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Individuals With Multiple Tattoos Exhibit Major Depressive Disorder

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This is to certify that the doctoral dissertation by

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Walden University
2024

Abstract

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Tracy A. Daniels

MS, Walden University, 2018

MA, Bowie State University, 2008

BS, University of Maryland, 2003

Proposal Submitted in Partial Fulfillment

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Abstract

Major depressive disorder (MDD) is a global health concern and is the second global leading cause of mental illness that produces disability and disease. Individuals with multiple tattoos who exhibit MDD have not been adequately studied. Individuals with multiple tattoos who exhibit MDD may struggle because of psychosocial associations of the diagnosis. Seven women and three men, ages 18 to 65, participated in this qualitative, phenomenological study. Data obtained from the semistructured; audio-recorded confidential video call interviews were analyzed with Moustakas' bracketing method. Bracketing as a phenomenological method was instrumental in searching for associations in meanings and understandings with individuals. Codes were gathered in groups of related answers to establish themes, of which five emerged: diagnosed with MDD, diagnosed with MDD before getting first tattoo, got first tattoo before age 18, has depression-related tattoos, tattoos are reminders of MDD. Positive social change includes societal and community awareness regarding individuals with multiple tattoos who exhibit MDD. Further studies should be conducted to develop a system where medical and other professional personnel can be trained to address individuals with multiple tattoos and MDD and to learn how to present information about how to identify predictors of MDD to such individuals. Future analysis might include follow-up studies on how MDD affects individuals with multiple tattoos.

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Dedication

This dissertation is dedicated to all my family members who believed in me but are no longer here with me today, but live in my heart forever. Love always, my father Carl John Daniels Sr; Luella Sherred “Grandmother”; Joyce Rodgers “Aunt”; Rudolph Daniels “Uncle”; Cecilia Burg “Cousin”; Odessa Parsons “Great Aunt”; Robert “Sunny” Hill “Uncle”, they all taught me to always remain loyal to the cause of life, never take things for granted and remember to never forget that life is successful with family and love. Though you may not be here in person, however, your spirit is forever with me, guiding me in completing this degree.

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Chapter 1: Introduction to the Study

In this phenomenological study, I focused on individuals with multiple tattoos who exhibit major depressive disorder (MDD) symptoms. Investigating this phenomenon required a detailed examination of how individuals with multiple tattoos experience behavior associated with major depressive disorder. The mental health community does not know the extent to which multiple tattoos contribute to major depressive disorder in individuals. In the United States, the commonness of tattoos has increased among various demographic groups. When surveyed, women with one tattoo were found to make up 23% of the population in the United States, while Caucasian men, Black men, and Hispanic men with one tattoo were found to comprise 19%, 21%, and 30% of the population, respectively. One in five U.S. adults have at least one tattoo, up from 16% in 2003 (Heywood et al., 2012). One in five individuals between the ages of 30–39 get the most tattoos. The majority of tattooing in the United States takes place on the West coast. Heywood et al. (2012) stated that the West coast (26%), East coast (21%), Midwest (21%), and South (18%) were among the most common areas for tattooing to occur. In these areas, adults aged 30–39 have the most tattoos (38%), followed by those aged 25–29 (30%), 18–24 (22%), 40–49 (11%), and, lastly, 50–64, the group with the fewest tattoos (5%) (Heywood et al., 2012). Subject matter, placement, and frequency (i.e., having multiple tattoos) of tattoos can be associated with major depressive disorder symptoms and other mental health problems (Zrno et al., 2015).

Background

Matthews (2008) and Swami et al. (2012) examined how significant similarities can occur when certain motivators and personality traits present in individuals displaying tattooing behavior and individuals who tattoo and pierce for self-expression. Matthews (2008) researched how depressive symptoms relate to tattoos, which can be seen as forms of cutting, and body modification addiction, which can contribute to negative consequences in thinking modalities. Additionally, the author examined the role that friends and family members play in helping individuals with major depressive disorder seek assistance when their tattooing behavior is becoming an addiction. Matthews (2008) also discussed the limitations of a participant's symptoms as they relate to tattooing, because they may not meet the criteria for major depressive disorder. However, she further stated that tattooing can be associated with depressive disorders. This research can be useful to individuals with multiple tattoos who have been diagnosed with major depressive disorder, helping them to understand the correct treatment methods that can be used to decrease their depressive symptoms.

Swami et al. (2012) examined the behavior of tattooed and non-tattooed participants with major depressive disorder. Similarly, Tate and Shelton (2008) discussed how the pain of being tattooed could mirror real-world differences between tattooed and non-tattooed individuals. These differences are evident in behavior patterns and pain tolerance; individuals with tattoos had higher scores than non-tattooed individuals in levels of depression, extraversion, need for uniqueness, and behavior seeking behavior subscale (Swami et al., 2012). Tattooed individuals demonstrated noticeably more

positive attitudes toward their tattoos, which increased their self-esteem. Furthermore, the factor of sensation-seeking suggested that tattooed individuals scored higher in extraversion than non-tattooed individuals. Additionally, Tiggemann and Hopkins (2011) explored how tattooed individuals displayed a higher need for uniqueness than non-tattooed individuals. Swami (2011) studied how tattoos are used as signs and forms of self-expression relating to an individual's identity and can decrease their depressive symptoms. Some societies commercialize tattoos as a source of individuality and demonstrate the role of different body markings in improving the self-perception of uniqueness (Swami, 2011). Tiggemann and Hopkins (2011) also stated that tattoos are an important display of emotions, by which individuals can develop their unique style and dominate their own appearance.

Problem Statement

In previous research, individuals with large tattoos exhibited higher scores on depression assessments compared to non-tattooed individuals (Heywood et al., 2012). Major depressive disorder symptoms can occur in many types of individuals, including those with multiple tattoos. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is frequently used as an assessment manual for diagnosing depression and other mental health disorders, such as major depressive disorder. Symptoms of depression include lack of concentration, fatigue or loss of energy, feelings of hopelessness, weight loss or change in appetite, reoccurring thoughts of suicide or death, and insomnia or hypersomnia (Bienenfeld & Stinson, 2016).

In this study, I addressed the gap in research surrounding individuals with multiple tattoos and major depressive disorder. Few studies have addressed the effects of tattoo placement on the body, which can visually display depressive events and thus can lead to major depressive disorder (Zrno et al., 2015). In their research, Zrno et al. (2015) discussed areas of the body, such as legs, hips, stomach, arms, breasts, shoulders, and hands, where tattoos serve as consistent reminders of depressive events, contributing to major depressive disorder. In other words, these tattoos are living testimonies of an individual's life history, whether it is positive or negative (Francis, 2018).

Purpose

The purpose of this study was to explore how individuals with multiple tattoos exhibit major depressive disorder. I gained an understanding of how individuals with multiple tattoos who exhibit major depressive disorder maintain their mental fortitude. My goal was to understand the challenges and obstacles individuals with multiple tattoos face who exhibit major depressive disorder and how they relate their multiple tattoos to their depressive symptoms. According to Matthews (2008) multiple tattoos are said to be associated with depressive disorders. Multiple tattoos can be viewed as a way in which individuals who have them live and perceive the world around them as meaningful. In contrast, tattoos are said by some individuals who have them, to be a state of peace and harmony that embrace the thought of the meaning of life and death. Individuals with multiple tattoos get their tattoos for various reasons; one of these reasons embrace their major depressive disorder (Matthew, 2008).

Major depressive disorder is the number two disorder globally and is responsible for 4.3% of global diseases. It is also the leading global cause of disability, especially in women (World Health Organization, 2016). Major depressive disorder also impacts the economy globally (WHO, 2016).

In this study, I evaluated whether individuals with multiple tattoos who exhibit major depressive disorder increased their awareness of their disorder and worked on ways to improve their mental health. Routine depression screenings could be helpful, in addition to improved quality of care for individuals with multiple tattoos and major depressive disorder. The results of this study may increase the knowledge of individuals with multiple tattoos seeking assistance for their depressive symptoms through mental health services.

Research Question

Do individuals with multiple tattoos exhibit major depressive disorder?

Theoretical Framework

The qualitative design of this study was based on transcendental phenomenology. Creswell (2013) discussed ways to answer research questions by gathering data in attempts to yield findings that are not prearranged, thus producing results that can be valid beyond the limitations of a study. Phenomenological designs are used to describe how an individual can become cognizant of a phenomenon that they are experiencing, and these studies can be used to address how distinctive types of experiences, such as thoughts, perceptions, and memories, are structured. According to Creswell (2013), such

research places importance on the phenomenon itself, which can give individuals an opportunity to explain their lived experiences.

Gros (2017) reported that transcendental phenomenology is not primarily about the interview process, but rather about the four core practices of bracketing, data collection, interviewer's viewpoint, and horizontalization. According to Hopkins (2016), Husserl's results on transcendental phenomenology's approach to leaning could be the basis for understanding the phenomenological psychology of human consciousness. Husserl (1962, 1970) developed transcendental phenomenology in 1913. In 1990, Moustakas modified its use and introduced the six core practices. Moustakas (1990) described the first core practice, bracketing, as a method that involves the researcher putting aside personal incidents, preconceived ideas, and biases. By focusing on bracketing during data collection and analysis, a researcher can reduce their personal attitudes, biases, judgments, and micro aggressions related to their own preexisting conclusions that could impact data findings. The second core practice is used for collecting data in the interview process; the individuals selected for interviewing must have experienced the fundamental phenomenon of the research study in question.

The third core practice is used by the researcher to acquire and explain a reliable representation of the phenomenon using the viewpoint of the individual. According to Moustakas (1990), the fourth core practice is called horizontalization, which involves cautiously examining interviews numerous times, emphasizing essential comments from participants, and making notes. This process offers an outlook that enhances the researcher's awareness of the individuals' experiences. Moustakas (1990) described the

fifth core practice as textural explanation. This practice involves an analysis of textural explanations that are used to highlight themes in the data. Textural explanations explain individuals' experiences. Finally, Moustakas (1990) described the sixth core practice as the examination of vital themes in the data and their significance. Taipale (2015) stated that transcendental phenomenology can be used to establish a distinction between nature and spirit and a balance between natural science and humanity.

Nature of the Study

In this study, I used a transcendental phenomenological design to explain how individuals' lived experiences relate to certain concepts or phenomena. Moustakas (1990) described conditions related to transcendental phenomenology as self-reflections requiring a researcher to be aware of their own viewpoint and biases that may occur while examining the experiences of participants. Kemparaj and Chavan (2013) indicated that qualitative research methodology has been used more frequently in recent years due to its focus on the beliefs, ideas, and perceptions of participants. Qualitative research enhances understandings in the spaces where exists a lack of concrete knowledge. Malagon-Maldonado (2014) identified the focus of quantitative research methods as changing hypotheses, testing and sanctioning expectations or principles, and defining cause–effect connections or relationships in the data; however, the tight structure of quantitative methodologies prevents the establishment of the expectations, opinions, and insights of study participants. Therefore, the qualitative transcendental phenomenological design was the optimal research method for this study.

Kemparaj and Chavan (2013) indicated that this design is used to focus on individuals' lived experiences. In this study, I used this design to examine participants' experiences relating to major depressive disorder and tattoos. Investigating the specific experiences of individuals with multiple tattoos who are experiencing major depressive disorder from their own perspective required a descriptive approach.

I considered other possible qualitative designs for this research, such as grounded theory, ethnography, and hermeneutic phenomenology. However, I selected a transcendental phenomenological design as the best method to observe the environmental, social, and personal experiences of individuals with multiple tattoos who exhibit major depressive disorder. Participants provided substantial histories of their feelings, thoughts, beliefs, and perceptions surrounding their tattoos and their disorder. I identified the lived experiences of individuals with multiple tattoos and major depressive disorder who have suffered from self-reported depression or experienced self-reported depressive symptoms. I conducted semistructured interviews using open-ended questions until the data saturation point was reached. Chapter 3 includes a more detailed summary of the nature and process of this study.

Definitions of Key Terms

The terms discussed in this phenomenological study are defined in this section to aid the reader in understanding how terms are used throughout this study.

Tattoos: The word tattoo originates from the word *tatau*, which means "to draw" or "to mark." Armstrong et al. (2000) defined tattooing as a technique in which colored dye is imported into the skin through numerous puncture holes, producing a permanent

design. According to Armstrong et al. (2000), the tattoo ink is driven 1/64th to 1/16th into the skin, within the primary dermal layer.

Tattooing anatomic sites: Anatomic tattooing sites include arms, legs, eyebrows, earlobes, inner lips, tongue, face, head, ankles, feet, hands, and genital areas (Antoszewski et al., 2009).

Body modification: This term denotes techniques that are intended to modify a person's bodily appearance through jewels, marking, hairstyling, cosmetics, cutting, piercing, scarification, and tattooing (Atkinson, 2004). Roberts, D. J., (2012) described how tattoos have shifted from signs of social nonconformity and character flaws to non-defamed and often positive forms of physical expression or modification.

Major depressive disorder: The *Diagnostic and Statistical Manual of Mental Disorders (DSM-V) 5th edition*: A major depressive episode is defined as a period of two weeks or longer during which an individual experiences either a depressed mood or loss of interest or pleasure, in addition to at least four other symptoms that reflect a change in functioning, such as problems with unexplained aches and pains, low energy, fatigue, concentration, and negative self-image (American Psychiatric Association, 2013).

Multiple tattoos: Multiple tattoos emphasize how individuals display measures of self-expression as a way of creating self-identity by drawing attention to the tattoo (Armstrong et al., 2004a).

Tattooing self-expression: An exhibition of personality through tattooing pictures, numbers, biblical scriptures, military symbols, or other art forms such as text or drawings (Millner & Eichold, 2001).

Depressive signs and symptoms: Depressive disorder is a mental state or acute mental disorder categorized by feelings of sadness, loneliness, despair, low self-esteem, and self-reproach; accompanying signs can include psychomotor retardation (or, less frequently, agitation), social withdrawal, and lack of or excess sleep (Lathrop, 2008).

Assumptions

Cohen et al. (2015) stated that researchers must disclose their underlying assumptions to reinforce the strength and relevance of their study. Assumptions are necessary for the retrieval of information to support the study results (Cohen et al., 2015). For this study, I assumed that individuals do not deliberately manufacture responses or purposefully provide incorrect statements regarding their experiences. Secondly, since the results can be common, repetition can occur. Finally, I assumed that the interviews used can address the assumptions essential for this study, leading to true interpretations from the gathered information.

Scope and Delimitations

In this study, I used semistructured interviews to engage with participants with multiple tattoos who are experiencing major depressive disorder. The groups were chosen to address whether major depressive disorder occurs among individuals with multiple tattoos. Certain parameters were excluded from the scope of the research. Participants' cutting or other non-suicidal self-injuries were not considered in this study. Factors such as cutting and non-suicidal self-injuries are not relevant to understanding the impact of individuals with multiple tattoos and major depressive disorder, they were not the focus or scope of this study. I also excluded minors or individuals with only one tattoo.

I recruited participants only in the United States, and I limited interviews to English-speaking participants. I asked open-ended questions in a semistructured and face-to-face interview process, which continued until the point of data saturation was attained. I conducted 20 to 45–minute organized interviews at agreed-upon locations, in order to increase the interviewees' level of comfort while participating in this study. I scheduled one interview per week, allowing time for transcript creation between interviews.

Limitations

Use of this phenomenological approach in my qualitative study had limitations. If researchers are not cognizant of their biases, interference can occur in the data-interpretation phase (Creswell, 2013). This study could also have been limited by the level of cooperativeness of participants with the me, which could have impacted the collection of individual demographics including race, ethnicity, and gender. Furthermore, this study may have been limited by participants' inability to fully articulate their experiences due to problems such as language barriers, discomfort with the setting or me, and difficulty explaining their tattoo's connection to major depressive disorder.

Another potential limitation for this study involved the selection of phenomenology as a qualitative approach. Phenomenological approaches are limited due to a researcher's ability to secure participants who have experienced the phenomenon being studied (Creswell, 2013). Additionally, phenomenology uses the self-reporting of individuals in their normal surroundings, which allows participants to speak freely about their story. My analysis was based on the information provided by the participants. However, my bias could have presented itself, causing my results to be inaccurate in the

event that I was unable to understand a participants' experiences and interpretation of significance concerning the phenomenon. In addition, if participants themselves may not fully understand the phenomenon, I could have encountered inaccuracies in their reporting. Moreover, my bias could have affected their report through my presentation of the information gathered from the participants. Participants may also have had trouble remembering certain details during the interview process. Finally, self-reporting studies are sometimes considered biased because of the emotional state of the participant at the time of completing the interviews (Kawulich, 2005). If a participant is feeling emotional or unwell while answering the questionnaire, for example, they might answer more negatively than a participant who is feeling happy or neutral. To avoid the aforementioned limitations, I addressed my observations and concerns with participants and use only valid and reliable data from participants.

Significance

I conducted this qualitative study to assist individuals with multiple tattoos who exhibit major depressive disorder and provided information regarding major depressive disorder. The findings of the study added to the bank of knowledge surrounding the mental health needs of individuals, specifically those with multiple tattoos and major depressive disorder. The results of this study may also be used to create psychoeducation and information about the disorder among this population and the potential challenges faced by these individuals without assistance. This information could be further helpful if made available to individuals with multiple tattoos and the population at large.

Furthermore, the results of this study could be used to assist individuals with the studied characteristics in gaining understanding of the signs and symptoms related to their depression. For example, a positive social change from this study might include community directors, mental health professionals, practitioners, health educationalist, clergy, and medical doctors sharing the information to help improve the mental health of such individuals, whose multiple tattoos are contributing to their major depressive disorder. Findings could also serve to bring increased consciousness and support within the mental health community and social services departments when working with individuals with multiple tattoos that have a possible relationship with major depressive disorder. More specifically, the results of this study could help these individuals by providing a way for mental health practitioners to directly address behaviors that connect the individuals' tattoo-related habits to their major depressive disorder.

Summary

This chapter provided a brief overview of my qualitative phenomenological study. In this study, I explored how individuals with multiple tattoos exhibit major depressive disorder. Andrews (2010) stated that individuals with signs and symptoms of depression or who have been diagnosed with a major depressive disorder are at higher risk of developing other severe mental and physiological disorders that affect their wellbeing. The chapter also defined the study's key terms in preparation for further discussion of these concepts in Chapter 2. Additionally, I used Chapter 1 to identify the scope and delimitations of this discussed using semistructured interviews as a way to gather information from participants with multiple tattoos who are experiencing major

depressive disorder. Significance discussed how findings could also serve to bring increased consciousness and support and positive social change from this study.

In this chapter, I discussed how my research addressed the gap in the literature surrounding the experiences of individuals with multiple tattoos and major depressive disorder. Chapter 2 includes an exhaustive review of the literature that I used to frame this study and the literature that addresses individuals with multiple tattoos who exhibit major depressive disorder.

Chapter 2: Literature Review

The purpose of this phenomenological study was to explore how individuals with multiple tattoos exhibit major depressive disorder symptoms. Investigating this phenomenon required a detailed look of how individuals with multiple tattoos experience behavior associated with major depressive disorder. Stirn et al. (2011) stated in their study of 432 participant's tattoos that 34% of the participants had special or personal reasons for their decisions to get a tattoo. Karacaoglan (2012) noted how tattoos can be seen as pictures with hidden meanings inside the image on the skin, conveying intimate and personal messages in contextual and obscured manners.

There is minimal literature on the phenomenon of how individuals with multiple tattoos exhibit major depressive disorder. There is a lack of scholarly sources that include the experiences of individuals whose tattoos contribute to major depressive disorder. I used ERIC, CINAHL, SAGE Journals, Thoreau Multi-database search, ProQuest Dissertations and Theses, Psych INFO, PubMed, EBSCO, Google Scholar, Ulrich's: Verify Peer, Science Direct, and BIOMED evidence-based articles for information relating to individuals who have tattoos and exhibit major depressive disorder. Multiple articles address tattoos, self-tattooing and injurious behavior, body piercing and tattooing, tattooing as an art, and tattooing and dermatology; however, limited articles discuss multiple tattoos and their association with major depressive disorder.

