Article

Contextualising therapeutic care for child survivors of sexual violence in situations of war: a reflection on theory, context and practice

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Abstract

In this article, the author sought to raise awareness of and discuss ways to effectively address contextual challenges faced by mental health workers who provide therapeutic services to child rape survivors in war-affected regions, in general, and in the cultural context of the eastern region of the Democratic Republic of Congo, in particular, where rape is considered a sexual taboo, causing or amplifying attachment issues for survivors. A qualitative analysis of current literature review and therapeutic practice has been conducted in this article. Two cases are presented to illustrate contextual challenges. The analysis of case one focuses on ethical dilemmas between asserting professional boundaries and addressing clients' needs in situations wherein there are no alternative resources beyond the therapist's scope of practice, whereas the analysis of case two focuses on relationship and attachment challenges for survivors because of the interpretation of rape as sexual taboo. It was observed that, given extraordinary contextual challenges, therapists who assist child survivors in war-affected zones interact with their clients beyond their offices. Connecting at an empathy level alone is not enough. It also takes the therapists' ability to demonstrate compassion and creativity in their effort to facilitate the healing journey of their clients.

Key implications for practice

- This article draws attention to wartime child rape and its context-specific consequences on the survivors' attachment security.
- Awareness is raised of the cultural context and ethical challenges surrounding the practice of therapeutic care for child survivors in war-affected regions.
- Observed limitations are reported to the Western model of therapeutic relationship and the requirement of compassion and solution-driven creativity by therapists beyond empathy for a more contextualised and effective support of their clients.

Keywords: child survivors, contextual challenges, rape, therapeutic approach, war

Introduction

This article reflects on therapeutic care for children and youth who have suffered sexual violence in war contexts. It builds on the attachment theoretical framework to discuss challenges and sources of healing for the survivors. It reflects on observations from an ongoing empirical research programme[1] conducted in the eastern region of the Democratic Republic of Congo (DRC), where rape as a weapon of war has been documented, with a significant number of survivors being young girls. It also draws on field observations during training and supervision sessions for psychologists and psychosocial workers in the region.[2] A case discussion illustrates cultural and societal challenges to effectively provide therapeutic services to survivors. A second case discussion, based on therapy sessions with Anna, a young, female survivor of sexual violence[3] illustrates a number of challenges faced by child survivors as social beliefs about rape weaken their attachment relations.

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Materials and methods

This work is a qualitative analysis of scientific literature mainly focusing on childhood trauma and healing. The author searched for scientific works on wartime sexual violence against children, but publications on this topic are extremely rare. The keyword-combination search included '*war*', '*armed conflict*', '*wartime rape*', '*wartime sexual assault/abuse/violence*', '*cultural context*', '*child victim*', '*child survivor*', '*attachment theory*', '*therapy*', '*therapeutic care*' and '*treatment*'. Exclusion criteria included '*women*', '*adult*' and '*men*'. Over 100 articles and books were found related broadly to the topic; the author has cited 29 in this article based on their relevance to the content discussed herein. Search engines included the University of Ottawa's database 'PsycINFO' and Google Scholar, as well as books and textbooks from Saint Paul University's library. A time limit of twenty years was set for the works referenced, except for classic and pioneer works such as those published in the developing years of attachment theory. Besides the scientific literature review, the qualitative analysis builds on field experiences such as clinical training and supervision sessions, as well as therapy sessions, reflecting on therapeutic practice for child survivors of rape and contextual challenges in the eastern region of the DRC.

Impact of sexual abuse on child development

In the past decades, wars have not spared populated areas nor have they spared civilian population as targets for military operations. From indiscriminate mass killings to ethnic, cultural and ideological genocides, war antagonists have also used rape as a weapon of war and genocide (Erikson Baaz & Stern, 2013; Maisha, Demasure, & Malette, 2017a; Rittner & Roth, 2012), causing extremely high numbers of civilian casualties, young and old, men and women. The impact of sexual violence on child development is well documented in scientific literature (Mullen, Martin, Anderson, Romans, & Herbison, 1996; Srinivasa & Rashmi, 2006). Among affected developmental areas are the perceptions of self and other, as expressed by some survivors who describe sexual violence as *a soul murder*. Both perceptions of self and other are critical in establishing relationships based on a secure attachment, where, in the case of adults, mutual needs are met and healing of psychological wounds happen (Doucet & Rovers, 2010; Rovers, 2005).

