nurse leaders need to look to the literature regarding body art research for guidance and direction to cultivate new knowledge and to fill the gaps where current science is lacking. Filling the gaps in literature helps further the advancement of nursing research and practice. By establishing significance and exploring common concepts in the literature a rich description of the body art phenomenon can begin to be developed. This description helped facilitate further scientific development and advanced the nursing profession by establishing the gaps in literature related to the health care experience of the body art patient.

Chapter 2

Review of the Literature

It is important to look at the literature examining body art to develop a perception of the phenomenon as well as establish gaps in knowledge that need to be filled. To do this a historical reference must be understood and major concepts identified. Those concepts then need to be applied to theoretical approaches to create a conceptual framework to help facilitate and guide the research study. The gaps in literature established a conceptual understanding of body art. An investigation looking at how patients with body art describe their art and their health care experience can provide clarity surrounding this phenomenon and help fill the gaps in knowledge. This research helped validate whether prior characteristics of this population still hold true, if perceived stigma surrounds this population as the theoretical approaches suggest, what (if any) variables (or conceptual/theoretical explanations) contribute to perceived stigma, and whether this has an effect on health care. The research question to facilitate this study as established by the conceptual understanding is: “How do individuals describe the relationship between body art and their health care experience?”

Level of Evidence

A review of the literature was conducted to identify evidence related to body art. Multiple databases were searched. Two priority databases used for review were, CINAHL and PsycINFO. The keywords chosen to complete the review were body art, tattoos, body piercing, body modification, perceptions, and stigma.

The search yielded 167 articles. Abstracts of 167 articles were reviewed for inclusion criteria: (1) research studies involving tattoos and body piercings, (2) an

identified research method, (3) contained original research data, and (4) involved perceptions of people with body art or behaviors of those with body art. Exclusion criteria included: (1) opinion articles, (2) essays, or (3) editorial articles. Of the 167 articles reviewed, 28 met the inclusion criteria including two qualitative studies explained below.

All qualitative studies that were identified in the initial 167 articles were examined in full. The studies were evaluated for rigor and trustworthiness by assessing for description of data collection, data analysis, quotes from subjects, concluding themes, and limitations. Additional criterion for qualitative studies was applied to determine utility in the literature review. The qualitative studies under review must have included information regarding body art perceptions or behaviors of those with body art. Two qualitative studies met the criteria for selection.

Historical Background

Body art originally served as a form of identification, but in modern society, tattoos and piercings have a variety of meaning including, but not limited to, allegiance, defiance, self-identification, and freedom (Gilliam, Donnelly, & Gopinath, 2009). Both tattoos and piercings are now considered a typical activity, and body art is no longer confined to prison populations, sailors, and gang members (Gilliam et al., 2009). Body adornment can be dated back to ancient times with the world's oldest tattooed mummy, Otzi (Deter-Wolf, Robitaille, Krutak, & Galliot, 2016). Otzi bore 61 tattoo markings across his body, and his death dates back to 3250BC (Deter-Wolf et al., 2016).

Body art became trendy in European nations after the initial Pacific Ocean voyage of Captain Cook in 1769 when his sailors embraced the Tahitian Natives' body art

(DeMello, 2000; Gilliam et al., 2009). Not only did the sailors adopt the body art themselves but, they brought Natives back to Europe and eventually the United States to “display” (DeMello, 2000). Throughout the eighteenth and nineteenth centuries, the display of tattooed natives was a money maker for businessmen (DeMello, 2000). These displays were not only for entertainment, but also highlighted the western advancement and help develop and solidify body art as a form of “savagery” belonging to savages (DeMello, 2000).

According to DeMello (2000), tattooing in this early phase was conflicting because natives with tattoos were seen as savages, however, the practice of tattooing was seen as exotic. Tattoos to working classmen, especially sailors, represented adventure, travel, exotic lands and people, and a free spirit. This belief ultimately became a deeply ingrained part of the North American working-class man and tattoos were transformed from a mark of primitivism to a mark of adventure (DeMello, 2000).

Tattooing as a business evolved in the twentieth century and is often referred to as the “golden age of tattooing.” This was the time that tattooing had perhaps the highest level of societal approval due to its link with patriotism and the nation’s service men fighting in both World War I and II (DeMello, 2000). When Uncle Sam’s fighting boys returned home the focus returned to home life and tattooing in this period became a form of defiance. This contributed to solidifying today’s negative views of tattooing as marginal groups began to wear tattoos in greater numbers. Tattoos began to represent bikers, gangs, prison inmates, hippies, and punks (DeMello, 2000).

However, the accessibility of tattoos and the freedom of the sixties and seventies lead to a “tattoo renaissance” in the eighties (Schildkrout, 2004). This term referred to the

shift in multiple aspects of Western tattooing. For example, the nature of people who created tattoos from tattooist to tattoo artist, a change in clientele from sailors, bikers, and gang members to the middle and upper class, and a change in tattoo design from the badge-like images of premade designs (known as “flash” tattoos) to the customized artwork created by the tattoo artist and client, hence the new term emerging, *body art* (Schildkrout, 2004). This renaissance has given birth to multiple varieties or categories of tattoos. The body art someone has essentially classifies them into a sub grouping (DeMello, 2000). Depending on the type of tattoo someone has it can signify them as an extremist, ex-convict, veteran, biker, and it can even define qualities related to their social status (DeMello, 2000).

Major Concepts

When looking at the literature surrounding body art there are several common themes that have emerged over time. One such theme is risk taking and deviant behaviors. Research conducted by Armstrong, Roberts et al. (2004a), King and Vidourek (2013), and Koch et al. (2010) concluded that people with body art are at an increased risk to participate in sexual promiscuity, alcohol use, and drug use. Another commonality in the research is negative perceptions surrounding those with body art. Research conducted by Totten et al. (2009), Caroni and Grossman (2012), and Dean (2010 & 2011), all found that tattoos and piercings negatively affect how someone is perceived. To elaborate further on perceptions, Caroni and Grossman (2012) and Thomas et al. (2010) considered how the amount of body art effected perceptions. Both studies revealed the number of body markings has a negative effect on people’s perceptions. Lastly, understanding why someone invests in body art was another frequently researched

topic by Armstrong, Owen et al. (2002a & 2002b), Armstrong, Roberts et al. (2004a & 2004b), and Armstrong, Koch et al. (2007). The significance of these major concepts will be explained in detail in the sections below.

Risk taking and deviant behaviors. The literature pertaining to body art can conclude that those with body art tend to engage in more risk taking and deviant behaviors than their non-tattooed and pierced peers. Armstrong, Roberts et al. (2004a), King and Vidourek (2013), and Koch et al. (2010) all used self-reporting questionnaires regarding various behaviors that were defined as risk taking or deviant. Armstrong, Roberts et al., King and Vidourek, and Koch et al. all defined risk taking and deviant behaviors as sexual promiscuity, alcohol use, and drug use. All three studies concluded that people with body art were at an increased risk to participate in such behaviors.

In the Armstrong, Roberts et al. (2004a) study of 450 college students from a large state-supported university from a conservative, rural, southwestern portion of the United States, the percentage who had 6 or more sexual partners in the past year for the non-pierced participants was 14% and for presently pierced was 26%; the prevalence of unprotected sex for the non-pierced was 14% while 87% of pierced participants with a tattoo engaged in unprotected sex. In the King and Vidourek (2013) study, college students ($n = 692$) with and without a tattoo were compared. Those students with a tattoo reported more oral sex ($X^2 = 19.900, p < .001$), sexual intercourse ($X^2 = 53.212, p < .001$), a higher number of lifetime sexual partners [$(M = 6.69, SD = 11.635)$ ($M = 5.27, SD = 9.243$) ($t = 5.439, df = 883, p < .001$)], and a higher number of sexual partners during the last 3 months [$(M = 1.10, SD = 1.253; M = 0.90, SD = 1.416)$, ($t = 2.066, df = 906, p < .039$)]. In the large Koch et al. (2010) study of 1753 American undergraduate

college students in four different convenience samples, two from private religious schools and two from state supported schools, concluded that individuals with four or more tattoos were roughly two to nearly ten times more likely to report various risk taking sexual behaviors (promiscuity and unprotected sex) than those without tattoos.

Comparable findings were found for alcohol and drug use. Armstrong, Roberts et al. (2004a) found that those with body piercings tended to drink five times more within the month than those without piercings. Those with piercings also stated they drank twice as often as their non-pierced peers. King and Vidourek (2013) found similar results. In their study those with tattoos were more likely to use drugs or alcohol before their last sexual encounter [$\chi^2 = 21.427, p < .001$], (King & Vidourek, 2013)] Similarly, Koch et al. (2010) found that individuals with 7 or more body piercings were twice as likely as those with no piercings to use marijuana monthly, and report other illegal drug use. As for tattoos, individuals with 4 or more tattoos were more likely to participate in binge drinking, marijuana use, and promiscuous sex (Koch et al., 2010).

Several other studies concluded an association between adolescents and substance abuse, mainly alcohol use. Deschesnes, Fines, Demers (2006) found an increase in substance use with the presence of body modifications in their study of 2,180 students between 12 and 18 years of age. Brooks, Woods, Knight, Shrier (2003) had similar findings with their study of 210 adolescents ages 14-18 in regard to substance use and an association with tattoos and body piercings. In the same year Stephens (2003) also found significance with having a tattoo and binge drinking ($p < .001$) in his convenience sample of 499 participants entering into military service. Oliveira, Matos, Martins, and Teles (2006) not only found a positive correlation with their sample consisting of 664 Brazilian

adolescents between body art and substance use, but with sexual experiences and illicit drug use as well. In a study of 484 adolescents ages 12-22 attending an Adolescent Naval Medical Clinic in San Diego by Carroll et al. (2002) those with just one tattoo or body piercing had a significantly greater degree of involvement in the areas of drug abuse, sexual activity, disordered eating behaviors, and suicide when compared to peers without a tattoo or body piercing.

Furthermore, additional research done in three separate secondary analysis of national data sets, two done in the United States and one in Australia, by Roberts and Ryan (2002), Laumann and Derick (2006), and Heywood et al. (2012) respectively found an association with body art and risk taking behaviors. In the Roberts and Ryan secondary analysis of the National Longitudinal Study of Adolescent Health data set, tattooed adolescents (ages 12-18) were significantly more likely to report involvement in sexual intercourse ($p < .001$), smoking ($p < .001$), marijuana use ($p < .01$), binge drinking ($p < .01$), fighting ($p < .005$), inflicted injuries ($p < .001$), gang activity ($p < .001$), truancy ($p < .001$), and failing school ($p < .005$). Laumann and Derick, using data collected from the Public Opinion Laboratory on behalf of physicians at the University of Chicago, found that tattoos and body piercings occurs more among those who participate in binge drinking ($p < .05$), drugs ($p < .05$), and actions leading to incarceration ($p < .05$). Finally, the Heywood et al. secondary study using the Australian Longitudinal Study of Health and Relationships data set had similar conclusions. The researchers found that having a tattoo increased involvement in smoking, cannabis use, and those with a tattoo had a greater number of lifetime sexual partners.

Solidifying the position that those with body art tend to be more deviant and participate in riskier behaviors, Ferreira (2014) determined that 15 participants who were actively engaged in a body art project spoke of desires to be *different*. They expressed a desire to show the *visible intensity* they felt about society or relationships, and they wanted to *stand out* among the crowd. These expressed themes in this qualitative study violate social norms and further show that even those with body art view themselves as having abnormal societal characteristics. Even a study done by Armstrong and Pace-Murphy in 1997 found that the majority of adolescents tattooed (57% $n = 121$) in their study labeled themselves as “risk takers.”