According to Armstrong and Murphy (1997) tattoos leave a permanent mark or colored design on the skin. According to Birmingham et al. (1999), tattoos date back as far as seventh century B.C. There are articles that address tattoos and body markings as

art, piercing, tattooing and self-harming behavior, tattoos, body piercing and tattooing, and body modification (Claes et al. 2005; Huxley & Grogan, 2005; Swami, 2011). Despite the number of studies that document tattoo prevalence in body art, body piercing, and body modification, there is a lack of studies that address major depressive disorder in individuals with multiple tattoos. The purpose of this study was to gain an in-depth understanding of how individuals with multiple tattoos exhibit major depressive disorder.

Men and women who have multiple tattoos experience factors related to mental health such as depression and a reluctance to accept mental health services (Roberti & Storch, 2005). Gender differences and ethnicity play a role in affecting whether someone has multiple tattoos. Twenty three percent of U.S. women have one or more tattoos. Fifteen percent of men in the United States have one or more tattoos. Of those, 19% are Caucasian men, 21% of Black men, and 30% of Hispanic men (Heywood et al., 2012). Men and women between the ages of 30-39 within every ethnic group get the most tattoos and the majority of these individuals live in the West coast of the United States (Heywood et al., 2012). Briere and Scott (2015) stated that between the genders, women are more disposed toward depression than men. In their research, women were more open to increased levels of depressive situations than men, with higher prevalence rates of post-traumatic stress disorder (PTSD) and major depressive disorder.

Frederick and Bradley (2000) pointed out how psychological aspects of tattooing can be manifested in the behavior of individuals who demonstrate signs of a major depressive disorder. Individuals diagnosed with major depressive disorder focus their tattoos on such themes as pornography, death dates, suicide coded punctuation such as

the semicolon, and pseudo heroism (Khosla et al., 2010). Individuals who were diagnosed with schizophrenia displayed idealistic and magical themes in their tattoos. Tattooing is seen as a form of expression for some; however, to others it is seen as an expression of their pain, hurt, or traumatic experiences. The literature presented in this chapter provided details about the need, importance, and benefit of this study, as well as the limitations and the strategies for establishing valid information that will be collected from participants. In this chapter, I discuss the phenomenological approach that I selected for this study as well as the literature in which researchers examined the relationship between having multiple tattoos and major depressive disorder.

Literature Search Strategy

In this literature review, I gathered scholarly articles with information about multiple tattooing, tattoo selection, tattoo placement on the body, frequency of tattoos, major depressive disorder, depression symptoms and mental health disorders are associated with individuals who have multiple tattoos. The databases that I used to gather scholarly peer-reviewed journal articles were ERIC, CINAHL, SAGE Journals, Thoreau Multi-database search, ProQuest Dissertations and Theses, Psych INFO, PubMed, EBSCO, Google Scholar, Ulrich's: Verify Peer, Science Direct, and BIOMED. Research literature specific to how individuals with multiple tattoos experience major depressive disorder were analyzed. Keywords that I used to search included: *tattoos, tattooing, multiple tattoos, piercing, cutting, body art, body modification, self-harm, self-injurious, branding, scarring, mental health, depression signs and symptoms, major depressive*

disorder, mental health first aid, depression and physiological markers, neurochemistry of depression, gender, and *depression.*

The words *tattoos, tattooing, multiple tattoos, depressive signs and symptoms,* and *major depressive disorder* were found in abstracts or titles of articles, a formal dialog of these words are present within the body of those articles. As a result, further limitations were set to not only include *tattoos, tattooing, multiple tattoos, depression signs and symptoms, major depressive disorder,* but also *piercing, cutting, body art, body modification, self-harm, self-injurious, branding, scarring, mental health, mental health first aid, depression and physiological markers, neurochemistry of depression, gender and depression* in the abstract or title, but to focus on the words *tattoos, tattooing and major depressive disorder.* A qualitative design was used in most of the research regarding *tattoos, tattooing, multiple tattoos, depressive signs and symptoms, and major depressive disorder*. A few qualitative evidence-based studies are included in this study, more evidence-based studies are essential in providing beneficial influence to the mental health field and this underserved population. In this phenomenological study, individuals who have multiple tattoos that have a diagnosis of MDD were examined.

Theoretical Foundation

Van Manen (2014) discussed phenomenology as a discipline of philosophy. Phenomenological reviews do not examine cognition of individuals; they are used to answer and understand the way individuals look at things through their lens of the world (Vagle, 2014). Phenomenological researchers look for ways to expose the principles of human experiences in the origin of their theories (Hatch, 2002). Finlay (2011) viewed

phenomenology as a way to inspire individuals to look closely at what is beneath the surface through investigation of the phenomenon that reveal unseen abilities in lived experiences. According to Reiners (2012) and Van Manen (2014), Husserl is known as the founding father of phenomenology. His roots were as an Austrian-German philosopher who believed in ideas that went against the positivist science of his era. Finlay (2011) stated that he placed great importance on the way people lived in the world and how their experiences shaped their world view. Nelson and Puolin (1997) stated that one of Husserl's core concepts was bracketing, which is a process used by people to put away their judgments about relationships between their involvement and worldly events, thus releasing the mind to observe its own pure experience, independently of everyday predispositions. According to Finlay (2009) phenomenology is thought of as a way to intersect sciences and humanities.

During the positivist tradition, phenomenology research established grounded methods which opposed other research methods. A naturalistic researcher is an individual who recognizes how reality does not ground itself on being secure as well as understanding how subjectivity being considered as part of the solution. Reiners (2012) described how information is gathered through interaction with the individuals who are under study. Lopez and Willis (2004) stated that phenomenological approaches are approaches that involve descriptive, empirical, hermeneutic and interpretive. Descriptive phenomenology is used to examine associations to the phenomena descriptions, whereas Husserl focused primarily on how descriptions closely relate to the phenomena in question (Moustakas, 1994).

According to Finlay (2011), Heidegger's phenomenological views were aligned more with hermeneutic phenomenology, where the interpretations of lived experiences are processed as valid and manageable. Finlay (2011) and Thomas and Pollio (2002) stated that other approaches to phenomenology include interpretive phenomenological analysis, which involves four first-person approaches such as assessments, reflective, relational, and existential analysis. Finlay (2011) pointed out how consideration factors are cautiously thought out, involving mingling factors of several distinctions within phenomenology. Giorgi (1985) emphasized how phenomenological researchers must pay attention to descriptions that embrace the original intent of the phenomena being investigated. For this to occur, he made reference to four important steps in the process, which include reading transliterated interviews multiple times, scrutinizing written information for content that involve meaning of the phenomenon, defining psychological features of the phenomenon, and synthesizing significances of the phenomenon. Nelson and Puolin (1997) pointed out that in phenomenological research, methods for observing numerous experiences relating to common goals and exceptions are essential in developing the research.

According to Giorgi (1985) phenomenological research concludes no matter if the variant is descriptive and reductionist, the meaning of the phenomena emerges. Reiners (2012) alluded to the philosophy of phenomenology as being grounded in traditions or beliefs. Finlay (2009) cited how phenomenology is understood as a low-hovering, in-dwelling, meditative philosophy that credits the strengths of individual's relations and lived experience, with all its uncertainty, ambiguity, and influence. Ellis (2014) described

how the phenomenological approach emphasizes the accounts of human experiences rather than just cause and effect.

One purpose in this study was to emphasize the contextual significance and interpretation of individuals' lived experiences of tattooing. One motive for this study was to move past simple descriptions and discover importance of phenomenological descriptions that address the interpretations of the participants' experience. It is important to ensure that accurate communication of meaningful experience is obtained and examined rather than just simple descriptions of that experience (Reiners, 2012).

Lopez and Willis (2004) wrote by retrieving the narratives of research participants, openness and clarity of their experiences are revealed which assist in understanding phenomenological approach methods. Creswell (2012) specified how approaches are encouraged by sharing stories, which allows participants to voice their opinions and empowers them to be transparent. This phenomenological design was rooted in the process of gathering and processing information from participants where phenomenological attitudes are characterized by openness, transparency, and trust.

Gros (2017) stated that phenomenology is not primarily about the interview process, but more about the six core practices as constituted by the activities of the individual's cognitive processes. Husserl (1962, 1970) pointed out how phenomenological design addresses individual's thoughts and behaviors such that it purposefully focuses our attention on them. According to Husserl's (1970) phenomenological perspective, individuals identify with factors solely from an external manner, which increases their perspective of understanding their world around them. This

increases what they are and how they come together as a group, observing and practicing fundamentals that suggest concepts that build upon phenomenological perspectives.

Phenomenology is used as a way to recognize consistent patterns of phenomena that are observed through increased knowledge of facts viewed by individuals. Bracketing is defined as the main emphasis of interpretive methods (Lopez & Willis, 2004). Moustakas (1990) described the first core practice *bracketing* as a method that involves putting aside personal incidents, preconceived ideas, and biases. Focusing on bracketing before the interview process, as well as during the data collection and analysis, can be used by a researcher to hold back attitudes, biases, judgments, and micro-aggressions concerning existing conclusions that could address data findings.

In bracketing, features are displayed in items where the source is originated in the relationship concerning the object and the observer. The interview process for collecting data is accomplished in the second core practice. Individuals were interviewed who experienced tattooing, as the fundamental phenomenon of this study. The third core practice enables the researcher to acquire and explain a reliable representation of the phenomenon using the viewpoint of the individual. According to Moustakas (1990) the fourth core practice is called *horizontalization* which involves all data collected having equal value.

This process enhances the awareness of individuals' experiences by allowing them the opportunity to view the change that is occurring. Moustakas (1990) described the fifth core practice as *textural explanations* and it involves an analysis of textural explanations that are used to divulge themes in the data. Textural explanations explained

individuals' experiences. Moustakas (1990) explained the sixth core practice as the opportunity to examine vital themes and the significance they represent. Preti et al. (2006) discussed how a majority of adolescent who have tattoos experience emotional instability and a lack of understanding involving their multiple tattoos on their mental health. In this study, phenomenology examined the relationship between having multiple tattoos and major depressive disorder. Influencing features such as age, gender, and ethnicity play important roles in deterring decisions to seek help for major depressive disorder. Phenomenology pursues the deeper meaning of themes connecting the lived experience of individuals with multiple tattoos and with their mental health (Van Manen, 1994).

Depression

Depression is a mood syndrome that create consistent emotions like sadness and loss of interest. According to the American Psychiatric Association (2013) names for depression are major depressive disorder or clinical depression, and affect how a person feel, think or behave which can lead to a variety of emotional and physical problems. Some affects are notice in daily living like not completing normal day-to-day activities, and sometimes feeling worthless, helpless, and hopeless, and life isn't worth living. Depression is one of the most common mental health disorders in the world, an estimated 280 million people world-wide are affected, including 5.0% among adults and 5.7% among adults older than 60 years (Institute of Health Metrics and Evaluation. Global Health Data Exchange, 2019). Depression is not the same as usual mood disorders because of vacillations and short-lived negative emotional reactions to everyday life

challenges (Institute of Health Metrics and Evaluation. Global Health Data Exchange, 2019). Depression in the United States affects nearly 17.3 million Americans (Evans-Lacko et al. 2019; Institute of Health Metrics and Evaluation. Global Health Data Exchange; Substance Abuse and Mental Health Services Administration, 2021; Reddy, 2012). Depression is one of the leading causes of disability in the world, with a global economic cost, 2010 estimate of US$800 billion and rising (Annan, 2014). Depression is exhibited within individuals with medical conditions such as type II diabetes, cardio-vascular and cerebrovascular disorders. Depression is seen as an independent risk factor for some medical conditions like hyper-cortisolism /Dysregulation of HPA axis (Reddy, 2012). Depression is defined as a mood disorder contributing to symptoms such as a loss of interest in activities, lack of pleasure and motivation, sleep disturbances, and suicidal ideations, thoughts, and gestures (APA, 2013). There are additional factors contributing to major depressive disorder such as genetic predispositions, environmental stressors, hormonal and chemical imbalances, and alcohol and drug addictions. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has an array of criteria and a vast scope of depression, however, it is non-inclusive of issues among the prevalence with individuals who are in a diverse group of individuals like multiple tattoos (Roberti & Storch, 2005). Because of atypical presentation regarding depression and major depressive disorder symptoms, it is important that healthcare professionals such as primary care physicians, psychiatrists, psychologist, registered nurses, and mental health practitioners be very observant when encountering someone who might be displaying depressive disorders and symptoms.

Reddy (2012). measured depression by using conventional clinical applicable descriptions relating to symptomology. An example of this was examined by the Center for Epidemiologic Studies Depression Scale that displayed comparable scales tested in American and European individuals within community settings where severity and frequency of symptoms were used (Reddy, 2012). Individuals with tattoos discussed reasons why their symptoms were increased and how motivations pertaining to depression affected them. According to Frederick and Bradley (2000) tattooed individuals stated they were affected and motivated by their level of identified and fundamental motives. These internal motives address experiences and expressions among men and women who get tattoos. Hammond (2012) stated how early detection, accurate reporting and diagnosis, and systematic intervention can lessen adverse effects regarding major depressive disorder in men.

The varied nature of depression can occur in different symptomatic profiles among individuals especially men who suffer from depression that present in different ways such as economic stress, psychosocial stressors, alcohol and substances misuse, lack of anger coping skills, and somatic symptoms difficult to describe like chronic stress or Acute Stress Disorder (Hammond, 2012). Hicinbothem et al. (2006) associated tattooing and piercing with increase rates of self-reported suicide attempts, where Roberti et al. (2004) alluded to individuals whose motives from tattooing and piercing, associate their symptoms to psychosocial stressors. Aizenman and Conover Jensen (2007) discussed how individuals who only self-injured and tattooed showed significantly higher scores on Depression scales and significantly lower scores on Self-Esteem and

Mastery/Control scales as well as individuals that did not have any body modification practices.

Depression and tattoos can have some devastating consequences that involve suicidal behavior. Carroll et al. (2002) pointed out how suicidal thoughts, gestures, and attempts have been correlated to females who obtained tattoos at early ages during adolescents. Dhossche et al. (2000) stated in their study that more than half adolescent white females who completed suicide had tattooed, compared to less than one-third of them were victims of accidental deaths. Dhossche et al. (2000) concluded that tattoos on young adolescent could be viewed as early indicators for lethality, particularly with young adolescents who complete suicide.

History of Tattoos

Tattoos have a five-thousand-year-old history expanding almost every country and continent during every time era and dispensation. The oldest date for tattoos is believed to occur between 3370 BC and 3100 BC. Evidence of tattoos span over 49 different locations around the world regarding tattooed mummies. Some locations where tattoos mummies were found include: Philippines, China, Alaska, Japan, Russia, Greenland, Mongolia, Egypt, and Sudan (Lewis, 2008). Tattooing at one time was thought to be for derelicts, freaks at circus, and military personnel, however, tattoos are more common within certain individuals in our society (Lewis, 2008). Tattoo artists are seen as celebrities through reality television programs about tattoos. Television programs such as *L.A. Ink* and *Miami Ink* base their shows on tattoos, the artists, and the stories of individuals receiving the tattoos. Tattoos are not new and the way they are exhibited on

the body are seen in many different forms. The Pew Research Center (2010) recently found three in ten (twenty-nine percent) Americans have at least one tattoo and that number is increasing. Kosut (2006) discussed how prevalence is higher in younger groups evidenced by 47% of Millennials with at least one tattoo. Tattoos have a volatile past in our society often characterized by stigma and negative stereotypes. Kosut (2006) stated that stereotypes are decreasing among individuals with tattoos. Individuals without tattoos stated that forty-five percent of individuals with tattoos embody rebelliousness, forty-seven percent found tattooed individuals less attractive, and twenty-nine percent equated those with tattoos as less intelligent. There are four major types of tattoos: traumatic, professional, amateur, and cosmetic (Kosut, 2006). The oldest known tattoo on the human body was found on a fifty-three-hundred-year-old mummy from the Swiss Alps. Tattoos have been identifiers to many things such as beauty, markings that display rites of passage, maturity, protection from evil spirits, fertility, healing, happiness, and depiction of suicide or death (Chrisman-Campbell, 2018). Tattoos are believed to represent emotions through displayed symbols on the skin. Sorrow can be conveyed through tattoos (Atkinson, 2004). In England at the National Maritime Museum, its exhibit of seafaring history regarding tattoos displays anthropological approaches that address a geographic, thematic and temporal theme. In its theme there are reminders that tattoos are nouns and verbs showing how globally tattoos have common traditional themes and the process is just as important as the end result. Chrisman-Campbell (2018) referenced how tattoos have been made and worn by men and woman and in some tribes in Borneo, the men carved tattoo blocks, however, women were responsible for the tattoo

branding. With the indigenous Ainu people, tattoos were performed solely by and on women and in the Arctic women tribe tattoos displayed marriage chin stripes signifying they were ready to get married. Chrisman-Campbell (2018) discussed how Jessie Knight was recognized as the first female to become a full-time professional tattooist in the U.K. in 1921. She was known as the first women to tattoo many men and women in the late 1930's that went to fight in World War II. Tattoos have a history of functioning as symbols of status, themes of shame, and displaying traumatic physical and psychological pain on individual's bodies. According to Chrisman-Campbell (2018) criminals of the nineteenth century were branded with tattoos quite often as rites of passage into the underworld. Prisoners from the Russian gulag described how their number of convictions from their crimes and life of years in jail showed their toughness and honor. During the Holocaust, Adolph Hitler forced tattoo numbers on Armenian and Jewish victims. The numbers were placed on the wrist and arm as symbols of identification and humiliation. Some grandchildren of survivors from the concentration camps voluntarily had their grandparent's tattooed number placed on their arm and wrist as a memorial tattoo showing unity and strength.

Some traditional indigenous tattoo traditions were stopped or erased by Christian missionaries during the "Age of Discovery" era where Western explorers and traders initially displayed their tattoos. Thomas Edison in 1876 was credited for making the first electric steel pencil that evolved into the first electric tattoo machine (Chrisman-Campbell, 2018). This new machine made it easier to ink up people and was said to be faster and less painful than tattooing people by hand. Even though this new technology

which was soundly becoming popular worldwide due to its ability to make intricate pictures soon faded away because many artists of today prefer the old fashion method of tattooing by hand. The Maori tattoo is known as one of the most painful tattoos blending in the tattoo with scarification. Chisels are used to cut channels into the skin often times in the face and this expression of cultural pride is enjoying a resurgence in present day New Zealand (Chrisman-Campbell, 2018). There are some modern-day tattoos when displayed under a black light depict a glow-in-the-dark tattooed sleeve which allow party goers access to nightclubs and certain exclusive venues. The Pew Research Institute (2010) reported from their 2010 study that thirty-eight percent of Millennials (individuals born after the year 1980) got at least one tattoo and of the thirty-eight percent, sixty-nine percent have more than one, and thirty-two percent of Gen X have at least one tattoo as well (Sanna, 2016). Generation X individuals were born after the baby boomers and before the millennials, they are born in 1965 through 1980 (Bennett et al., 2017). According to Kosut (2006), slightly over one-third of the Generation X population reported getting one or more tattoos.

Matthews (2008) and Swami et al. (2012) examined how similarities can occur when certain motivators and personality traits occur in individuals who display tattooing behavior as well as individuals who tattoo and pierce for self-expression. Matthews (2008) provided research on depressive symptoms that relate to tattoos as forms of cutting and body modification addiction that contributed to negative consequence of thinking modalities. The author outlined the progress made by individuals who experience depression and how their symptoms create behaviors that lead to tattooing.

