

Torture survivors who engage in advocacy in the U.S.: Review, characteristics and policy implications

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Key points of interest

- Psychological symptoms are not predictors of advocacy participation, and thus should not necessarily be used to “screen” survivors from becoming advocates

Abstract

Introduction: Despite facing many challenges, some survivors of torture seeking asylum in the U.S. have courageously engaged in advocacy efforts to bring attention to human rights issues relevant to their own personal experiences. This study sought to add to our understanding of the characteristics of survivors

who engage in advocacy in comparison with those who do not.

Method: We analyzed demographic, social, and psychological quantitative data collected from survivors (n=730) connected to a support agency that regularly facilitates advocacy events using between-groups t-tests and regression analyses. Based on theory, clinical insights, and past research around survivor advocacy we predicted that participation in advocacy would be associated with and predicted by factors indicating lower levels of trauma-related symptoms and higher social power and stability.

Results: We found no significant difference in clinical symptoms or most demographic or social characteristics between advocacy participants (n=75) and non-participants. However, advocacy participants had spent significantly more time in the U.S. and were less likely to have had employment authorization at time of service intake, and were more likely to be male, compared to non-participants. Without controlling for other demographic factors, higher spirituality and not having been detained at entry to the U.S. also predicted advocacy participation.

Discussion: Our findings suggest that, despite some patterns of difference indicating greater stability and access to power (e.g., being male, having more time in the U.S., more daytime availability, a strong sense of

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spirituality, and less experience of detention in the U.S.), survivor-advocates are diverse and not consistently differentiated from non-advocates by specific characteristics. Thus, we find no evidence to support using psychological or demographic indicators as a “screening” criterion for selecting advocacy candidates. We contend that it is important to adopt a gender-inclusive approach in providing wider opportunities that help more survivors overcome potential (racial, socio-economic, mental health, etc.) barriers to engagement, and to pay close attention to who is being left out of advocacy opportunities.

Keywords: Torture survivors, advocacy, activism, trauma healing

Torture survivors who engage in advocacy in the U.S.: Review, characteristics and policy implications

Many individuals tortured within their home countries have sought political asylum in the United States of America (U.S.). Despite the trauma and persecution they have endured, often for expressing their political views—and ongoing experiences of depression or post-traumatic stress as a result (e.g., see NCTTP 2015, Grasser, 2022)—some of these individuals courageously engage in advocacy activities in the U.S. to call attention to human rights abuses and promote more humane treatment for those seeking freedom. By doing so, they may place themselves at risk of further persecution or re-traumatization. At the same time, they may benefit from upholding their political ideals, influencing international policy on human rights abuses in their home countries, and affirming their personal worth (O’Connor, S., Byimana, L., Patel, S., & Kivlighan, D. M., Jr., 2021). This study sought to provide further insight into those survivors of torture who choose to participate in advocacy

by identifying psychological and demographic characteristics as factors that may distinguish them from others who do not engage in advocacy. It focuses specifically on survivors connected with one of the agencies within the U.S.’s National Consortium of Torture Treatment Programs (NCTTP), which was established to both support survivors’ healing and prevent torture worldwide.

Survivors engaging in advocacy

In its broadest sense, advocacy involves publicly supporting a cause or policy. In the context of the U.S., which has institutionalized structures for democratic political participation, advocacy activities may include meeting with politicians and their staff, making formal written or oral submissions during decision-making processes, or engaging in public speaking or writing about a cause.

The role of advocacy in torture treatment—impacts for survivors

Engaging in advocacy is less commonly seen as a form of “treatment” for trauma in the U.S. but is consistent with the emphasis placed on social justice by traditions such as liberation psychology (Martín-Baró, 1994), which points to the importance of collective anti-oppressive action in individual healing. It also presents a means of highlighting the political and socio-cultural origins of trauma, which have been increasingly recognized as important in work focusing on healing from complex, chronic, and interpersonal trauma (e.g., Herman, 2015). A more circumscribed form of advocacy, involving “testimony therapy” (in which survivors prepare a testimony of their torture experience within the safety of a therapeutic relationship), has been tested and incorporated in some torture treatment settings (Weine, 2006) but does not appear to be widely in use in the U.S. at

present.