Negative perceptions. Stangor and Crandall (2000) define negative perceptions as perceptions that lack positive and affirmative qualities and show tendency toward opposition or resistance. After the description of risk taking and deviant behaviors that are associated with body art it is no surprise that they are negative perceptions surrounding this population. In 2001, Forbes noted that Western society views those with tattoos as “perverts, psychopaths, prostitutes, criminals, gangs, and psychotics” (p.774). Supporting this concept Totten et al. (2009) found that the majority of their respondents ($n = 496$) in their study agreed that the presence of tattoos (85.3%) and piercings (80.8%) a person has makes a difference in how someone is perceived by society. Lastly, in a 2012 qualitative study of nurse assistants conducted by Caroni and Grossman (2012) found that all seven nurse assistants had negative perceptions towards people with body art. The themes associated with those perceptions were deviant behaviors, health risks, and mental disorders.

Compelling research shows body art is viewed negatively in-service occupations as well. Dean completed two studies in 2010 and 2011. Both studies were conducted to investigate customer perceptions of service employees with visible tattoos. Together the studies showed that having tattoos was negatively related to people's perceptions of the quality of service they received. The 2010 study using a convenience sample of 122 college students ranging from 18-24 years in age, listed several service occupations, including nurses, and words associated with nurses who had body art were unsanitary and dirty. Dean's 2011 study directly supported his 2010 findings. The study used 191 participants stretching in age from 18 to older than 49, showed that the confidence in the ability of the tattooed employee was significantly less than that for the non-tattooed employee (mean difference of 1.40, $t = 4.06$, $df = 120$, $p < .001$).

Resenhoft, Villa, and Wiseman (2008), Seiter and Hatch (2005), Thomas, et al. (2010), and Westerfield, Stafford, Speroni, and Daniel (2012) used similar research methods to show that having visible body art on a healthcare provider affects people's perception of the health care providers in a negative way. In the Resenhoft et al. study the 158 community college participants rated the model without tattoos as more honest and religious, and those models with tattoos as less caring and less attractive. Seiter and Hatch using a convenience sample of 148 undergraduate college students determined that models without tattoos were significantly higher rated on competence, character, sociability, and extroversion. All 240 subjects in the Thomas et al. study that consisted of patients, nurses, students and faculty, rated the nurses with the most amount of body art as the least skilled, caring, and knowledgeable. The nurses with the lowest amount of body art were rated statistically more positively on all three attributes (mean caring = 3.6,

$p < .05$; mean skill = 3.5, $p < .05$; mean knowledge = 3.4, $p < .05$), whereas the nurse with the highest level of body art was rated most negatively (mean caring =2.6, mean skill =2.5, mean knowledge=2.4). The Westerfield et al. study of 150 hospitalized adult patients concluded that females ($n=150$) without visible body piercings were considered to be more confident (50%), professional (70%), efficient (51%), and approachable (55%) than pierced female care providers.

Amount. Caroni and Grossman (2012) and Thomas, et al. (2010) also discovered that the amount of body markings has a distinct correlation on people's perceptions. Caroni and Grossman conducted seven interviews with patient care assistants, and several common themes were found in all interviews. One of those themes was that the number, location, and type of tattoos and piercings interfered with their perception of the patient. Likewise, Thomas et al. found that the more body markings a health care provider had the more negatively they were perceived. The nurse with the minimal level of body art was rated statistically higher in caring, skill and knowledge (mean caring = 3.6, mean skill = 3.5, mean knowledge = 3.4), whereas the nurse with the highest level of body art was rated lowest in all three attributes [(mean caring = 3.6, $p < .05$; mean skill = 3.5, $p < .05$; mean knowledge = 3.4, $p < .05$) (Thomas et al., 2010)].

Interestingly, in the Koch et al. (2010) study the researchers found that individuals with four or more tattoos (compared to those with none, one, two, or three tattoos) were statistically more likely to engage in monthly marijuana use ($p < .001$), have multiple sex partners (9 or more) ($p < .001$), participate in binge drinking ($p < .01$), and have an arrest history ($p < .001$). Similarly, they found that that individuals with seven or more body piercings were twice as likely as those with no piercings to use marijuana monthly and

report other illegal drug use ($p < .001$). These findings suggest that there is a possible connection between amount of body art and risk-taking behaviors.

Motivators. Body art is popular with college students because it provides strength in their own identity and image (Armstrong, Owen, et al., 2002a). When looking at the research conducted by Armstrong, Roberts et al. (2004a & 2004b) major motivations for obtaining body art among college students were “uniqueness,” “to be myself,” and that it was a form of “self-expression.” Armstrong, Owen et al. (2002b) found a common theme among tattoos in their convenience sample of 520 college students for obtaining a tattoo, “I just wanted one.” In their research, they found that most college students, both tattooed and non-tattooed, agreed that there was no underlying reason for getting a tattoo, but that it was a form of self-expression (Armstrong, Owen et al., 2002b). Another study conducted by Armstrong, Koch et al. in 2007 using data gathered from contemporary college students regarding body piercings found that uniqueness was a key deciding factor for obtaining a piercing. This supports the findings found in the two Armstrong, Roberts et al. studies that were previously stated. It can be determined from these studies that body art is an important aspect of self-identity for those who choose to obtain it.

Theoretical Framework

Sub cultural identity theory. One theory stands out when looking at the existing literature surrounding body art, sub-cultural identity theory. The theory was first used by Berger (1967) to describe religious groups. He argued that extremely religious groupings are essentially sub-cultures experiencing their religiosity together under what he termed a “sacred canopy” (Berger, 1967). Wellman (1999) further summarizes that for sub-cultural identities to thrive they need to be in tension with, though not separate from, the common

cultural norms. Thus, those within the culture create “out-groupings” to further solidify their identity, essentially making societal norms the enemy (Wellman, 1999). The underlying logic of sub-cultural identity theory is the common theme that sub-cultures stand within, but are distinctly different from, mainstream society (Koch et al., 2010).

The Koch et al. (2010) study propositioned that tattoo collectors, artist and piercers must not only increase the number of tattoos and piercings they have in order to uphold their sub-culture identity, they are also more likely to distinguish their status with elevated levels of risk taking and deviant behaviors. This need to increase body art was due to the increase prevalence of tattoos in society and the “normalization” of body art, thus the need to stand out from the normal with more amounts of artwork and deviance (Koch et al., 2010). Schildkrout (2004) also discussed the need to push the limits of acceptability regarding body art to ensure outsider status and maintain sub-culture identity. In the Armstrong, Roberts et al. (2004b) study sub-cultural identity theory was used explain how social and psychological motivators to procure body art illustrate emotional needs of belonging to a group, shocking peers, and keeping people at a distance while attracting others into a specific social network. In both these studies sub-cultural identity theory was a notable theory to use. The theory was an excellent choice when exploring some of the defining characteristics of the body art phenomenon.

Stigma. The research using sub-cultural identity theory concluded that the body art population considers themselves a sub-culture apart from mainstream society. From the acquisition of more artwork and partaking in more risk taking and deviant behaviors, to the motivators of uniqueness and self-identity, the body art population, or culture, has

made sure they stand-out from the norm. This desire to stand out from society is the very definition of stigma as defined by Goffman (1963).

It is important to define what stigma is and understand how it develops on a societal level when talking about how it effects health care. Such an understanding of stigma and its development exposes how societal influences can affect perceived perceptions that can contribute to the quality of health care for a stigmatized population, and possibly those with body art. Erving Goffman was the leading scholar on stigma in society and his philosophical approaches to stigma remain the cornerstone of stigma research, Goffman's principles, as they pertain to body art, will be explained below.

Goffman's philosophy. Stigma has been defined in many different ways.

According to Goffman (1963) stigma is "evidence that arises showing someone possessing an attribute that makes him different from others in the category, and then in turn makes them less desirable" (p.3). Goffman states that stigma causes a discrepancy in someone's social identity, but that not all undesirable attributes are an issue. It is only those attributes that are incongruous with societal norms of what a given type of individual should be (Goffman, 1963). The research done using sub-cultural identity theory established the body art population as a sub-culture, and the very nature of the theory suggests a grouping that is distinctly different from mainstream norms. Thus, the argument can be made that stigma is associated with the body art population.

Perceived stigma. According to Goffman (1963) stigmatized individuals tend to hold the same beliefs about social identity as non-stigmatized people. Goffman concludes that, "the basis of these claims are not on what someone thinks he is due, but only on where he belongs or fits into in society" (p.7). Based on this philosophy a stigmatized

person may perceive that others do not really “accept” them and may not view themselves on equal ground. This leads to a stigmatized person possibly accepting the treatment associated with the stigma and even anticipate receiving it, because they believe that their attributes warrant the stigmatization and associated treatment (Goffman, 1963). Thus, using this philosophy one can predict that someone with body art believes they are going to be stigmatized, and are in turn choosing that distinction as the motivator of “uniqueness” suggest. Thus, a person with body modifications may anticipate the treatment associated with their stigmatization and may even welcome it. This could increase the likelihood of this population having preconceived notions of certain behaviors.

Visibility. Another area that Goffman speaks passionately about is visibility and the correlation to stigma. Goffman’s (1963) philosophy discusses individuals with “body abominations” (e.g. facial deformities, amputations, scars, etc.) as being more likely to be perceived as different or deviant, and therefore, the associated stigma is more pronounced. Goffman also concludes that the more deformities someone has the more deviant or different they are and therefore, the more stigmatized the individual. Goffman ascertains that “abominations of the body” are generally associated with rejection and avoidance of the individuals, and the stigmatized treatment is more pronounced for more visible body alterations. Using Goffman’s philosophy, the more visible the body art the greater the associated stigma. This is supported by research from Caroni and Grossman (2012) and Thomas et al. (2010). Both studies found that the larger the amount of body art the higher the correlation with negative perceptions.

Theory of stigma development. What is known from the sub-cultural identity research is that the body art population considers themselves different from mainstream society and strives to be so. What we know from Goffman is that being different can cause stigma. What needs to be understood now is how stigma develops on a societal level. Stangor and Crandall's (2000) theory of stigma development will be used to explain how stigma develops on a societal level (see Figure 2).

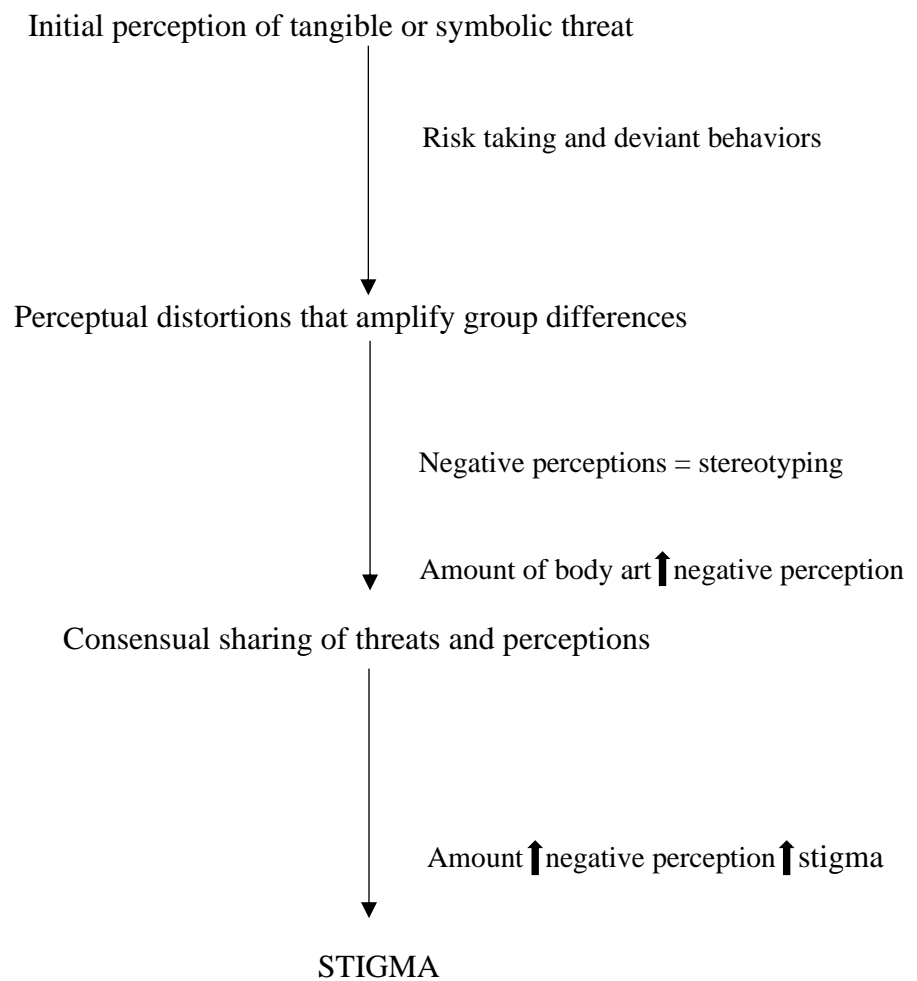
Figure 2. Theory of Stigma Development with Body Art Inferences

Figure 2. Stangor and Crandall's theory of stigma development. The role of threat, perceptual distortions, and societal sharing in the development of stigma with body art concepts added. Adapted from "A Theory of Stigma Etiology," C. Stangor and C. Crandall, 2000, *The social psychology of stigma*, p. 73. Copyright 2000 by The Guilford Press.