Additionally, the author explained the role that friends and family members play in helping them seek assistance when their tattooing behavior is becoming an addiction. The research on tattooing and self-injurious behavior used qualitative data collected by observing participants during their interview process.

The data collection from the interviews follow research carried out by researchers who have examined participants with multiple tattoos, where life functioning have been interrupted due to their depressive symptoms. This article is significant because it identifies emerging trends that illustrate how tattooing and depressive symptoms can occur when triggers are not understood. Matthews (2008) discussed limitations where participant's depressive symptoms relating to tattooing, however, she further stated in her research that tattooing can be associated with depressive disorders.

This research can be useful in helping individuals with multiple tattoos who have been diagnosed with major depressive disorder implement the correct treatment methods as a way of decreasing their depressive symptoms. Swami et al. (2012) examined behavior and the individual changes occurring between tattooed and non-tattooed participants regarding depression. Tate and Shelton (2008) discussed how planning, permanence, and pain involved in tattooing could mirror real-world variances between tattooed and non-tattooed individuals. Swami et al. (2012) discussed a number of statistically important changes occurring between tattooed and non-tattooed individuals that involve individual differences relating to personality. It was noted by the researchers, tattooed individuals demonstrated noticeably more positive attitudes toward their tattoos

and this increased their self-esteem. Another factor such as sensation seeking suggested that tattooed individuals scored higher in extraversion than non-tattooed individuals.

Tiggemann and Hopkins (2011) explained how tattooed individuals displayed a higher need for uniqueness than non-tattooed individuals. The results from their study support ideas that tattoos are being used as signs and meanings of self-expression/identity decreasing their depressive symptoms (Swami, 2011). Swami (2011) explained in certain societal norms where the body is increasingly commercialized, tattoos are a source of individuality that display marks of being different and attaining improved self-perceptions of uniqueness. Tiggemann and Hopkins (2011) talk about how tattoos are an important display of emotions by which individuals can develop their unique style showing dominance in their appearance.

Although the results suggest statistically substantial changes occurring with tattooed and non-tattooed individuals in statistics of observed variables, the effect sizes of examined changes were generally small (Swami et al., 2012). Tate and Shelton (2008) discussed implications of small differences between tattooed and non-tattooed individuals are insignificant factors. The existing results suggested no statistical changes occurred in tattooed and non-tattooed individuals which involved quantity of other variables, self-esteem, religious and spiritual beliefs (Swami et al., 2012). An individual change approach can be helpful for scholars identifying certain aspects of individuals who most likely will get a tattoo, adding to research where motivational features of tattooing are approached from a sociological perspective (Kosut, 2006).

Tattoos and Identity

Tattoos have long been a conversation piece for many and for some a source that speak to their problems and pain. The Star Tribune blog explained how Angi Stevens who is a Minneapolis bus driver talk about her tattoos on her body with her passengers during their bus ride (Harlow, 2016). The tattoo bus design was chosen by Stevens, because it commemorated her award for winning the transit driving skills competition in 2012. Brice (2016) described tattoos as memorial tattoos that serve purposes in people's lives that bring meaning to them. In his work with the military, he documented many tattoos that sometimes told stories of their military quest and adventures, as well as their combat pain. Brice is the co-founder of the project ink foundation. His foundation tells stories of combat veterans whose memorial tattoos help people see that combat veterans are not crazy or dangerous nor are they a source of PTSD baggage waiting to explode and become unhinged due to their inability to control their anger and nightmares. Their tattoos are a source of relief and create a relationship of peace from one human to another (Brice, 2016). Lande et al. (2013) made mention that various people get their motivation from tattoos as their daily expression, where as individuals that get their first tattoo display their way of describing self-expression while less than 10% described regret for getting their tattoo. Overwhelmingly tattoos are seen as symbols of psychological uncertainty, lack of mental instability and misunderstanding by the observer and disallows the bearer to become involved in the explanation of the true meaning of their reason for the tattoo (Anderson and Sansone (2003); Aryan (2006); Favazza (1996); Grumet (1983); Karacaoglan (2012); and Roberti & Storch, 2005).

Roberti and Storch (2005) pointed out that individuals who exhibit body modifications display more symptoms of depression and anxiety than individuals without body modifications. Larsen et al. (2014) suggested that individuals' tattoos that are considered a contemporary tattoo are involved in culture that is increasingly complex and practitioners should think far greater outside the box than the normal when drawing conclusions about tattoo interpretations. A difficult assumption regarding the therapeutic relationship of tattoos is the judgements of practitioners and researchers who interpret the tattoos of individuals. Descriptions of tattoos are sometimes seen as morbid forms of self-help expression that are regulated intensely dysphoric, affecting states of mind by resembling hysterical signs and symptoms as well as attributing to an anti-psychotic meaning due to the tattoo (Anderson & Sansone, 2003; Favazza, 1996; Karacaoglan, 2012; and Roberti & Storch, 2005). Some literature does not take into account the tattooed individuals' expression, meaning or desire for getting the tattoo and the process involved. In their study, Aizenman and Conover Jenson (2007) mentioned how tattooing is seen as a form of wellbeing for body modification rather than self-harm and individuals' reason for tattooing are unconnected forms of psychological grief or impossible emotional behavioral states. Increased prevalence regarding anxiety and depression was evident within individuals who had tattoos; however, other studies showed no statistical significance in theirs (Roberti & Storch, 2005; and Stirn et al. 2006). Birmingham et al. (1999) discussed how individuals with psychotic disorders such as schizophrenia and bi-polar exhibited depressive symptoms relating to the significance of the tattoo, however, Frederick and Bradley (2000) mentioned how tattooed individuals

with depressive symptoms were within manageable ranges of normal psychological functioning. Frederick and Bradley (2000) presented that tattoos are potential reasons for depression, however, Stirn et al. (2006) discussed how individuals with tattoos display lower depressive symptoms than non-tattooed individuals.

The contradictions within the findings in the literature suggest that it is difficult to come to a reasonable conclusion regarding this phenomenon. Birmingham et al. (1999) stated that evidence specified that a tattoo's presence and not its artistic content correlates with certain mental health disorders. Many individuals see tattoos more than unassuming symbols that hold psychiatric meaning to their mental health brokenness. If treatment involving tattooing and major depressive disorder is not assessed correctly, important information will be missed within the therapeutic process for counseling individuals with tattoos.

Depression and Tattoos

The wearing of tattoos has changed from an emblem of social nonconformity or personality weakness to a denounced or even optimistic form of communication (Roberts, 2012; Tate & Shelton, 2008). Countless individuals with tattoos live with depression making it very hard for them to function in life (Roberti & Storch, 2005). There are many reasons for getting a tattoo, one reason could be those individuals whose tattoos depict depression symbols can be signaling to a mental health practitioners who service this population they need help.

Millner and Eichold (2001) defined tattooing as injections of coloring particles underneath the skin that remain on the skin creating ornate and specific designs or

numbers. These designs and/or numbers have many different meanings based on the thought processes of individuals receiving the multiple tattoos. Tattooed individuals point to indicators relating to pathologies associated with depression, anxiety, and excessive risk taking (Roberti & Storch, 2005). According to Atkinson (2004) tattooed individuals exhibit psychological theories about their tattoos and some tattoo individuals believe their tattoos represent emotions that create depressive symptoms. Many individuals attempt to cover up unfavorable tattoos, especially tattoos from their past that describe events that create depressive symptoms (Grumet, 1983). Getting tattooed remains an act considered to be a hazardous activity with individuals that get multiple tattoos. They present with impulsivity and act upon depressive behaviors that display greater risks with their mental health. Atkinson (2004) pointed out that sorrow can be expressed through tattoos from negative feelings. Individuals can feel they are in control of their physical pain however they are not in control of the emotional pain they are experiencing, causing them to display their pain through their tattoos (Atkinson, 2004). In some areas tattoos are seen as a badge of honor that expresses a type of pain tolerance and physical endurance (Armstrong et al., 2000). Tattooing is more common among adults who experience psychopathology difficulties relating to their tattoos and the meaning behind the tattoo (Roggenkamp et al., 2017). Certain type of tattoos trigger behavioral and emotional responses such as depression, aggression, and deviance, these behaviors and emotions are exhibited more and more as society embraces tattooing (Roggenkamp et al., 2017).

Tattoos differ vastly in their designs, locations on the body, numbers and different content (Khosla et al., 2010). There are classification of tattoos, however, Ferguson-

Rayport et al. (1955) divided them into seven groups such as identification tattoos (service emblems; personal information; key life events), love tattoos (idealized, sentimental or maternal love; pornographic images), bombastic and pseudo-heroic tattoos (Skull and crossbones, 'Death before Dishonor', powerful animals), inveighing fate (horse shoe with 'Good Luck'; 'Friday the 13th'), religious and commemorative, private symbols (of significance only to the individual), miscellaneous (animals, birds, flowers).

Tattoos such as clothes hanger represents an individual struggling against needing an abortion, leaving a scar of sadness and depressive symptoms. A scar covering tattoo is understood as an individual moving on from self-harming acts. Individuals that struggle with depression or even attempted suicide see the scar as a consistent reminder of their pain and covering it up is an attempt to hide from the pain they are experiencing (Roggenkamp et al., 2017). A semicolon tattoo represents individual's exhibiting mental illness. It expresses the thought that continuing of a sentence instead of an abrupt ending to their life like the period suggest in writing. Individuals with tattoos experiencing depressive symptoms have completed suicides or are contemplating it use this symbol a reminder that their story does not need to end abruptly (Roggenkamp et al., 2017). The serotonin tattoo is used as symbol to show individuals who exhibit depression. Individuals equate the tattoo as a lack of the chemical serotonin which causes depression and it reminds them that their depression is not their fault.

During the centuries past in Western society, individuals with tattoos have advanced from tattooing being culturally offensive to mainstream fashion statements among the rich and famous (Schmid, 2013). Consequently, past biases and pathological

associations regarding tattoos warrant reconsideration for current tattoo bearers. Even though the current literature on tattooing is instructive, availability for the data is restrained to specific tattoo populations drawn from United States which offer a small viewpoint on the collaborations of characteristics of tattoo bearers such as age, ethnicity, socioeconomic status on the public view (Schmid, 2013).

Summary

As noted in the review above, tattooing and major depressive disorder can occur when findings involve therapeutic measures that assist individuals when over tattooing is difficult due to stigma, lack of services and the inability of the individual to recognize their depressive symptoms. Larsen et al. (2014) point to negative associations and the shame of nonconformity are prevalent within the literature as well as in the predominant views of individuals with tattoos in society. Far-reaching over-generalizations concerning tattooing with individuals has taken place with the ability to live in every part of a tattooed individual's life, including in the context of clinical implications. The purpose of this study expounded upon the current literature in order to reach better clinical outcomes regarding lived experienced of individuals with tattoos who exhibit major depressive disorder. As the research displays, there are certain behavioral symptoms that present with negative consequences with individual's whose tattoos contribute to major depressive disorder. Atkinson (2004) discussed how mental health professionals normally assess that individuals with tattooed bodies manifest a mind oppressed with disorders. Practitioners normally rely on the stories of their clients to enter into their world as a means to understand their position and in this study, such is the case. Bringing awareness

about individuals whose tattoos could contribute to major depressive disorder is important because of their possible quest to seek help for their mental health disorder. Such empathetic engagement, as well as knowledge and skills for practitioners regarding individuals with tattoos can help them facilitate their desired need for change.

The next chapter outlines how this qualitative research design relates to this study. A detailed description is presented on the way phenomenological methods are applied in this study. Limitations address deficiencies in this study by outlining weaknesses, biases, and measures. The final segment of Chapter 3 evaluates contributions and possible associations with the method approach selected within this study, followed by a detailed summation of this chapter's main points.

Chapter 3: Research Method

Introduction

In this study, I examined the experiences of individuals with multiple tattoos and major depressive disorder. I used a qualitative, phenomenological approach to gain knowledge of their experiences, thereby developing a broader understanding of their perception of their own mental health.

There are five major sections in this chapter, in which I address the research design and rationale, my role as the researcher, the research methodology, the trustworthiness and transferability of the research, and a summary of the chapter. The research design section includes key components of this study and a justification for the research design. The second section includes a discussion of my role as the researcher and the biases and ethical concerns that could have created conflict of interest during the study. In the third section, my methodology, including participant selection, instrumentation, procedures, and data analysis, are reviewed. The fourth section includes a discussion regarding issues of trustworthiness, credibility, transferability, and reliability. Finally, the fifth section is a summary of the main points of Chapter 3 and a brief discussion of and introduction to Chapter 4.

Research Design and Rationale

I conducted this qualitative study with a phenomenological design. Creswell (2013) described various methods of answering research questions by gathering data for valid results. I used the phenomenological design to understand how a relationship could exist between having multiple tattoos and having major depressive disorder. An

advantage the qualitative approach is the flexibility of the design. Due to this flexibility, I asked open-ended questions of study participants. Creswell (2013) described how a phenomenological design can be used to explain the "how" and the "what" of an individual's lived experience of a particular phenomenon. Creswell (2013) explained how phenomenology can be used in a study to demonstrate how an individual can become cognizant of the phenomenon in question; furthermore, he described how phenomenology can address the ways that distinctive types of experiences, such as thoughts, perceptions, and memories, are structured.

Creswell (2013) described five major qualitative approaches that researchers can use for their studies. The five qualitative approaches are narrative research, phenomenology, grounded theory, ethnography, and case study. Rudestam and Newton (2007) described the narrative research design as the recording of biographic information that narrates the lives of individuals as they experience the events being studied and researchers concentrate on the significance of the experiences. Grounded theory designs are used by researchers to develop methods and theories that are based on similarities in the experiences of members of groups (Rudestam & Newton, 2007). Moustakas (1990) stated that the grounded theory approach can be used to gain knowledge of the nature and meaning of an experience for a specific group of people in a particular setting. According to Moustakas (1990), ethnographers create direct interpretations of the behaviors of groups in a range of settings over a long period of time. Rudestam and Newton (2007) explained that ethnography is used to record and preserve the lives of a specific group of people, as researchers witness their patterns of behavior, their customs, and their

lifestyles. According to Rudestam and Newton (2007), a case study is an attempt to understand a single unit of study within a complex context. Similar to this, Creswell (2013) explained that case studies can be used when the researcher's focus is to develop an in-depth description of a single person, organization, event, program, or method. The aforementioned designs were not suitable for this study because I could not use them to examine the relationship between an individual having multiple tattoos and having major depressive disorder.

The phenomenological approach is useful for the examination of the experiences of certain individuals or groups related to their particular social or human problems (Moustakas, 1990). In this study, I gained knowledge of the lived experiences of individuals with major depressive disorder who also have multiple tattoos. The phenomenological method was the appropriate approach to gain knowledge about the experiences of individuals who have multiple tattoos and major depressive disorder. My use of the phenomenological method gave the participants the opportunity to discuss their own experiences, thus capturing how individuals experience this phenomenon.

Participants in phenomenological studies are provided with opportunities to discuss their personal perceptions, descriptions, feelings, judgements, and reflections for making sense of the phenomenon in question (Finlay, 2009). According to Madjar (2014), a quantitative approach does not afford opportunities to gain valuable in-depth details from participants, because its primary focus is on the examination of relationships between variables. Tashakkori and Teddlie (2010) stated that quantitative methods are

most often used for testing predictions or hypotheses, whereas qualitative methods are used for discovering emerging themes, which is the goal of this project.

Role of the Researcher

As the researcher, it was imperative that I understood my role in the research process. According to Madjar (2014), there are complex balances between objectivity and subjectivity when conducting research from a qualitative perspective. As an objective and impartial researcher, I was honest in presenting the responses of my study participants. However, my ability to remain objective meant that I was discerning in my observations based on the data gathered from participants, as well as during the data analysis process.

In this section, I explore my role as the researcher in more detail. I also addressed specific ethical criteria, such as the requirement to do no harm by obeying ethical codes as a practicing therapist (American Psychological Association, 2017). I observed the policies and procedures of Walden University's Institutional Review Board (IRB) for protecting an individual's health and safeguarding their identity by using fictitious names when reporting the data gathered from individuals during the interview procedure. I also ensured that participants complete informed consent forms before beginning their interviews and I explained their rights to continue or terminate participation in this study.

My Role

According to Creswell (2013), the researcher is influential in their study due to their ability to gather data, examine documents, observe behavior, and interview individuals during the study. For this study, it was important that I examined my influences, because I gathered data by personally interviewing individuals, observing

participants' behavior during interviews, interpreting interview notes, and evaluating data. I addressed how my biases affected the results. Biases are attitudes that people hold toward other people, situations, or concepts, and include stereotypes (Kawulich, 2005). I was instrumental in the gathering of data, and, therefore, I addressed how my implicit biases, prejudices, stereotypes, macroaggressions, and microaggressions impacted the interviews or analysis, in order to reduce my level of influence on the results. I used bracketing as my focus during the data collection to manage my biases. Bracketing improves the research process and researchers use it to focus on the research questions, exclusively reflecting the theme under examination. Moustakas (1990) defined bracketing as a phenomenological method that is instrumental in searching for associations in meanings. Madjar (2014) explained that researchers must discontinue thoughts or views that oppose the authenticity of the individual's world surrounding the phenomenon. Giorgi (1985) pointed out that, when gathering data, researchers must also prevent their previous knowledge, which can influence the current information collected from individuals, from interfering with the development of their analysis. Madjar (2014) described how perspectives of individuals can help bring awareness to experiences associated with phenomenon's. When performing this research, I used recording equipment and an interview protocol form to gather data.

Ethical Issues

According to Patton (2002), it is important to use ethical research methods, which involve checklists that outline parameters relating to research design, data collection, and analysis. I used a 10-item checklist designed by Patton to confirm the credibility of my

study and minimize ethical concerns. The 10 checklist items are: (a) defining the purpose, (b) understanding potentials and interchange for individuals, (c) assessing threats for individuals, (d) creating confidentiality and/or privacy, (e) classifying informed consent, (f) data admission and possession of data, (g) raters' mental health, (h) recommendation or raters' confidence, (i) restrictions of data collection, and (j) ethical as opposed to legal concerns. I initially reviewed individuals during the interview process, before the completion of the informed consent document. The ethical concerns are listed in Appendix A. To highlight the study's ethical concerns, a flyer discussing the purpose of the study was given to all participants.

The flyer included five criterion questions and my contact information for interested individuals. When interested individuals contacted me, I reviewed their answers to the five criterion questions, and discussed the purpose of the study and the interview process. I ensured individuals are aware of the following parameters: my role as the scholar in accumulating and examining data, the function of Walden's Institutional Review Board (IRB) when engaging with human subjects throughout a study, and the function of my dissertation committee for peer debriefing and establishing confidentiality and informed consent. All checklist items addressed the ethical concerns identified within this qualitative study in Appendix A.

Methodology

I considered numerous aspects when establishing the methodology of this study. Specifically, I examined four functions of this study: participants, instrumentation, data collection, and data examination. I identified individuals with multiple tattoos who

exhibit major depressive disorder, I conducted 20 to 45-minute audio recorded video organized and structured interviews at agreed-upon locations, in order to increase the participants' level of comfort while taking part in this study. I scheduled one interview per week, allowing time for transcript creation to occur between interviews. When conducting the interviews, I took into consideration my own thinking toward the research question as to not cause bias within the study.

According to Madjar (2014), a qualitative research method centers on credibility; therefore, my skill, proficiency, and thoroughness was operative as instruments of this research study. I followed these three steps: (a) informed individuals about the purpose of this study, (b) did not allow individuals to remain on site for the interview process longer than needed, and (c) provided individuals with opportunities to discuss any concerns they had about me, the research design, or the interview process. Each area was given significant consideration throughout the design of the research plan to ensure that each function of the methodology was aligned with the research question. The particulars of each function listed above was outlined in this section.