Past research suggests that advocacy, activism, or giving public testimony can be beneficial for survivors of human rights violations. For instance, studies of the experiences of individuals testifying in Truth and Reconciliation Commissions and International Criminal Courts have found that some advocacy/testimony participants gained a sense of agency, empowerment, self-esteem, or tranquility from their sense of being able to hold government officials accountable for abuses they endured (Laplante, 2007; Stepakoff, S., Shawn Reynolds, G., Charters, S., & Henry, N., 2015), and felt pride or satisfaction about having the truth of their experiences known and shared (Stepakoff et al., 2015). Suarez (2011) identified higher resilience among women survivors of war in Peru who engaged in activism and participated in civic activities with indigenous NGOs and women's organizations. Sadiq-Tang (2018)'s review of survivor experiences of engaging in activism in the UK indicated that survivors reported starting to feel more control of their own narratives and viewed speaking out as important in their healing process. In the U.S., a recent study of survivors of torture who have participated in advocacy and given public testimony indicated that survivors benefited from feeling heard, from being "a voice for the voiceless", from relief at having been able to share their stories, from gaining a sense of hope and ongoing motivation, and from feeling more empowered and confident about speaking in public and influencing government policies on human rights (O'Connor et al., 2021). Other research suggests that the benefits of advocacy may be experienced by those not directly involved in the advocacy itself—for instance, in Sierra Leone Cilliers and colleagues (2016) found increased harmony, trust and cohesion within commu-

nities where Truth and Reconciliation Commissions had been held.

Within a therapeutic setting, researchers in multiple countries have found that survivors who engaged in testimonial therapy have experienced benefits such as decrease in distress, anxiety and post-traumatic stress symptoms (an increase in self-esteem, pride, and empowerment (Agger, I., Igreja, V., Kiehle, R., & Polatin, P., 2012), a sense of being able to help others by sharing their story, an increased sense of social support, and increased social functioning and participation (Agger et al., 2012; Cienfuegos & Monelli, 1983; Jorgensen, M. M., Modvig, J., Agger, I., Raghuvansh, L., Shabana Khan, S., & Polatin, P., 2015, Lustig, Weine, Saxe, & Beardslee 2004; Nickerson et al., 2013; Puvimanasinghe & Price, 2016; Shalhoub-Kevorkian, 2005).

However, research indicates that there may also be some notable costs or harmful impacts of engaging in advocacy, activism, or giving testimony. These may include fatigue and frustration involved in the logistics of being politically active and visible (Laplante, 2007), psychological stress from recalling and talking about traumatic experiences (Brouneas, 2008, 2010; Cilliers, J., Dube, O., & Siddiqi, B., 2016; Stepakoff et al., 2015), concerns about retribution (Brouneas, 2008, 2010; Laplante, 2007), pain and disappointment if appropriate restorative justice is not offered (Pham et al., 2011), or a sense that the space, time, or format available for communicating an important message or narrative is inadequate or tokenizing (Taylor, 2014). The context and framing of advocacy and giving testimony may also significantly alter its impacts—for instance, being more harmful if survivors feel pressured into speaking in a state of discomfort, or asked to engage in advocacy for the benefit of the audience more than the

benefit of the survivor and their message (e.g., Hamber & Lundy, 2020).

Factors influencing participation in advocacy

Clinicians and scholars have suggested that particular characteristics may be important for survivors engaging in advocacy to benefit and participate safely, particularly if it involves giving testimony about their personal traumatic experiences. These include good emotional coping skills and motivation (Van der Veer, 1992); feeling prepared to tell their story, not experiencing high symptoms of trauma, and feeling safe from threat (Weine, 2006); having support from others and faith within themselves to manage challenges as they arise (Mollica, 2006); and seeing the sharing of personal experiences in connection to collective issues as both culturally congruent and important for future social transformation (e.g., Lustig et al., 2004).

Similarly, research suggests that the impacts of participating in advocacy vary according to contextual factors. These include whether those who testify are still in the communities in which their abuse occurred and are visible there, placing them at more risk (Brouneas, 2010; Delker et al., 2020); feel listened to, rather than cross-examined on the veracity of their experiences (Stepakoff et al., 2015); and are supported in preparing for their advocacy or testimony experiences (Jorgensen et al., 2015; Stepakoff et al., 2015; Fields et al., 2020). Some research suggests that there may also be variations in outcome by gender—for instance, Jorgensen and colleagues (2015) found that men experienced greater increases in social participation and motivation to continue campaigning for human rights after giving testimony with a human rights organization. Based on a review of sociological and historical analyses, Delker et al. (2020)