The basis of Stangor and Crandall's (2000) theory is that stigma is caused by a perceived threat. As defined by Stangor and Crandall, a threat is a characteristic an individual perceives as a danger to the individual or to the culture. Per the information provided in the literature people with body art are associated with more risk taking and deviant behaviors. The risk taking and deviant behaviors pose a threat to the individual, and the simple motivators to stand out from society make the body art population a perceived threat to culture. A 'threat to culture' causes perceptual distortions to occur and amplifies the group distinctions, i.e. stereotyping. Once stereotyping ensues stigmatization at a societal level develops and consensual sharing of beliefs occur. Enhancing this theory, according to Koch et al. (2010) the more body art someone has the more risk taking and deviant behaviors they participate in, therefore the more pronounced the threat and associated stigma.

Amount. From the science it can be determined that the amount of body art is associated with an increase in negative perceptions (Caroni & Grossman, 2012; Thomas et al., 2010). This is in direct correlation with Goffman's philosophy on visibility. He suggests that the more visible the stigma, the more pronounced the stigmatization. It makes sense that the more tattoos and piercings someone has the more likely they are to be visible or become visible to society.

Applying this concept to Stangor and Crandall's theory and Goffman's philosophy suggests as the amount of tattoos and piercings increase so does the perceived threat, and therefore, associated negative perceptions. Thus, causing an increase in stigmatization to occur. For example, someone with a single small tattoo is still associated with stigmatization, but is stigmatized less than someone who has several

large tattoos. In turn, someone who presents several large tattoos would perceive stigmatization at a greater level than someone with a single small back tattoo. Using Stangor and Crandall's theory provides an understanding of stigma development, and how it is preserved, tolerated, and condoned in society. The theoretical application of consensual stigma toward the body art population led to the research question, "how do you assess the associated stigmatization of a population, and what effects does this have on the health care experience?" To do this, research from the patient perspective was needed.

Taking the concepts from the literature and previous theoretical approaches given one can identify that body art is a sub-culture that participates in risk taking and deviant behaviors, and because of this has associated negative perceptions that lead to stigmatization on a societal level. Furthermore, there is evidence to support that an increase in negative perceptions correlates to the amount of body art present. These theoretical insights lead one to question if stigma surrounds the body art population due to their sub-culture identification, motivators, and associated behaviors, and does this stigmatization compare to the amount of artwork? As stated previously Koch et al. (2010) found that individuals with four or more tattoos were statistically more likely to engage in risk taking and deviant behaviors and the same was true for individuals with seven or more body piercings. Leading one to concluded that there is a possible connection between perceived stigma and the amount of body art. No research has been conducted looking at perceived perceptions and to see if these concepts and further associated theoretical approaches holds true as the dated literature suggests.

Advancement of Nursing Research

The vast majority of studies identified from the literature search were conducted in the late 1990s and early 2000s. With the lack of current research on this growing trend further research regarding tattoos and body piercings need to be done. Furthermore, no research could be found looking at perceptions from the body art patient perspective. There is no data to determine if perceived stigma surrounds this population as the literature suggests, or if perceived stigma influences health care. With the lack of recent knowledge scholars are forced to use dated information to gather information. New research needs to be done to cultivate a new modern understanding of this phenomenon. People with body art may be linked to risk taking and deviant behaviors, but new research needs to be done to determine if this dated research still holds true. Current qualitative research would explore if indeed perceived stigma surrounds this population, and if these perceptions in turn have an effect health care.

Also, there is only very basic research, if any, regarding the location of the tattoo contributing to stigma. If we use Goffman's (1963) research, we can hypothesize that "abominations of the body" that are more visible and located on the face cause more stigma than tattoos are piercings that are hidden from view. Unfortunately, there is very limited research specifically targeting the impact of the variables associated with body art.

Those with multiple body markings are easily identified and stand out among those with smaller or less noticeable artwork. Conducting contemporary research would help identify if perceived perceptions are the same for all those with body art or if those with more conventional tattoos and/or piercings are perceived differently than those with

gang, or derogatory artwork. By researching this patient population further, a better understanding of the impact of body art variables on stigma can be achieved. It is important to have new investigations into this phenomenon to discover if there are differing features that make a distinction in perceived experience of the body art patient.

When reviewing articles finding high quality research studies that conducted rigorous research, had proven instruments, and used large sample sizes was not challenging. With all research, however, there are areas that need improvement and topics that need further investigation. Just as with the strengths of the research the weaknesses of the research were conclusive, and gaps in the research guide the need for future studies. The numerous research studies that have been done speak to the strong level of evidence, however the lack of current research on this topic leaves someone to question if this evidence still holds true and has relevance today.

Current application to practice. Understanding the science surrounding the body art phenomenon allows health care providers to provide education and counseling on a patient specific level. After reviewing the literature, it can be determined that people with body art tend to participate in more risk taking and deviant behaviors (Armstrong, Roberts, et al., 2004a; King & Vidourek, 2013; & Koch et al., 2010; Deschesnes et al., 2006; Brooks et al., 2003; Stephens, 2003; Oliveira et al., 2006; Carroll et al., 2002; Roberts & Ryan, 2002; Laumann & Derick, 2006; and Heywood et al., 2012). Knowing that people with body art participate in this type of conduct can alert health care providers for signs and symptoms of these activities and can provide for personalized patient teaching. As previously stated, people with body art view their art work as a piece of their identity, and health care providers need to recognize this as such. Recognizing body art as

a form of self-expression helps build a therapeutic relationship and can facilitate education and counseling on a patient specific level.

Future practice implications. Using the concepts described and applying them to Stangor and Crandall's (2000) theory of stigma development (see Figure 2), suggests that negative perceptions toward the body art population can progress into stigma. Stangor and Crandall propose that stigma requires an initial function incentive, which in this case is the risk taking behaviors. Their theory simply states that negative perceptions develop into stereotypes that are widely known, tolerated, and accepted in society. Thus, there is a consensus that people with tattoos and body piercings are connected with societal stigma because of their risk taking behaviors that lead to negative perceptions. It can be further concluded from the literature that the amount of body art someone has may contribute to perceptions. An increase in body art may increase negative perceptions, and therefore associated stigma. Furthermore, since body art helps nurture someone's identity the stigma associated with this population could in turn affect health care.

Perceived stigma impact. Nurse leaders need to look to the literature regarding body art research for guidance and direction to cultivate new knowledge, and to fill the gaps where current science is lacking. Filling the gaps in literature helps the further advancement of nursing research and practice. What is known about body art is that this population is associated with risk taking and deviant behaviors, and people who have body art are perceived negatively. What is known about perceived stigmatization from the Hall et al. (2015) study regarding racial implicit bias is that perceived stigmatization has a negative effect on health care outcomes. Further investigations need to be done to, validate or refute, perceived stigmatization on health care access and quality.

Therapeutic relationship. The exact effect body art has on health care quality and the therapeutic relationship has yet to be research. However, what we do know about the therapeutic relationship from Spector (1991) is that when health care providers become sensitized to their own bias, they may become more accepting of client differences. By researching the effects of body art on health care from a patient perspective an understating of perceived perceptions of health care providers can be ascertained. Applying Spector's principle, once health care providers are able to understand the health care experience of someone with body art, they are able to comprehend how they are perceived. Once this realization takes place, health care providers can recognize their own possible bias and begin working toward overcoming it and in turn, improve the therapeutic relationship.

Variables. The motivations for obtaining body art have also been investigated, but limited research has been conducted examining the variables associated with body art and perceived perceptions. Yes, there is some research regarding how the amount of body art negatively effects people's perceptions, but there is no data regarding if the people who have body art believe it affects societal perceptions. In turn, there is no data looking at how those societal perceptions alter the perceived perceptions of the body art population. Again, no research has been done looking at how having body art effects the health care experience from the perspective of the body art patient.

Another question presented by Funk and Todorov (2013) is, "does number of body markings make the difference in societal perception, or is it location?" Funk and Todorov conducted a study regarding facial tattoos and the effects of guilty verdicts. They conducted three different studies, and each study concluded that the presence of a

single facial tattoo affected guilt ($p < .001$). Is it location, visibility, or amount that effects perceived perception of the experience? Do these characteristics have an effect on the perceived health care experience? These questions are answered by conducting new investigations into this phenomenon.

Conclusion

Body art is a highly diverse subject that requires multiple lenses to establish a complete comprehension of the phenomenon of interest. In order to address what is not known and to see if there are perceptions of stigma from the body art population, concepts must be derived from the existing literature and multiple theoretical perspectives must be utilized to understand the effects on perceived stigma and health care. It is necessary to examine the literature and to gather an understanding of common concepts to apply to theoretical approaches that cultivate an understanding of the phenomenon and together fill the gaps in knowledge. From the theoretical and conceptual approaches presented a correlation toward body art and stigma can be uncovered. By conducting research from the patient perspective regarding the health care experience of those with body art the effects of perceived stigmatization on health care are established and closes the gap in this lacking subject area.

Chapter 3

Methodology

Qualitative Methodology

The general purpose of qualitative research is to ascertain an understanding of how people make meaning out of their daily lives (Merriam, 2009). Qualitative research is concerned with describing the process of achieving meaning, and describing how people interpret what they experience, rather than producing analytic and statistical outcomes (Ravitch & Carl, 2016). The research question presented in chapter one is directed toward how people decipher their experiences, how they create their worldviews, and what significance they attribute to those experiences, which is the principal goal of qualitative research (Merriam, 2009). Qualitative research in body art shed some new light on the dated findings and opened the door for a fresh understanding of this patient population. Body art is very humanistic in nature as it is a common human expression, has historical roots, and is simultaneously unique for each person and every person's experience. No one piece of artwork is the same, nor is the rationale for obtaining one. Thus, its interpretation of how it is perceived by others, and how it is experienced by the participant themselves is highly subjective. The qualitative research process allows for various avenues to be explored through the lived experiences of the targeted population to achieve an understanding for the whole (Merriam, 2009).

Postpositivism. Many forms of qualitative research fall within a postpositivism paradigm (Creswell, 2013). Postpositivism uses a social science framework that does not use strict cause and effect and recognize that all cause and effect is measured in the possibility that it may or may not occur (Creswell, 2013). According to Streubert and

Carpenter (2011), postpositivism provides an opportunity to answer questions based on social experiences and takes into consideration how those experiences have shaped an individual's reality. Simply put, postpositivists recognize that truth is a matter of perspective, and that no one person's experiences is the same (Finlay, 2009). The focus of postpositivism is on having a relative understanding of the phenomenon by uncovering the lived experience not empirical evidence (Finlay, 2009). Postpositivists concede there are multiple different life experiences and realities to consider and, therefore, forego any need for a true fixed meaning (Streubert & Carpenter, 2011; Finlay, 2009).