I used the Speaker–Listener method for directing the interview topic. I completed researcher notes using the interview protocol form. Creswell (2013) claimed that when interviewers are able to incorporate nonjudgmental listening techniques, they are able to listen effectively and give individuals the opportunity to communicate without frequent interruptions from the researcher.

Participants

This study focused on individuals with multiple tattoos and analyzed differences that exists with individuals with multiple tattoos and major depressive disorder. Moustakas (1990) stated that there are no specific rules for sample sizes when performing qualitative research; however, the phenomenology design was essential in my research for identifying participants with sound understandings of this phenomenon. A specific group of individuals with multiple tattoos was identified because of a possible relationship to major depressive disorder and, by extension, lived experiences with this mental health disorder. Rudestam and Newton (2007) described how studying small numbers of participants who relate to a phenomenon over a period of time provides opportunities to understand the experiences of individuals who experience the phenomenon. Narrowing my identified population, I chose 10 people within Hillsborough and Pinellas County, located in the state of Florida, as participants. Information was gathered for an invitation for participation (See Appendix C).

Sampling Strategy

Initially, a flyer providing a brief outline of this study and participant recruitment was passed out individuality at the Clearwater Mall and Countryside Mall in Florida from Pinellas County and the International Mall from Hillsborough County. Information in the flyers clarified the reason for participating in this study. I also reviewed my contact information for participants interested in speaking with me directly about this study. The flyer contained the five criterion questions (provided later in this section), which was designed to help participants self-identify as appropriate for this study. I asked

participants the same five criterion questions. This consistency was necessary to identify candidate appropriateness, as well as participation in this study. I provided a brief overview of the interview procedures and the methods for contacting me in the case of concerns or questions. Once I establish the suitability of participants, scheduled interviews were completed in confidential and secured locations within participants home to ensure confidentiality and the privacy of research participants. To protect the identities of volunteer participants, all information collected during the interview process was kept anonymous.

For accurate study results, it was necessary to purposefully select suitable participants. Five criterion questions were used for the selection to help safeguard data collection until the point of saturation was established. I used the five criterion selection questions listed below:

(1) Was your diagnosis of major depressive disorder given before you received your first tattoo?

(2) Did your diagnosis of major depressive disorder influence the type of tattoos you received?

(3) Did your diagnosis of major depressive disorder influence your decision to receive tattoos that are considered “depression tattoos?”

(4) Did your diagnosis of major depressive disorder influence the number of depression tattoos you received?

(5) Did your major depressive disorder get worse after receiving one or more depression tattoos?

Participants who do not have a diagnosis of major depressive disorder before their first tattoo was excluded from the study. Moustakas (1994) indicated that participants' knowledge of and/or experiences are important when making participant selections regarding the phenomena in studies.

Data collection began after participants were selected. Selected participants allowed me to gather data for cases related to this study. Prior to interviews, participants were asked to complete informed consent forms, consenting to the use of their handwritten notes and/or audio-recorded interviews for gathering data. Informed consent took place after I interviewed participants about the purpose of this study. By completing inform consent forms, participants were able to acknowledge their understanding of the study, my role as the researcher, their role, and the study requirements. Moustakas (1990) described that informed consent involves full disclosure and decides ethical principles and practices when working with human participants. The informed consent form listed interview information (See Appendix B).

Once informed consent forms were completed and gathered, face-to-face interviews began. According to Moustakas (1994), the interview process should be informal and create a comfortable and stimulating environment for participants. The maximum number of participants for this study was 10; however, this number could be adjusted based on the point of saturation determined during data collection. Rudestam and Newton (2007) explained that heterogeneous groups containing small numbers of participants (i.e., 10 or fewer) are suitable for phenomenological studies. For this study, the range for selection was 10 participants because the point of saturation for this study

was met with this number. Rudestam and Newton (2007) mentioned that redundancy can happen when no new information is gathered from the samples, causing the study's point of saturation to be reached. Termination of data collection for my study occurred when the point of saturation was reached with 10 participants. Repetition happens when the information provided is alike between participants; no new information was collected from the 10 participants. When the point of saturation occurs the conclusion phase of data collection will be reached. I finished the data collection stage which allowed me to move forward to the data analysis process causing saturation to be achieved.

Open-ended questions concentrating on the participants' experiences, attitudes, and beliefs surrounding major depressive disorder was used during semistructured 20-to-45-minute face-to-face interview sessions; the information provided by participants was used to determine whether a greater number of participants was needed to reach the data saturation point. Saturation was met with 10 participants in this study.

Instrumentation

Moustakas (1994) described how some phenomenological studies use in-depth interviews as sources for gathering data because they allow participants to describe their experiences surrounding a phenomenon. According to Creswell (2013), interview forms can also be used, in addition to researcher notes, to document participant responses and comments during the interview. Rudestam and Newton (2007) stated that different types of interviews, such as telephone and face-to-face, are available to researchers, who can select for their study the most appropriate avenue for gathering information to answer their research question. The interviews for my research used a mixture of three processes

for collecting data: (1) protocol interview forms, (2) researcher notes, and (3) device for recording. Semi-structured interviews permitted me to gather data about the participants' beliefs, experiences, opinions, feelings, and knowledge about major depressive disorder; I was able to gather their opinions on whether these five elements have influenced their ability or choice to acquire more tattoos.

I used researcher notes to gather data, and the notes permitted me to develop initial conclusions when data exploration began. Furthermore, researcher notes was intended to aid me if any malfunctions or glitches were to occur with the recording equipment during the interview process. I formatted the research notes and interview forms that were used to gather the data as well as list questions that was discussed with participants during the interview process. Each participant was asked the same standard set of questions, all of which were derived from the research questions. The format of the research notes consisted of the following items: interview date, time, location, questions, and the interviewee's initials. Interview questions were a combination of "what" and "how" questions, which typically produce in-depth responses. Example question were as follows: do you think a relationship exist between individuals with multiple tattoos and those with major depressive disorder? This interview format aided me in keeping the interview on the topic of the research question.

A Philips Digital Voice Tracer DVT 2710 portable digital voice recorder was used to record participants during the interview procedure. The portable digital voice recorder has the capacity to record and decipher both an interviewer and an interviewee

while they are speaking. The recording features were tested before data collection, in order to gauge the adequacy of the devices.

Data Analysis

The data analysis phase included the categorization of the gathered information into themes or interpretations. Giorgi (1985) indicated that analyzing data can be challenging, especially when conducting qualitative research; consequently, researchers must have defined steps for questioning numerous sources of data. My data analysis process used direct quotes, personal experiences, opinions, feelings, and knowledge collected in the interviews. The data analysis process withdrew conclusions from participants' personal history, and experiences that exists between having multiple tattoos and having major depressive disorder; these conclusions were meant to bring understanding to this phenomenon. Creswell (2013) pointed out three strategies for structuring the data analysis phase: (1) preparation and organization of data, (2) classification of data for developing themes, and (3) representation of data. For this study, I implemented these three processes.

Classification of Data

An important step in the data analysis process is the arrangement of data into categories of themes or interpretations. Giorgi (1985) specified an outline of steps to be used during the data analysis stage, and I implemented these steps in my process. I began the process by ensuring my understanding of the interview transcripts. Reviewing the transcripts permitted me the opportunity to break down the larger descriptions from the interviews into smaller sections, which is a necessary step in identifying themes

regarding the research question. I reviewed each transcript line by line to identify important statements for classification of the themes and the meanings of multiple tattoos. Identifying specific descriptions from the interviews were necessary to the development of themes. I examined multiple tattoos with similar meanings and note their similarities, in order to gather related meanings together. Whenever I recognize new meanings, I separated them and marked their relevance. Marking meaning similarities permitted me to create large and small categories for identifying the themes of the tattoos (Moustakas, 1990). The researcher notes and interview protocol form notes allowed me to organize the data into theme groups.

To organize theme categories, I clustered all statements from participants into the emerging themes after reviewing their quotes. Giorgi (1985) stated that themes are comprised of broad categories, which involve numerous smaller groups that form the same overall idea. To assist in the gathering and classification of the data, I created a grid with three columns. The first column consisted of direct quotations from the participants. According to Giorgi (1985), this third-person account allows a researcher to view the participant's description of the data analyzed. I formed themes and subthemes to create categories, which supported related statements in the data to be gathered from participants. I utilized the written descriptions of the participants' experiences to identify textual explanations for a relationship between individuals' multiple tattoos and their major depressive disorder. Descriptions consisted of verbatim statements from the participants on whether a relationship exists between these experiences. I drew on textual explanations of the significance of the phenomenon. The textual and structural

explanations detailed what occurred for these participants when experiencing the phenomenon being researched by this study. Structural explanations were utilized to illuminate the experiences of participants with multiple tattoos and demonstrate how these circumstances are related to major depressive disorder. Therefore, my textual and structural descriptions assisted me in identifying the principle of existences between individuals' multiple tattoos and their major depressive disorder.

Trustworthiness

In qualitative research models, the process of validating the research is called "trustworthiness." Moustakas (1990) pointed out that establishing the validity of qualitative research involves checking the accuracy of the findings and the research approach using specific strategies or procedures. Creswell (2013) mentioned that trustworthiness is established through validation of a study's credibility, transferability, dependability, and confirmability. I established the validity of this study through the concept of trustworthiness. Moustakas (1990) recommended that researchers use multiple strategies when checking for internal and external accuracy of a study; thus, I selected various strategies and procedures for this study. I established the internal accuracy of my findings by reviewing the differences between participants' checklist protocol forms and my researcher notes. The participants' checklist protocol forms established the study's credibility on the research topic by ensuring the accuracy of participants' statements about the phenomenon. This helped form an association between the researcher, the participant, and the data collected process. Internal accuracy was established through my

memo notes. My memo notes permitted me to expound on my original thoughts, experiences, implicit biases, stereotypes, and assumptions surrounding this phenomenon.

The external correctness of this study was established through the use of Walden University's Institutional Review Board guidelines as well as Walden's dissertation guidelines. The use of different sources allowed me to verify the trustworthiness of my process and outcome within this study. When trustworthiness of the process and outcomes are not fully understood, ethical concerns can arise. Ethical practices are required for qualitative studies when collecting data from human subjects. As Rudestam and Newton (2007) stated, ethical practices and procedures are defined as details, norms, and values that a researcher considers before conducting any qualitative research. Ethical concerns for the participants and data of this qualitative study were outlined in this section. Before conducting this research study, I needed to obtain consent from the University Research Review (URR) prior to the submission of an application of research with Walden University's IRB. The purpose of Walden University's IRB is to ensure that ethical procedures protect participants in research studies. Walden University's IRB assesses risks to participants by examining the suggested data collection techniques of the research studies. My proposed study conformed to ethical procedures for working with human subjects after the board grants approval for this research to be executed. Once Walden University's IRB grant approval for my research on human subjects, I began gathering data for this study.

I took several steps to protect the human participants in my study. I used fictitious names when evaluating the data or directly citing participants, for the sake of

safeguarding their identities. According to Rudestam and Newton (2007), guaranteeing participant confidentiality safeguards the participant's uniqueness as it offers them the chance to safely divulge their experiences to the fullest. Furthermore, I discussed risks and benefits of the study with all individuals in the initial intake interview. I also provided a list of referrals to local mental health agencies, as well as the National Suicide Hotline number (1-(800) 273-8255), to provide easy access to follow-up care if needed for any participants who are triggered by the interview questions. Various ethical factors can occur within a study, explanation of the factors to participants can assist in understanding of the processes. Ensuring clarity of interview questions and the data collection process can decrease ethical concerns of participants. Patton (2002) stated that all questions in study interviews should be clear, straightforward, and understandable, as participants should have an easy understanding of the study. According to Rudestam and Newton (2007), it is important for all participants to understand the purpose and risks of a study. I took this principle into account in my research. Moreover, security was ensured as all data gathered, such as recordings, transcripts, and documents, was doubled-locked in a filing cabinet in my office. Data will be deleted five years after the conclusion of this study. Based on the research question, I believe the philosophical framework, recruitment strategies, research methodology, and ethical practices of this phenomenological study are sound in methods and procedures, as I guarantee the safeguarding of the data and the protection of the participants.

Summary

Chapter 3 described the qualitative methods used for this phenomenological study. The chapter began by addressing the research design and rationale for this study. The purpose of the study was reiterated numerous times, following thoughts regarding the traditions of research and the research question. The chapter also discussed my role as the researcher, my responsibility for gathering data, and ethical concerns. The next section defined the details of my methodology, including the participants and location, sampling plans and sample sizes, use of interviews for gathering data, and approaches to the data analysis phase. The fourth section reflected on the techniques employed for creating trustworthiness and the procedures implemented for ensuring the internal and external correctness of this qualitative study. The last section explored ethical concerns involving the health and wellbeing of participants and the storage of data for this study. In Chapter 4, the text focused on the findings of this study. Chapter 4 explicated the purpose of this study, demographics of participants, data gathered from interviews, analysis of the study data, demonstration of the evidence for trustworthiness, and the final results of the study.

Chapter 4: Results

Introduction

In this research study, I explored the lived experiences of individuals with multiple tattoos who exhibit major depressive disorder. This chapter includes data about the research conducted. Interview settings are discussed, and research participant consents are presented. The method of data collection is described as well as changes made during the process of data collection. Data analysis is defined, and evidence is presented regarding data trustworthiness.

Research Question and Sub-Questions

The following research question was developed to guide this qualitative study: Does individuals with multiple tattoos exhibit major depressive disorder? From this question, these sub-questions were developed:

1. Was your diagnosis of major depressive disorder given before you received your first tattoo?
2. Did your diagnosis of major depressive disorder influence the type of tattoos you received?
3. Did your diagnosis of major depressive disorder influence your decision to receive tattoos that are considered “depression tattoos?”
4. Did your diagnosis of major depressive disorder influence the number of depression tattoos you received?
5. Did your major depressive disorder get worse after receiving one or more depression tattoos?

This chapter includes a discussion of the strategies for enlisting participants, the interview settings, data collection and analysis procedures, and the results of the study.

Recruitment

I recruited participants from Clearwater Mall and Countryside Mall in Florida from Pinellas County and the International Mall from Hillsborough County, after receiving acceptance of approval from Walden University's Institutional Review Board (IRB) to conduct the study (IRB approval number 08-03-23-0146090). After receiving this notification from Walden's IRB, I contacted participants from the two designated counties. I submitted flyers and informed consent forms to participants at the three different locations in Hillsborough and Pinellas counties. The flyers and informed consent forms included a brief overview of the study, the five inclusion criteria questions for the study, and my contact information for participants who wanted to speak with me relating to concerns or questions about this phenomenological study.

The data collection phase began on August 4th, 2023, by disseminating flyers and informed consents at the three designated locations, Clearwater and Countryside Malls in Pinellas County and the International Mall in Hillsborough County. Participants consented to the informed consent that explained the use of audio-recorded confidential video call interviews.

Each participant identified agreed to read the flyer and informed consent. If they agreed to participate, they emailed "I consent" to my email address with a day and time to complete the audio recorded interviews via a confidential video call.

I conducted a total of 10 interviews. using audio-recorded confidential video calls for gathering data. Three participants from Clearwater Mall accepted flyers and informed consent, four participants from Countryside Mall accepted flyers and informed consent, and three participants from International Mall accepted the flyer and informed consent.

The audio-recorded organized and structured video call interviews were completed in confidential and secured locations within participants home to ensure confidentiality and the privacy of the research participant. This permitted participants to feel at ease in their setting during the interview process. Participants reported no levels of stress before, during or after the times of the audio-recorded confidential video call; as a result, I estimated that participants' stress levels were low due to their familiarity with their home setting, allowing me a chance to collect accounts of participants' lived experiences. All of my audio recorded confidential video call interviews were conducted in my home in a secure and private location.

Demographics

The research participants consisted of 10 adults between the ages of 18 and 65. Each participant selected from the three designated locations used an alias for the interview. The research participants consisted of 10 adults between the ages of 18 and 25, including seven women and three men. Each participant had two or more tattoos and a diagnosis of major depressive disorder from a psychiatrist or a clinical psychologist, except one. Nine participants described being diagnosed with MDD, while one stated that he had not officially been diagnosed. Eight of the participants resided in Pinellas County, two in Hillsborough County. (See Table 1 for participant information).

Table 1

Participant Demographics

Participant	Number of Tattoos	Diagnosis of MDD
P1	5	Yes
P2	4	Yes
P3	6	Yes
P4	9	Yes
P5	4	Yes
P6	5	Yes
P7	11	Yes
P8	11	No
P9	2	Yes
P10	9	Yes

Data Collection

I identified the 10 participants for this study by standing outside of the Clearwater Mall and Countryside Mall in Pinellas County, Florida and the international Mall in Hillsborough County, Florida. Participants who were interested contacted me via my contact information on the flyer. I conducted audio recorded confidential video call interviews with the 10 participants. I used the audio recorded confidential video call interviews for data collection. These audio-recorded confidential video call interviews

took place in my office and in their location of choice during a time when the participant was available to speak in a quiet space to minimize background noise. The 10 audio recorded confidential video call interviews were held in each participant's preferred location based upon their accessibility and comfort level. The audio recorded confidential video call interviews with each participant ranged from 20 to 55 minutes with the average interview time being 20 minutes. I recorded all audio recorded confidential video call interviews using a Philips Digital Voice Tracer DVT 2710. Each audio recorded confidential video call interview transcription was created by this researcher after listening to each recorded interview. A Microsoft Word folder was created for documenting participant's interview order during the data collection process.

I used five interview questions during the interview process to gather data from the participants. The five interview questions were created to answer the main research question of this phenomenological study. I took minimal notes during the interview process due to the interviews being recorded and I was able to focus on the participants' lived experiences with multiple tattoos and major depressive disorder. If more clarification was needed pertaining to a participant's response, follow up questions during the interview were asked to get more clarity for that response. My main focus during the interview process was to pay attention to the responses of the participants and reflect on the content heard from each participant regarding their lived experience with multiple tattoos and major depressive disorder.

The initial contact with potential participants took place at the three designated mall locations, where I handed out the flyer and informed consent papers to individuals

walking by me who had multiple tattoos. Interested participants made contact with me via email by sending “I Consent.” I responded to each participant with a request for a time and day to complete the interview for the research and they responded back with a time and day to complete interview. At the start of the audio recorded confidential video call interview, I introduced myself to the research participant, thanked them for their participation, reviewed the purpose of the study as well as the risks and benefits, volunteer nature of the study, confidentiality, their agreed consent to participate in this study and the five criteria questions for the study. If needed, I jotted down important points during the interview for follow up questions at the end of the interview. Each participant agreed to participate in the study and was at ease and comfortable with the video recording method. Interviews were conducted over a 5-week period. Two interviews per week were scheduled allowing time for transcription between interviews. During the initial email correspondence, participants were made aware that a quiet environment would be needed during the audio recorded confidential video call interview to decrease any background noise during the interview recordings as well as confidentiality. Interviews occurred during a variety of times from morning until evening as well as weekdays and weekends that were convenient for participants which allowed for no interruption or background noise during the interview. After each interview, participants were offered opportunities for any follow up questions regarding the research. No follow-up interviews were needed because participants provided well thought out, reflective and detailed responses during the interviews. Each participant was

thanked for their interest and eagerness to participate in this study prior to the conclusion of the interview.

Data Analysis

Audio recorded confidential video call interviews were conducted for collecting data from individuals with multiple tattoos who exhibit major depressive disorder. I used the audio recorded confidential video call interviews to attain actual accounts of the lived experiences of participants (Giorgi, 1985). I used a phenomenological design during the data analysis phase for categorizing themes associated with the phenomenon being examined for this study. I used Moustakas's (1990) method to analyze the data. Moustakas's (1990) method involves creating textural-structured accounts of my familiarity with the phenomenon and addressing each participants lived experience with the phenomenon. After finalizing the actual accounts for each individual participant, I combined all the data into complete textural-structured interviews of the phenomenon. I transcribed the interviews and placed them into folders, each participants' interviews were put into folders associated with their given code of P1, P2, P3, P4, P5, P6, P7, P8, P9, and P10. The overall description of the textural-structured interviews captured the testimonies of all participants for a balanced understanding of the phenomenon.