propose that individuals experiencing intersectional oppression are less likely to publicly engage in advocacy and testimony, or to benefit from it. In a recent qualitative study, O'Connor and colleagues (2021) highlighted the potentially moderating impacts of survivor-advocates' legal status and stability (e.g., whether they felt concerned about speaking out due to pending asylum claims), and their sense that some form of justice could be achieved by speaking out (e.g., whether the U.S. government was likely to influence their country's practices on torture and human rights violations). These findings also suggested that an existing identity as a professional, educator, or leader may be part of what motivates survivors to engage in advocacy. Of note, survivor-advocates in O'Connor and colleagues (2021) study also identified feeling "ready" to engage in advocacy, indicating that this could take some time and may be linked to stabilization of (although not complete remission of) symptoms of distress and level of proficiency in spoken English.

However, there remain gaps in our knowledge about which survivors are most likely to *participate* in (and thus may have the opportunity to benefit from) advocacy. Understanding more about the characteristics of survivors who voluntarily engage in advocacy could assist in future efforts to support survivors' healing through empowering and culturally appropriate means by offering them opportunities to participate, and in efforts to effectively "screen" for advocacy participants who may experience more re-traumatization (Allan, 2000). Additional information about who is primarily participating in advocacy also sheds light on whose voices are being privileged—and whose may be omitted—in public spaces and in the representation of survivor experiences.

The present study

This study sought to identify, among a group of self-identified survivors of torture who sought services from a NCCTP member agency on the U.S. East Coast, characteristic features of those who decided to participate in advocacy activities. We took a quantitative approach to investigate whether certain demographic or contextual indicators were positively associated with participation in advocacy, usefully predicted participation in advocacy, or significantly differed between those who participated and those who did not. Drawing from the past research summarized above, we hypothesized that having lower levels of trauma-related symptoms (which may be suggestive of higher coping skills and a higher felt-sense of safety) and higher social power and stability (e.g., being a man, having a higher level of education, having employment authorization, and having a more secure immigration status) would be associated with, and differentially predictive of, participation in advocacy.

Methods

This study used archival data collected by one NCCTP member agency and was deemed exempt from Human Subjects Research requirements by the Loyola University Institutional Review Board for research ethics.

Participants

Data used in this study was collected by the agency during the period 2016 to 2019 from individuals who sought services at the agency and reported having been subject to torture in their home country. The study sample included 730 survivors (487 men, 243 women) with an average age of 36.63 years old at intake. The majority also identified their home country as Ethiopia (n= 500; 68.49 %), with others reporting countries of origin as Cameroon (n= 85; 11.65 %), Eritrea (n=

42; 5.75 %), Uganda, (n=17; 2.33%), DRC (n=9; 1.22%), and Honduras (n=7; .96%). The remaining of survivors were from 35 other countries; country of origin was not listed for only 1 survivor (.14%). Approximately 10 percent (n=75) had participated in advocacy. All 730 survivors were included in the analysis.

Measures

The majority of variables investigated in this study were collected using a standard intake assessment form developed by the NCTTP member agency in this study. This form included questions on demographic variables (e.g., age, gender identity, country of origin, years of education prior to arrival, and marital status), relevant immigration history (e.g., if client arrived in the U.S. with a visa, if client was detained at entry, if client had a lawyer, and if client applied for asylum), and post-migration factors impacting psychosocial wellbeing (e.g., housing status, if client has employment authorization, and if client needs an interpreter). The intake form also records clients' self-report of their level of connection to spirituality on a single item question with a scale from 1-4, with 1 being the least connected and 4 being the most connected. In addition, variables assessing psychological symptoms were collected using a formal clinical tool, detailed below.

Harvard Trauma Questionnaire (HTQ-30 Part IV; Mollica, McDonald, Massagli, & Silove, 2004): This measure comprises 30 questions on symptoms of post-traumatic stress that survivors of torture commonly experience, e.g., recurrent nightmares and difficulty concentrating.

Hopkins Symptoms Checklist (HSCL-25; Mollica & Caspi-Yavin, 1991; Mollica et al., 2004): This measure comprises 25 questions on symptoms of anxiety and depression. Re-

spondents were asked to identify on a 4-point scale how much they were bothered or distressed by each symptom over the last week.