The theories presented in chapter two are compatible with the postpositivist movement. The tenets of the theories in chapter 2 provide logic and understanding that guide a meticulous study, yet still left flexibility and subjectivity that is needed when looking at the lived experience (Creswell, 2013; Finlay, 2009). As previously stated, the body art phenomenon itself has a very humanistic nature with multiple personal experiences and viewpoints to consider. In turn, eliciting multiple perspectives from participants rather than seeking a single reality is the best suited way to conduct research, and this is the very heart of the postpositivism movement.

Descriptive Phenomenology. When looking closer at the research question, and applying the lens of postpositivism, the best fit to explore the answers is a descriptive phenomenological methodology. Phenomenology focuses on the lived experience itself and how that experience is transformed into consciousness. The aim of descriptive phenomenology is to describe a particular phenomenon, or appearance of it, through the lived experience of the participant (Streubert & Carpenter, 2011; Merriam, 2009). The lived experience and one's direct awareness of an event is given through a rich

description of perception, thought, memory, imagination, and emotion (Reiners, 2012). This statement is the central component for the research question.

Descriptive phenomenology provided a rich description with breadth and depth of the lived experience of someone with body art in the healthcare setting (Spiegelberg, 1975). A descriptive phenomenological approach guided the exploration of the current experiences of those with body art by addressing it as a part of their daily life, or life world. This stimulation allowed for a free look into the experiences of people with body art with no underlying assumptions by setting aside judgments and hypothesis (Reiners, 2012). Through this methodological approach, descriptions surrounding perceptions of participants, body art characteristics, individualities of the participants, and health care experiences began to take shape. Since no research has been done looking at the lived experience of the body art patient new insights for further research studies were uncovered.

Philosophical background. It is important to understand the philosophical background of the chosen methodology when using a qualitative approach, specifically a descriptive phenomenological approach, The founding father of phenomenology is Edmund Husserl (1859 – 1938). The method is a descriptive, qualitative study of the human experience with the aim to conceptualize the processes and structures of life (Wertz et al., 2011). Husserl argued that life situations should be viewed as they are lived and experienced, with nothing added or subtracted (Wertz et al., 2011). The philosophical underpinning of Husserlian phenomenology is that of the lived human experience, which is at the very core of the research questions presented (Chistensen, Welch, & Barr, 2017). Husserl justified the importance of focusing on the human world

as a foundation of science that brought justice to the everyday lived experience—*the going to the things themselves* (Lopez & Willis, 2004). Husserl believed that the experience as recognized by human consciousness has importance and should be a target of scientific study (Lopez & Willis, 2004). Furthermore, Husserl concluded that humans generally go about their daily lives without reflection on those experiences, and he believed that a systematic or scientific method was needed to help enable this critical reflection (Lopez & Willis, 2004). Husserl's descriptions of the life-world does not capture the raw essence of the phenomena or how the phenomenon was experienced, but explores the nuance, the contextual underpinnings, the emotiveness, and the actions that are evoked in consciousness (Chistensen et al., 2017).

Husserl believed that in order to 'return to the things themselves' the researcher must put aside all other knowledge about the phenomenon (Wertz et al., 2011). *Bracketing* requires the researcher to remain neutral and unbiased with respect to the existence of the body art phenomenon. This act of *bracketing* prior knowledge of subject matter allows the researcher to address what Husserl referred to as the "lifeworld" and accurately describe the phenomena under investigation (Wertz et al., 2011). Husserl referred to the power of 'phenomenological reduction', a concept whereby the researcher focuses on the existence of the phenomenon independent of the subjective experience. This enables the researcher to describe how the situation presents itself as itself through the lived experience. Through this process the researcher can selectively turn the existence of the phenomenon into meaning by discovering *essences*, or lived experiences, that are common to all persons who have experienced the phenomenon (Lopez & Willis, 2004).

The goal of the researcher is to achieve *transcendental subjectivity*, a Husserlian concept. *Transcendental subjectivity* means that the influence of the researcher on the investigation is constantly evaluated, and biases and preconceptions are defused, so that they do not influence the study (Lopez & Willis, 2004). This suspension of beliefs and assumptions begins the *bracketing* process (or *epoche*), and thus *bracketing* begins phenomenological reduction. According to Wertz et al., (2011) the phenomenological reduction process is reflective and rather than narrowing the field, it opens the field to embrace all the complexities of life.

This philosophical orientation was suited for the study of body art because of the complexity of the experience in question. Due to the individualistic nature of body art, the phenomenon had multiple facets to be explored: What is the nature of acquiring body art? What does the experience of deciding upon and acquiring body art include? How have your life experiences influence your decision? What effects do body art perceptions have on your life? What effects do those perceptions have on your health? Body art is not one dimensional, and all of these questions present consequences that have an effect on the individual and their lived experience. A descriptive phenomenological study grounded in Husserl's philosophy allows for these multiple perspectives to be taken into consideration.

Human actions are manipulated by what people perceive to be real, and Husserl argued that, because of this, subjective information should be of value to scientists seeking to comprehend human motivation (Lopez & Willis, 2004). Perceived perception and, therefore, associated actions may be present with the body art population. If they have perceived perceptions of stigmatization due to their associated negative perceptions

as the literature suggests, these harmful perceptions may impact their acquisition of health care. By conducting a descriptive phenomenological study situated in Husserlian philosophy, an understanding of the health care actions linked to behaviors of individuals in this population can be described.

Colaizzi. Using Husserlian philosophy, Colaizzi (1978) developed a seven step approach to data analysis in descriptive phenomenological nursing research. Colaizzi's (1978) method of data analysis is rigorous, stays close to the data, and therefore ensures the credibility and reliability of the results. According to Morrow, Rodriguez and King (2015), using Colaizzi's method ensures that the end result is an all-encompassing description of the phenomenon that is further validated by the participants. Colaizzi's method provides direction to decoding Husserl's philosophy and allows meaning to form from rich descriptions. Using Colaizzi's method guides researchers to uncover themes among entwined relationships by providing a clear and logical process through which the general structure of the experience can be explored (Morrow et al., 2015; Reiners, 2012).

Methods

Looking at how a qualitative descriptive phenomenological approach with an associated Husserlian philosophy influences setting, sample, methods, and data analysis will be explored in the sections below. Data analysis using Colaizzi's seven steps will be described in further detail, and how using this method ensures trustworthiness and provides reliability to the research study will be explained.

Research question. The research question that was used was a question that allows the description of the phenomenon to *show itself* in broad ways. As previously stated, the primary research question to guide the interview and tackle the presented

problem was: "How do individuals describe the relationship between body art and their health care experience?" An interview guide outlining the interview process is presented in the Appendix section (see Appendix A).

Setting. According to Streubert and Carpenter (2011) the setting for qualitative research is in the field, and the field is where individuals of interest live and where they experience life. For this study it was necessary for the interviews to take place in a location that was selected by the participant but agreed upon by the researcher. This allowed the participant to be in a natural setting and for trust to begin based on the reciprocal nature of the decision making (Streuber & Carpenter, 2011). For example, the interviews took place in a restaurant, hospital cafeteria, and over the phone.

Sample. To achieve answers to the research problem and related research question purposeful sampling was done, because it selected individuals for study participation based on their specific awareness of the phenomenon for the distinct purpose of communicating that knowledge (Streubert & Carpenter, 2011). Visible location of body art and amount of body art were key deciding factor in selection to ensure that the most influential information was obtained. Inclusion and exclusion criteria were defined based on existing literature pertaining to what amount, location, and type of body art, produced the most significant findings.

The research study done by Koch et al. in 2010 found that those with seven or more piercings (excluding earlobes) had a stark difference in deviance from those with one to three piercings. The same study found significant differences in level of deviance if four or more tattoos was present verse just one tattoo. The Wallace rule of nines (see Figure 1), which is the standardized method used to quickly assess how much body

surface area has been burned on a person, was applied to those with tattoos (Hettiaratchy & Papini, 2004). The Wallace rule of nines allows you to estimate the amount of burned body surface area on an adult by using multiples of nine (Hettiaratchy & Papini, 2004). By applying this principle to tattoos, one can approximate the body surface area on an adult that is coated in tattoos. Participants had to have at least 9% visible body coverage with tattoos to participate, and/or at least seven piercings that were not located in the earlobes.

Since the research question focused on how people with body art describe their health care experience, participants had to have prior exposure to health care facilities and/or health care treatment. Participants must have been exposed to health care through the acute care setting, primary care services, or outpatient facility at least once, with the body art qualifications stated above. This allowed for a truthful response to the research question, and an accurate understanding of the phenomenon of interest.

A brief survey was done with each possible participant via email, text message, or phone call prior to the interviews to determine inclusion criteria (see Appendix B). There were no race or gender limits on participants, and all participants were adults. Exclusion criteria consisted of not meeting the tattoo or piercing requirements, not being the legal age of eighteen or older, and not having prior health care experiences while having body art. The sampling concluded once saturation occurred and no new information was discovered.

By using the Wallace rules of nines the *BSA of tattoos* will be estimated and by applying this principle one can approximate the body surface area on an adult that is coated in tattoos. Using this tool allows for control of the amount of tattoos while trying

to maintain the four or more tattoo findings of the Koch et al. 2010 study. Participants will have to have at least 9% visible body coverage with tattoos to participate, and/or at least seven piercings that are not located in the earlobes.

The tattoo and piercing requirements were constructed by using the Wallace rules of nines and using it to estimate the *BSA of tattoos*. Using the Wallace rule and provided control over the amount of tattoos while trying to maintain the four or more tattoo findings of the Koch et al. 2010 study. Participants had to have at least 9% body coverage with tattoos to participate, and/or at least seven piercings that are not located in the earlobes.

There was a total of 12 participants who met the study requirements and participated in the study. There were four additional participants who originally showed interest in the study, but there was no contact from them after several attempts via email, text message and phone call to schedule an interview. Two people showed interest, but on further review with the follow up email one had never sought health care while having tattoos and one did not meet the 9% tattoo requirement. Only two participants had piercings. One had a piercing in the navel, and one had a nose piercing. No participant had seven or more body piercing. The participants ranged in age from 18-40, and when they received their first tattoo fluctuated from age 18 to 40.

Data collection. Recruitment of possible subjects was done at various body art studios. Flyers outlining the research study with the researchers contact information were handed out at random to people presenting to the studios (see Appendix C). Permission from the body art studio was obtained prior to distribution. The flyer was also shared on social media outlets. Each potential interview subject was screened for eligibility via

follow up email, direct message, text message, or phone call using an enrollment eligibility phone/email script (see Appendix B). Snowball sampling was also exercised in sample recruitment. According to Ravitch and Carl (2016) snowballing allows existing study subjects to recruit future subjects from among their acquaintances.

Due to the nature of descriptive phenomenology and the presented research question, open ended semi-structured interviews were used to collect data. This allowed for the presence of an unstructured conversation, but still provided some focus toward the research question. Using semi-structured interviews provided the opportunity for greater latitude in the answers provided, and since the research question was general and descriptive in nature the respondents were able to move about freely getting to the essence of the phenomenon and the lived experiences of the participant (Streubert & Carpenter, 2011). All interviews were audio recorded and verbatim transcriptions of the interviews were prepared for data analysis.

Journaling was done by the researcher after each interview and while data analysis was occurring. Journaling was used to write down ideas, feelings, and responses that emerge during the data collection process. Furthermore, journaling was done to assist with *bracketing* (explained in detail in data analysis section). Journaling was considered data in the context of the study for the part it played in contributing to the analysis process and study results.

Data analysis. According to Husserl, the analysis process begins with phenomenological reduction, which is the revisiting of initial recognition regarding the phenomenon under investigation (Streubert & Carpenter, 2011). Husserl challenged individuals to go “back to the things themselves” to uncover original awareness

(Spiegelberg, 1975). Husserl's reference "to the things" meant a new tactic toward the phenomenon and being as free as possible from the theoretical assumptions in an attempt to describe the phenomenon as authentically as possible (Spiegelberg, 1975).