War-related sexual violence on children: the current state

Consequences of sexual violence are more complex in the situation of war as the assault is usually committed with extreme atrocity and is often coupled with other forms of violence imposed on the victims, including the collapse of their support system, death of loved ones, poverty due to forced separation with parents and looting (Maisha, 2017; Maisha, Demasure, & Malette, 2017a). Moreover, during wars, sexual violence has historically been considered as collateral damage and therefore minimised, making victims' therapeutic care less of a priority. In the case of DRC, for example, in general, care is provided when the attacker physically wounded the victim leading to medical treatment. Overlooking child sexual violence in situations of war tends to be a universal issue. In fact, during the scientific literature search for this article, it was observed that very limited research has focused on assessing the direct impact of wartime rape on child survivors or identifying therapeutic needs for their psychological recovery. As a matter of fact, our keyword base search in PsycINFO and Google Scholar returned more articles dealing with war-related trauma, in general, and very limited on child rape. When mentioned, it is mostly about statistical reports or as products of rape – that is, children born from rape. There is, therefore, a scientific knowledge gap in understanding war-related sexual violence committed against children, making it even more difficult to find adequate theories that specifically focus on how to best support child survivors' recovery. This explains why our discussion in the current article is mostly founded on a literature review of children and war-related trauma in general, while also discussing research field and clinical observations during our work visits in the DRC.

Impact of war trauma on children and current debate on therapeutic approaches

War has an extreme impact on children due to risks of its events shaping their worldviews. Their development is brutalised; some are born and grow up to become adults in the same cruel environment of war. Their social values are founded on war culture: *'the implication is of damaged psychologies and moral norms and of diminished humanity'* (Summerfield, 2002, p. 1105). Moreover, the war context renders children extremely vulnerable to repeated violence, including sexual violence especially in the case of girls, as the family and social protection structures are broken (Plunkett & Southal, 1998). Prostitution and rape of underage girls is common in refugee camps and around military camps, in part, because of perceived low risk of the children carrying HIV virus given their young age (Plunkett & Southal, 1998). It is understood from consulted literature that, besides posttraumatic stress disorder (PTSD) symptoms that most child survivors will exhibit, those attacked in the context of war also face a generalised moral vacuum, exposing them to normalising inhumane attitudes and behaviour. This creates an existential crisis for these children with a distorted perception of humanity. Available literature raises questions about approaches used to assess and treat trauma among children in war-affected countries, whether these approaches can effectively help to understand and address social and cultural factors contributing to the suffering (Jones, Rrustemi, Shahini, & Uka, 2003; Miller & Rasmussen, 2010). As Jones et al. (2003, p. 540) put it, *'Mental health services that only address traumatic stress may fail to meet the needs of war-affected children.'* These approaches may not fully grasp the meaning of events as seen through social lenses of survivors: *'[a] comprehensive, culturally appropriate CAMHS [child and adolescent mental health service] is needed to address a wide range of problems.'* In fact, most post Second World

War armed conflicts are civil wars (Summerfield, 2002)[4] in developing countries where many of the acclaimed therapeutic approaches that address trauma have not been validated. Given the significance of social factors and their amplifying role in survivors' suffering, it is important to assess the contextual adaptability of therapeutic services provided.

Helping beyond help? Compassion and ethics-related dilemma

Therapists who care for child survivors in war situations have reported multiple contextual challenges in their therapeutic relationships. The children face amplifying issues due to lack of adequate state-sponsored services and loss of family relationships due to forced displacement, death or rejection/neglect founded on cultural interpretation of rape. *'Sometimes I have to wear the hats of a therapist, a father to my client and a father to her child born of rape, a paralegal, and many others to address urgent needs beyond therapy,'* stated a participant during a training session in the DRC, in May 2018. How do therapists help beyond therapy? In some contexts, where state and community services are well established, this is an important question with a simple answer: 'referral'. This is because knowing where to draw the lines in a therapeutic relationship is critical for a successful therapy; it is more so with children given the developmental vulnerability of younger clients and higher risk of compassion fatigue for their therapists (Negash & Sahin, 2011). Referring a client to other professionals or community services is hence an important clinical and ethical skill for therapists who must be aware of their own professional boundaries. In regions ravaged by war, however, children and their therapists have very limited, if any, places to find needed help beyond therapy. The tendency is that psychologists and psychosocial assistants become more than therapists to their clients and transgress what would be regarded as professional boundaries. This is a common topic among psychologists and psychosocial assistants in the DRC as illustrated by the following story reported by *Eunice*, a participant in one of our training sessions whose real name is not being reported for confidentiality reasons.