Procedure

Data collection

Participant data was collected and securely stored by the NCTTP member agency for internal record-keeping purposes. Case managers (trained, licensed social workers and social work interns) conducted intake appointments in which they met with survivors to: (i) obtain their informed consent for services to be provided and for their personal data to be stored and used in a deidentified fashion for evaluation, research, and reporting; (ii) collect demographic and contextual information by giving survivors paper intake forms to self-complete and following up using clinical interviewing skills to verify, clarify, or expand on the information provided; and (iii) self-complete symptom measures to provide further details on their wellbeing. Professional interpretation was offered for intake appointments if required and (professionally translated) paper measures were available in English, Amharic, Tigrinya, Spanish, and French. Case managers then entered demographic data in a secure data management system, and stored scores from the symptom measures in a separate database (with unique identifying numbers for each survivor) for use in annual reporting. If not all information could be collected during a single intake session, later appointments were scheduled.

Separate from the social service intake process, survivors who visited the service agency offices or joined the e-mailing lists were invited by advocacy staff to participate in advocacy activities, including an annual “Advocacy Day” event involving visits to government offices. Survivors were informed that

all participation was voluntary and would not impact on their receipt of any services from the agency. Some survivors were also referred to advocacy staff from social services after expressing an interest in advocacy to their case managers. Advocacy staff maintained a list of all advocacy participants for each year. For the purposes of this study, the advocacy list was linked to survivors’ unique identifying numbers to identify those who were receiving social services.

Deidentified data was aggregated from the social service databases and advocacy lists to form the dataset for this study.

Data analysis

All analyses were undertaken using STATA version 16.1. In the initial stage of data analysis, data was cleaned, and missing data was coded as “missing”. Variables with a high number of missing variables were removed from analysis. The following demographic variables were explored in this research study as dichotomous variables: gender (male/female), years of education prior to arrival (less than/more than 16 years of education), and marital status (married/not married). Country of origin was measured as a categorical variable and age was measured as a continuous variable in years.

The following variables related to relevant personal history were coded as dichotomous variables: arrival to u.s. with a visa (yes/no), detained at entry to the U.S. (yes/no), did member apply for asylum (yes/no), and does member have an attorney (yes/no). The following post-migration variables impacting psychosocial wellbeing were coded as dichotomous variables: housing status (secure/insecure), employment authorization (yes/no), and does client need an interpreter (yes/no). Level of spirituality was coded as a dichotomous variable (1-2 / 3-4) and as a contin-

uous variable from 1-4. HSCL Scores were coded as a continuous variable and as a dichotomous variable if the client met criteria for clinically significant symptoms (Yes/No). HTQ scores were coded as a dichotomous variable if the client met criteria for clinically significant symptoms (Yes/No).

We then ran descriptive statistics and identified mean scores and associations across groups that participated in advocacy and those that did not participate in advocacy. In the next stage, we ran two separate sets of analyses.

First, we tested the null hypothesis that advocacy participants would not significantly vary in mean scores on any of the variables included in the study when compared to non-participants using a series of two-tailed t-tests comparing the group of participants in advocacy (n=75) with the group of non-participants in advocacy (n=655). Second, we ran a stepwise linear regression predicting participation in advocacy (the “outcome”) from demographic variables and post-migration variables. We also checked if demographic variables and postmigration variables predicted HSCL scores.

Results

Descriptive statistics are presented in Tables 1 – 5. Results of further analyses are reported below.

Correlations between variables

Male gender and HSCL scores were strongly negatively correlated, $r(291) = -0.253, p = .01$. Men’s average HSCL scores were 0.25 points less than those of women ($p < 0.01$).

Differences between advocacy participants and non-participants

It was hypothesized that having lower levels of trauma-related symptoms would be associated with higher levels of participation in advocacy.

However, there was no significant difference in clinical symptoms between individuals that participated in advocacy and those that did not participate in advocacy. It was hypothesized that higher social power and stability (e.g., being a man, having a higher level of education, having employment authorization, and having a more secure immigration status) would be associated with participation in advocacy. Two variables were significantly different when looking at differences between those that participated in advocacy and those that did not participate. Consistent with the primary hypothesis, time in the U.S. was significantly longer for those who participated in advocacy, $t(730) = 0.459$ (years), $p < .05$. Contrary to the primary hypothesis, having employment authorization was less likely, $t(713) = -0.197$ (percentage points), $p < .001$, in those that participated in advocacy.

Predicting participation

We hypothesized that greater participation in advocacy could be predicted by lower levels of trauma-related symptoms, male gender, higher levels of education, having employment authorization, and those that were not detained at entry to the U.S.. We found that while gender itself does not significantly impact participation in advocacy, adding controls including HSCL scores, marital status, years of education prior to arrival, and age at intake shows that being a male increases the likelihood of participation in advocacy by 10 percentage points (see Tables 6-10). The results of the regression indicated male gender explained 1.47% of the variance ($R^2 = .0147$, $F(1,294) = 4.39, p < .05$).