As stated prior, the researcher wanted to achieve *transcendental subjectivity*. To do this the researcher was constantly assessing for bias to ensure they remained neutral. This, in turn, ensures that the researcher's attitudes and beliefs did not influence the study (Lopez & Willis, 2004). This *bracketing* prior assumptions helped achieve *transcendental subjectivity*, and by doing this the researcher was able to observe and describe the body art phenomenon objectively. Once this objectivity was created, the researcher began to locate commonalities in the data. Husserl believed that there are *essences* to lived experiences that are shared with all persons who have that experience, and these *essences* represent the real complexity of the phenomenon (Lopez & Willis, 2004). For the description of the lived experience regarding people with body art to be considered a science, cohesions in the experience of the participants was found, so a common description was achievable.

Colaizzi's method. The first step in Colaizzi's data analysis is to read and re-read each transcript to gain understanding of the content as a whole (Morrow et al., 2015). The first read through was read out loud by the researcher, and during the second read through notes were taken in the margins of the transcripts regarding the thoughts generated from reading the interview. Key phrases and statements were highlighted using a color coding system with each color representing a different idea.

Once this was done each significant statement was extracted and recorded on a different sheet noting their line and page number (Morrow et al., 2015). This completed

Colaizzi's second step. Meanings from these significant statements was then formulated in accordance with Colaizzi's third step (Morrow et al., 2015). Then these were formulated into meanings and grouped together into categories, and the categories were further grouped together into clusters to create themes or *essences* (Morrow et al., 2015). Thus, completing the fourth step.

Step five took the uncovered *essences* and integrated them into an exhaustive written description of the phenomenon (Morrow et al., 2015). Once this was done the researcher begin step six, which concluded when the exhaustive descriptions were condensed down to a short statement that captured just the aspects deemed to be essential to the structure of the phenomenon, in turn creating a fundamental structure (Morrow et al., 2015). The last and final step was done by taking the fundamental structure statement to the participants to ask whether it captured their experience (Morrow et al., 2015). Of the 12 participants 11 agreed to the fundamental structure statement. One participant never provided any feedback regarding the statement even after several attempts to contact her via text message, email, and phone call.

Once the interviews were complete, they were transcribed by a professional transcriptionist, and were read and reread by the primary researcher looking for significant statements. Significant statements were first underlined and then highlighted using a color coding system by the primary researcher. Once all significant statements were accounted for and color coded, meaning was driven from those statements through a thorough analytical process using an analysis group that consisted of the primary researcher and an expert in qualitative research. The primary researcher controlled the

conversation and each significant statement was read aloud, discussed, and categorized to ensure census in meaning.

Four additional meetings included other expert researchers that were on the researcher's dissertation committee. These additional colleagues provided valuable feedback and were able to help deduce that the analytical process was objective and rigorous. Each member of the research team had the opportunity to have input into the analysis discussion and was able to conclude how significant statements were derived and patterns and essences discovered.

Through this process a clustering of the statements revealed two overarching themes and three associated essences and a fundamental structure. The fundamental structure consisted of a signal descriptive statement which was presented to the participants for verification. The statement that was presented to the participants is as follows, "Tattoos have meaning, they are a representative of "who I am" as a person. Tattoos are art, and location of artwork and being able to cover is a conscious thought due to the stigma still associated with them. Stigma is still present with tattoos, but this is changing, and younger generations are leading this change. Regarding healthcare, if you don't have anything nice to say don't say anything at all. If negative comments are made about someone's body art that person will typically switch providers. If you do have something nice to say, body art makes a great conversation starter." One of the 12 participants refused to offer a reply after several attempts to contact them. The other 11 participants replied in agreement to the above statement.

Trustworthiness. To ensure rigor and validity of the study Colaizzi's strategy and steps of descriptive phenomenological data analysis was used (see Figure 3).

Implementing this method helped define the analysis process and provide an outline for the study. This outline provided structure and a well-defined understanding of how the data analysis was carried out, and how *essences* were discovered. Using Colaizzi's strategy demonstrated links between the results and the data by ensuring that direct quotes and phrases from the participants was used to formulate significant statements and categories (Elo & Kyngas, 2007). Colaizzi's method also supported outcome validation by using "member checking," which was having agreement from the participants on the emerged results (Shosha, 2012). Once the data analysis was completed and an exhaustive description of the phenomenon was done, the researcher reviewed the results with the participants to ensure accuracy.

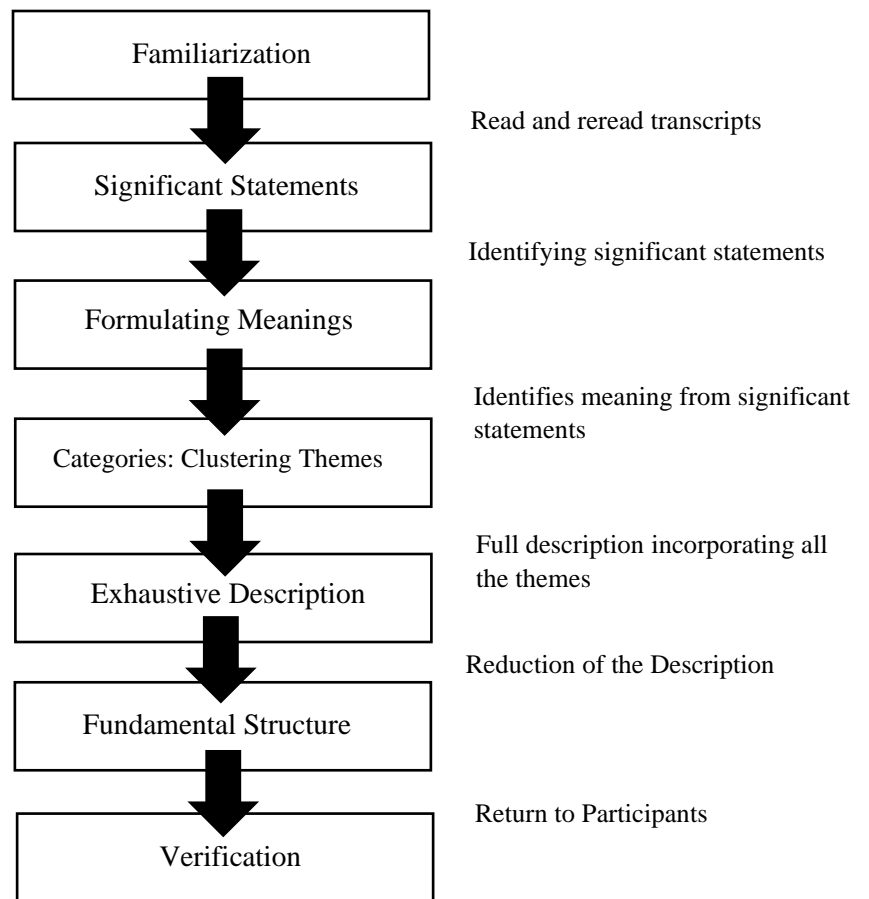
Figure 3. Colaizzi's Strategy for Phenomenological Data Analysis

Figure 3. Illustration of the process of descriptive phenomenological data analysis created by Colaizzi in 1978.

Human Subject Protection

Participation in the study was voluntary and participants were allowed to withdraw their consent at any time. The entire interview was audio-recorded and transcribed by an experienced transcriptionist that took out all names and identifying features so that the data was completely anonymous. The audio-recordings were destroyed once the de-identified transcripts were checked for accuracy. Audio-recordings

and de-identified transcripts were exchanged via a password protected secure computer system and electronic copies of the de-identified transcripts are kept in a password protected secure computer system. Paper copies of the de-identified transcripts are kept in a locked secured cabinet for research and educational purposes only. IRB approval was obtained from the University of Missouri St. Louis (see Appendix D) for the study and prior to participant recruitment.

Conclusion

A descriptive phenomenological approach grounded in the philosophy of Edmund Husserl provided a rich picture of the body art phenomenon and extend the knowledge of this under researched population. The findings in this qualitative study helped facilitate a postmodern understanding that is current and helps cultivate new notions yet to be discovered. Not only did the study allow for the birth of new concepts, but the descriptive nature of the study also reconfirm some dated findings. This research helped address the gap in literature by determining if negative perceptions surround this population, and to what effect these perceptions had on health care. Conducting a descriptive phenomenological study provided an understanding of how body art influences health care through various variables and perceived perceptions.

Chapter 4

Findings

This study addresses the experience of body art patients, mainly those with tattoos, as constructed from descriptions of 12 individuals. Each participant recalled their experience as a person with body art and as a patient with body art. Descriptive findings were derived using Colaizzi's seven step method of analysis (Colaizzi, 1978). The participants are understood as representative voices for people with at least 9% visible body coverage with tattoos by using the Wallace rule of nines to participate, and/or at least seven piercings that are not located in the earlobes (Hettiaratchy & Papini, 2004). In the deconstruction and review of the transcripts a common understanding across storied representations emerged. Through the interview process, participants constructed the story, bringing to the forefront the essences of the experience of the body art person. The findings help clarify the experiences of body art patients, a significant element to help health care professionals design and implement more effective holistic care.

Participants

The participant sample consisted of 12 adults, Janis, Lisa, Cheryl, Karen, Cindy, Stephanie, Joyce, Deb, Chris, Kim, Eric, and Nick, who had varying sizes, location, amount, and designs of tattoos. The names are chosen pseudonyms to maintain anonymity and were chosen at random and based on names of current colleagues the researcher works with in higher education. The participants ranged in age from 28-45 years old. Nine out of the 12 participants were female. Five of the 12 interviews were conducted in person and the others were conducted over the phone. All 12 participants had sought health care while having body art present and one sought health care for a

tattoo related infection. The 12 participants were recruited over approximately seven months. Age, race, gender, education level, age of first tattoo, and place of residence was the only demographic information collected.

Overarching Patterns and Associated Essences

In essence, the findings indicate that individuals with body art consider their tattoos as a part of them and a representation of who they are through artwork. Because of this representation deep meaning is associated with body art and participants have a devotional impetus to extend that representation. Participants illustrated strong feelings about the ability to cover their tattoos and the visibility of them. However, several participants described associated stigma and judgment with their body art, even with health care professionals. These findings beckon healthcare professionals to reframe their thinking and expand their understanding about the meaning that underlies an individual's body art.

After using Colaizzi's method two overarching patterns emerged: *See Me* and *Judging a Book by its Cover*. These two patterns subsume associated essences that show the importance of someone's body art, as well as, how they view themselves through society's convictions. Both patterns and their contributing essences help answer the question, "how do individuals describe the relationship between body art and their health care experience?"

Table 1

Patterns and Essences Discovered

Overarching Patterns	<i>See Me</i>	<i>Judging a Book by its Cover</i>
Essences	<i>This is me</i>	<i>You can't hide anymore</i>
	<i>Art defines who I am</i>	<i>Society is changing</i>
	<i>I have more to say</i>	<i>Younger generations are more accepting</i>

See Me. The first principal pattern, *See Me*, illustrates the importance of body art to its owner, “You know, they’re a part of me, and if you don’t want to see them, you don’t want to see me (Janis, 1. 209-210).” Not only do tattoos have meaning, but they are an outward expression on the skin of what that person feels, believes, and cherishes. When talking about her tattoos Janis stated, “You know, they’re a part of me, and if you don’t want to see them, you don’t want to see me (Janis, 1. 209-210).” By *seeing* someone’s body art you are realizing the significance, artistic portrayal, and devotion behind the tattoo, and these are the essences connected to this overarching pattern.

This is me. Cheryl talked very openly about her body art, further representing that they are just a part of her, “I mean, they’re there. I have them. And, you know, it’s part of my life (Cheryl, 1. 339-340).” And she says later in the interview, “Because, I mean, I just feel like this is – this is me. This is who I’ve always been (Cheryl, 1. 97-98).” These statements by Cheryl represent the significance body art has to a person. When looking at someone’s body art you are looking into the very heart of who that person is. Body art is an outward depiction of someone’s soul. This was very intimately described by Kim and Nick (respectively):

I think it describes me and like describes who I am and my beliefs and my feelings. And it just describes – like my husband, like when I was talking to him about it, I was like, “Is there any tattoo on my arm that you don’t like?” That kind of a conversation. And he’s like – he said, “No, because that – your arm is you. It’s like everything that you are (Kim, 1. 313-318).