'*I worked with an eight-year-old girl whose single mother of other four (four other) children brought her to the centre after she was raped and rejected, people in the local community referred to her as the "wife of commander XXX" (the army officer's name is not being reported for confidentiality reasons and for the safety of the victim and her family). The child believed this – she had introjected the social categorisation – and she referred to herself as "useless wife of commander XXX". Her mother left her with us and she became very attached to me. When her hospital stay was over, she had nowhere else to go. Her mom had returned to the village and was not coming back. I took the girl to my house and started caring for her just like my own child. I then looked for her mother who eventually came to the city as she managed to find a temporary caregiver for her other children. She had a serious financial problem and asked me to help her. I asked her to stay with my family and work as a housekeeper. I paid her a monthly salary and she was able to save enough money to buy and resell a few basic items; she eventually went back to the village with her daughter and reunited with her other children.*'

Case analysis: implications for ethics, context and practice

One may say that the therapist in the case above was very passionate about her job to support child survivors and their family in their healing journey; their wellbeing is very important to her, and she does all she can to facilitate that. This is every good therapist's goal. In the case of Eunice, however, her actions are of survival. She cannot imagine what would happen to her young client who became strongly attached to her if she does not act out of her own means because '*because there is nowhere else to turn*'. Although her actions may be performed in good faith, they go way beyond a traditional therapist–client relationship, which distinguishes between professional and personal lives, restricting the relationship to professional obligations only. It is not so simple for Eunice and her colleagues to care for child survivors in the context of war. Scholars have established a difference between empathy and compassion. The first refers to a person's ability to access another's mental state through perspective taking or emotional contagion, whereas the second goes further, emphasising helping behaviour aimed at alleviating another person's suffering (Barrett, Lewis, & Haviland-Jones, 2016). On one hand, it can be favourably argued that Eunice's actions were founded on strong empathy and compassion, as well as a deep understanding of contextual challenges calling for every capable member of the community's involvement to support the most vulnerable among them. Considering contextual challenges described earlier, Eunice's client had limited organisational resources and could only count on people of good will in her community to help with her complex situation. Like many of her colleagues, the therapist decided to lead on this role as a member of the client's extended community. In doing so, it can be argued that she used herself as the tool towards an effective and holistic healing journey for her client and the latter's family. She showed both empathy and compassion. Although the extent to which the therapist let her client get involved in her personal life deserves to be re-evaluated; she showed an important clinical competence – the effective use of self in her role as a therapist to support the client's healing process. It remains debatable whether this was safe for both parties in the relationship. Assuming it was, Eunice's actions, analysed through her social lenses, can be interpreted in relation to a safe and effective use of self, defined by the College of Registered Psychotherapists of Ontario as *'the psychotherapist's learned capacity to understand his or her own subjective context and patterns of interaction as they inform his or her participation in the therapeutic relationship with the client'* (Gianvito, 2018, p. 4). On the other hand, Eunice went too far in her professional role as a therapist, by

taking on multiple roles with conflicts of interest. Besides being the child therapist, she became a mother figure to her, meeting attachment needs unrelated to therapeutic work. She also became the employer of the child's mother and hosted both of them in her own house. This is ethically questionable. Whether one sees Eunice's actions as an illustration of strength or weakness in her professional abilities is up for debate. Nevertheless, those actions exemplify the uniqueness of the therapeutic relationship in areas affected by wars. Being empathetic is not enough; being compassionate is an essential skill to effectively provide therapeutic services to survivors in these areas (Ugeux, 2015). In other words, doing therapy requires an adaptation of the service to the context and help beyond the traditional understanding of therapy. It is relating and engaging with the client beyond the office. Of course, there still needs to be defined boundaries allowing therapists and agencies providing mental health support to make sure the safety and wellbeing of their clients remain their number one priority as they navigate contextual challenges. As for their own wellbeing, among many risks, helping beyond their professional role exposes therapists to feeling powerless given the complex needs (economic, safety related, developmental) presented by most of their clients. In fact, it is very common to hear about compassion fatigue among therapists working with clients who have faced traumatic events (Craig & Sprang, 2010; Meldrum, King, & Spooner, 2002). It is more so for therapists such as Eunice and her colleagues whose clients' expectations are beyond those of trauma survivors in industrial countries where therapists' professional skills and competencies are supported by a network of support services. These therapists may benefit from peer supervision[5] allowing them to discuss cases among themselves and receive mutual support and guidance on cultural- and societal-specific challenges.