Those with a higher level of self-reported spirituality of 3-4 (as opposed to 1-2) were 5.4% more likely to participate in advocacy at the 10% level. This difference, however, was not observed when controlling for de-

Table 1. Participant Characteristics for Categorical Variables

Variable	Category	Advocacy Participants (N=75). n (%)	Non-Advocacy Participants (N=655). n (%)
Gender	Male	54 (72%)	433 (66.1%)
	Female	21 (28%)	222 (33.9%)
Marital Status	Married	45 (60%)	323 (49.3%)
	Not Married	29 (38.7%)	306 (46.7%)
	Missing	1 (1.3%)	26 (4.0%)
Education Level	More than 16 Years	20 (26.7%)	160 (24.4%)
	13 – 16 Years	30 (40%)	260 (39.7%)
	9 – 12 Years	22 (29.3%)	189 (28.9%)
	5-8 Years	1 (1.3%)	25 (3.8%)
	1-4 Years	0 (0%)	1 (.2%)
	Missing	2 (2.7%)	20 (2.3%)
Arrived on a Visa	Yes	32 (42.7%)	309 (47.2%)
	No	1 (1.3%)	34 (5.2%)
	Missing	42 (56%)	312 (47.6%)
Detained at Entry	Yes	2 (2.7%)	57 (8.7%)
	No	69 (92%)	525 (80.2%)
	Missing	4 (5.3%)	73 (11.1%)
Applied for Asylum	Yes	65 (86.7%)	550 (84.0%)
	No	10 (13.3%)	105 (16.0%)
Has an At- torney	Yes	42 (56%)	289 (44.1%)
	No	20 (26.7%)	185 (28.2%)
	Missing	13 (17.3%)	181 (27.6%)
Interpreta- tion Need	Yes	9 (12%)	132 (20.2%)
	No	56 (74.7%)	467 (71.3%)
	Missing	10 (13.3%)	56 (8.5%)
Housing Status	Stable	54 (72%)	389 (59.4%)
	Unstable	8 (10.7%)	85 (13%)
	Missing	13 (17.3%)	181 (27.6%)
Employment Authoriza- tion	Yes	28 (37.3%)	331 (50.5%)
	No	43 (57.3%)	283 (43.2%)
	Missing or Other	4 (5.3%)	41 (6.3%)
Spirituality Level	1-2	40 (53.3%)	242 (36.9%)
	3-4	22 (26.7%)	232 (35.4%)
	Missing	13 (17.3%)	181 (27.6%)

Table 2. Participant Characteristics for Continuous Variables

Variable	Advocacy Participants (N=75) M (SD)	Non-Advocacy Participants (N=655) M (SD)
Age at Intake (Years)	38.23 (10.32)	36.45 (9.76)
Spirituality Level (1-4)	2.77 (.80)	2.61 (.93)
Time in U.S. Before First Advocacy (Months)	17.1 (13.92)	N/A

Table 3. Descriptive Statistics of HSCL Scores for Advocacy Participants

Factors	N	Range	M	SD	Prevalence
Anxiety	48	1.00-4.00	2.17	.65	79%
Depression	48	1.00-4.00	2.21	.59	81%
Emotional Distress	48	1.00-4.00	2.18	.61	83%

Note: Prevalence was determined by a score equal to or greater than 1.75

Table 4. Descriptive Statistics of HSCL Scores for Non - Advocacy Participants

Factors	N	Range	M	SD	Prevalence
Anxiety	254	1.00-4.00	2.22	.75	68%
Depression	254	1.00-4.00	2.34	.75	74%
Emotional Distress	254	1.00-4.00	2.26	.67	73%

Note: Prevalence was determined by a score equal to or greater than 1.75

Table 5. Descriptive Statistics of HTQ PTSD for Participants

Category	N	Prevalence
Advocacy Participants	46	70%
Non-Advocacy Participants	219	68%

mographic variables including marital status, gender, age at intake, and years of education prior to arrival. Those being detained at entry were 8% less likely to participate in advocacy. This was significant at the 10% level. This difference, however, similarly was not observed when controlling for demographic variables including Marital Status, Gender, Age at Intake, and Years of Education Prior to Arrival.

