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Measuring Violence: Vicarious Trauma Among Sexual Assault Nurse Examiners

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Sexual Assault Nurse Examiners (SANEs) are now commonplace in the continuum of care for victims of sexual violence in the United States. The presence of SANE programs has increased precision in the use of rape kits, improved patient care, and increased the effectiveness of expert court testimony. However, SANEs are exposed to a working environment that demands a professional response to devastating acts of trauma and violence perpetrated towards adults and children. This exploratory article presents the rates of vicarious trauma found among the SANE sample as reported through the 17-item Secondary Traumatic Stress Scale to understand the extent of secondary victimization among these service providers. By placing vicarious trauma within the context of sexual violence victimization, we expose a hidden "site" of violence and call for expanding our definition of "victim" of gender-based violence.

Key words: gender-based violence, nurses, vicarious trauma, social suffering

Christina is 33 years old, White, divorced, and has been practicing nursing for 11 years. She earned a two-year technical degree and is board certified by the state of Ohio as a Registered Nurse. Though she carries a pager and responds to all emergency room presentations of sexual violence, she is not certified as a Sexual Assault Nurse Examiner for adults or children because it is not required by her state licensure board. Though she recognizes that there is little chance of promotion and she is constantly being blocked by "red tape," she generally enjoys her workplace and colleagues. Unlike some nurses in her positions, she doesn't report experiencing the sensation of "reliving the trauma" of the acts perpetrated upon her patients—rape at gunpoint, gang rape, sexual assaults of young girls at the hands of intoxicated family members, or the ubiquitous college-aged woman coming in after being raped by a boyfriend. However, she says that she almost always has trouble sleeping, regularly feels discouraged about the future, and lives in a constant state of anxiety because she expects bad things to happen. Despite all of this, she plans to continue her work with the hospital, performing her regular duties as a Registered Nurse as well as performing sexual assault forensic exams.

Introduction

To what extent are the people working at the front lines of gender-based violence accumulating the pain and trauma of those with which they work? How do we measure the accumulation of trauma that is a result of gender-based violence, particularly sexual violence? Gender-based violence is a persistent social and public health problem. The impact of gender-based violence expands when we account for the hidden sites of violence, such as the effect on victims' caregivers. What, then, is the true cost of gender-based violence? How can we account for the radiating impact of gender-based violence?

This article describes characteristics of the Sexual Assault Nurse Examiner workforce and explores the occurrence of vicarious trauma among Sexual Assault Nurse Examiners (SANEs). SANEs provide expert medical care in emergency settings in response to sexual violence and are a unique population of frontline workers in the gender-based violence intervention system. Their work exposes them to trauma that places them at risk for vicarious trauma, leading to chronic changes in a person's perception of the world around them, and eventually to significant psychological duress and

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professional degradation. Through a discussion of vicarious trauma rates among SANEs, we demonstrate that the effects of gender-based violence radiates far beyond the immediate victims and can be measured quantitatively in the levels of personal and professional distress experienced by those at the front lines of sexual violence intervention services. Therefore, we expand the scope of gender-based violence victimhood to more adequately measure the human costs of violence by suggesting that the experience of vicarious trauma is a dimension of gender-based violence in our society.

Sexual Violence and Sexual Assault Nurse Examiners

Gender-based violence is "violence against an individual or population based on gender identity or expression" (Wies and Haldane 2011). As Merry (2008) further explains, "Gender violence is violence whose meaning depends on the gendered identities of the parties. It is an interpretation of violence through gender. For example, when a blow is understood as a man's right to discipline his wife, it is gender violence." Sexual violence is a form of gender-based violence, here defined using the Ohio Revised Code (2907.01-2907.09) as: "...an umbrella term covering a wide range of [sexual] actions taken against a person without the person's consent, against the person's will, or under force, threat of force, or coercion." This is often constructed by popular American culture as something that happens to "other people." It is frequently portrayed as a random act of violence perpetrated by a stranger, for example, a rapist jumping out of the bushes. However, research shows that sexual violence is perpetrated by people known and unknown to the victim and includes a wide range of unwanted sexual actions, including coerced sexual actions, sexual harassment, and rape (Bachar and Koss 2001). According to a national study, nearly 26 percent of American women have been victims of some sort of gender violence in their lifetime (Tjaden and Thoennes 2000). Nearly 8 percent of women in the United States report being a victim of rape. Alarmingly, less than one-fifth of women raped by a known perpetrator reported their most recent rape to the police due to fear of the perpetrator and a perception that the police would not be able to "do anything" (Tjaden and Thoennes 2000).