Pertinence of psychological therapies

Although the challenges discussed above call for a more adapted and flexible approach to effectively address contextual needs in therapy, consulted scientific literature provides a range of intervention goals that can be explored with children affected by war. Jones et al. (2003) found that psychological therapies are relevant for children presenting more serious mental health symptoms or behaviour problems in Kosovo where they found that approaches such as family systems and cognitive behavioural and play therapy were complimentary to traditional therapies when these have shown limitations. In post apartheid South Africa followed by Rwanda and Yugoslavia, Summerfield (2002) reports therapeutic gains from PTSD symptoms based on survivors' emotional reaction. The study, on p. 1105, reports that negative *'emotional reactions of people affected by war are perceived as harmful to themselves and dangerous to others.'* Therefore, interventions based on emotion regulation and modification through positive thinking will contribute to alleviating war-related PTSD symptoms. There are reports on applying this approach on a community scale in Rwanda and former Yugoslavia (Summerfield, 2002).

We will now explore the pertinence of attachment theory and its notion that healing from childhood trauma is possible through healthy relationships where internal working models can be remodelled (Doucet & Rovers, 2010; Rovers, 2005).

Attachment-based therapy for survivors: healing relationships

A brief look at attachment theory

Attachment theory, an approach that focuses on the quality of the relationship to the early-life caregiver in shaping how an individual views and engages with his environment, was pioneered by John Bowlby and Mary Ainsworth in the mid-20th century (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1954, 1958). At the centre of this theory is the concept of internal working models resulting from experiences with the primary caregiver (Bowlby, 1954, 1958). Depending on how the caregiver makes herself available and responsive to the child's attachment needs, the child will develop beliefs such as *'I am loved or not; my needs are important to my caregiver or not; and my needs can be met by my caregiver or not.'* Affirmative answers to these questions will allow the child to develop a secure attachment and take the risk to explore the world, knowing that she or he can count on the caregiver's support, if necessary. Internal working models include, among other aspects, beliefs, attitudes and expectations about self and others developed through relationship experiences (Guédeney & Guédeney, 2009, 2015). They reflect the concept of self, one's identity as formed from internalised messages. In the context of war, it is important to assess the impact of the deterioration of social norms on the quality of relationships and attachment security. In fact, prolonged exposure to traumatic situations can have lasting impact on the internal working model, including distorted beliefs due to normalisation of negative behaviours and social interactions. Therefore, the war context and its impact on cultural norms pose serious challenges in experiencing safe and nurturing interpersonal relationships.

The therapists practising from an attachment perspective know how important it is to have a caring, nurturing relationship where individuals feel emotionally and physically safe, a secure attachment-based relationship (Bowlby, 2005; Johnson, 2004; Rovers, 2005). They also understand the consequences of suffering violence and neglect of one's needs at the hands of a trusted person, such as a parent and a partner, leading to feeling unworthy or insecure in relationship with current and future attachment figures. As we stated earlier, most of recent wars have taken place in developing countries where collectivist views fundamentally shape one's concept of self, their identity. In these cultural contexts, influence on internal working models goes beyond the quality of relationship with the primary attachment figure; relationships to one's family, family in-law and community are also instrumental in shaping and reshaping the individual concept of self in relation to the collective self. It is worth noting that these two concepts of

self are interdependent and equally important for individual and collective wellbeing. Does attachment theory provide relevant knowledge for therapeutic care with child survivors of rape in the cultural contexts described above? Although attachment theorists' focus would be on how a single relationship to a primary attachment figure shapes the individual concept of self, it is important to emphasise the concept of relating safely and dependably as a critical element in developing a secure attachment where survivors will feel acknowledged, elevated and perceived positively, so that they can overcome their shame and develop more positive views of self (Munford & Sanders, 2015). In collectivist societies, a secure attachment for child survivors of rape implies social acceptance of and self-acceptance by the child as a normal human being who belongs to their family and community (Maisha, 2017). As illustrated in the case of Anna below, social practices rooted in cultural views of pre-marital sex, including rape, as a sexual taboo, a source of defilement and danger to self and others (Maisha et al., 2017a), contributed significantly to a mistrust between the survivor and her attachment figures (both primary and secondary), leading to a more complex situation where she not only had to endure suffering from rape, but also found herself in conflict with her family and community.