I started getting tattoos ‘cause my wife and I were going through multiple, multiple miscarriages and we kind of wanted something to commemorate that. So, I started with like the tree of life, and each one of the branches was like, ah, a miscarriage that we had had. And so that – that kind of progressed. And then I put my dog on me, who he was like our son at that time since we couldn’t have children at that point. And it – it’s kind of like been a journey for both of us, um, seeing the additions that we’ve been able to have, both good and bad -- you know, having a son around. And it’s just – it’s a way of sharing a story (Nick, 1. 112-123).

For Kim and Nick their body art is an intimate conversation of their life and by *seeing* their body art they are letting you see into the deepest parts of their life. When looking at some ones tattoos you are looking at them describing outwardly very particular aspects of their life, personality, and relationships. An individual with body art is asking you not only to see their tattoos, but to see that *This is me*, that they are their tattoos and their tattoos are them.

Art defines who I am. We can describe tattoos as a visual representation of who an individual is through artwork. When looking at someone’s tattoos you are looking at them describing outwardly varied aspects of their life, personality, and relationships.

Joyce stated, “But I feel like it demonstrates and articulates art through my body is the way that I feel. That it really – I don’t know how to explain it other than it defines who I am through art (Joyce, 1. 15-18).”

This artistic reflection was something seen with almost every participant. Several participants referred to their skin as ‘canvas’ or their tattoos as ‘piece of art.’ Making it clear that tattoos are artwork done by an artist and the canvas is the skin. “Cause that – that’s also the appeal to me with tattoos is it is somebody’s art that you are being that canvas for (Eric, 1. 167-169),” this was statement made by Eric. He even referenced this again later in the interview:

I liked the experience and I – I just think this goes back to, yes, it was the design I had a friend draw, but after that it’s kind of you’re the canvas and you get kind of art put on you. I like that process (Eric, 1. 295-297).

This feeling of *tattoos as art* is described often in the interview process.

Participants describe the need to have a personalized ‘piece of artwork.’ Deb not only talked about the artist, but what he created, “And the tattoo artist, what he did – what he created was awesome. He freehanded like how he shaded it, and it’s unique and I love it (Deb, 1. 63-66).” She references how he freehanded the piece and the uniqueness of the tattoo signifying that the uniqueness and individualized aspects of the tattoo are what makes her love it. The explanation behind each tattoo is as unique as the tattoo itself, and that is what drives people to obtain them and to keep acquiring them.

I have more to say. With the personal connection to tattoos and the experience of obtaining a tattoo, it is no wonder that tattooed individuals describe a devotional attribute towards their body art. This need to get more was seen with several participants and not

only the need to get more, but the desire to represent different parts themselves. In Nick's interview he stated he was "hooked" on getting tattoos, and when asked about getting more tattoos his eloquent response was, "Um I—I think I have more to say (Nick, 1. 403)." This simple statement tells us again that tattoos are a desire to say more and to tell more through art. Tattoos are a thirst that body art people feel compelled to quench.

This compulsion to get more tattoos is derived from the need to artfully represent more aspects of themselves or life events. As seen with Joyce's comment, "I mean, until my entire body is full, I don't know that I'll be completely done. You know (Joyce, 1. 289-290)?" Joyce was not alone in her comment. This need and desire to obtain more tattoos was seen in numerous participants. This devotional quality, *to say more*, is not only represented in the artwork, but the need commemorated life experiences:

I just have weird – like every time I've been tattooed, I just have distinct memories of every single process. And I can always think of like details of the artist, the music that was playing, and just like the type of day it was. Like it's just weird. It's like some of that is tattooed on there as well. And that's part of the process and the story that – you know, I guess it's like memory. It's not only just what you're getting, but that experience (Eric, 1. 416-419).

When looking at someone's body art you are accepting an intimate look into that person's life. You are allowed access to their life through their artistic representation. By seeing a tattoo, you are not just looking at colors on skin, but a noteworthy piece of that person's life. When you look at someone's tattoos you are *seeing* them, and by seeing them you are witnessing an individual who is devoted to a lifestyle that is a direct reflection of who they are.

Judging a Book by its Cover. All participants shared that they felt stigma or judgement associated with their tattoos. However, several participants expressed not caring about what others thought or they stated they “don’t pay attention” to other people. Nevertheless, it was clear when completing these interviews that perceived stigma was present among this group. Cheryl stated within the first minute of the interview that she feels judged, “I do because I feel like you’re automatically judged. Like judging a book by its cover (Cheryl, 1. 10-12).” Another essence associated with stigma is the visibility of a tattoo and the ability to cover if needed due to the correlating stigma. However, along with stigma comments associated with age and a change in culture were made. Participants suggested that older generations harbor more judgement. Consequently, several participants made direct mention of parent or grandparent disapproval.

You can’t hide anymore. One thing that was clear when interviewing these participants was that visibility of tattoos was a concern. That is, they expressed concern over whether the tattoo could be covered if needed or the tattoo was located in a place that could not be covered easily. This need to cover and the discussion of location was discussed multiple times further strengthening the understanding that stigma still does exist. Eric talked about how not having a tattoo that is not easily hidden (a tattoo located on the neck or hand) makes him a coward:

Cause that – I – I don’t know. Maybe ‘cause that’s like a leap with tattoos I wouldn’t take. Why, I don’t know. Because maybe that makes me a bit of a coward because I’ve got tattoos I can – I can hide. Where all of a sudden, when you get ‘em on your neck or your hand, it is out there. You can’t hide it anymore (Eric, 1. 73-82).

A comment from Karen shows how crucial to her it is to be able to cover her artwork when needed linking again stigma and tattoo visibility:

So, I will do my best to make sure everything's covered because I don't know how that person will perceive me. Just because I don't know the personality how – you know, because I still must remember some people are what I call old school. Where they look down on body art. And I don't want them to look at me and say, oh, I don't know if I want to work with that person. I don't know if I want interaction with them just because of what they see (Karen, 1. 569-579).

This need to cover at work was the same for Eric:

But this goes back to as well, you know, I – it was in the back of my mind that I – here's my typical work uniform. Here's my imaginary line of where – where I'm gonna stop – just so I'm not crossing that line at work. Not that there is one, but just keep that side to myself when I have my shirt and tie on (Eric, 1. 339-345).

This statement further solidifies the need to cover tattoos when wanted, especially for Eric, because of the associated stigma surrounding the culture. Stephanie further emphasized that visibility of a tattoo has a direct impact on the associated stigma:

I guess if I had one on my face, people's perceptions are going to change. Like if I had a giant neck tattoo across the middle of my throat, people would think differently. Yeah, totally. Um, mine are in not inconspicuous spots, but like more normal spots, I guess is the word. Like on my forearm. One's on my ankle. One's on my bicep. It's a little more traditional places to put 'em that most people have 'em. Um, but if I was to get like, you know, like I said, my face

tattooed – which I'd never do – then, yeah, people would probably treat me differently or think differently about me (Stephanie, 1. 439-452).

By having tattoos that are easily visible and by allowing an individual to see your tattoos *You can't hide anymore*. You are allowing an individual not only to see your tattoos, but who you are as a person, and in turn are inviting in stigma related to society's perceptions. Having an individual show you their body art means they are letting down their guard and letting you into a very special aspect of their life. They are asking you to *See Me* through their artwork regardless of society's convictions.

Society is changing. Even though the participants felt stigma was still present most participants referred to a change in the culture, meaning that tattoos are more accepted now than in the past. Karen, even referred to her own stigma towards tattooed people and how it has evolved “I know before I got my first one, I know how – to me the way I thought the way people looked at people with tattoos is they don't have good jobs. Or they're into things that they shouldn't be – and everything else. But society is changing (Karen, 1. 144-150).”

Cheryl referenced this shift towards acceptance by stating, “And I think just because so many people have so many tattoos now, it's just really, um – it's just so mainstream now (Cheryl, 1. 480-481).” Stephanie also commented on this change “It was kind of seen as a fringe – the fringes of society are people who would get tattoos on their bodies. It wasn't a common practice like it is today (Stephanie, 1. 258-260).” Nick even indicated that he waited till it was more socially acceptable to get his first tattoo:

You know, I – I got into tattoos late. Ah, I didn't get my first tattoo until I was thirty-six. I think it was – it – it's just become more socially acceptable for

people. Ah, it's no longer, you know, the bikers, the – the bad boys, the people who are in jail. I – I think it's transitioned in like a lot of generations now where – where people are more open to seeing it. And – and it doesn't lead to a stereotype anymore (Nick, 1. 46-52).

However, it is important to note that even though society is changing towards a more accepting culture, stigma is still present. As Cindy states, "I think it's a lot more accepted than it was, but there's still people definitely that – that look down on you for choosing to present yourself this way (Cindy, 1. 206-208)." Cindy goes on to elaborate that you are looked at as a criminal or a lower-class citizen.

Younger generations are more accepting. Several participants referred to age playing a factor in perceived stigma. They stated that younger generations are more accepting than the older generations, and that older generations grew up in a "different time." This was noted in Cheryl's interview, "Let me say that, um, people of younger generations are a little bit more accepting than older generations (Cheryl, 1. 45-46)." Lisa clearly stated in her interview that she gets, "a lot less (judgement) from younger people than I do from those maybe like forty and up (Lisa, 1. 69-70)." and Kim goes as far as to say that she gets "looks and stares from older-older people (Kim, 1. 53)." Cindy even discussed how in a previous job she did not cover her tattoos because she felt it made her "seem more accessible to the younger people (Cindy, 1. 17)." The accessibility Cindy suggests describes a connection between younger people and the acceptance of tattoos.

Multiple participants indicated some form of parental disapproval. This reference to parents and/or grandparent disapproval promotes the concept that older generations harbor more stigma toward body art. Also, it should be noted that the two participants

who did not express parental disapproval are the two oldest participants in the study, and they are the two participants who were the oldest when they received their first tattoo.

This begs the question if they view themselves in this older generation.

This pattern of *Judging a Book by its Cover* pulled judgement and stigma to the forefront. While it centered on visibility and a positive change in culture there were stressors that came to a head. People with tattoos feel that their tattoos are a direct reflection of who they are through art and when judged because of their choice of self-reflection they defend those choices. Joyce, had a strained relationship with her grandparents because of her tattoos, and this came out in the interview:

I think that it's neither here nor there whether I have a tattoo or not. Because does that make you love me less? Does that make you feel less about me? Does that make me less of a person? Like you have to explain. I understand that they grew up in a different era. I understand that they grew up with different, you know – I – I just don't think that they would've ever accepted me with tattoos (Joyce, 1. 700-708).

The same was true for Janis:

My body art put a huge strain on my relationship with my grandparents. Um, one set of my grandparents disowned me because of it. They've since figured out that I'm still the same person and they can get over it and look past me having tattoos. I'm still their granddaughter. We're – we're better now (Janis, 1. 165-169)”

When seeing someone's body art they are showing you a private story. When someone feels judged because of their choices it's frustrating for them as they are

devoted to their tattoos and view themselves as incomplete without them. Not accepting someone because of their body art is the same as not accepting them at all.

Body Art Connection and Health Care

Taking the two overarching patterns and the associated essence into the consideration, we can describe the experience of body art patients as well as different connections to health care. Several participants made comments like “they don’t pay much attention to it,” meaning negative stares or comments. “I don’t give much – pay a whole lot of attention to, you know, like people looking at me negatively (Lisa, 1. 37-38).” And maybe my way of thinking where I don’t – I don’t lend that much credence to other people’s opinions (Lisa, 1. 137-138),” was the direct comment made by Lisa. This was followed in the interview with Cheryl when she said, “I started getting tattoos when I was eighteen, so I’m over it (referring to the negative stares). I mean it is what it is. You know, I don’t regret it. I wouldn’t change a thing and, you know, I still want more (Cheryl, 1. 31-36).”