Beginning in the 1960s, feminist social movement activists in the United States began to raise awareness of sexual violence and seek structural mechanisms to redress sexual violence (Ferree and Hess 1995). Raising awareness, as a form of activism, includes organizing activities such as Take Back the Night rallies to demonstrate the need for women's space to be recognized and respected into the public eye (Tice 1990). The results of these awareness raising campaigns are persistent in our contemporary society, as "private violence" is now considered more than a "personal problem" (Wittner 1998:81).

To create structural change, activists in the 1970s sought to define sexual violence as a "social problem" rather than a "private matter" and targeted the legal system as the primary system for reform (Chasteen 2001). Amidst lobbying to eliminate legal clauses that allowed "marital rape" to be permissible and establishing codes that focused on the issue of consent to expand our understandings of sexual violence, activists began to create intervention systems for victims and survivors of sexual violence. Sexual assault organizations formed to provide hotlines for crisis counseling, accompaniment to hospitals for forensic evidence collection and physical care, legal advocacy, and other support services for those affected by sexual violence. Today, rape crisis centers serve three main functions, including crisis intervention, short-term counseling, and community education. One component of sexual assault intervention systems is coordinating, making accessible, and/or providing Sexual Assault Nurse Examiners in hospital emergency rooms to enhance evidence collection and ensure the provision of sensitive care for victims of sexual violence. Their work is deeply embedded in the cultural ideologies of sexual violence and rape that pervades American society because their role emerged in direct response to epidemic rates of gender-based violence.

Sexual Assault Nurse Examiners (SANEs)

SANEs provide "medical and/or nursing care to a client while performing forensic procedures that include objective documentation, which may be utilized in a legal setting at a future date" to patients presenting sexual violence victimization, including rape (LaMonica and Pagliaro 2006). Originally considered a routine component of emergency care, SANEs now often hold specialized credentials in forensic nursing.

A nurse can become a SANE by meeting the eligibility requirements and completing an examination. Eligibility requirements include a current, unrestricted nursing license and experience of usually two or three years, though these requirements vary by state and are often revised. According to the International Association of Forensic Nurses (IAFN), the certification is important because it demonstrates professional commitment. Most training programs require didactic training, clinical training, a culminating preceptorship (tutorial), and an examination (Ledray 1996). Two certifications are available that demonstrate the highest level of achievement in each area. The SANE-A certification indicates that the nurse has had extensive training and has demonstrated the highest standards in forensic nursing as a sexual assault nurse examiner for adults and adolescents. The SANE-P certification indicates that the nurse has demonstrated proficiency in providing forensic nursing for pediatric and adolescent victims of sexual assault (Hammer, Moynihan, and Pagliaro 2006). SANEs are trained to use medical equipment usually used by physicians to diagnose and treat disease. Since SANEs use these tools, such as the coloscope, to improve the forensic examination of their patients, the role of the SANE is within the scope of basic rather than advanced practice nursing (Ledray 2000).

SANE programs have been extremely successful in mending the problems in the care of sexual assault victims in

the emergency department. A lack of quality and consistent forensic care was recognized by nurses and other medical professionals as well as advocates and others working with victims who began to demand changes in the way their patients' cases were being handled (Ledray 1996). The first three SANE programs were formed in the late 1970s, and by 1990, there were 20 programs across the United States. In 1992, representatives from the existing programs, which had grown in number to 31, came together and formed the IAFN. In 1995, the American Nurses Association officially recognized forensic nursing as a new specialty (Ledray 1996).