Anna[6]

Craig and Sprang (2010) states, '*On a beautiful day of August 2015, in the eastern region of the DRC, Anna is excited as she goes to her mother's village to attend her cousin's wedding. Once there, she goes to look for firewood in a nearby field. Unfortunately, a village militiaman finds and rapes her. Angry, Anna's family confronts the rapist's family and demands that he marries her as she has been defiled by his actions. In the process, Anna is forced to recount the rape situation in front of a crowd gathered for the matter; she feels humiliated and blames her family. As the marriage[7] talks continue, Anna endures extreme stigmatisation from the community which blames "the bad girl in her". "She's not from here, she has bad habits and makes up stories of rape", she recalls people saying about her. The situation became unbearable for Anna and her family. In an attempt to avoid further shaming and stigma, Anna's parents send her to live in the city under the care of one of her cousins. Sadly, the cousin renews criticism of Anna, doubting her story and blaming her for the rape. She has no choice, but to go back to the village. Upon her return, the parents observe a drastic behavioural change: she has become very oppositional, insulting her mother, saying that her brother is planning to kill her and refusing to share meals with other members of the family. She even denies her parents. During a therapy session, Anna says of her mother: "I cannot say anything in the presence of this woman, this witch. She must leave first, she has nothing to do with my care, and I do not even know her. She is not my mother. My mother is Mary, and Rome is my home. I do not know this woman". Anna's father, who has not attended therapy sessions with his daughter, is reportedly alcoholic, emotionally absent and does not fulfil other parental responsibilities such as securing finances for his children's basic needs and school. To the family, Anna has gone crazy; she needs to be treated. This is what brings them to a mental health clinic run by the Catholic Church in the nearby city. There she finds psychotherapeutic and biopharmaceutical care. She also participates in spiritual and field activities. New attachment figures, her ergo therapy session facilitator and a nurse, are established and provide a great improvement in Anna's condition; but they are only temporary!*'

Therapists reading Anna's case will note (a) the drastic change in behaviour, (b) the repeated traumatisation (rape, public humiliation, stigma by the community and the family), (c) the mistrust and attachment issues with family and community members – leading to relying on new and secondary attachment figures (hospital personnel, Mary and Rome), (d) the unhealthy family environment (alcoholism, neglect) prone to causing complex trauma (Gibb, Chelminski, & Zimmerman, 2007; Greger, Hanne, Myhre, Klöckner, & Jozefiak, 2017), (e) the apparent psychotic and dissociative episodes and (f) the tendency of paranoia. Anna's case reveals serious impact of rape or an amplifying role of rape on her attachment; it also shows that reintroducing a new model of relating that is accepting and safe can be a starting point for healing.

Who are the attachment figures for child survivors in the cultural context affected by war?

Parents (mostly the mother) are described as the primary attachment figure. However, in collective communities in countries affected by most recent wars, secondary attachment figures can also play a significant role in shaping a child's worldview. These other attachment figures include cultural and ideological symbols or personages, teachers, extended family members, siblings and even neighbours. In the case of Anna, both primary and secondary attachment figures reacted in such a way that she cannot trust most of them, except Mary, symbolising her Christian faith, the ergo therapy session facilitator and one of the nurses caring for her. Even therapists had difficulties establishing a strong therapeutic alliance with her given the legal obligation to obtain her parents' consent before they can work with her. She refuses to allow individuals she can no longer trust to have anything to do with her therapy; another way to say that only a trusted person can be expected to support her healing. Anna expresses the need to feel safe with people who surround her as fundamental to her care and healing. Like Eunice's client, Anna's family and community's reaction to the rape situation has caused a serious crisis of attachment to the family and community of origin. The hospital personnel became necessary alternative attachment figures to allow healing. Both situations are an indication that therapists working with child survivors in cultural contexts where rape is regarded as sexual taboo must take into account the attitude of the family and community; the client's long-term healing depends on whether the family and community can be safe and nurturing environments for her again (Maisha, Malette, & Demasure, 2017b). These cases have shown that multiple challenges stemming from

cultural views and institutional shortcomings demand adaptability of therapeutic services.