This attitude toward perceived perceptions may lead body art patients to not acknowledge, or possibly deny, stigma that is present in health care because they simply do not pay attention to it. Consequently, they may have a cynical opinion of health care in general and that may influence their perceived perceptions of health care as seen with the interview with Stephanie. She talks about seeing a lot of psychologists and switching doctors and she does not consider this a bad experience. She states that her experiences have been, “Just kind of a typical, this is how – this is what I expect of a healthcare experience (Stephanie, 1. 78-79).”

Three participants did have negative experiences with health care providers in relation to their body art, and of those three, all said they “don’t care if people like it” or that they could “really give a shit less” (referring to their tattoos). However, all three of these individuals switched providers based on their negative experience. This signifies the importance of body art to the individual, and while they may say they don’t care about people’s opinions, if stigma is perceived, they will change providers as in the interview seen with Kim:

I mean, I thought that was kind of rude and aggressive in how she like grabbed my arm. (Sic) Um, she – I – I thought it was like – I tell people all the time – they like ask about my tattoos and stuff and I’ve had someone say something before, but it definitely has stuck with me on how she was going on and on about it. I guess it made me feel uncomfortable, but at the same time like uncomfortable as like how dare you in a way (Kim, 1. 68-75).

Still, two participants could recall a positive experience with health care providers. Janis talked about going to see her obstetrician,

“My OB in particular, every time I go in she’s like, “Do you have any new ones? And we go over all of ‘em, and she’s always super excited to see all of ‘em. (Janis, 1. 106-108).”

The same was seen in Cheryl. She talked about her health care providers making positive comments about “liking the way they look or having enough courage to get one (Cheryl, 1. 582-583).” This shows that meaningful experiences are remembered no matter their context.

Another thing to note was that all participants responded that their body art would not or did not prevent them from seeking health care. On the flip side, two participants did not let health conditions keep them from getting tattooed. Cindy nonchalantly talked about getting tattoos while on immunosuppressants for Crohn's Disease, "Ah, I still actively get tattooed with all the healthcare concerns that I have. (Laughter) Even when I was on immunosuppressants I was still getting tattooed (Cindy, 1. 216-218)." This shows the devotion and deep connection people have to their body art. Not only do they view it as a part of them, but they will not hesitate to continue getting tattooed even if that means putting their own health at risk.

Taking note of someone's body art and initiating a conversation about the significance, artwork, and devotion behind it helps to establish a 'personal connection piece.' Looking at body art and recognizing the deep meaning associated with it prevents the *how dare you* attitude felt by patients and contributes to holistic care. Tattoos may also offer healthcare providers with a visual medical history and possibly identify health concerns. As we have seen those who felt they were stigmatized did not hesitate to switch providers. Even those participants who said they did not have a negative experience with health care providers said they would switch providers if they perceived one. By openly talking about body art in conversation health care providers would help strengthen therapeutic relationships and the overall complete care of the body art patient.

Discussion

The current study confirmed previous research in at least three ways. First, negative perceptions persist with the body art culture today as the dated literature suggested. Totten et al. (2009) suggested that presence of tattoos makes a difference in

how an individual is perceived, and when analyzing the interviews, the participants still felt some associated stigma. However, when looking through these interviews it seems that society is changing and becoming more accepting of tattoos with the younger generations are leading this revolution.

Caroni and Grossman (2012) and Thomas, et al. (2010) established a correlation with amount of body art and negative perceptions, with more body art correlating with more negative perceptions. This was discussed in the interviews as well with not being able to *hide anymore* with tattoos. The location of a tattoo and the ability to cover tattoos was something brought up by the participants. The ability to cover a tattoo and hide it gave some great angst as described by Eric and his 'imaginary line.' This correlation with amount and visibility go hand in hand. The more tattoos you have the more likely they are to be visible and in turn the associated negative perceptions would increase. This was discussed with Joyce when talking about her covering her tattoos for the sake of her children, "But when it comes to big decisions like that are empirical or impressive situations for my children, I try very hard to not be showy-showy. I'm gonna have to cover 'em all up." This simple statement portrays that she covers up her body art to hide from the negative perceptions associated with it.

Another interesting topic that was found in the research that was discussed in the interviews was the motivators surrounding obtaining body art. In Armstrong's (2002a, 2002b, 2004a, 2004b, and 2007) collective work it was found that body art was popular among college students because it was a form of self-expression and an important aspect of self-identity. This remains true. When analyzing the interviews, it was found that by

looking at someone's tattoos you are essentially looking at a visual representation of who they are as a person. They are saying *see me*, this is who I am through artwork.

One thing that was found in the literature that was not found in this study was risk taking and deviant behaviors. Multiple studies found an association with body art and various behaviors that were defined as risk taking or deviant (sexual promiscuity, drug use, and alcohol use). However, only one participant mentioned using alcohol and drugs to self-medicate. No other interviewees ever approached the topic or mentioned it in conversation. However, no questions in the interview guide pertained to risk taking or deviant behaviors.

Application to Sub Cultural Identity Theory, Goffman's philosophy, and the Theory of Stigma Development previously suggested that having body art would lead to negative perceptions toward this population and stigma would develop on a societal level (Koch et al., 2010; Streubert, & Carpenter; 2011; Goffman, 1963). Thus, this would integrate into health care and perceived stigma from health care providers could interfere with health care. Even though only a small number of participants had negative experiences with health care their experiences were profound. All three participants that had a negative experience switched health care providers, and of all the participants asked if they perceived stigma if they would switch providers, all said 'yes' except one. The intense meaning tattoos have to their owners means it is essential for health care providers to know that their actions, both positive and negative, will have lasting ramifications.

When discussing what health care providers should say or do regarding body art participants simply answered nothing. Those who have body art view it as an extension

of themselves, as you would an outfit choice, hair or eye color. It does not require comment, unless that comment is one of intrigue and understanding.

Chapter 5

Discussion

The purpose of this study was to achieve an understanding of how people with body art describe their health care through their lived experience. Through this research descriptions surrounding perceptions, body art characteristics, traits of the participants, and health care experiences took shape. By exploring the relationships between patients with body art and their interaction with health care providers the ability to answer the research question, "How do individuals describe the relationship between body art and their health care experience?" was obtained by finding the commonalities in each interview. These commonalities were categorized in two overarching patterns and from each pattern essences emerged to further portray the theme. The interviews revealed that tattoos are an artistic representation of a person and there is deep meaning and devotion associated with body art. This research was able to corroborate findings, produce new questions surrounding the dated research, and provide direction for the future.

Methods and Procedures

A descriptive phenomenological methodology was used to explore the perception of the lived experience of the body art patient. Using a descriptive phenomenological approach addressed body art as a part of daily life, which was the core of the problem and research question presented (Spiegelberg, 1975). Data was collected using open-ended semi-structured interviews with 12 participants. All participants met the nine percent body coverage requirement of the research study and had interactions with health care providers while tattooed. Participants were recruited using flyers that were posted at

various body art studios and on social media sites. Snowball sampling, due to the sub-culture nature of the population, was also used.

Once the interviews were complete, they were transcribed by a professional transcriptionist and analyzed using Colaizzi's (1978) seven step method. They were read, and reread looking for significant statements. Meaning was driven from those statements, and a clustering of the statements revealed two overarching themes and three associated essences. Lastly a fundamental structure, or a signal descriptive statement, was presented to the participants for verification. Of the 12 participants, 11 replied in agreement to the fundamental statement. One participant refused to offer a reply even after several attempts via phone call, email, and text message.

Analysis was conducted primarily by the researcher but was discussed with committee members throughout the progression of interviews. Several analysis sessions were completed by the researcher and committee members, while every interview analysis was dialogued with at least one member to ensure rigor and trustworthiness. Each committee member had the opportunity to have input into the analysis discussion and was able to perceive how conclusions of significant statements, patterns, and eventual essences were made.

Major Findings

When an exhaustive analysis was completed and no new data was discovered, two overarching themes and three essences within each theme were uncovered. All participants described their tattoos as a deeply personal artistic representation of who they are and all shared they felt stigma or judgment, the two overarching themes; *See Me* and *Judging a Book by its Cover*. These two patterns both have associated essences that show

the importance of someone's body art, as well as how they view themselves through society's convictions.

The first theme *See Me* means that when observing someone's tattoos you are seeing their outward depiction of particular aspects of their life, personality, and relationships. Someone with tattoos believes that this is who they have always been (*this is me*), and that their tattoos are an artistic reflection of who they are as a person (*art defines who I am*). Not only that, but that need to reflect who they are does not stop. There is always a compulsion or devotion to say more through their tattoos (*I have more to say*).

Judging a Book by its Cover was the second theme discovered. When you have tattoos, they are presented for everyone to see and they represent very deep and personal aspects of the person's life and essentially *you can't hide anymore*. Their tattoos are out there for everyone to see and that means the judgment and stigma associated with having them. However, even though stigma is still connected with tattoos *society is changing* and becoming more accepting and *younger generations* are commanding this societal change.

Discussion

When observing someone's tattoos you are seeing their outward depiction of particular aspects of their life, personality, and relationships. With this deep connection towards body art it would be beneficial for health care providers to take notice to contribute to the holistic experience. Looking at the previous literature and comparing it to the findings the motivators surrounding why one receives tattoos remains the same, and even though the culture of body art is changing, judgement and stigma persist.

Preceding literature suggest that when stigma is present the therapeutic relationship and health care access and quality are affected. However, this research presented that having body art does not affect health care access and quality. Nonetheless, several participants stated having negative experiences with health care providers that they perceived were related to their body art and promptly switched providers. These memorable experiences show the importance of body art to the patient and the overall therapeutic relationship.

Motivators. This was the first research study done from the body art patient perspective and it provided a new and modern insight into the phenomenon of body art. The devotional aspect a body art participant has to their artwork and the continual progression of it is in line with previous research regarding the motivators associated with obtaining body art. Armstrong, Roberts et al. (2004a &2004b) found major motivators were “to be myself” and tattoos were seen as a form of “self-expression.” This was corroborated in the interviews. Multiple participants described their artwork as a form of “self-expression.” One participant even dialogued that she felt “naked” without her tattoos. All participants were able to describe their tattoos and associated meaning in detail, and some participants even described their tattoos “as this is me.” Again, verifying the previous research behind the motivation “to be myself” and “self-expression” in the first place.

Stigma. The research on body art indicates that people who participate in body art are associated with risk taking and deviant behaviors. Taking this information and applying it to sub culture identity theory, Goffman’s philosophy on stigma, and the theory of stigma development one can contest that stigma surrounds the body art

population. When looking at the interviews conducted, and the data collected from them it can be said that yes there is stigma that surrounds this sub culture. However, this fact is changing. Society is evolving and people in general are much more accepting of body art than in the past. Younger generations are leading this change in perception as they see tattoos as “mainstream.” Conducting further research would solidify if/when the stigma that surrounds this population dissolves.

Access and quality. Through the literature review, the question was presented that if body art patients perceive stigma does this affect health care access and quality? The data suggests that stigma is indeed perceived by this population, however, it does not affect health care access or quality. People with body art repeatedly said that having tattoos did not directly affect their health care. Their body art did not stop them from seeking health care nor prevented them from it. Nevertheless, it is important to note that if a negative comment was made or if direct stigma toward their body art was perceived participants changed providers and did not hesitate to do so. One patient even expressed when seeking treatment stating she felt, “pigeonholed” and while she would seek treatment for her chronic illness, she expressed she was hesitant to explain her symptoms accurately. While health care access and quality may not be affected the relationship with providers is.

Therapeutic relationship. Another question that presented from the literature was, does body art affect the therapeutic relationship? The simple answer is yes. Participants who perceived judgement regarding their choice of body art from their health care providers did switch providers. Revealing that if a person with body art perceives judgment from a health care provider this will cause a negative relationship, so much so

that the patient feels it necessary to end that relationship all together. And as described above one patient referenced not describing her symptoms accurately due to perceived judgment.