SANEs operate at the intersection of the medical system and advocacy. They are both forensic technicians and nurses. They are concerned for the well-being of the whole patient but remain distinct from rape crisis advocates (Ledray, Faugno, and Speck 2001). Indeed, the IAFN newsletter is entitled "On the Edge," a title reflective of their positionality as situated on the cusp of advocacy. The SANE community has consistently retained their primary position as that of nurse to ensure that SANEs understand their role first as a medical practitioner. For example, at the 1996 meeting of the IAFN, SANEs rejected the label "forensic examiner" and opted to use "nurse examiner" instead (Ledray, Faugno, and Speck 2001). However, SANEs are not just forensic technicians but positioned to provide "bio-psycho-social" support to victims of sexual violence (Ledray, Faugno, and Speck 2001). However, the technical work that SANEs perform is distinct from the work of advocates, and while they remain compassionate, "advocacy" is not often included in a SANE job description. With a thin line between objective forensic examiner and subjectively-engaged advocate, SANEs are situated at a unique front line in gender-based violence response systems. While not labeled as an advocate, SANEs provide the forensic examinations that are often pivotal for sexual assault cases to move through the United States' justice system.

Vicarious Trauma Among Frontline Workers in Gender-Based Violence Interventions

Vicarious trauma is a change in an individual's fundamental conceptualization of the world in response to repeated exposure to individuals who have been through traumatic experiences (Little 2002). Vicarious trauma symptoms are similar to those of post-traumatic stress disorder (PTSD) and include feelings of anxiety, emotional irritation and/or numbness, sleep irregularities, avoidance of people and/or places that remind individuals of tragic events, and difficulty concentrating.

The main difference between vicarious trauma and PTSD is that the person with vicarious trauma has not experienced the traumatic event firsthand; rather, they experience trauma through working with victims of such events. This type of stress is often seen among careworkers in social service institutions that provide services to marginalized and underserved populations (Brookings et al. 1985; Collins and Long 2003; Kosny and Eakin 2008; Maslach and Jackson 1981; Perry 2003). Researchers have measured and substantiated vicarious trauma among careworkers providing services to people receiving end-of-life care (Abendroth and Flannery 2006), emergency room patients (Little 2002), and psychiatric care patients (Robinson, Clements, and Land 2003). Very often, these careworkers experience job conditions that include long hours, low pay, and exposure to violence and disease that increase the risk of suffering from symptoms of vicarious trauma (Collins and Long 2003). Additionally, vicarious trauma is well-documented in careworkers who provide gender-based violence intervention services, including social work clinicians with sexual assault caseloads (Cunningham 2003), forensic interviewers (Campbell and Wasco 2005), sexual assault therapists (Rasmussen 2005), and rape crisis workers (Clemans 2004). These frontline careworkers experience the consequences of being deeply involved in and committed to their professional responsibilities. The careworkers confront their worldviews, personal relationships, fear, and sense of vulnerability everyday while working with victims of gender-based violence.

Clemans (2004) articulates three dimensions affected when a person experiences vicarious trauma. First, workers individually experience an increased feeling of vulnerability and fear, suffer from symptoms of PTSD such as vivid nightmares, and become more cautious regarding their personal safety. Secondly, their personal relationships change through an intensification in their concern about the safety of their children, a loss of interest in and discomfort during sex, and a restriction of their personal boundaries. Third, more generally they become constantly distrustful of people and situations in all aspects of their lives.

SANEs are now commonplace in the continuum of care for victims of sexual violence, resulting in increased precision in rape kits, improved patient care, and increased effectiveness of expert court testimony (Campbell and Diegel 2004; Ledray and Simmelink 1997). SANEs are exposed to a working environment that demands a professional response to devastating acts of trauma and violence perpetrated towards adults and children. Although their importance is undeniable and their numbers continue to increase, little has been done to document the effect that this work has on SANEs (Sabo 2006). To what extent are SANEs affected by the trauma they encounter? We describe here the presence of vicarious trauma among SANEs working in hospital emergency rooms and with rape crisis centers, legal systems, and judicial systems across the state of Ohio.

Methods

The 17-item Secondary Traumatic Stress Scale (STSS) was initially developed in order to assess the symptoms of PTSD as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) among people exposed to trauma secondarily or vicariously. Its design is such that it can be applied to many specialized careworkers (Bride et al. 2003). The instrument is divided into subscales specifically developed

for this purpose including: (1) a scale to determine the frequency of intrusion, such as dreams about work with clients or thinking about clients when it is unintended; (2) a scale to determine the frequency of avoidance behavior, including general feelings of discouragement about life and the desire to skip work; and (3) a scale to assess the frequency of arousal symptoms, including feelings of restlessness or foreboding. What makes this scale specific for Secondary Traumatization is the design of several of the questions in each subscale to deal with specific reactions to client or patient interactions. A general demographic questionnaire was also distributed to participants to contextualize the data and to gain a greater understanding of the people who are doing SANE work.