I captured and documented my impressions of each participant as well as their audio responses to the five research questions, and the interview process overall and placed in their folder. Each participant's audio recorded confidential video call interview was separated into their own folder involving the five research questions. Each of the audio recorded confidential video call interviews represented a theme pertaining to the

five research questions. I began reading over the interview data, sometimes deleting any information that was not relevant, repetitive, or entirely not related to the research question or the phenomenon.

After examining the themes for all five-research question for the 10 research participants, I would reread through the data again attempting to shrink comprehensive themes, into shorter classifications that revealed the experience of major depressive disorder for that specific research participant. When the accuracy of each persons lived experience concerning the completion of the five research questions were answered, I summarized their testimony into textual accounts describing exactly what their experience with major depression disorder is like and the relationship between that experience and their multiple tattoos.

The textural-structured accounts were established from historical data resulting from the participant's experience. Data from the textual-structured accounts was examined and their experiences with major depressive disorder was discussed because of the way it affected their choices for their tattoos. This process was conducted for all 10 interviews conducted with the participants. For the purposes of staying unified and doing the same thing for every research participant, once again non relevant, repetitive or entirely not related to the research question or the phenomenon were eliminated or omitted. The final developing themes, the collective description of the phenomenon of individuals with multiple tattoos who exhibit major depressive disorder was described during their audio recorded confidential video call interviews for collecting data. Data

that emerged offering alternative views for the phenomenon was discussed and omitted from the study due to non-relevancy.

Evidence of Trustworthiness

Chapter 3 discussed the components of trustworthiness, which is the method used for authenticating research when conducting qualitative research studies. Giorgi (1985) described how specific submission of detailed methods and approaches permit research studies to be replicated and its results verified. This phenomenological study established particular approaches, methods, and processes for checking the accuracy of the results (Moustakas, 1990). The trustworthiness of this qualitative study was made up of four parts: credibility, transferability, dependability, and confirmability (Creswell, 2013). This study consisted of numerous methods for checking internal and external accuracy as well as establishing trustworthiness of the study.

For creating internal accuracy of this study three areas were examined, interview process planning, researcher notes, and member checking. The interview process planning permitted me to use the same five interview questions with each participant in the same order for guaranteeing uniformity in the questions asked of each participant for data collection. The interview process planning assisted me as a format for directing the audio recorded confidential video call interviews and for allowing the focus to remain on the lived major depressive disorder experiences of the participant. The interview process planning also assisted me in documenting my researcher notes throughout the whole interview process. When listening to the audio recorded confidential video call interview transcripts while transcribing, I recalled information heard during the interview that

assisted me in better understanding the importance of the interview process planning during each interview. Creswell (2013) stated, all the notes acquired during the data collected phase are important; therefore, nothing discussed by the participant should be taken for granted.

The interview process planning, and the researcher notes permitted me to knowingly and empirically look at the participant's lived major depressive disorder experiences. The researcher notes involved my initial thoughts, participant comments, experiences, fixed ideas, and expectations associated to the phenomenon of study. Creswell (2013) stated how researchers should understand their position, biases, or assumptions due to these factors being impactful on a qualitative study. My researcher notes permitted me to continue to focus on participants as well as their lived major depressive disorder experiences and note any countertransference if information discussed was relatable.

The final approach for creating internal accuracy is member checking. After participants answered all five interview questions, member checking was addressed internally. I thought about the messages discussed by each participant by using the Speaker/Listener method which assisted me in understanding their lived major depressive disorder experiences. This was a deliberate approach for concentrating on the participant's lived major depressive disorder experiences and their understanding related to their experiences.

According to Moustakas (1990) intentionality indicates an effort of being cognizant of a participants lived experiences with the phenomenon. Precision and

attention to detail for understanding the participant's answers was centered on their direct statements to me, which aided as raw data for discussing their lived major depressive disorder experiences and the meanings related to their experiences. Each approach recognized the credibility and transferability of this study by indicating an association between the researcher, participant, and the data collection method. Transferability was established with each participant's accounts and background information on the sample populations lived major depressive disorder experiences.

The five interview questions followed the emphasis of this study; therefore, the data collected was thoughtful pertaining to the range of this study. Last, transferability was established throughout the approaches and the equipment used for collecting information and analysis. Each area assisted in guiding future replication of this study since transparency in each area was described.

External accuracy is utilized as evidence for creating trustworthiness in a study. The IRB determines trustworthiness by ensuring that a study's established goals and objectives are accomplished or ascertained according to university standards and if they are not, approval is not given.

My dissertation committee consists of my committee chair and committee member. An expert methodologist is one role served on the dissertation committee. During the course of this qualitative study, I was in consistent communication with both committee members for direction, encouragement, and clarity while finishing the data collection and analysis phase. Both committee members gave assistance and corrective feedback during the course of both, data collection and data analysis phase. Upon

conclusion of both the data collection and analysis phase, both committee members assessed the results of this study before submitting them to the university for evaluation and acceptance.

Finally, the committee members proposed many questions to me concerning the different sections of my study such as the methodology section, findings section, results section, meanings sections, interpretations section, and reflective implications of a phenomenological study.

The four factors that defined internal and external accuracy of this study are credibility, transferability, dependability, and confirmability, they provide prospective researchers the methodology approaches for replicating this phenomenological study.

Results

Ten participants agreed to take place in this phenomenological study. The sampling participants consisted of seven women and three men. Participants' diverse backgrounds played no part in their willingness to participate in this study as well as their beliefs and awareness of their lived major depressive disorder experiences. The participants were open and forthwith concerning their major depressive disorder mental illness. Pseudonyms were given to each participant for securing confidentiality regarding their interview responses.

The five questions research questions are:

1. Was your diagnosis of major depressive disorder given before you received your first tattoo?

2. Did your diagnosis of major depressive disorder influence the type of tattoos you received?
3. Did your diagnosis of major depressive disorder influence your decision to receive tattoos that are considered "depression tattoos?"
4. Did your diagnosis of major depressive disorder influence the number of depression tattoos you received?
5. Did your major depressive disorder get worse after receiving one or more depression tattoos?

These five questions are explored in the section below with participants.

When quoting the research participants all profanity is omitted for message clarity.

Participant 1

P1 was peaceful and calm during our interview. Her responses seemed sincere with some moments of humor while sharing her experiences. She received her first tattoo when she about 18 or 19 years of age from her daughters' father.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P1 stated, "It was not." She stated that she has five tattoos and did not get her first tattoo before she was diagnosed with major depressive disorder. She addressed her diagnoses with major depressive disorder as something she knew she had in her life as a teenager, but never received a formal diagnosis until she was admitted into a mental health hospital in 2022.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P1 indicated that she is not sure if her undiagnosed major depressive disorder at the time she received her first tattoo influenced the type of tattoo she received. She indicated that she never really put much thought into what influenced her into getting a tattoo, however, her reason for getting her first tattoo which is a heart with an arrow going through it, was due to a relationship she was in at that time. She indicated that she has since covered it up because her heart got broken and it was a reminder of the psychological abuse and trauma she experienced in that relationship.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P1 indicated, yes; she detailed the heart with the arrow going through it is now covered up with a lotus flower. To her it represents blossoming from the muck of the hurt she experienced from her past relationships. P1 stated it means to her, “Rising from the muck.” P1 got a tattoo with a broken heart symbolizing the broken relationship she was in, eventually she covered it up with a pair of lips, which is supposed to be her ex's lips, but she stated that “I'm going to get that covered up because I don't want to see it anymore.”

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P1 stated, “It's a possibility because if I had the money, I'd probably have way more tattoos.” P1 discussed times when she got tattoos it was because of situations and

the meaning behind the tattoo would bring her down. P1 stated, “Yes, at that time when I got them it was because of the situation that was present at the moment. However, looking now in the place where I am now, no, the tattoos don't bring me down anymore.” P1 mentioned that when they did bring her down, she would get into a mental state of stuckness. She said that she would stay stuck in that mental state which caused her to argue with herself "Damn why'd you get it? Why'd you have to go and do it?" She mentioned that it was on and off for weeks.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P1 stated, “I'm going to go with yes, I believe it did, yes.” P1 discussed how she’s learned to live with depression and how it feels living with depression and making decisions about tattoos. P1 stated that certain tattoos are, “Reminders of the previous relationship and I learned my lesson from it. I don't want to keep reliving it and thinking about it or thinking about her. I learned from it, that's it. I got to move on.” P1 indicated that some of her tattoos are negative reminders and can increase her depression. P1 indicated that some of her tattoos created and caused her to feel more depressed because she kept looking at it, it was a reminder of her depression. P1 stated that, right now, at this point in my life, identifying it with depression, it's not a no, but it's not a yes. It's a possibility because I've learned to recognize the symptoms and the signs and the overthinking and the needing to shut my head up when I need to and not let it take over.

She mentioned that she would identify it as depression and it would influence the type of tattoo she received. P1 said that “People get tattoos based on what's going on in their life, and what it means to them, and what the tattoo represent.”

Participant 2

P2 was very open regarding her disorder and explained about her tattoo experience that involved her diagnoses of major depressive disorder as well as being on the spectrum. Her responses were centered on her disorder and what she did to assist her with her mental health and mental illness. She discussed her experiences of getting diagnosed with major depressive disorder and why her tattoo is significant in her life because of her disorder of major depressive disorder.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P2 indicated she was diagnosed with major depressive disorder before her first tattoo. She indicated that she was 13 years old when she was diagnosed. She indicated that she was diagnosed by a psychiatrist, however, she does not remember which type of major depressive disorder she was diagnosed with. She indicated that she got her first tattoo when she 23 years old after watching the Netflix series “13 Reasons Why,” because she could relate to the series. She mentioned how her four tattoos hold significance in her life and are reminders to her to keep living.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P2 stated, "Yes," because of her depression she decided to get her first tattoo which was the "Semicolon" after watching the series "13 Reasons Why." She stated that she decided to get "Find, Save Me" tattoo maybe like 2 years after that and then the "Pomphrey and the Sun" tattoo and the "Fire Rose," were the last one she received.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P2- Yes, she stated, "the semicolon represents anybody with depression, suicidal thoughts, self-harm, anything like that. And then the period is "you're the author and you could have ended your life which is the period", but the comma is, but you chose to keep living." She stated that she heard about depression tattoos and decided to read about them on google. She stated that the semicolon represents the suicidal tendencies in my life, but I chose to keep going. The "Save Me, I'm fine" tattoo is one where people ask me what's wrong, I always say "I'm fine," but internally I'm screaming out "I need help!" Like "save me." She stated for her sexual abuse she decided to get the "Fire Rose" tattoo, however, her depression is affected due to night terrors she experiences when she looks at the tattoo.

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P2: Yes, she indicated the 4 tattoos she currently has are due to her major depressive disorder. She mentioned that situations in life would cause her to get

depressive tattoos. She stated that when she becomes nonverbal, “I will shut down, or anything like that, and when I need to make a mental crisis call, they will see my tattoos and recognize them as mental health/depression tattoos and it will help them know that I have those experiences in life and issues in life.” She indicated that her major depressive disorder influenced her to get tattoos due to the negative experiences in her life. She mentioned how she decided to get the semicolon tattoo which was her first tattoo, “Because I got tired of promising everybody that I was going to stop cutting automatically, so after I watched “13 reasons why,” it was just a tattoo that has perfect meaning behind it and is really sentimental to me.” She explained an incident where the police were called to her place, and she was unable to speak fully due to her depression and her depression tattoos helped her with getting assistance. She mentioned how a female officer noticed her tattoos and talked with her about them. She indicated that the female officer asked her the meaning of them and that she also has the semicolon tattoo, so she knows the meaning behind it. She mentioned due to the female officer understanding the meaning of the depression tattoos, she was able to get the assistance needed without being treated as if she was crazy.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P2: Yes and no, she stated, “It got a little better, not perfectly 100% gone, but when I am having a bad day, I look at my tattoos and say, “I’m stronger than depression, I can get through this; I’ve done it before, I can do it again.” She further stated, “I mean, well, some days are better than others. Before I got the tattoos my depression was really

bad, and now that I've gotten the tattoos it's not as bad. I mean, of course it's still bad, just not as bad as it was." She indicated that when she thinks about her tattoos, she think of them as something that's positive for her because of past behaviors. She mentioned how her tattoos in some ways make her think about depression when she looks at them because of the past involuntary hospital placements. She stated that, "After I got my tattoos, I started to get less involuntary placements into a mental health hospital." She mentioned that the tattoos are not a magical cure that she doesn't have depression anymore, but they helped a lot to look at them especially when times do get tough.

Participant 3

P3 was polite and soft spoken during our interview. Her responses were truthful as well as direct to the point about her reasons for getting her tattoos and the causes for them. Her decision to receive her tattoos were centered on her depression as well as negative romantic relationships.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P3: Yes, she got it when she was 16 years old. She was in romantic relationship and decided to get her first tattoo to express her love towards her boyfriend. She was diagnosed with major depressive disorder when she was 15 years old.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P3: Probably, "Because every tattoo I received is, it was like a coping of showing somebody I loved them, or you know I guess just making myself feel accepted." She

mentioned that her tattoos were connected to her depression, but at the time she said she did not think about it that way because she was 16 years old. She mentioned that her tattoos would take her out of being unhappy.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P3: Yes, she stated that, "I was unhappy back then, so I feel like being depressed was like, it was a major crutch for me. So, having that outlet, which at that time was a tattoo, you know an adrenaline, a different happiness, yeah, I think it influenced it because it was a different feeling emotionally." She stated that she considers her tattoos to be depression tattoos because, "Every tattoo I've got was, I got it when I was going through a really bad time in my relationship. And it's all I know attached to my relationship." She stated that her major depressive disorder influenced her decision of the type of tattoos she received such as a name tattooed on her that bring back bad memories, doves that display peace and happiness after a traumatic experience, being accepted by a significant person, feeling unhappy, or a tattoo with a positive meaning. She stated that her tattoos did not make her major depressive disorder better it made it get worse. She stated, "I got this tattoo off of an emotion, a sad emotion, and it didn't make it better. It caused a lot of regret and memory of the bad times."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P3: Yes, she stated, "Because I was depressed, sad, miffed, I was going through you know, I would go to a tattoo shop or I'd be like "Oh, I need to go find somewhere to

get a tattoo and this and that." She discussed how she got one of her tattoos covered up because of the pain she experienced in the relationship. She stated that, "It was a current, well really recent relationship and there was just so much pain behind looking at that name at that time, and I got a tattoo that I had to sit down for three and a half hours for just to not see that again. And I think that was really the most positive tattoo I've got out of all of my tattoos. It was something for me, not somebody else." She stated that "her major depressive disorder was very painful and bad because with that tattoo it was connected to a relationship that was full of hurt, deception, and I couldn't let go of it. And so it made me sad. The depression got bad because I couldn't let go of it and that tattoo was just like an outlet thinking that it would fix things and then you know it didn't so." She mentioned that she felt like the number of tattoos she decided to get were influenced by her major depressive disorder because of the way she felt about herself and the relationships she was involved in. She stated, "I felt like "Why would I do something? Why would I put that person's name on my body?" And then all I'd think about is how they don't deserve to be placed on my body, you know all the hurt caused and pain."

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P3: She stated, "Yeah, after my fourth one, the last two were the worst. It was pretty dark during that time." She mentioned how the pain was hard to deal with following the tattoo she had covered up. She stated that the tattoos were constant reminders when she would look at them and they would affect her major depressive

disorder symptoms. She stated, “There were moments where seeing those tattoos took my major depressive disorder to a whole different level of constant reminders of darkness.

Participant 4

P4 was very candid about her major depressive disorder and how it affects her life and the influences she experiences from her tattoos. Her responses were transparent and heartfelt as well as emotional at times as she discussed her struggle with mental illness. She discussed openly her diagnoses of major depressive disorder and why her tattoos hold significance in her life because of her disorder of major depressive disorder.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P4: No, she stated that she did not have a diagnosis of major depressive disorder before her first tattoo. She mentioned that she received her first tattoo at age 18 and was diagnosed with major depressive disorder when she was 23 years old. She stated that she has a total of nine tattoos, six were received before she was 23 years old and three, she received after her diagnoses.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P4: No; she stated that her major depressive disorder was diagnosed after she her medical diagnoses of Grand Mal seizures. She mentioned that she had six tattoos before she got diagnosis of major depressive disorder and after her diagnoses, she received three more tattoos.

She stated that, “I had my ex’s name on me, and I covered that up after my divorce. So, one of the tattoos had our wedding date and the other one had her name, and I got both of those covered after my divorce.” She mentioned that she got them covered up by using a feather and tiny hearts.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P4: No, she stated, “I think I just wanted a reminder that I have to keep pressing forward. But it wasn’t like, I wasn’t depressed at the time. I just, I wanted something that to me was beautiful but also illustrated my strength but was also a reminder to me.” She mentioned that she does not consider her tattoos as depression tattoos, however, she has several that are depression tattoos such as the butterfly with a semicolon. She discussed her butterfly with the semicolon not being a depression tattoo to her. She stated that, “I wanted something that illustrated my strength. I got the semicolon with the butterfly. So, I wanted something that illustrated me along with what I’ve come out of and what I’ve conquered. And that’s what drove me to choose that tattoo.” She mentioned that most of her tattoos were received when she was having happy times in life and symbolized love and happiness. She stated, “My first three tattoos, I got them at the same time. They’re 3 hearts, which are for my sister’s children, my niece, and nephews. And then my second tattoo I got when I was drunk in Toronto with my cousin. It was like hangover; we wake up with tattoos. I got the letter “M” for somebody I was madly in love with. She got something for someone she was madly in love with. You know, at that time it symbolized love and just being young and dumb. And then the tattoos on my thighs were of someone

that I was married to. You know, something that symbolizes our love. And then when I covered them up, that too was a happy time for me because I was in a really good place getting out and closing that chapter. So, none of my tattoos were ever done because I was saddened in any way, shape, or form."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P4: Stated, "I wouldn't say so because I already had 6 before getting diagnosed. I will say that, had I been diagnosed sooner, and gone through extensive therapy sooner at a younger age, I probably wouldn't have gotten so many tattoos because of the fact that I would have understood self-worth and red flags what I would look for in a relationship, and not do things that would exhibit love such as putting someone's name tattooed on me." She made mentioned that only two tattoo represented times in her life that were not good or happy times for her. She stated, "There's only 2 tattoos that I got altered, and the only reason was because it was someone's actual, physical name. And the other one was our actual, physical date. I mean, that's a reason to get it covered up." She was pretty candid in her thoughts and beliefs about her reasons for covering up tattoos that had meaning, she stated, "how the tattoos is positioned, the hearts are kind of overlapping on the "M" and a lot of people when they look at it, they think it's a butterfly. So, it isn't anything that I'm like oh my God, I got to go get this covered up. My maiden name starts with an "M", and it looks like a butterfly."

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P4: According to her she stated, “I don’t know how to answer that because I feel like I got my diagnosis of major depressive disorder, but I dealt with it, I think had major depression all my life and just for a large portion of my life didn’t know it.” She discussed after getting diagnosed she felt like during her depression she was able to mask her symptoms very well. She pointed out that her tattoos did not contribute to her major depressive disorder. She mentions that her seizures made her major depressive disorder get worse. She stated, “Waking up when I was younger and drunk when we got these tattoos in Toronto, I look at it now and I laugh. Like, although I had probably been depressed at that time, or like around that or just anything in life during those years, I have some good memories. I woke up in Toronto, drunk, with a tattoo, with my cousin. So, none of them keep me or are reminders of bad times. The one on my finger is a reminder to me of how strong I am.” She indicated that she was not aware that the tattoos she had symbolized major depression.