On the flip side, participants also dialogued multiple positive experiences with their health care providers regarding their body art. This further substantiates the importance of body art to the patient. When health care providers are viewing someone's body art they are asking you to *see them* because they view body art as an extension of themselves. For this population their body art is no different than choosing an outfit, having blue eyes, or having a particular hair color. It is an artistic representation of *who they are*, and health care providers need to realize body art as such. Viewing someone's body art as an extension of themselves creates a positive therapeutic relationship and opens the door for conversation. As one participant said, "it's a conversation starter." It opens dialogue about their life, themselves, and creates a positive experience for the patient.

Not only can body art help facilitate a positive therapeutic relationship through general intrinsic conversation it can also help map out life events and provide health care providers with a unconventional life story. Tattoos often represent aspects of a person life and life events. It is not uncommon for someone to have tattoos that represent diseases, deaths, births, and a storied medical history. In these 12 interviews alone, there were tattoos that represented infertility, miscarriages, births, deaths, health conditions, and family history. Tattoos provide an artistic reflection of a person's life and health care providers can use this not only to help engage conversation, but to learn medical history that guides future care.

Conclusion

Tattoos have meaning and represent who someone is as a person. Tattoos are art, and the location of artwork and being able to cover body art is a conscious thought due to the associated judgement. Stigma is still present with tattoos as previous research suggests, however, according to this study society is changing and body art is becoming more accepted and more mainstream. This study supported previous findings regarding the motivators for obtaining body art as a form of “self-expression” and the need to “be myself.”

Consequently, this research could not support if risk taking and deviant behaviors recontributed to this population as previous research suggests. New research focused on this particular concept would help bring the old research up to date. Also, research focusing on location and visibility of tattoos would enlighten this newly found aspect of this phenomenon.

This research suggests that health care access and quality are not affected by body art. Body art patients do not avoid seeking health care due to stigma, they will just switch providers if stigma is perceived. In health care the golden rule applies, “if you don’t have anything nice to say don’t say anything at all.” If negative comments are made towards or about someone’s body art that patient will seek health care elsewhere. Health care providers need to be aware that body art can provide a visible and artistically open dialogue of life events and patient history and at the very least body art can be an engaging conversation starter.

Future Research

While completing this research I was able to bridge some gaps in the literature and it did leave some gaps still open while presenting new questions that need to be answered by future research. This study was not able to properly answer if old research surrounding risk taking and deviant behaviors associated with this population still hold true. While interviewing the participants new questions were found surrounding visibility and locations of body art and the associated stigma. Further research in these areas and the phenomenon of body art in general would help close the gaps in knowledge.

Risk taking and deviant behaviors. This new research from the patient perspective presented new questions that need to be addressed further. A large portion of the research done to date on body art focuses on risk taking and deviant behaviors. Multiple studies were done showing that having body art was linked to higher instances of drug use, binge drinking, and sexual promiscuity. However, this concept was never approached in the interviews. Only one participant referred to self-medicating with alcohol and drugs during a period in her life, but the reference was brief at best. For the most part the participants never mentioned any risk taking or deviant behaviors and never referred to themselves in such a way, and during the interviews the participants never guided the interview anywhere near this conclusion.

Yet it should be mentioned that there were no questions in the interview guide directed toward this behavior. Further research making a pointed indication of this behavior would give a better representation if the prior research is still valid. Health care providers should still be aware that the prior research suggests that these behaviors are present with this population because this research cannot directly refute those findings.

However, new research clearly confronting this major concept seen in the literature would serve as a better foundation.

Visibility and location. When looking at the previous literature surrounding body art it was concluded that an increase in body art increased negative perceptions and this was thought to increase associated stigma. However, what presented itself in the interviews was not so much amount increasing stigma, but the visibility and location of body art. Several participants talked openly about it being necessary (for various reasons) to cover their body art when they wanted to. This allowed them to hide it and hide from the associated judgment. To further elaborate on visibility, multiple participants talked openly about how having a face tattoo or neck too was something that they would never consider. Again, showing the need to be able to cover their artwork if they felt necessary. Having a tattoo that could not be hidden was a line that could not, and almost should not be crossed. Some participants even talked openly about their own stigma towards people who have face and neck tattoos.

Further research needs to be done looking at visibility and location of artwork increasing negative perceptions and stigma. Does having a face and/or neck tattoo cause more negative perceptions and stigma then having a large number of tattoos in traditional locations? Or is it the visibility and location of the tattoo the main contributing characteristic? Is being able to cover tattoos seen as a conditional way to avoid associated societal stigma? By continuing to research this phenomenon these questions could be answered.

Recommendations for Practice

It is important for health care providers to be educated about body art so they can provide holistic care. Health care providers need to be aware that body art serves as a form of deeply personal self-identification and could be a gateway to start a meaningful conversation. Body art serves not only as a good conversation starter, but as a direct reflection of that person's life. By presenting open conversation about someone's body art as one of intrigue and admiration health care providers can begin to be enlightened about that person's personality, relationships, medical history, social history, family history, and life choices.

By being educated about body art and being able to have a personal conversation about its significance without stigma or judgement can only strengthen the therapeutic relationship. Providers need to realize that if stigma is perceived regarding someone's body art it is viewed as a direct attack on someone's identity, and patients will remember these occurrences and switch providers because of them. Nevertheless, patients not only remember the negative occurrences, but the positive ones as well. Therefore, health care providers should strive to take note of someone's body art and listen intently to their meaning as this unlocks a whole new dynamic of patient care and therapeutic relationships.

Closing

Body art is an ever growing and ever changing phenomenon and the need for further research to help reconfirm dated data and stay abreast of current trends is a must. Health care providers need to be informed of the experience of the body art patient so they can refrain from negative comments and strive to create positive relationships that

help facilitate care and engage open truthful conversations. When health care providers view body art as an interictal part of someone's life and refrain from making judgmental statements, they are displaying knowledgeable attributes that can facilitate meaningful relationships and provide holistic care.

Even though the body art culture may be changing and stigma maybe fading stigmatization will always be present in society. The therapeutic relationship will suffer if stigmatization is perceived and this research and previous research can attest to that. Accepting someone's body art as an integral piece of who they are and is just one small piece toward creating a holistic environment and fostering a trusting patient relationship.

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Appendix A

Interview Guide

As you know, I am interested in the effects of body art and the healthcare experience. I would like to know as much as I can about your experience so that I can adequately describe the health care experience of the body art patient, and determine the health care needs of this population. I will be audio recording the interview and I will tell you when I start the recording.

I will ask an opening question and then we will talk about your experiences as you tell me about them. Feel free to think for a while, take as much time to think as you like, and just get comfortable. When you have said all you want to say, I will ask some basic questions about your age, race, gender, education, and where you live, then we will stop. The recording will then be typed word for word and any possible identifiers (your name, the names of others, places, anything unique that could identify you) will be taken out.

Do you have any questions at all about the process? OK, let's begin; I will turn the recording on...

Hi, NAME... We have already talked about this study and I have started audio recording our conversation. As you know, I am interested in your healthcare experiences as a body art patient. I would like to begin by asking you to describe your health care experiences

As you think about what it's like to be a person with body art right now, is there anything that stands out for you? Is there a situation or a story that comes to mind? Can you describe how having body art may be related to your health or health care?

Subsequent questions that may be asked are:

As you think about what it's like to be a person with body art right now, is there anything that stands out for you? (*Pause and listen fully and attentively*). Is there a situation or a story that comes to mind? (*Pause and listen fully and attentively*).

Can you describe how having body art may be related to your health or health care? (*Pause and listen fully and attentively*). Have you had any problems (or health concerns) with your body art itself? (*Pause and listen fully and attentively*) Does your body art prevent your seeking health care for any reason? (*Pause and listen fully and attentively*) Can you describe how health care providers responded to your body art? (*Pause and listen fully and attentively*)

Can you tell me about your tattoos and/or piercings...(*Pause and listen fully and attentively*)

When did you first acquire your body art? (*Pause and listen fully and attentively*) Can you describe why you decided to get a tattoo (*Pause and listen fully and attentively*) Additional tattoos? (*Pause and listen fully and attentively*)

When did you first acquire your body art? (*Pause and listen fully and attentively*) Can you describe why you decided to get a body piercing (*Pause and listen fully and attentively*) Additional piercings? (*Pause and listen fully and attentively*)

Tell me more about that...

Can you give me an example...?

What was that like for you...?

Anything specific to health care?

Others have told me about... Is that anything like your experience?

Closing Questions:

Anything more you remember?

Is there anything else that needs to be said or you would like me to know?

Please provide some basic demographic information about your age, race, gender, education, and where you live? If you would rather not provide the information then we will stop the interview now. Thank you for your time.

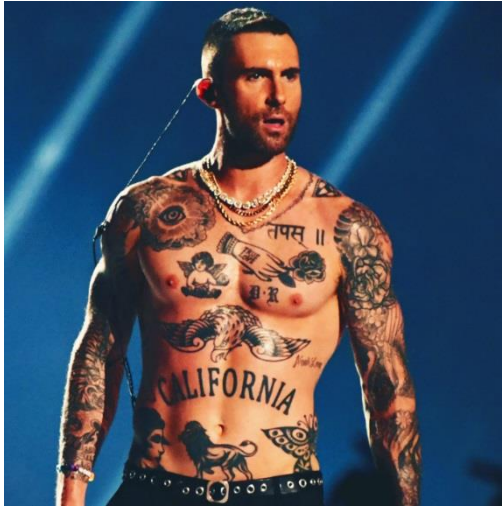
Appendix B

Enrollment Eligibility Phone/Email Script

1. Estimate, please, the percentage of your body having tattoos.
2. How many piercings do you have? Where on your body?
3. How many tattoos do you have? Where on your body?
4. How often do you seek health care?

Appendix C

Do You Look Like This?



Research Study

*University of Missouri St. Louis have reviewed and approved
for human subjects participation*

Volunteers needed

**for a study about the experience of someone with body art in
the health care setting**

Are you Tattooed and/or Pierced?

Have you been treated in the health care setting?

Will you share your experience?

Confidential audio-recorded conversations with a nursing
researcher (approximately 1 hour).

Please contact Lacey Kaufmann to learn more or schedule an
interview. Confidential private email lak27f@mail.umsl.edu
OR Confidential private phone at 314-984-7454

Appendix D**Office of Research Administration**

One University Boulevard
St. Louis, Missouri 63121-4499
Telephone: 314-516-5899
Fax: 314-516-6759
E-mail: ora@umsl.edu

DATE: March 3, 2019

TO: Lacey Kaufmann, Phd
FROM: University of Missouri-St. Louis IRB

PROJECT TITLE: [1382690-2] Body Art
REFERENCE #: [1382690-2]
SUBMISSION TYPE: Amendment/Modification

ACTION: MODIFICATIONS APPROVED
DECISION DATE: March 3, 2019
EXPIRATION DATE: February 14, 2024
REVIEW TYPE: Expedited Review

This modification was approved by the University of Missouri-St. Louis IRB for the term of this protocol. The University of Missouri-St. Louis IRB must be notified in writing prior to major changes in the approved protocol. Examples of major changes are the addition of research sites or research instruments.

An annual report must be filed with the committee. This report should indicate the starting date of the project and the number of subjects since the start of project, or since last annual report.

Any consent or assent forms must be signed in duplicate and a copy provided to the subject. The principal investigator must retain the other copy of the signed consent form for at least three years following the completion of the research activity and they must be available for inspection if there is an official review of the UM-St. Louis human subjects research proceedings by the U.S. Department of Health and Human Services Office for Protection from Research Risks.

This action is officially recorded in the minutes of the committee.

If you have any questions, please contact Carl Bassi at 314-516-6029 or bassi@umsl.edu. Please include your project title and reference number in all correspondence with this committee.