Participants were recruited via a snowball sample, which was accomplished by contacting hospital emergency rooms and rape crisis centers in Ohio. After initial contact, requests were made to distribute the instrument and demographic questionnaires to any nurses who self-identify as working with and providing care to victims of sexual assault and who would be willing to participate in a voluntary survey. The Institutional Review Board approved the research protocol, the survey was distributed electronically, and the results were collected through an online service, allowing for complete confidentiality. There are no sources indicating the number of sexual assault nurse examiners in the state of Ohio, as SANE nurses are not required to register with any institutions that would maintain such data.

Participant Population

The demographic portion of the survey asked respondents to identify information about several different aspects of their lives in order to better understand each section of the survey. This included basic demographic information, including race, partnership status, and age. Additionally, respondents were asked about their education, their licensure, and additional certifications, as well as about their employment status and the length of time they have been working as a nurse and at their current place of employment.

Of the surveys that were completed (N=42), 95.2 percent of the respondents identified their racial identity as White or Caucasian, 2.4 percent identified as Black or African American, and 2.4 percent identified as Hispanic. The ages of the respondents ranged from 27 to 61 with a median age of 48. Only one respondent considered themselves to have a disability. Sixty-nine percent of the respondents classified their partnership status as married, 14.3 percent were divorced, 7.1 percent were single, 4.8 percent were partnered, and 4.8 percent were separated.

When asked to identify the highest educational degree that had been earned, 40.5 percent had earned a two-year technical degree, 42.9 percent of the respondents had earned a baccalaureate degree, 7.1 percent of the respondents had earned a Master's degree, and 9.5 percent of the respondents classified their highest degree earned as "other." Respondents were also asked to describe their nursing license credentials. The large majority of the respondents, 95.2 percent, listed Registered Nurse (RN).[1] Respondents were also asked to list any additional certifications. Of all of the respondents, 76.2 percent listed additional certifications,[2] most of which were connected to advanced trauma care. The most common certifications were both SANE-A and SANE-P. Of the nurses who listed additional certifications, 68.75 percent mentioned at least one SANE certification, totaling 52 percent of the total survey population.

The majority of respondents reported working full-time, at 90.5 percent.[3] Respondents were employed as nurses from one year to 40 years with an average of 16.4 years. When asked how long they had been working at their current place of employment, respondents' answers ranged from one month to 28 years, and, on average, the respondents had been working at their current place of employment for 12 years. However, it should be noted that in a few cases, the respondents had been working at their current place of employment for longer than they had been a nurse, implying that the respondent was doing other work at that location before becoming a nurse.

Measuring the Radiating Impact of Gender-Based Violence: Data Analysis and Results

A total of 42 surveys were completed, and the results were analyzed based on a rubric validated by the developer of the STSS (Bride et al. 2003). If a respondent indicated that they experience a symptom described by the survey *occasionally*, *often*, or *very often*, then that was taken as a positive indication that the respondent had the symptom described by that item. According to the STSS validation study, a respondent had to have a minimum of one positive symptom in the intrusion category, two positive symptoms from the arousal category, and three positive symptoms from the avoidance category for a determination of the presence of vicarious trauma. Following the scoring rubric, we analyzed each subscale separately to determine whether the minimum number of items were positive in each scale. If the respondent met the minimum criteria, they were counted in the "Met Criteria" category. According to these standards, 38.1 percent of the participants in the survey suffer from vicarious trauma, and 61.9 percent of SANE respondents did not meet the criteria for experiencing vicarious trauma (see Table 1).