Participant 5

P5 was forthcoming about his major depressive disorder and how it has impacted his life. His responses were open and honest about his battle with mental illness and his reasons for getting his tattoos. He discussed his diagnoses of major depressive disorder and why his tattoos hold importance in his life. He discussed his memorial tattoos and how they could be depression tattoos because of the way they remind him of them that sometimes make him feel depressed.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P5: Yes, he stated that he was diagnosed when he was 16 years old by a psychologist. He stated that he has four tattoos. He stated that he was diagnosed with major depressive disorder moderate with recurrent features after the age of 18.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P5 stated yes, he thinks they are. He said, "That's a good question. Well, I mean two of them are about God. One is just kind of a memorial for my mom. She just passed and I had the state of Texas tattooed with "Mom" in it. And then I got a "Bad Toad" tattoo. That's my nickname in the Air Force. So, I would say, mildly yes because this tattoo on my forearm says Jesus wept. It's a verse. It's the shortest verse in the Bible, but I felt like it was the one that made him feel more human. P5 stated he believes so, maybe, a little. "He mentioned how other influences contributed to his tattoos. He said, because I lean on God a lot. You know, I lean on God, so one has a cross with the people I've lost on there, their names on the ribbon. It just says, "In memory of those I've lost." It's got my brother, my dad, my son-in-law, and my mother-in-law. Texas is "Mom" because she passed away. So, these are all people that I've lost on my left arm. So yeah, I guess I would maybe say the depression had something to do with it a little bit."

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P5 stated, “I don’t think it influenced my decision to do it because I’ve always kind of wanted a tattoo. The first one I got was the little, short verse. I got that one when my mother-in-law went on vacation with us. She wanted to get a pink ribbon because she was dying of cancer, but she did not want to get one alone so I got one with her. It was more of a support kind of thing. So I would say no to that, probably, not that I’m aware of. Now, I don’t think that that had an influence on it.” He mentioned that his thoughts from his depression sometimes influenced his decisions to get tattoos. P5 stated, “Um. Its’ weird. I’m going to say, probably, only for my mom. Because the other times I was pretty upbeat when I did it. Even though the one was the one showing the people I’ve lost, I felt good about it because I felt like I was honoring them.”

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P5 stated, “Maybe it did. Maybe I was subconsciously. I’m always subconsciously down a little bit. So maybe it did. Maybe I was depressed, and I wanted to feel good. Maybe I replaced drinking with tattoos, I don’t know. So, I would say there’s a strong possibility that my tattoos are depression tattoos.” P5 discussed how he got a tattoo due to his mother-in-law who was dying of cancer, her situation was a reason for him to get a tattoo. He stated, **“**But maybe it did have something to do with it. Maybe I was trying to feel better. You know, my mother-in-law is dying of cancer, and I loved her like a mom, and she wanted to get a tattoo so there I am. I’m getting a tattoo with

her." P5 mentioned how his depression caused him to get a tattoo for his mother who passed away even though they did not have a good relationship. He stated, **"**I think probably it was, I was depressed a little bit because I was upset, I wasn't as sad as I should be. I would say it probably had some influence on it because I think right now, especially over the last year or so, depressions influenced probably my whole life. Depressions influenced every decision I've probably made."

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P5 stated, "Well, I'd have to say yes to that because the really bad depression hasn't happened until after the tattoos. The bad depression hit after my tattoos were on." The tattoos he contributed to getting worse were the cross and his mother. He stated, "Probably the cross and my mom. The cross is the one with the names of the people I've lost, and then my mom. They were about two years apart though, so I would say more my mom than the cross, honestly just given the time frame and everything. It's probably my mom's."

Participant 6

P6 discussed her disorder and explained why she decided to get tattoos. She discussed her experiences with being diagnosed with major depressive disorder and this impacted her decisions to get tattoos. Her responses explored her disorder and how having major depression has her mental health and mental illness. She discussed her experiences of getting diagnosed with major depression and the importance of her tattoos and the impact they have in her life.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P6 stated, "No," she was not diagnosed before her first tattoo. She stated that she received her first tattoo when she was 18 years old and have a total of five tattoos, she was diagnosed with major depressive disorder when she was 19 years old.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P6 said that her major depressive disorder did not influence her to get any type of tattoo. She stated, "I've always just liked how they look. I think that's my main reason of wanting them. I like to have meaning for them, but I do like how they look as well." P6 mentioned also that she thinks tattoos are cool and according to her it is simple. She discussed how she likes flowers and shape like that.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P6, she stated, "No." She said that she did not think about depression when she received her tattoos. She stated, "No, I never really had depression in mind." She mentioned when she was diagnosed, she did not think about her depression contributing to her tattoos. P6 said that her friends influenced her to get tattoos as well as her environment growing up. She mentioned that she would not consider any of her tattoos as depression tattoos. P6 discussed how songs influenced her decision to get some of her tattoos. P6 stated that, "One of them is "Love yours", which, that kind of speaks for itself. I don't think it comes from a place of depression, but I think it's just like a reminder, like

on days I don't feel the best. And then the one on my back is a Mac Miller song. I guess it has to do with anxiety, like feeling anxious because I use that song when I need to be grounded. The one on my hip is an envelope for my mom, because we exchange letters a lot, and she's always instilled that in me. And then I have 2 on my arm of flowers, and it's an iris, which is for my dog."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P6 stated, "No" she stated that she her decision to get the number of tattoos was the people she was raised around, like her best friends. P6 said, "I think also, in my generation, I'm finding a lot of my friends, t's becoming more popular to get tattoos." P6 stated that before she gets a tattoo she try and think about them for at least 2 months to one year because it is a permanent thing and she does not want to get one that she does not like. She stated that she her depression did not influence the number of tattoos she received because she did not want them to define who she is. She said, "I don't want that to define me, so I think a lot of my tattoos, they're not defining, but it does have to do with my character, so I don't want them for that reason. I wouldn't want that to become something that defines me."

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P6 stated, "No" because she got the flower tattoo 2 months before she got diagnosed with major depressive disorder and none of them made her depression get worse. P6 said that got the words, "love yours" and added the flower after she got

diagnosed. She stated that none of her tattoos made major depression got worse. P6 explained that she went with her roommate, and they decided to get them in a spontaneous way. P6 stated, “I’ll say it was spontaneous, but my choices weren’t spontaneous, because I had been thinking about them. But to actually go do it in that moment was spontaneous.”

Participant 7

P7 discussed her disorder and explained why she decided to get tattoos. She discussed her experiences with being diagnosed with major depressive disorder and this impacted her decisions to get tattoos. Her responses explored her disorder and how having major depression has her mental health and mental illness. She discussed her experiences of getting diagnosed with major depression and the importance of her tattoos and the impact they have in her life.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P7 stated that she cannot remember if she received her first tattoo before she was diagnosed with major depressive disorder, but thinks she received all of her tattoos after she was diagnosed. P7 stated that she received her first tattoo when she was 18 years old and currently has 11 tattoos. P7 stated she cannot remember who diagnosed her with major depressive disorder, but she knows she was diagnosed.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P7 said that her diagnosis of major depression did not influence the type of tattoos she received. P7 stated that her tattoos are a rose, a Playboy bunny, the grim reaper, an ocean, and several flying black bats.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P7 mentioned that her major depressive disorder somewhat influenced her decision to receive tattoos she considered depression tattoos. She stated that when she got her tattoos, she like the way the needle felt when she got her 11 tattoos. P7 stated, "When depressed I like to get tattoos because the stick of the needle makes me feel relief from the pain of depression."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P7 said that her major depressive disorder did not influence her number of depression tattoos. She also mentioned that she does not consider her tattoos to be depression tattoos. P7 said that she got her tattoos because she felt they were cool. She mentioned the reason why she got the grim reaper tattoos was because she thought it was cool and something to get for her 18th birthday. P7 said that she was not depressed when she got the tattoo because she did not think about it being for depression, but she like it and wanted to be cool wearing that kind of tattoo. She mentioned that she considers

herself Goth and like getting tattoos that are dark because she like black colors which has nothing to do with being depressed, but a cultural statement for being Goth.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P7, she stated, “Yes” and being happier now then the way it was before. P7 indicated that she was not happy and have a lot more negative thoughts and can’t find a way to make herself happy. P7 indicated that she is not sure how her tattoos played a part in to her depression feeling worse. P7 stated, “I wouldn’t say they play into my depression, but I would say that a part of me likes to get tattoos because I like the way that it feels, and it makes me feel good when I am sad.” P7 indicated that when she feels depressed, she get tattoos because they make her feel good when she feel the stick of the needle while getting her tattoos.

Participant 8

P8 discussed his lack of accepting his disorder of major depressive disorder and how he feels about being known as someone with a mental illness. He explained that his tattoo experiences are from themes and patterns in his life that shaped his life. His responses were centered on his thoughts about his tattoos and not a lot about his mental illness. He discussed his acceptance of getting diagnosed with major depressive disorder and why he acknowledges how his tattoo are significant in his life, not because of his disorder of major depressive disorder but because of his life experiences.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

P8 stated, "No," not an official diagnosed by a psychiatrist or psychologist. P8 indicated he got his first tattoo was at the age of 15. He indicated that he has 11 tattoos. One of his 11 tattoos have a negative connotation because of the meaning of the tattoo. He stated, "I have one tattoo that says betrayed on it with a crossed-out heart which is negative." P8 indicated he might have been depressed or feeling depressed or going through something that could affect the way he feels. P8 discussed how he was into hip hop and the underground rap scene and a characteristic trait that was popular in the underground rap scene in California at that time was to be sad and depressed. P8 indicated that he probably wouldn't get the word "betrayed" written on his arm again because of the strong negative connotation that made him feel lost and depressed.

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

P8 stated, "No," he indicated that he is not sure why he gets tattoos other than to be cool or pick up girls. He stated, "I got my mother's name on my arm, and I don't know why. I was just really young and was really wanting a tattoo." P8 indicated that he wanted to be like one of the cool kids by getting tattoos. P8 indicated that his second tattoo was a bible verse that relates to his date of birth and the book of Psalm from the bible. P8 indicated that his third and fourth tattoos say, "God's Son" on his arms. P8 indicated that his fifth and sixth tattoos are elephants, and his seventh tattoo are Japanese words and symbols. P8 indicated that his eight, nine and ten tattoos are transformers and

sci-fi symbols, and tattoo number eleven is tiger stripes on the back of his hands. He indicated that none of his tattoos are influences for major depressive disorder.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

P8 said, "No," because none of his tattoos are considered depression tattoos. P8 stated, "Mainly my tattoos were just to attract women and mainly just so that I can be visibly appealing to society and to look cool." He indicated that none of his tattoo were because of major depression or his mental illness. P8 stated, "I'm feeling pretty happy right now, and I've been happy for quite some time."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

P8 said, "No," his tattoos did not influence the number of tattoos because none of his tattoos are considered depression tattoos. P8 indicated that his tattoos he has are for reason that he cannot really explain or for fun. P8 indicated that he decided to get tattoos at times in his life where he was young and foolish and allow peer pressure to cause him to get them.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

P8 said, "No," nothing happened that made it worse, but there were situations he regretted about getting tattoos that could be considered depression, but he would not call it depression. P8 stated, "On my hand I got a pretty big tattoo, at times I would feel pretty regretful that I got that one because it just wasn't work appropriate and it made me feel

like a convict." P8 indicated that he was regretful more than depressed and that he would not say he is depressed, but regretful. P8 stated, "Regretful is the word that I'm going to go with."

Participant 9

P9 was very calm during our interview. Her responses were based on her thoughts, which were centered on her traumatic experiences with the death of her cat. She was honest and sincere in her approach to sharing her experiences. She mentioned that her first tattoo was in 2018 and that she had two tattoos.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

Yes, I was given my diagnosis in 2016 by my psychiatrist. The presenting symptoms came when I went to my first appointment, and they did a few assessments, and that was the result. First, it was major depressive episodes (MDE), and after the medication, they changed the diagnosis to major depressive disorder (MDD).

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

Yes. The first tattoo that I have is an anchor, and it has a scripture on it. And I got that tattoo because I had been on medication for a little while and I felt like I was finally starting to feel a little better. And so the anchor was just a reminder, you know, that I could stay grounded and rooted, and I ended up getting that tattoo. I would say sometimes positive, sometimes negative. I'm not always in a place that I want to reflect on everything, but when I analyze the tattoo, it forces me to reflect and think, because I

know that's why I got it. The second tattoo sometimes negatively affects me because it puts me in that mindset of why I got it, which is something sad. Even though it represents something that I want to remember, it does represent a sad situation.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

Yes, the second one, definitely. The second one I got because I was really, really sad over a situation, and I got it as, like, a remembrance piece because my cat died that I had for a long time. I woke up that day, and I was really missing the cat, and I was really, really sad. Probably, like, you know, it's normal to grieve an animal, but I probably took it overboard, and so I went and got my cat tattooed on one hip. She mentioned how the cat tattoo makes her sad when she analyzes it or thinks about it, "It causes me to think about the cat all the time. And then it's like, for me, sad feelings are overwhelming, so I don't know if that's such a good thing for me to experience all the time."

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

I would have had more, yes, had certain circumstances been different. But yes, I would say yes. I also like receiving the tattoos; I like the feeling of the tattoo needle. So, it's not really painful; It's like a pleasant pain. I don't know how to explain it. So, I also like receiving the tattoos.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

Yeah, prior to getting it, I was feeling depressed. And then once I got it, I wouldn't say it made me feel extremely worse, but it caused it to be on my mind more often.

Participant 10

P10 was soft-spoken during our interview. His responses were based on his understanding of his addiction at the time of his tattoos. He was uncertain with his answers regarding his tattoos and depression. He stated that he received his first tattoo when he was a teenager in Maryland.

Question 1: Was Your Diagnosis of Major Depressive Disorder Given Before You Received Your First Tattoo?

He mentioned that he got diagnosed when he was a teenager, around age 16 or 17. He stated that he got his first tattoo when he was 18, and his psychiatrist diagnosed him with major depressive disorder (recurrent moderate).

Question 2: Did Your Diagnosis of Major Depressive Disorder Influence The Type Of Tattoos You Received?

It's hard to say, because I got them as either symbols of resiliency or symbols of things to get me through whatever I was dealing with. Maybe I was depressed at the time, or I guess this one was to remind me of the amount of suffering I had gone through and still made it through. I'm not sure if that answers the question.

Question 3: Did The Diagnosis of Major Depressive Disorder Influence Your Decision to Receive Tattoos That Are Considered Depression Tattoos?

I never thought, "Oh, I'm depressed; I'm going to get something that's a symbol of my depression." I might have seen it as a symbol of my suffering or a symbol of me powering through some really shitty situation that was horrible, but I never saw it as "I'm depressed therefore I'm going to get this tattoo." Those are never my exact thoughts.

Question 4: Did Your Diagnosis of Major Depressive Disorder Influence the Number of Depression Tattoos You Received?

No.

Question 5: Did Your Major Depressive Disorder Get Worse After Receiving One Or More Depression Tattoos?

I would have to think of my most recent one, which is the wave on my arm. I don't think my depression got worse with that. The one on my wrist it's hard to explain, because it was when I went to alcohol detox and then I relapsed after. You're asking me if, basically, it pushed me into a depressive state.

Facts Analysis

An open-coding method was used to evaluate participants' narrative answers to determine themes (Table 2). A line-by-line, phrase-by-phrase, and word-by-word technique was used. To improve the intelligibility of the research, a few transcripts that displayed a lack of clarity expounded on the interpretations of the transcriptions. They were explained between the researcher and participant after rereading answers during the interview method as needed.

Moustakas (1994) described how the beginning stage of a phenomenological analysis is referred to as the epoch, wherein the researcher sets aside their biases and judgements and obtains meanings that participants in the study want to convey. Moustakas described Stage 2 in this analysis as reduction, wherein the researcher allocates codes to every answer that each participant displays and discusses. Words, thoughts, expressions, and statements directly associated with the phenomenon of what participants experienced when they were diagnosed with MDD were recognized as a way of coding. Moustakas's third stage describes imaginative variation, wherein themes are shaped and established based on the codes appropriated from the interview transcripts. Finally, the last stage is the synthesis of significances and principles, which are based on the instinctive incorporation of the essential textural and structural explanations into a united statement of the principles of the practices of the phenomenon.

Outcomes

The ensuing research question directed the study. Do individuals with multiple tattoos exhibit major depressive disorder?

Codes and Themes

Table 2

Interview Questions, Codes, and Responses

Question	Yes (Participant #)	No (Participant #)
Q_1: Was your diagnosis of major depressive disorder given before you received your first tattoo?	2, 3, 5, 7, 9, 10	1, 4, 6, 8
Q_2: Did your diagnosis of major depressive disorder influence the type of tattoos that you received?	1, 2, 3, 5, 9, 10	4, 6, 7, 8
Q_3: Did your diagnosis of major depressive disorder influence your decision to receive the tattoos?	1, 2, 3, 7, 9	4, 5, 6, 8, 10
Q_4: Did your diagnosis of major depressive disorder influence the number of depression tattoos that you received?	1, 2, 5, 9	3, 4, 6, 7, 8, 10
Q_5: Did your major depressive disorder get worse after receiving one or more depression tattoos that you got?	3, 4, 5, 7	1, 2, 6, 8, 9, 10

The codes were gathered in groups of related answers to establish themes, of which five emerged: diagnosed with MDD, diagnosed with MDD before getting first tattoo, got first tattoo before age 18, has depression-related tattoos, tattoos are reminders of MDD, and never received an official diagnosis of major depressive disorder (Table 2).

Table 3

Themes

Theme	Number of Participants
Diagnosed with MDD	9
Diagnosed with MDD before getting first tattoo	6
Got first tattoo before age 18	4
Has depression-related tattoos	7
Tattoos are reminders of MDD	7

Theme 1: MDD Diagnosis

Participants were asked whether they were diagnosed with MDD and who diagnosed them. P1, 2, 3, 4, 5, 6, 7, 9, and 10 have a diagnosis of major depressive disorder, whereas P8 stated he never received an official diagnosis of major depressive disorder. P1, 2, 3, 7, 9, and 10 were given a diagnosis of major depressive disorder by a psychiatrist, 5 by a psychologist, P6 by a therapist and P4 by a neurologist. P5, 3, and 10 discussed their level of major depressive disorder severity as recurrent moderate. P1, 2, 4, 6, 7, 8, and 9 could not recall if they were given a severity level as well as not sure about their severity level pertaining to their major depressive disorder.

Theme 2: Diagnosed with MDD Before Getting First Tattoo

Participants were asked whether they received their diagnosis of MDD before getting their first tattoo. Participants discussed how many tattoos they have, the ages at which they received their tattoos, and the reasons why they got their tattoos. Participants

made references of whether they received their first tattoo before their 18th birthday and what significance their tattoos played into their lives that involved major depressive disorder. P2, 3, 5, 9, 10 stated they received their diagnosis of major depressive disorder before getting their first tattoo. P1, 4, 6, and 8 stated that they did not receive their first tattoo after their diagnosis of major depressive disorder. P7 stated that she could not remember when she received her diagnosis of major depressive disorder and her first tattoo. P1, 2, 3, 9, and 10 described their reasons for getting their tattoos were due to their major depressive disorder whereas, P4, 5, 6, 7, and 8, indicated that major depressive disorder played no part in them getting their tattoos. P1 and 3 received their tattoos because of their relationships. P3 said that it was her way of expressing her love toward her boyfriend at the time, while P1 described the experience of her depression and her tattoos as her getting her heart broken. P2 described her semicolon depression tattoo as her choosing to live and not allow depression to win. P4 described getting a tattoo on the inside of her right middle finger as a suicide butterfly tattoo with a semicolon because she wanted a reminder that she has to keep pressing forward on life. P5, 8, and 10 described their tattoos as memorial tattoos that held significance in their lives. P4, 5, 6, 7, and 8 described their tattoos as having nothing to do with depression at the time they received them. They made statements such as, “I wanted them because I like tattoos, my tattoos as purely aesthetic, I wanted something that was beautiful to illustrate my strength, my military nickname, biblical scriptures with meanings, honor my mother’s death, also I wanted something cool for my 18th birthday.”

