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Incidental mental harm through a decolonial lens: A culturally and contextually sensitive implementation of the principle of proportionality

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Abstract

Conflict-affected populations experience harms beyond those to life and limb, yet narratives about the effects of attacks remain dominated by war's physical impacts. This

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article highlights the incidental mental harms of war, which are not necessarily the objective of an attack but which can nevertheless be devastating to those affected. It proposes a critical analysis of international humanitarian law's principle of proportionality in attack through a decolonial lens. Among the rules regulating the conduct of hostilities, proportionality has attracted attention for its protective potential against incidental mental harm, but its interpretation remains the subject of fierce debate. This article argues that mental harm should be considered in jus in bello proportionality assessments, but not in a manner that undermines the decolonizing global mental health agenda. A decolonial lens reveals that some legal interpretations encourage the consideration of incidental mental harm in decisions of attack, but only for a fraction of the mental harms experienced in conflict (such as post-traumatic stress disorder or a traumatic brain injury), thus omitting much of the lived reality of mental harm. These interpretations might succeed in deconstructing the hierarchy between physical and mental harms, only to replace it with one between types of mental harms – a hierarchy that privileges and prioritizes Western understandings of mental health. Rather, this article posits, the application of proportionality should centre localized and socio-culturally appropriate notions and experiences of mental harm.

Keywords: mental health, international humanitarian law, decolonial, civilian harm, principle of proportionality.

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Introduction

No part of life goes unimpeded by the devastation of war, but narratives of the negative impacts of war are dominated by physical harms – harms to life and to limb – and are often reduced to counting the number of individuals killed or injured. Yet, for every casualty statistic in conflict, there are countless more who have been harmed in a less visible but no less poignant way. This article draws attention to the overshadowed yet extensive mental harms of conflict; the one in five in conflict-affected populations who experience a mental health “disorder”¹ and the many more who experience mental harm beyond “disorder” categories, which are constructs centrally reflected in major clinical approaches to mental health diagnosis and treatment.² Many devastating mental harms occur when civilians are not intentionally attacked,³ and these are thus referred to as incidental (or collateral) harms. Although the distinction between incidental and intended harms is key for determining the

- 1 Fiona Charlson *et al.*, “New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis”, *The Lancet*, Vol. 394, No. 10194, 2019, p. 244.
- 2 The term “disorder” is used in this article with caution due to its potentially hegemonic, stigmatizing and overly clinical nature.
- 3 Steve Wilkinson, “Incidental yet Monumental: Incorporating Mental Health Impacts into IHL Proportionality Assessments”, Advanced Training Program on Humanitarian Action, 7 April 2017, available at: <https://reliefweb.int/report/world/incidental-yet-monumental-incorporating-mental-health-impacts-ihl-proportionality> (all internet references were accessed in May 2026).

applicable legal norms, for those on the receiving end of the violence, the intention (or lack thereof) of the attacker may hold little relevance. This article undertakes a doctrinal analysis of international legal norms that do, or should, prevent mental harm in the conduct of hostilities, and proposes a critical analysis of the international humanitarian law (IHL) principle of proportionality in attack. Proportionality is the test through which the upper limit of permissible incidental civilian harm in attack is curated and which has thus attracted attention among the rules regulating the conduct of hostilities for its protective potential against incidental mental harm. In contributing to the ongoing debate on whether mental harm should be considered in *jus in bello* proportionality assessments, this article joins scholars such as Liebllich and Knuckey *et al.* in positing that it should.⁴

A decolonial critique adds a new dimension to the debate and answers the compelling calls for cultivating a decolonial attitude to knowledge production.⁵ In drawing on the work of decolonial scholars and the decolonizing global mental health agenda, this article remains cognisant of heterogeneous knowledges and the impact of colonialism and imperialism on knowledge creation,⁶ and recognizes diverse understandings of mental harm. This decolonial lens reveals that piecemeal legal interpretations have encouraged the consideration of incidental mental harm in decisions of attack, but in a way that reproduces a Western-centric hierarchy between types of mental harms.⁷ For example, some scholars, such as Liebllich, Schmitt and Highfill, and Knuckey *et al.*, opine that the proportionality rule should be interpreted to include only certain mental health “disorders” like post-traumatic stress disorder (PTSD) or a traumatic brain injury (TBI).⁸ However, such categorizations of mental harm rely on a Western-rooted conceptualization of mental health. The present article rejects this assumption of Western values and knowledge systems as