Discussion

Survivors of torture seeking asylum in the U.S. face many challenges, including coping with the sequelae of their trauma while navigating the multitude of social and cultural obstacles

involved in resettling in a new country, often with minimal support. Despite this difficult context, some survivors have courageously engaged in advocacy efforts to bring attention to human rights issues relevant to their own personal experiences. This study sought to add to our understanding of the characteristics of survivors who engage in advocacy by examining demographic, social, and psychological data from survivors connected to a support agency that regularly facilitates advocacy events.

Based on theory, clinical insights, and past research around survivor advocacy (e.g., Herman, 2015; Laplante, 2007; Sadiq-Tang,

Table 6. Multiple Linear Regression 1

Variable	<i>B</i>	<i>SE(B)</i>	<i>p</i>
Constant	-0.009	0.086	0.920
Spirituality	0.042	0.029	0.150
Marital Status	0.042	0.029	0.152
Age at Intake	0.022	0.027	0.401
Years of Education	0.003	0.009	0.698
<i>n</i>	517		
<i>F</i>	1.72		
<i>R</i> ²	0.013		

Table 7. Multiple Linear Regression 2

Variable	<i>B</i>	<i>SE(B)</i>	<i>p</i>
Constant	0.118	0.013	<0.001
Detained at Entry	-0.082	0.044	0.062
<i>n</i>	626		
<i>F</i>	3.49		
<i>R</i> ²	0.006		

Table 8. Multiple Linear Regression 3

Variable	<i>B</i>	<i>SE(B)</i>	<i>p</i>
Constant	0.105	0.012	<0.001
<i>n</i>	686		
<i>F</i>	0.00		
<i>R</i> ²	0.000		

Table 9. Multiple Linear Regression 4

Variable	<i>B</i>	<i>SE(B)</i>	<i>p</i>
Constant	0.089	0.038	0.020
Gender	0.096	0.046	0.037
<i>n</i>	296		
<i>F</i>	4.39		
<i>R</i> ²	0.015		

2018; Stepakoff et al., 2015; Suarez, 2011; Weine 2006), we predicted that participation in advocacy would be associated with and predicted by factors indicating lower levels of trauma-related symptoms (e.g., PTSD, anxiety and depression) and higher social power and stability (e.g., being a man, having a higher level of education, having employment authorization, and having a more secure immigration status). Our findings provided some support for these predictions, although we found that most variables we investigated did not have any statistically significant relationship with engagement in advocacy, especially when controlling for other variables such as demographics and symptom scores.

Compared to the non-participants, advocacy participants were more likely to, at the time of their intake at the NCTTP-member agency in this study, have spent more time in the U.S. and not yet be authorized for employment. These differences may reflect that advocacy participants had more stability in and

familiarity with the U.S., given their longer period of living in the country, but also had more time available to engage in daytime advocacy activities given their employment status. Given the variation across survivors, and time between intake and time of advocacy, however, it may be the case that their employment status had changed by the time of participation, which was not captured in the available data, and some survivors may also have been engaged in informal (“under-the-table”) jobs.

Survivors who had not been detained at entry to the U.S. were more likely to participate in advocacy than those who had been detained (who may have felt more fearful of negative consequences from the U.S. government if they spoke out, and less secure in their immigration status; Keller et al., 2003). However, this difference did not persist once other demographic factors were taken into account, reflecting the higher incidence of detention among some groups of survivors who may face additional barriers to participation in advocacy.

Similarly, survivors who identified as having a higher level of spirituality were more likely to participate in advocacy. This may reflect a sense of moral compulsion, a spiritual meaning placed on participation (e.g., Boehlein, 2006), a sense of protection and guidance from a higher power when engaging in advocacy, or a broader sense of connection to and support from others through a spiritual community (noting that collective identity may be particularly salient for torture survivors—Kira et al., 2019). However, once again, this difference did not persist once other demographic factors were taken into account, which may reflect varying rates of spiritual identification among different groups of survivors who also share other motivations for or barriers to participation in advocacy.

Only one demographic characteristic appeared to most reliably predict advocacy participants, even after controlling for other factors: being a man. This may be attributable to a range of factors that could increase men's feelings of readiness, motivation, and ability to engage in advocacy, including gender norms in their countries of origin that may have made men more likely to have a history of being politically active and vocal; men feeling a duty and being more equipped to travel independently to the U.S. (potentially ahead of their families), and then less consumed with the daily tasks of caring for dependents once in the U.S.; or men being socialized to feel more empowered to speak out and more drawn to an action-oriented approach to channeling their thoughts and emotions (rather than to more private, in-depth interpersonal exchanges)—e.g., see Griffiths, 2015; Crawley & Lewis, n.d..

