Scars Without Wounds: Cumulative Mental Harm and the Limits of IHL

2 OCTOBER 2026

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This blog post highlights the latest issue of the *International Review of the Red Cross*, which examines mental health during armed conflict. An interesting statistic shows that one in five people who have experienced war in the past decade lives with a mental health condition(World Health Organisation, 2024). However, while casualties in Gaza, Sudan, and Ukraine are counted, the mental impact remains largely unquantified. The question is not whether international humanitarian law (IHL) protects mental health (it does), but how to operationalise these safeguards.

Who bears the harm?

The uneven distribution of harm has both legal and humanitarian significance. The Review's editorial identifies groups with particular mental health and psychosocial needs, including individuals wounded by weapons, families of the missing, persons deprived of liberty such as prisoners of war, and survivors of torture or sexual violence (Andersen et al., 2026, p. 656).It also highlights humanitarian workers' potential 'triple burden': they belong to affected communities, operate within conflict zones, and are continually exposed to the suffering of victims and survivors (p. 656). Displaced populations and those subjected to protracted conflict are even more vulnerable to mental harm, still (Diamond & van Benthem, 2026, pp. 775-777). Thus, these patterns of vulnerability are predictable, and in IHL, what is knowable becomes, in effect, foreseeable. As such, they should inform both the legal and the operational assessment alike.

What IHL says

Protections of civilians during armed conflict, including against forms of psychological harm, are already included in international treaties. Geneva Convention III (GC III) forbids "physical or mental torture" (1949, art. 17). Geneva Convention IV (GC IV) forbids "physical or moral coercion" (1949, art. 31), "moral coercion" being the older version of what we now call "psychological coercion". Additional Protocol I (AP I), applicable during international armed conflicts, prohibits acts or threats of violence whose primary purpose is "to spread terror among the civilian population" (1977, art. 51(2)). Similarly, in non-international armed conflicts, this prohibition is found in AP II (1949, art. 13(2)).

At first glance, this legal framework appears protective. However, the difficulties lie in the interpretation. The prohibition on terror depends on the primary purpose, including acts or threats of violence primarily intended to spread terror, compared to the fear ordinarily accompanying hostilities. Similarly, "injury to civilians" in the proportionality rule (AP I, art. 51(5)(b)) does not refer exclusively to physical injury, yet whether incidental mental injury may enter the proportionality assessment remains contested (ICRC, 2016, p.35).

Harm that accumulates

Diamond and van Benthem (2026) shift the subject from one strike to the accumulation of many: mental harm following, directly or as reasonably foreseeable indirect consequences, from a series of events in a party's military operations (p. 762). Additionally, they note "operations" rather than "attacks" deliberately, and it stretches to evacuation orders or closing an aid centre (as a military operation) (p. 763).Their argument rests on already-existing law, such as general protection of civilians (art. 51(1)); the duty of constant care (art. 57(1)); and proportionality.

A right, not a relief item

As Hassine (2026) observed, mental health is an inseparable part of the right to health under art.12 of the ICESCR, and that Covenant carries no derogation clause allowing a state to set these duties aside because a war began (p. 785). Human rights law continues to apply alongside IHL, wherever a state has jurisdiction or effective control, occupation included (p. 786). A person needing care is therefore a rights-holder, not the beneficiary of someone's goodwill.

Recognising these rights does not resolve the implementation challenges. The editorial acknowledges that mental health and psychosocial support (MHPSS) remains difficult to implement, as integration from the outset of humanitarian responses is still challenging. Specialists are scarce, and the evidence base for effective interventions in complex conflicts remains limited (Andersen et al., 2026, pp. 655,656). Hassine adds that fragmented data and monitoring systems impede documentation and accountability (p. 796). Thus, a right that is not measured may be, in effect, a right that is not enforced.

Conclusions

This post did not intend to find a definitive answer, but to compare the different perspectives with the written law. Diamond and van Benthem argue that AP I already requires a party to assess the mental harm its operations accumulate, and the duty of constant care being more demanding as it is applies continuously, compared to the proportionality requirement. Further, since the ICESCR admits no derogation, this obligation is reinforced rather than replaced by a right binding in peacetime and in war alike. What is missing is therefore neither a rule nor a right, but their implementation, and the resources and access any assessment of harm, services and compliance requires.

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