Table 1. SANE Respondents Who Met and Did Not Meet Vicarious Trauma Criteria

	Number	Percent
Met Criteria	16/42	38.10%
Did Not Meet Criteria	26/42	61.90%

Table 2. SANE Responses to STSS Instrument Items

Question	Never	Rarely	Occasionally	Often	Very Often	Percent Met
1	19.05%	35.71%	30.95%	14.29%	0.00%	45.25%
2	30.95%	50.00%	7.14%	9.52%	2.38%	19.05%
3	45.24%	57.14%	21.43%	0.00%	0.00%	21.43%
4	19.05%	35.71%	33.33%	4.76%	7.14%	45.24%
5	33.33%	23.81%	26.19%	16.67%	0.00%	42.86%
6	23.81%	45.24%	23.81%	7.14%	0.00%	30.95%
7	47.62%	26.19%	19.05%	2.38%	4.76%	26.19%
8	54.76%	30.95%	14.29%	0.00%	0.00%	14.29%
9	40.48%	28.57%	14.29%	11.90%	4.76%	30.95%
10	19.05%	21.43%	42.86%	14.29%	2.38%	59.52%
11	19.05%	42.86%	26.19%	9.52%	2.38%	38.10%
12	45.24%	23.81%	23.81%	7.14%	0.00%	30.95%
14	38.10%	30.95%	7.14%	7.14%	0.00%	14.29%
15	19.05%	23.81%	35.71%	16.67%	2.38%	54.76%
16	42.86%	28.57%	21.43%	7.14%	0.00%	28.57%
17	52.38%	26.19%	11.90%	4.76%	4.76%	21.43%

Table 2 presents the answers provided by respondents for each of the STSS instrument items. Many of the respondents who did not meet the criteria to be considered someone who suffers from Secondary Traumatic Stress or vicarious trauma still indicated a positive response to some or many of the items in the survey. For example, a significant number of those SANEs surveyed (21.43%) had more than five positive responses to STSS criteria, but they did not meet the minimum number of six positive responses.

Discussion: Expanding the Scope of Victimhood

This exploratory research was carried out in order to determine the prevalence of vicarious trauma in SANEs, a group of frontline careworkers in gender-based violence intervention systems that are neglected in the literature pertaining to vicarious trauma and occupy a position "on the edge" of advocacy and clinical care. The following discussion focuses on expanding the scope of victimhood to include these frontline workers, the ramifications on the quality of care for primary victims of sexual violence, and the social suffering experienced by individuals living within a culture of sexual violence.

Stress, Trauma, and the Scope of Victimhood

Our results indicate that among SANE nurses, there is a high rate of secondary traumatic stress, with 38.1 percent of the nurses surveyed reporting symptoms of vicarious trauma. This number alone is based on the scoring recommendations as determined by Bride et al. (2003), wherein a positive indication to six criteria would be categorized as experiencing secondary stress or vicarious trauma. Yet, a deeper look at the responses indicates that many more SANEs experience vicarious trauma related to their work. Many respondents positively responded to five of the criteria in the STSS instrument, just missing the minimum to be identified as experiencing vicarious trauma. We would argue that an individual who responds to five signs of vicarious trauma as experienced *occasionally*, *often*, or *very often* in the last seven days is suffering from traumatic stress, even if the results of their survey do not meet the standards. If SANE nurses who experience a minimum of five signs are considered in our results, then the number of respondents who have experienced vicarious trauma swells to 59.52 percent (see Table 3).

Regardless of whether the number is 31.80 percent or 59.52 percent of SANEs, our results indicate that substantial numbers of SANEs suffer from vicarious trauma as a result of their work with victims of sexual violence. SANEs who experience trauma vicariously are not often considered victims of gender-based violence or sexual violence, yet their experiences of trauma are real. How then are we to define victimhood in a world marked by gender-based violence?

Table 3. SANE Respondents Meeting Expanded Vicarious Trauma Criteria

Met Criteria	Met 5 or More Criteria	Expanded Total
38.10%	21.43%	59.52%

The data presented here show that the scope of sexual violence in the United States far surpasses the numbers generated by counting primary or secondary victims. The scope of victimhood extends to those working at the frontlines of gender-based violence interventions systems in concrete, documentable ways.

Quality of Life, Quality of Care

People experiencing vicarious trauma perform their daily tasks, both personal and professional, with a compromised quality of life. Whether marked by nightmares, sleeplessness, fear of intimacy, overall anxiety, or other symptoms in the array of stress and trauma-related criteria, trauma changes a person. This compromised quality of life is a form of suffering that has very real implications for a person's life and well-being.

It also has implications for the quality of care that a careworker provides. A change in a frontline worker's quality of life as a result of vicarious trauma will affect the quality of care and possibly care outcomes. Vicarious trauma is associated with lowered patient satisfaction with clinical care (Leiter, Harvie, and Frizzell 1998) and a decrease in the quality of the work of the SANE (Maslach and Leiter 2008). Therefore, the presence of vicarious trauma among SANEs becomes a quality of care issue. As a result, acts of sexual violence affect not just victims and careworkers, but a broader, tertiary population as well.