Theme 3: Got First Tattoo Before Age 18

The participants were asked whether they had received their first tattoo before their 18th birthday. Only Participants 3, 8, and 10 responded that they had. Participants who did not receive tattoos before their 18th birthday gave reasons such as "parental restraint due to age, did not think about getting a tattoo before their 18th birthday as well as peer influence while being inebriated."

Theme 4: Has Depression Related Tattoos

The participants were asked whether they considered any of their tattoos to be depression tattoos, or tattoos related to depression, and why. P4, 5, 6, 7, 8, and 10 discussed their tattoos as meanings that held significance and at time did not think of them as depression tattoos. P1, 3, and 5, said after thinking about their tattoos currently they would consider them to be depression tattoos. P4, 5, 6, 7 and 8 indicated no relationship with depression and their tattoos. P1 and 3 described their tattoos as broken hearts from relationships that made them feel depressed. They discussed how they covered up their depression tattoos as a way to get away from the unhappy times in their lives. P2 discussed her tattoo as a semicolon depression tattoo that represents her suicidal ideations, gestures and attempts. Receiving her depression tattoos helped her chose to keep going despite the way her depression makes her feel. She discussed how her "Save Me, I'm Fine" tattoo represented people asking what's wrong and saying I always am fine, but really hurting inside and needing help from someone. P3 discussed how she was depressed and her tattoo was connected to her relationship that was full of hurt. She mentioned that her depression got bad and her tattoo was an outlet for thinking it would

fix things, but it did not. P5 discussed how he like getting tattoos and the way they look, but would say based on his major depressive disorder diagnosis there is a strong possibility they are depression tattoos. He discussed that it is a possibility they are depression tattoos, however, at the time they were seen more as memorial tattoos than depression tattoos. P4 described her tattoos as being happy tattoos despite the reason for getting them. She stated that none of her tattoos were ever done because of sadness in any way, shape, or form. She discussed how one of her tattoos was received when she was drunk with her cousin in Toronto. P6 discussed that she got her tattoos because of her friend group. She said that her and her friends got their tattoos together and none of them had anything to do with depression. P7 described getting her tattoos as a cool thing for her 18th birthday. She stated that she got the grim reaper because it is a cool tattoo and she is goth and like dark tattoos. P8 discussed how his tattoos had more to do with regret than depression. He discussed how one of his tattoos was from his favorite rapper and a song called betrayed. He said he got the word betrayed with a heart crossed out on his forearm. P1 and P10 discussed how he never thought about depression when he as getting his tattoos. He said that he saw them more as symbols of his suffering or a symbol of him powering through some difficult situations that were horrible.

Theme 5: Tattoos Are Reminders of MDD

The participants were asked whether any of their tattoos were reminders of their MDD. P 1, 2, 3, 5, and 9 stated their tattoos are reminders of major depressive disorder and P 4, 6, 7, 8 and 10 said their tattoos are not reminders of their major depressive disorder. P1 discussed how her tattoos would bring her down and cause her to get stuck in

a depressed mental state. P2 mentioned before she got the tattoos her depression was really bad, and now that she gotten the tattoos it's not as bad. She said, of course it's still bad, just not as bad as it was before. P3 discussed how her struggles with major depression affected how her tattoos on her body are reminders of her major depressive disorder. She discussed how her tattoos were connected to a relationship that was full of hurt and deception. She said looking at the tattoo's made her more depressed. P5 discussed how his major depressive disorder got worse after he received his tattoos. He said his cross tattoo has names of people who passed away like his mom and brother. He said his mom wanted to get a pink ribbon because she was dying of cancer, but she did not want to get one alone so I got one with her. P9 discussed how the second tattoo she got was a reminder of her cat that died. She said she was really sad over his death and how it is normal to grieve an animal's death, but she said that she probably took it overboard. She said that she got her dead cat tattooed on one hip. She discussed how it caused her to think about her cat all the time and the sadness was overwhelming feelings she experienced all the time. P6 discussed how each tattoo has its own meaning that has nothing to do with his major depressive disorder. P4 said that she is kind of dainty about her tattoos and would not want to have tattoos that display meanings that she would have to have removed one day. She stated that some people have depression correlations, but they do not have any depression correlation for her. P# 7 said she would not say they played into her depression, but she would say that a part of her likes to get tattoos because she like the way that it feels and it makes her feel good when she is sad. P1 and

P10 said that he got them as either symbols of resiliency or symbols of things to get him through whatever he is dealing with.

Evidence of Reliability

I discussed in Chapter 3, trustworthiness, it was a process I used for substantiating the research for this qualitative study. Giorgi (1995) discussed how the functions of specific methods and strategies permit ways for studies to be replicated and findings confirmed. According to Moustakas (1990) phenomenological studies established detailed strategies, methods, and processes for examining the accurateness of findings. Creswell (2013) described trustworthiness in a qualitative study consisting of four parts: credibility, transferability, dependability, and confirmability. For this study several approaches were used for examining the internal and external accuracy for determining trustworthiness.

For determining internal accuracy, I used semistructured recorded interviews, researcher notes, and member checking. The semistructured recorded interviews permitted me to give the same interview questions to each participant. This allowed me to present questions in the same order to participants ensuring consistency in questions asked when collecting data. The semistructured recorded interviews served as a probing guide by focusing on the lived experiences of each participant. The semistructured recorded interviews provided me opportunities to document my researcher notes after each interview. Transcribing the interview transcripts allowed me to recall information heard during the semistructured recorded interviews. The semistructured recorded interviews and the researcher notes allowed me to intentionally and empirically examine

participant's experiences. My researcher notes contained my initial beliefs, participant reflections, capabilities, presumptions, and assumptions associated to the phenomenon of this study. Researchers should understand their views, predispositions, or expectations because factors like these can have an impact on a qualitative study (Creswell, 2013).

Member checking is the final strategy for establishing internal accuracy. After each participant answered the interview questions, member checking occurred. I thought about messages discussed by participants by using Speaker/Listener methods by understanding my knowledge of their experience. This was a deliberate approach for concentrating on participant's knowledge and the meaning they related to their experiences. According to Moustakas (1990) intentionality signifies efforts in being conscious of participants lived experiences in a phenomenon. Participant's accuracy and thoroughness response were based upon their direct statements which functioned as raw data. This helped reveal their lived experiences and the meanings related to their experiences. Strategies in this study recognized credibility and transferability by exhibiting an association between the researcher, participants, and data collected. According to Creswell (2013) notes acquired from data collected is significant; therefore, everything discussed by each participant was not taken for granted.

Transferability was established with participant narratives, demographics, and experiences. Interview questions followed the emphasis of this study; consequently, the data was relevant of the scope of the analysis. Transferability was presented through the approaches I used for data collection and examination. Every area function as a way to monitor future replication of this study because the areas are clear in explanations.

External accuracy was used as evidence for determining the trustworthiness of this study by the Institutional Review Board (IRB) and the Utilization Research Reviewer (URR), and my dissertation committee. The IRB and URR guidelines determine trustworthiness because studies are not approved until founded objectives are accomplished or established according to university principles. The dissertation committee is made up of a committee chair and a committee member. The committee chair serves as the expert and main committee member who offers direct guidance and direction for overseeing the dissertation process. The second committee member serves as the expert methodologist while accomplishing their role on the dissertation committee.

During this qualitative study, direct communication with both committee members afforded me opportunities to discuss guidance, assistance, and clearness while finishing data collection and evaluation. Both committee members provided assistance and consistent feedback during the data collection and data evaluation process. Upon completion of data collection and data evaluation process, both committee members assessed the outcomes of this study before submitting for review and approval to the university. Lastly, the committee members questioned me about the methodology, outcomes, values, results, analyses, and associations of this phenomenological study. Each element reviewed for the internal and external exactness of this study recognized the credibility, transferability, dependability, and confirmability recommending impending researchers the methodology approaches for replicating this phenomenological study.

Summary

This chapter comprised analysis from the data within this qualitative phenomenological research study that was collected from ten individuals whose multiple tattoos exhibited major depressive disorder. Data was collected by using semistructured recorded interviews from ten individuals whose multiple tattoos exhibited major depressive disorder. I questioned and evaluated individuals' lived experience and how individuals with multiple tattoos exhibit major depressive disorder. According to Moustakas (1990) four steps (epoch, reduction, imaginative variation, synthesis of significance and principles) were utilized by this researcher, codes were assigned to every answer that every individual presented. Words, concepts, expressions and accounts directly relating to the phenomenon of how individuals with multiple tattoos exhibit major depressive disorder were recognized as a way for coding and themes were established based on the codes from the interview transcripts. Individuals' views and beliefs were gathered to create themes. The assembled themes were completed per the research question shown in Table 2 in this study.

I recorded all audio recorded confidential video call interviews using a Philips Digital Voice Tracer DVT 2710. Each audio recorded confidential video call interview transcription was created after listening to each recorded interview. I identified five interview questions and five themes. The five interview questions are: Q_1: Was your diagnosis of major depressive disorder given before you received your first tattoo? Q_2: Did your diagnosis of major depressive disorder influence the type of tattoos that you received? Q_3: Did your diagnosis of major depressive disorder influence your decision to

receive the tattoos? Q_4: Did your diagnosis of major depressive disorder influence the number of depression tattoos that you received? Q_5: Did your major depressive disorder get worse after receiving one or more depression tattoos that you got? The codes were gathered in groups of related answers to establish interview questions, of which five emerged: diagnosed with MDD, diagnosed with MDD before getting first tattoo, got first tattoo before age 18, has depression-related tattoos, tattoos are reminders of MDD. Interview questions and the five themes were designed for exploring areas with individuals whose multiple tattoos exhibit major depressive disorder. First, I wanted to explore how individuals with multiple tattoos understand their major depressive disorder. Secondly, I wanted to explore if any of their multiple tattoos are depression tattoos. Thirdly, I want to explore if they decided to get their tattoos when they were depressed and did depression play a role in them getting their tattoos. Fourth, I wanted to explore if individuals with multiple tattoos considered their tattoos to not be depressive tattoos. And last, I wanted to explore how individuals with multiple tattoos view their tattoos when they are depressed and if their tattoos contribute to their mental illness. Data gathered from individuals answered my questions for studying these five areas. Six out of ten of the participants were diagnosed with major depressive disorder before their first tattoo. They mentioned that their diagnosis major depressive disorder did influence the type of tattoo they received. Four participants stated that they did not get diagnosed before they received their first tattoo. Five out of ten participants stated that their diagnosis of major depressive disorder did influence their decision to receive their tattoos and four out of ten described their tattoos as depression tattoos. Four participants stated that their major

depressive disorder did not influence the type of tattoos they received, while five participants described no influence of major depressive disorder with decision when they received their tattoos. Six participants stated that they do not have any tattoos that are considered depression tattoos. Four out of ten participants described their major depressive disorder getting worse after receiving one or more of what they considered to be depression tattoos. Six participants said that their major depressive disorder did not get worse after receiving one or more depression tattoos.

Chapter 4 described data gathering, collection methods, and summary of themes for this phenomenological study. In Chapter 5, I defined explanations of the findings, study limits, future study recommendations, positive social change suggestions, and the study's conclusion based upon the findings of Chapter 4. Also, in Chapter 5 a summarization addressed the spirit of the study based upon the summary findings.

Chapter 5: Discussion and Conclusion

Introduction

The purpose of this qualitative study was to explore the lived experiences of individuals with multiple tattoos who exhibit MDD. Stirn et al. (2006) stated in their study of 432 participants with tattoos, 34% of the participants had special or personal reasons for their decisions to get a tattoo. Karacaoglan (2012) noted how tattoos can be seen as pictures with hidden meanings inside the image on the skin, conveying intimate and personal messages in contextual and obscured manners. Roberti and Storch (2005) described how men and women who have multiple tattoos experience factors related to mental health such as depression and a reluctance to accept mental health services.

I used a phenomenological approach involving interviews to gather information from 10 individuals. I used an open-ended interview technique to allow participants to describe their MDD symptoms and experiences instead of simply answering yes or no during the interview questions. Five interview questions were used: (a) Was your diagnosis of major depressive disorder given before you received your first tattoo? (b) Did your diagnosis of major depressive disorder influence the type of tattoos you received? (c) Did your diagnosis of major depressive disorder influence your decision to receive tattoos that are considered "depression tattoos?" (d) Did your diagnosis of major depressive disorder influence the number of depression tattoos you received? (e) Did your major depressive disorder get worse after receiving one or more depression tattoos?

I examined individuals' emotions and perceptions regarding MDD and how their multiple tattoos played a part in their MDD. Stirn et al. (2006) pointed out how

psychological aspects of tattooing can be manifested in the behavior of individuals who demonstrate signs of a major depressive disorder. The purpose of this study was to deepen the understanding of and add validity to the scarce existing literature regarding individuals with multiple tattoos who exhibit MDD. To guide this study, I developed the following research question: Does individuals with multiple tattoos exhibit major depressive disorder? From this question, I developed the following sub-questions: (a) Was your diagnosis of major depressive disorder given before you received your first tattoo? (b) Did your diagnosis of major depressive disorder influence the type of tattoos you received? (c) Did your diagnosis of major depressive disorder influence your decision to receive tattoos that are considered "depression tattoos?" (d) Did your diagnosis of major depressive disorder influence the number of depression tattoos you received? (e) Did your major depressive disorder get worse after receiving one or more depression tattoos?

I used the first sub-question to understand individuals who received a diagnosis of MDD before their first tattoo, the reasons for their diagnosis, and the reasons they got their tattoos. I used the second sub-question to gain insight into individuals with MDD and what influenced them to get their tattoos. I used the third sub-question to examine whether individuals with MDD understood their tattoos to be depression tattoos and whether their MDD was a factor in them receiving the depression tattoos. In response to the fourth sub-question, individuals could explain whether their depression tattoos were a direct consequence of their MDD or whether they were not depression tattoos at all.

Lastly, I used the fifth sub-question allowed me to gain insight into individuals whose MDD worsened after getting their depression tattoos.

The study revealed how the participants viewed their multiple tattoos and their MDD. In this chapter, I combine the results in the framework of the literature I reviewed in Chapter 2 to explain the lived experiences of individuals with multiple tattoos who exhibit MDD. I also explain the findings and examine what I studied and how it relates to, challenges, or supplements the literature. The findings are interpreted within the conceptual and theoretical framework. The limitations of the study are then discussed. Recommendations for future studies are proposed, followed by suggestions on how the findings can lead to positive social change.

Interpretation of the Findings

I conducted this phenomenological study to listen to the participants' reflections on their lived experiences. According to Giorgi (1985), qualitative methods give the opportunity to examine participants' "lifeworld" from their perspective. The research was based on my understanding of the participants' accounts of their lived experiences. For analysis, I used five strategies to gather distinctive accounts and themes of participants' lived experiences.

Giorgi (1985) stated that themes are derived from narratives that are established by summarizing and interpreting participants' accounts. Themes are used as a way to recognize the meanings of participants' associations with their lived experiences. From the analysis, I recognized five main themes. The five main themes were as follows: diagnosed with MDD, diagnosed with MDD before getting first tattoo, got first tattoo

before age 18, has depression-related tattoos, tattoos are reminders of MDD. By associating the outcomes from this study to the base understanding of how individuals with multiple tattoos exhibit major depressive disorder, I provided focus for additional research and practice.

Theme 1: MDD Diagnosis

This theme indicated how participants disclosed their diagnosis with MDD and stated who diagnosed them. Nine participants described being diagnosed with MDD, while one stated that he had not officially been diagnosed. Participants in this study indicated how they feel depressed, or going through depressive symptoms that affected the way they felt. Seven participants said that their diagnosis had been given by a psychiatrist, one was diagnosed by a psychologist, one by a therapist, and another by a neurologist. Three participants stated that their MDD level was diagnosed as recurrent moderate, and seven could not recall whether they were given a severity level or remember what their severity level was. According to Roberti and Storch (2005), many individuals with tattoos live with depression, making it hard for them to function in life. The APA (2013) stated that stressful life events are primary causes of MDD and the development of mood disorders. Some participants in this study made references to how their MDD influenced the way they feel.

Participants received their diagnosis of MDD for various reasons and at different ages. The varied nature of depression can occur in different symptomatic profiles among individuals especially men who suffer from depression that present in different ways such as economic stress, psychosocial stressors, alcohol and substances misuse, lack of anger

coping skills, and somatic symptoms difficult to describe like chronic stress or acute stress disorder (Anderson & Sansone, 2003). Some participants described their MDD as recurrent moderate, which created thoughts that caused more mental impairment. MDD's effects range from mild to moderate to severe and always include emotional sadness and/or reduced or entirely absent enjoyment of things, activities, or events that once brought pleasure. The APA (2013) described the symptoms of MDD as including problems thinking clearly and loss of the ability to make simple decisions. The participants' descriptions of the process getting diagnosed with MDD is consistent with the literature. Depression is one of the most common mental health disorders in the world, an estimated 280 million people world-wide are affected, including 5.0% among adults and 5.7% among adults older than 60 years (Institute of Health Metrics and Evaluation, Global Health Data Exchange 2019).

Theme 2: MDD Before Getting First Tattoo

The second theme that occurred in this data set indicated how participants were asked whether they received their diagnosis of MDD before getting their first tattoo. According to Tiggemann and Hopkins (2011), tattoos are an important display of emotions by which individuals can develop their unique style and show dominance in their appearance. Participants discussed the number of tattoos they received before their MDD, their age at the time of their first tattoo, and why they decided to get their tattoos. Participants who did not have MDD before their first tattoo gave reasons such as simply liking tattoos and their aesthetic; wanting something that was beautiful to illustrate their

strength, military nickname, biblical scriptures, or honor their mother's death; and wanting something "cool" for their 18th birthday.

Countless individuals with tattoos live with depression making it very hard for them to function in life (Roberti & Storch, 2005). Participants' references regarding having MDD before getting their first tattoos were consistent with statements made about multiple life stressors at the time of their tattoos. According to Frederick and Bradley (2000) tattooed individuals stated they were affected and motivated by their level of identified and fundamental motives. Some participants did not receive a diagnosis of MDD before their first tattoo for various reasons like, the idea did not occur to them at that time of life, they thought they were too young, or they felt as if it was not a "cool" thing to do.

According to Frederick and Bradley (2000), tattooed individuals are affected and motivated by their level of identified internal motives. These internal motives concern experiences and expressions among men and women who get tattoos. Pew Research Center (2010) discussed how prevalence is higher in younger groups evidenced by 47% of Millennials with at least one tattoo. In my study, participants' diagnosis of MDD influenced their thinking about getting their first tattoo. Lande et al. (2013) made mention that various people get their motivation from tattoos as their daily expression, where as individuals that get their first tattoo display their way of describing self-expression while less than 10% described regret for getting their tattoo. Participants in this study admitted to getting an MDD diagnosis before getting their first tattoo and their reasons varied

based on the individual and mental health functioning at the time of their diagnosis of MDD.