A holistic and adapted approach complementing empathy with compassion

Miller and Rasmussen (2010) compared trauma-focused and psychosocial approaches based on their levels of effectiveness in addressing mental health needs of people affected by war trauma. Although the first focuses on direct exposure to war violence and destruction, the second primarily focuses on the stressful social and material conditions caused or worsened by armed conflict conditions. These include poverty, malnutrition, displacement into overcrowded and impoverished refugee camps, strife and divisions within communities, the destruction of social networks and the resulting loss of social and material support, and the ostracism and struggle for survival of groups such as former child soldiers, widows, sexual assault survivors, orphans and people with war-related disabilities. Observations from our training and research trips are that, in the eastern region of the DRC, child survivors' care requires a combination of treatment for psychological distress, as well as the psychosocial needs such as those Miller and Rasmussen (2010) have identified. As discussed in the cases above, adaptation of therapeutic approaches to the context and flexibility or creativity on the part of therapists are also key in providing effective care to child survivors in war-affected regions. Indeed, understanding the needs of child survivors of rape in the context of war requires exploring beyond traditional psychotherapeutic approaches, beyond a counsellor's office. Summerfield's (2002, p. 1107) statement is of great relevance to this clientele. As the author puts it:

'*Recovery is not a discrete process: it happens in people's lives rather than in their psychologies. It is practical and unspectacular, and it is grounded in the resumption of the ordinary rhythms of everyday life – the familial, sociocultural, religious, and economic activities that make the world intelligible.*'

Conclusion

As Plunkett and Southal (1998, p. 73) put it: *'Rape as a crime of war is not restricted to adult women.'* It is our hope that this article sheds a light on the use of rape as a weapon of war against children and teenage girls and on the complexity of their care due to their age-related vulnerability and contextual challenges. In war zones and around refugee camps, younger girls are particularly vulnerable to rape. Owing to the endemic presence of sexually transmitted diseases (STDs), including AIDS, they are preferred over more mature women as they are considered to be of lower risk (Plunkett & Southal, 1998). Young girls are sold as a commodity to the rapist by the family in response to economic hardship. This forms a wound between the girls and attachment figures who would have been a support for healing. Also, when they are spared, children are often forced to witness the rape of loved ones (Maisha et al., 2017a). The war leaves deep scars on families and communities; it leaves even deeper scars on children leading to a multidimensional long-term crisis. Perverted social norms and values have a severe impact on the concept of identity. When it comes to therapeutic care for child survivors in situation of war, this article has emphasised the need for practice adaptation, with therapists needing to demonstrate three key competencies: empathy, compassion and solution-driven creativity for a more effective support of their clients.

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[1]This qualitative, grounded theory-based, research programme has been ongoing since 2014. The first round of data collection and analysis was completed in 2016 that resulted in the publication of two books, an article and a book chapter. Three of these publications have been cited in this article. The second round of data collection and analysis started in 2017 and is expected to conclude in 2019.

[2]Dr. Maisha has conducted several work-related trips to train and work with mental health workers and conduct research in the DRC since 2014. The latest trip was under a consultancy contract with War Trauma Foundation in May 2018.

[3]Anna is a fictitious name of a young girl who was raped while searching for wood in the bush; her unidentified aggressor is believed to be a member of a militia group. The real identity of Anna has been concealed for confidentiality and safety reasons.

[4]The author reports that 90% of recent wars are civil.

[5]I would like to mention that in October 2018, War Trauma Foundation funded a training on peer supervision for therapists at the Panzi Foundation in DRC; the training, which was very well received by therapists and psychosocial workers there, and was delivered by Linda Verhaak and myself. It was a confirmation of the relevance for peer supervision in the context of war and limited resources.

[6]The real identity and the name of the city have been withheld to protect the safety of Anna and her family.

[7]Anna's case exemplifies the issue of rapists marrying victims in rural parts of the DRC, as a way to restore honour to the latter's family. This practice is also observed in other parts of the world as reported by Getahun (2001).