Social Suffering and the Culture of Sexual Violence

The United States is a society characterized by what Sanday (1990) identifies as a "culture of rape." Sexual violence is so commonplace in the United States as to demand a need for gender-based violence intervention systems, such as SANE programs in hospitals across the nation. These response systems are chronically underfunded and undersupported by institutional powers, which in turn contributes to the presence of stress (Kosny and Eakin 2008), burnout (Brookings et al. 1985; Maslach and Leiter 2008), and vicarious trauma by the workers situated at the frontlines, as demonstrated here.

Thus, we situate these results within the context of social suffering. Kleinman, Das, and Lock (1997:ix) speak of social suffering as that which "...results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems." In this case, we have quantified individual-level experiences of vicarious trauma among a careworker population responding to a problem that is so much more than health-related. Indeed, when institutional structures fail to prevent and provide adequate response mechanisms for gender-based violence, the issues become both "political and cultural matters" (Kleinman, Das, and Lock 1997).

By placing local-level, individual acts of sexual violence within structures that are created to maintain and execute violence in society, we expose a hidden "site" of violence (Scheper-Hughes 1992). Essentially, by connecting data that substantiates the high levels of human suffering to a political economy of sexual violence victim care via a structural violence framework, we must expand our scope for defining victims and measure the societal costs of violence against women.

Conclusion

SANEs arose as a result of activism and advocacy to bring sexual violence out of the domestic sphere and into the public's eye. These activisms are situated within a specific political economy that inadequately responds to and provides resources for responses to sexual violence. Today, frontline workers such as rape crisis workers and SANEs operate in a political economy that fosters competition for limited resources for social service work (Rodriguez 2007), mandates professional standards for frontline workers (Wies 2009), and disproportionately lays the burden of proof and action on victims of sexual violence. Adelman (2008) reminds us that "to be effective in terms of social change is to present unfamiliar ideas or introduce new ways of presenting existing phenomena." This article advances the scope of the sites of violence (Scheper-Hughes 1992) that contribute to individual-level trauma and social suffering.

With 38.10 percent of SANEs reporting symptoms that indicate experiences of vicarious trauma, the radiating effect of the culture of sexual violence is significant. Anthropologists have problematized the definitions and terms used to describe gender-based violence, such as sexual violence (Singleton 2010); we hope that this article prompts scholars to expand our understandings of victimhood in another direction by considering the extent of which frontline workers physically and emotionally come to possess the trauma of gender-based violence. Frontline workers have not been considered as victims, an oversight in our societal and academic discourse. By expanding our conceptions of victims of violence, we can move towards a more valid account of the scope of sexual violence. This expanded scope of sexual violence would capture more fully the extent of the social suffering that sexual violence causes.

An anthropology of gender-based violence will continue to challenge our imaginaries of "victim" and "provider" as well as compel us to rethink our social service structure to understand the nuances of contemporary frontline carework. These actions must be contextualized within a political economic framework that confronts structural mechanisms that prevent people from accessing support and/or resources.

Notes

[1]The other two respondents, both of whom had their highest educational degree listed as a master's degree, had Registered Nurse,

Certificate of Authority, and Prescriptive Authority listed as their nursing license credentials.

[2]Participation certifications included: Certified Emergency Nurse (CEN), Advanced Cardiac Life Support (ACLS), Emergency Medical Technician (EMT), Sexual Assault Nurse Examiner (SANE), 1st Lieutenant United States Army Nurse Corps, Pediatric Advanced Life Support (PALS), Trauma Nursing Course Certified (TNCC), Basic Life Support (BLS), Neonatal Resuscitation Program (NRP), Critical Care Registered Nurse (CCRN), Certified Pediatric Nurse Practitioner (CPNP), Registered Nurse, Certified (RNC), Family Nurse Practitioner, Board Certified (FNP-BC), Nurse Practitioner, Certified (NP-C), Psychiatric and Mental Health Nurse, Legal Nurse Consultant, Special instructor for Ohio Peace Officer Training Academy (OPOTA), Special instructor for Paramedic Education, and Licensed Chemical Dependency Counselor (LCDC-III).

[3]In addition, one reported working part-time, one reported working through a contract service, one reported working full-time and part-time, and one reported working full-time through a contract service.

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