Theme 3: First Tattoo Before Age 18

Participants stated whether they received their first tattoo before their 18th birthday. In this study participants who had their first tattoo before they were 18 years old discussed various reasons for getting their tattoo before their 18th birthday. Some participants gave reasons for getting a tattoo before they were 18 years old like their MDD diagnosis, expressions of love toward a boyfriend, death of a pet, a broken heart from a relationship, a reminder that they must keep pressing forward in life, and choosing to live and not allowing depression to win. Participants who did not receive tattoos before their 18th birthday gave reasons such as parental restraint due to age, the thought not occurring to them, and them not wanting one at before their 18th birthday. Lande et al. (2013) say that some peoples daily expression is their motivation from their tattoos. Tattooed individuals point to indicators relating to pathologies associated with depression, anxiety, and excessive risk taking (Roberti & Storch, 2005). There was no single cause of not getting a tattoo before age 18, however, in this study participants discussed reasons for them getting their tattoo before the age of 18. Participants who received their first tattoo before the age of 18 based their reasons on situations occurring in their life such as life stressors and immaturity. Tattoos are seen as symbols of psychological uncertainty, lack of mental instability and prohibits the bearer to become involved in the explanation of the true meaning of their reason for the tattoo (Anderson & Sansone, 2003; Aryan, 2006; Favazza, 1996; Grumet, 1983; Karacaoglan, 2012; Roberti

& Storch, 2005). Participants who received their tattoos after the age of 18 discussed reasons that displayed thought out plans and decisive actions as well as mature thinking about the type of tattoo they wanted.

Theme 4: Has Depression-Related Tattoos

Participants were asked whether they considered any of their tattoos to be depression tattoos, or tattoos related to depression, and why. Tattooing is more common among adults who experience psychopathological difficulties relating to their meaning behind their tattoos (Roggenkamp et al., 2017). Roggenkamp et al. (2017) explained how certain types of tattoo trigger behavioral and emotional responses such as depression, aggression, and deviance and why these behaviors and emotions are exhibited increasingly often as society embraces tattooing. Some participants in my study did mention their tattoos being depression-related, whereas some did not. According to Atkinson (2004), tattooed individuals exhibit emotional imbalances regarding their tattoos, some tattooed individuals believe that their tattoos represent emotions that create depressive symptoms. Participants who mentioned that their tattoos were depression-related tattoos used their tattoos as a way to help them overcome their depression. Some participants in this study did not think of their tattoos as being depression-related at the time of placement, and some did research after getting their tattoos and discovered that their tattoos were depression-related. Some participants do not consider their tattoos to be depression-related. Depression tattoos are expressions of meaning based on the trauma in the person's life or traumatic events that enhance their depressive symptoms. Some participants in this study stated that when they look at their depression tattoos, they are

reminders of the pain or traumatic event they went through that is causing them to stay in their depression. Some participants identified their tattoos to be depression tattoos and distinguished them based on what they represented to them.

Khosla et al. (2010) say that tattoos differ vastly in their content, designs, and locations on the body and in how many people get. Some participants identified their tattoos not as depression tattoos, but as expressions of routines based on their life events. Previous researchers have classified tattoos. Ferguson-Rayport et al. (1955) divided them into seven groups: identification tattoos (service emblems, personal information, key life events), love tattoos (idealized, sentimental, or maternal love; pornographic images), bombastic and pseudo-heroic tattoos (skull and crossbones, "Death before Dishonor," powerful animals), fate tattoos (horse shoe with "Good Luck," "Friday the 13th"), religious and commemorative tattoos, private symbols (of significance only to the individual), miscellaneous tattoos (animals, birds, flowers). Some participants in this study recognize their tattoos as depression tattoos and indicated that the type of tattoos such as the semicolon represented depression in their life as well as suicidal thinking.

Participants recognized their tattoos as meanings that held significance based on their thoughts about their depressive tattoos and the meanings they believed about their depressive tattoos. The influence of their MDD shaped their desire to get tattoos they considered depression tattoos.

Theme 5: Tattoos Are Reminders of MDD

The participants were asked whether any of their tattoos were reminders of their MDD. Some participants said that their tattoos were reminders of their MDD and caused

them to experience symptoms that increased their depression. The varied nature of depression means that it can occur in different symptomatic profiles. Especially among men who suffer from depression, it can present in different ways, such as economic stress, psychosocial stressors, alcohol and substances misuse, lack of anger-coping skills, and somatic symptoms that are difficult to describe, including chronic stress or acute stress disorder (Evans-Lacko et al., 2019). For some participants, their symptoms worsen when they look at their tattoos. Some participants mentioned how their tattoos held meaning due to death or abusive circumstances that caused them to ruminate and make their MDD worse. Participants indicated that the number of their tattoos and their ability to look at the tattoos every day increased their MDD, causing them to remain in their depressive state. Some participants stated that their MDD deteriorated when they looked at their tattoos and caused them to contemplate suicide.

Aizenman and Conover Jensen (2007) discussed how individuals who only self-injured and tattooed showed significantly higher scores on depression scales and significantly lower scores on self-esteem and mastery/control scales as well as individuals who did not have any body modification practices. Hicinbothem et al. (2006) associate tattooing and piercing with increased rates of self-reported suicide attempts. Roberti et al. (2004) indicated that individuals whose motives from tattooing and piercing are associated with psychosocial stressors. Participants discussed the reasons their symptoms increased and how motivations pertaining to depression affected them. Participants mentioned how their thinking moved into dark areas which influenced their motivations to become stagnant as well as develop fatigue. Participants reported that their

MDD symptoms created behaviors that led to their tattooing. Matthews (2008) discusses limitations in how closely someone's depressive symptoms can be related to tattooing; however, she further states that tattooing can be associated with depressive disorders. In my study, some participants with multiple tattoos who had a diagnosis of MDD did not see their tattoos as reminders and their MDD did not worsen. Participants whose tattoos were not reminders of their MDD indicated that they did not see their tattoos in this way and they did not pair them with their MDD. Participants mentioned that their thoughts were not fixating on their MDD or their tattoos and they used positive coping strategies to assist with the MDD. However, participants in this study who were immobilized because their tattoos were a reminder of MDD mentioned various reasons.

Some participants described how their tattoos were reminders of their MDD, suicide ideation/gestures or attempts, difficulties at home, social isolation and withdrawal, relationship problems, and severe health complications. Swami (2011) stated that the results from their study support the idea that tattoos are being used as signs and meanings of self-expression/identity that involve depressive symptoms. In my study, participants who decided to get multiple tattoos acted emotionally and irrationally when their MDD was at its worse. Participants whose tattoos were reminders of their MDD discussed how they were frequently slower and less supportive when they were depressed. Some participants described concentration issues caused by depression, which also contributed to decreases in their performance. Some participants whose tattoos were reminders of their MDD also described fatigue and low productivity that affected their

general functioning. All these factors had a negative impact on the participant's mental health that caused their tattoos to be reminders of the MDD.

Limitations of the Study

The main limitation of the study is the size of the sample (10 participants). According to Kawulich (2005) although it is not uncommon for samples to be smaller in qualitative, phenomenological research, limitations can occur due to the generalizability of the findings. Nevertheless, Kawulich (2005) states that findings can be generalizable when samples have comparable demographics. Furthermore, according to Kawulich (2005) using "thick description" when collecting data and processing the analysis enhances the likelihood of follow-up research studies. Another weakness of the study is that participants' understandings of depression were obtained through self-report. While it is conceivable that some participants were officially diagnosed by a mental health professional or clinician, clinical diagnosis was not a condition for participation in the study. I trusted participants' self-reports of depression. Although not a recognized diagnostic tool, the recruitment flyer for the study did ask questions concerning having multiple tattoos and a diagnosis of MDD. Individuals who thought that they had these experiences and fitted the criteria for the study sent their information by email and inquired about participation.

An additional possible limitation of the study involved the information discussed by research participants. As reviewed in Chapter 2, previous researchers have expressed some concern that participants who had multiple tattoos and MDD were reluctant to accept mental health services (Roberti & Storch, 2005). Withholding and not being

honest about information given could compromise the reliability of the research findings. To decrease the likelihood of this happening, pseudonyms were used as a way to safeguard the identities of research participants. In addition, any data that could reveal their identity were removed for their protection. According to Kawulich (2005), this approach can foster trust, emotional safety, and enhanced rapport. During each interview session, I made substantial effort to connect with all participants by making them feel comfortable with me by getting them to discuss their personal experiences. For the most part participants engaged in the conversation and shared their experiences with me. Moreover, age differences between participants could also be a constraint to the study. The 10 research participants' ages were between 18 and 65. Assumptions, beliefs, and perceptions relating to MDD vary by age (Annan, 2014). It is not clear whether the results would have been different had the sample size included more individuals under the age of 18 or over the age of 65.

Recommendations

It may be practical to reassess this study's population to see if there are differences between the lived experiences of participants whose multiple tattoos effect their MDD and those participants whose multiple tattoos have no effect on their diagnosed MDD. Some participants discussed how their MDD had no bearing on their multiple tattoos whereas others indicated the opposite. In the current study, tattooed individuals pointed to indicators relating to pathologies associated with depression, anxiety, and excessive risk-taking (Roberti & Storch, 2005). A study to conduct a comparison between individuals with multiple tattoos who exhibit MDD and individuals

whose multiple tattoos do not exhibit MDD is recommended. This will aid in helping individuals with multiple tattoos understand more about their MDD and how it is instrumental in their decisions to get certain type of tattoos such as depression tattoos. Atkinson (2004) discussed how mental health professionals normally assess that individuals with tattooed bodies manifest a mind oppressed with disorders. Additional studies can also shed light on assisting health care professionals on how to recognize when certain tattoos are triggers and give more insight regarding depression tattoos.

Also needed, providing professional mental health services in the community to help individuals whose multiple tattoos are factors in their MDD. Furthermore, mental health professionals should be trained to provide education on how MDD is manifested in individuals with multiple tattoos. Moreover, MDD studies should be conducted to raise awareness among individuals with multiple tattoos who have a diagnosis of MDD. Early detection and treatment can help individuals with multiple tattoos at risk of MDD.

Results from current studies provide information that discuss how individuals consider their tattoos to be contemporary tattoos and this can have an implication on cultural norms as well as effects on health care practitioners. Larsen et al. (2014) suggested that individuals' tattoos that are considered a contemporary tattoo are involved in culture that is increasingly complex and practitioners should think far greater outside the box than the normal when drawing conclusions about tattoo interpretations. Meaning and expression of multiple tattoos should be considered when working with individuals who display multiple tattoos. Aizenman and Conover Jenson (2007) mentioned how tattooing is seen as a form of wellbeing for body modification rather than self-harm and

individuals' reason for tattooing are unconnected forms of psychological grief or impossible emotional behavioral states. Training mental health professionals that work in psychiatric inpatient hospitals recognize when individuals with multiple tattoos who exhibit MDD are involuntary or voluntary placed in their hospitals due to their MDD from the tattoos. Assisting the professionals to recognize that the involuntary or voluntary placement was due to the individuals MDD and their multiple tattoos are their triggers.

Lastly, it is recommended that additional education be provided to mental health practitioners' and society on the topic of helping individuals whose multiple tattoos affect their MDD. Certain type of tattoos triggers behavioral and emotional responses such as depression, aggression, and deviance, these behaviors and emotions are exhibited more and more as society embraces tattooing (Roggenkamp et al., 2017). Individuals whose tattoos contribute to MDD is significant because of their reasons for seeking help for their mental health disorder. A need for empathy and understanding, as well as knowledge and skills from practitioners regarding individuals with multiple tattoos who exhibit MDD, can help them facilitate their desired need for change.

Implication for Positive Social Change

The purpose of this study was to better understand individuals with multiple tattoos who exhibit MDD. All participants reported having multiple tattoos and experiencing MDD or having some form of depressive symptoms. Some participants (2 of the 10 participants) reported that their tattoos were not associated with MDD or did not cause their MDD to worsen.

There is a gap in the literature regarding how individuals with multiple tattoos exhibit MDD. To extend this study to address how individuals with multiple tattoos exhibit MDD, more therapeutic services should be added as a way to encourage them to participate in studies. This research could be used to advise and identify new information that assists in reducing the number of depressive episodes individuals with multiple tattoos exhibit. Since individuals with multiple tattoos are frequently unfamiliar with their MDD, healthcare professionals could add studies that assess how individuals with multiple tattoos exhibit MDD. Another implication for positive social change includes societal and community awareness regarding individuals with multiple tattoos who exhibit MDD.

Individuals who experience discrimination due to their multiple tattoos and MDD or medial discrimination due to their multiple tattoos and MDD should be monitored to avoid this type of abuse and the trauma that can lead to them never seeking services due to their treatment. Counselors and clinicians who counsel individuals with multiple tattoos who exhibit MDD can use psychotherapy models. Psychoeducational workshops should be made available at no or low cost to help prevent discrimination due to their multiple tattoos and MDD or medial discrimination due to their multiple tattoos and MDD.

Results of this study may also be used in distinguishing and focusing on the challenges that individuals with multiple tattoos who exhibit MDD experience such as stigmas, guilt and shame. Clinicians can increase awareness of long-lasting effects that affect individuals with multiple tattoos who exhibit MDD. Moreover, clinicians

functioning in executing psychoeducational programs can use these findings to help justify reasons for developing and employing prevention programs.

Moreover, I hope that this study can inspire the introduction of healthcare systems that provide mental health services, education, and resources that address individuals with multiple tattoos who exhibit MDD. To create clear and succinct criteria that define MDD, it is helpful to institute atmospheres that assist individuals with multiple tattoos and MDD regarding positive social change. Another implication for positive social change includes defining roles and responsibilities for mental health professionals who provide services for individuals hospitalized within mental health hospital. Furthermore, data gathered from this study can help create criteria for diagnosing MDD in individuals with multiple tattoos.

Implications for Future Study

Further study should be conducted to develop a system where medical and other professional personnel can be trained to address individuals with multiple tattoos and MDD and to learn how to present information about how to identify predictors of MDD to such individuals. Future analysis might include follow-up studies on how MDD affects individuals with multiple tattoos. Moreover, further studies should be conducted to provide training for psychiatrists, psychologists, and medical personnel concerning behavior that involve individuals with multiple tattoos diagnosed with MDD and their need for professional help. Family members could also be instructed how to recognize symptoms in individuals with multiple tattoos diagnosed with MDD. Additional studies should be completed through community awareness assemblies that inform the public

regarding stress and communication related to individuals with multiple tattoos diagnosed with MDD. A principal theme in the outcomes of this study was that individuals with multiple tattoos diagnosed with MDD lacked comprehension and communication about their MDD.

This study also emphasizes the necessity for social change within community agencies' that involve essential training for psychiatrist, clinical psychologists, license clinical social workers, counselors, victim advocates, and any educator involved in human rights services.

The results of this study have the ability to enhance knowledge related to the public, psychological, and everyday danger elements that contributed to the mistreatment of individuals with multiple tattoos diagnosed with MDD. This probable support may further notify and inspire practices and methods where psychiatrist, clinical psychologists, license clinical social workers, counselors, victim advocates, and other professionals provide services to individuals with multiple tattoos diagnosed with MDD.

Conclusion

This phenomenological study explored the lived experiences of individuals with multiple tattoos who exhibit MDD and how their multiple tattoos affected their MDD. I wanted to know how their feelings about their multiple tattoos played a role in their MDD and how they received assistance from mental health practitioners and medical personnel. Face-to-face interviews were used for data collection from 10 participants: Seven women and three men aged between 18 and 65. Participants provided thick descriptions of their lived experiences. The data included five main themes and five sub-

themes. I categorized the data by rereading every transcript line by line numerous times to identify themes, meanings, and codes. Finally, I cataloged the 5 themes by assigning the participants' meanings into explanations by scrutinizing the data from an innovative perspective. I studied the spirit of the participants' lived experiences and the significance made of the lived experiences by the participants.

The results showed that participants displayed symptoms that could become worse when they were not cognizant of their depressive episodes. When problems were beyond the ability of the individuals to cope, their MDD could become worse. Some of the individuals whose depression-related tattoos caused them to experience severe symptoms participated in mental health services. The analysis also showed how participants used their family and friends to assist with coping skills when their symptoms grew. However, receiving help from family and friends meant that some individuals did not seek assistance from formal mental health treatment services.

The first theme is *MDD Diagnosis*, nine of the 10 participants said that they were diagnosed with MDD. The second theme is *MDD Before Getting First Tattoo*, five participants said that they had MDD before their first tattoo. The third theme is *First Tattoo Before Age 18,* three participants had their first tattoo before they were 18 years old. The fourth theme is *Has Depression-Related Tattoos*, five participants stated that their tattoos were depression-related tattoos. The fifth theme is *Tattoos Are Reminders of MDD*, five participants said that their tattoos reminded them of their MDD.

From the research data I learned that individuals with multiple tattoos who exhibit MDD often times do not pair their diagnosis with their tattoos. They get multiple tattoos

at times when they are experiencing MDD. The data recognized individuals with MDD who get multiple tattoos often times use them as way to help when they are depressed. Individuals get certain kind of tattoos that have meaning for them when they are depressed and the tattoos create themes that encourage them to get more and more tattoos. Some individuals with multiple tattoos enjoy getting their tattoos when they are depressed because of the pleasure they receive from the stick of the needle. The analysis identified individuals who get depression tattoos sometimes do not think of them as depressions tattoos, however, as their depression increase the tattoo serves as anthem of suicidal thoughts, gestures, and attempts.

In conclusion, this study enabled me to answer the research question about the lived experiences of individuals with multiple tattoos who exhibit MDD. Furthermore, in gathering this information, I was able to expand on the literature on how individuals with multiple tattoos exhibit MDD. The study also gave me a better understanding of the behaviors of individuals with multiple tattoos who exhibit MDD and how their tattoos play a role in their lives. This research analysis offered support to the negative impact regarding individuals with multiple tattoos who exhibit; it has the likelihood to inform the growth of therapeutic methods, programmable strategies, community interventions, and numerous other forms of interferences and preventable processes. In turn, these interferences can play a crucial role in assisting individuals with multiple tattoos who exhibit MDD get the assistance and help they need when they are experiencing debilitating depression. The insight from this study assisted me in seeing how individuals with multiple tattoos see their tattoos and the meaning behind their multiple tattoos that

exhibit MDD in their lives. With the increased empirical evidence of the development of individuals with multiple tattoos who exhibit MDD, participants will be more knowledgeable at recognizing and producing a resolution that involve unresolved issues related to prolonged submersion to MDD symptoms. Finally, a socially transformed nation should meet the needs towards generating proper mental health services for individuals with multiple tattoos who exhibit MDD as well as be classified as an at-risk population that should get mental health treatment that involve outpatient, inpatient and psychotherapy services.

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Appendix A: Ethical Concerns Checklist

1. Will participants be assured that participation is voluntary and that they can refuse or withdraw at any time?

2. Ensure that no participant is excluded on the grounds of sexual orientation, age, gender, religious belief, ethnic group or disability?

3. Ensure informed consent are obtained, either verbal or written?

4. Ensure that all identifying data is removed and that all records (paper and computer) are anonymized?

5. Results will be presented in a way that does not identify individuals.

6. Data will be kept in accordance with the Data Protection Act (2018) and General Data Protection Regulations (GDPR).

7. Outcomes be monitored and evaluated.

8. Ensure any potential hazards are addressed, including unwitting disclosure of medical condition or personal circumstances.

9. Ensure potential participants receive verbal or written information about the study.

10. Discuss any expected benefits to participants.

Appendix B: Invitation for Participation

Dear [Name will be inserted here],

My name is Tracy Daniels and I am currently a doctoral student at Walden University. I am investigating how do individuals with multiple tattoos exhibit major depressive disorder? Your participation will be greatly appreciated. Participation will involve participating in an interview which will take approximately 20 - 45 minutes. Audio-recorded organized and structured video call interviews will be completed in confidential and secured locations within your home to ensure privacy and confidentiality. Interviews will be conducted via-audio recorded video calls during a time that is most convenient for you. All information obtained from the interviews will be kept strictly confidential. Those who choose to participate will not be identified in any findings from the study or prepared reports. Thank you in advance for your consideration and assistance with my research.