Significantly, symptom scores alone did not appear to predict participation in advocacy. Interestingly, however, men did appear to have lower symptoms of concern than the women in the sample, which may have contrib-

uted to their higher participation rates. Studies with torture survivors have been mixed on the connection between gender and clinically significant mental health symptoms. Some studies have found that female torture survivors often endorse higher levels of symptoms including depression, anxiety, and trauma (Chu et al., 2013; Song et al., 2018) while other studies found that gender was not a significant predictor variable (Bazaz, 2020; Carswell et al., 2011).

Implications

The findings from this study suggest that, although it may be the case that survivors feel more inclined to engage in advocacy or give testimony about their personal experiences if they are in positions of greater current stability and safety (as proposed in existing literature), survivor-advocates are diverse and not consistently differentiated from non-advocates by their demographic, economic, or psycho-social characteristics. Thus, such indicators should not necessarily be a “screening” criterion for participation, especially if taken alone. By focusing on specific aspects of a survivor's current situation or mental health, for instance, other important aspects of their lives that influence their engagement in advocacy may be missed. This may be especially important in the context of social support agencies that are organizing advocacy activities (such as the agency involved in this study), where survivors may be differentially encouraged to participate in advocacy efforts based on staff assessments—a process that may be either explicit or unconscious. It may be important to provide wider opportunities for engagement that help survivors overcome potential barriers (including both physical barriers such as transport, and internal barriers such as a lack of knowledge that speaking out in a public way might be something they *could* do in the

U.S.) A relational approach to understanding each survivor's unique context and motivations in a richer, qualitative way may also be helpful for facilitating engagement when and in the manner that survivors feel ready.

Our findings also point to the need for further conversation around potential concerns (consistent with a Western diagnostic perception of trauma as a disorder, invoking fragility; e.g., see Nickerson, Bryant, Silove, & Steel, 2011) that participating in advocacy may be "too much" or even detrimental to mental health. Although we adopted a cross-sectional design and did not specifically measure mental health indicators *after* advocacy participation, the measures we did include did not show a significant association between anxiety or depression and participation. Additionally, other recent research (e.g., O'Connor et al., 2021) suggests that although symptoms may be triggered around advocacy participation, the overall experience could be viewed by survivors as healing and positive. This suggests that symptoms may be only one aspect of a broader sense of "health", and that being "stirred up" may be inherent to the process of engaging in advocacy, but not an indicator of being broken or too fragile. Excluding survivors with higher levels of symptoms may prevent them from engaging in an activity that they have other strong motivations for—for instance, as an important form of healing, conscientization (Martín-Baró, 1994), ongoing connection to their homeland and community, or means of assuaging their sense of survivor guilt (e.g., Boehnlein, 2006; Agger et al., 2012).

Furthermore, it appeared that average levels of trauma, depression, and anxiety symptoms were clinically significant across the study's sample, indicating that those who are "doing better" may be outliers and are not necessarily representative of the survivor pop-

ulation—thus, they may have different advocacy messages to communicate, and if selected to speak on behalf of the community may not represent its full range of views. It is also important to note that survivors' trauma, unfortunately, is not solely located in their past; in the U.S. context there are many ongoing stressors involved in awaiting asylum outcomes, adjusting to a new culture, and coping with racism and other forms of systemic oppression, all of which can contribute to chronic traumatization (O'Connor et al., 2021). Those less distressed by these stressors may have different concerns to share compared to those who are deeply affected by them but nevertheless still motivated to advocate.

Importantly, this study's findings also suggest that men may be overrepresented among survivor-advocates, reinforcing societal privileging of male perspectives and their resulting ability to shape policy. It is important to pay close attention to who is being left out of advocacy opportunities (Waxman, 2003)—for instance, if women's voices are less heard, or if people who are more expressive in their grief are held back from public advocacy spaces because of the potential discomfort of the audience, key messages in our ongoing efforts to prevent torture and to support individual and societal healing from torture may be missed.

Limitations

The above suggestions should be viewed with this study's limitations in mind. Despite examining data from a relatively substantial, multi-year, sample of survivors, the variables included in our analyses were limited to those historically collected by the NCTTP member agency at the point of service intake and were reliant on the level of detail collected. As a result, some of the measured social factors (e.g., employment or housing status) may

have changed by the time that survivors participated in advocacy. There may also have been several important factors that influence participation that were not included in our analyses (e.g., situational factors such as not receiving emails notifying them of advocacy opportunities or not being around people who were talking about upcoming opportunities, background factors such as types of torture experienced or past advocacy activities in country of origin, or logistical factors such as current transport or support in caring for dependents). Additionally, some of our analyses were limited because psychological measures were not completed by all survivors, perhaps owing to the additional time involved in completing these multi-item assessments; in the context of a busy service and when social needs are pressing, detailed mental health assessments may be a lower priority to complete, especially if not directly related to accessing priority services.

Another contextual factor that may limit this study's generalizability is its connection to a specific agency and geographic region; the agency's historical trajectory (initially established by a survivor who was strongly engaged in advocacy, and expanding to provide psychosocial services over time, in contrast to other agencies that may initially have been developed as health service providers) and its location on the U.S. East Coast where there is a larger population of survivors with certain countries of origin (e.g., Ethiopia), and where there are more accessible opportunities for high-profile advocacy and political engagement may have influenced the likelihood of participation in advocacy in ways that this study did not capture. Additionally, the results may not be generalizable to forced migrant populations who were not politically persecuted or not as politically or socially active prior to migration.

Recommendations

To better understand longer-term patterns and impacts of advocacy engagement among survivors, it is important to have increased ability to follow survivors' wellbeing and advocacy activities over time. Clinical settings such as torture treatment centers do not necessarily collect data in a systematic way, are responding to survivor needs in the moment, and the impact of their services is not necessarily well captured. Thus, although larger-scale quantitative studies across centers could further test and expand on this study's findings, such investigations may also be limited in their ability to explore determinants and outcomes of survivor engagement in depth.

Future research could usefully expand our understanding of survivor engagement in advocacy by exploring the stories of advocates in more depth (e.g., using qualitative approaches) to gain a richer understanding of their characteristic features, what influenced their participation over time, and both the costs and benefits of speaking out publicly in the shorter and longer terms. Spirituality and its connection to advocacy could be a particularly rich avenue to explore. Multiple time point studies with pre- and post- testing around advocacy engagement could also help to better measure potential changes associated with participation. It would also be helpful to have further consideration of the focus, type, audience, and content of the advocacy (noting that the advocacy in this study involved speaking to political staff, with a focus on briefly sharing personal experiences and addressing contemporary human rights issues).

Additionally, it is important to further investigate potential barriers to participation by exploring the experiences of those who have not participated in advocacy, focusing in particular on women's experiences. As future planning around advocacy efforts takes place,

researchers, clinicians, and human rights supporters could all invest further in survivor-centered discussions around the factors influencing participation, what different groups of survivors want to see represented in advocacy messages, ways in which forms of leadership and advocacy might look different across different cultural groups and between genders, and what visibility as a survivor means in a public space.

In terms of practice, study findings suggest that survivors who report interest in participating in advocacy should not be discouraged or prevented from doing so even if they also present with high symptoms of distress or other variables that may be associated with higher levels of post-migration psychosocial stressors (i.e., employment, housing, language, etc.). Instead, it is recommended that programs take a survivor-centered approach to supporting advocates before, during, and after their advocacy experiences to help manage and make meaning from their experiences. If programs do not cast a wide net in advocacy participation, they run the risk of potentially selecting advocates that are not representative of the population of torture survivors as well as potentially limiting access to what can be a meaningful experience for survivors themselves.

Conclusion

In summary, this study has contributed to our evolving understanding of survivor engagement and advocacy by highlighting the complexity behind participation. When controlling for demographic variables, there was no single factor that distinguished survivors who participated in advocacy from those that did not participate. However, it was found that those who participated in advocacy were more likely to be male when controlling for other demographic and symptom variables. Thus, participation largely cannot be attrib-

uted to any one factor, which has implications for future research and practice with survivors of torture. In particular, more qualitative and longitudinal lines of research, as well as studies covering a wider survivor population, are needed to build a more detailed understanding of survivors' experiences when engaging in advocacy, and the potential risks and benefits involved. In practice settings, findings from this study can be drawn on to inform further survivor-centered programming that incorporates advocacy as a central element for survivors who would most benefit from it. Researchers and practitioners should also make a concerted effort to understand why men are more represented in advocacy and how to amplify the voices of female torture survivors. All of these efforts are essential in our collective, survivor-led work to build a world in which torture no longer exists.

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