4 Eliav Liebllich, “Beyond Life and Limb: Exploring Incidental Mental Harm under International Humanitarian Law”, in Derek Jinks, Jackson N. Maogoto and Solon Solomon (eds), *Applying International Humanitarian Law in Judicial and Quasi-Judicial Bodies: International and Domestic Aspects*, T. M. C. Asser Press, The Hague, 2014; Sarah Knuckey, Alex Moorehead, Audrey McCalley and Adam Brown, “The Proportionality Rule and Mental Harm in War”, in Claus Kreß and Robert Lawless (eds), *Necessity and Proportionality in International Peace and Security Law*, Oxford University Press, New York, 2020.

5 Sabelo J. Ndlovu-Gatsheni, “The Dynamics of Epistemological Decolonisation in the 21st Century: Towards Epistemic Freedom”, *Strategic Review for Southern Africa*, Vol. 40, No. 1, 2018, p. 33; Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples*, 3rd ed., Zed Books, London, 2021; Africa Charter for Transformative Research Collaborations, 5 July 2023.

6 L. T. Smith, above note 5, p. 1; Vivetha Thambinathan and Elizabeth Anne Kinsella, “Decolonizing Methodologies in Qualitative Research: Creating Spaces for Transformative Praxis”, *International Journal of Qualitative Methods*, Vol. 20, 2021; Samantha Holmes, “Beyond Compliance Symposium – Strategies to Reduce Harm and Need in War through a Decolonial and Intersectional Lens”, *Articles of War*, 26 September 2024, available at: <https://lieber.westpoint.edu/strategies-reduce-harm-need-war-through-decolonial-intersectional-lens/>.

7 The term “Western-centric” describes the perspective of prioritizing Western – primarily Western European and North American – experiences, values and knowledge over others and perceiving them as superior or universal. While the notion of the West is not entirely unproblematic, it is used throughout this article as a concept to facilitate the comparison and problematization of dominant approaches to mental harm which stem from Europe and North America.

8 See below notes 130–137 and associated text.

universal or omnipotent, as it minimizes some lived experiences of mental harm through inappropriate contextualization or comparison.⁹ Thus, it cautions against unduly narrow interpretations of the principle of proportionality that overlook much of the lived reality of mental harm and would block some individuals from receiving the protection of this key IHL principle. Instead, an alternative approach to reconciling proportionality in attack with incidental mental harm is proffered, grown in response to a critical, decolonial evaluation of the law and its interpretation and in light of the decolonizing global mental health agenda, but equally applicable beyond (post-)colonial contexts. At the core of this approach is the prioritization of the lived experiences of conflict-affected individuals – a factor relevant for the best practice implementation of IHL in all conflict situations. Two key features of this approach are suggested: (1) centring localized and culturally appropriate notions of mental harm, and (2) acknowledging socio-cultural and economic circumstances. Through its critical, decolonial exploration of the interpretation and implementation of the principle of proportionality, this article aligns with the United Nations (UN) Secretary-General’s call for a “more holistic approach [to civilian protection] that has meaning for all civilians affected by conflict”.¹⁰

The article begins with an overview of the concept of mental harm through a decolonial lens before sharing reflections on the lived experiences of mental harm from attacks in armed conflict. It then summarizes the principle of proportionality in attack and its interpretation in existing literature and military policy regarding incidental mental harm. Next, the article critically evaluates mental harm within proportionality in attack through a decolonial lens, before concretely suggesting an alternative approach to implementing proportionality that seeks to respond to the decolonial critique. Finally, it articulates how this approach could be operationalized, anticipating potential critiques and exploring how the challenges of foreseeability, measurability, causal attribution and feasibility can be overcome.

Mental harm through a decolonial lens

Mental harm is used here expansively to cover challenges, impacts, injuries or impairments to mental, psychological, cognitive, behavioural and/or emotional well-being.¹¹ Engaging with the concept of mental harm should not be done without first acknowledging the Western ontological and epistemic hegemony embedded within the dominant conceptualization of mental health. This article seeks to recognize and respect non-Western ways of knowing and experiencing mental harm in conflict; it centres “world views of non-Western individuals” in order to reflexively unlearn and

9 V. Thambinathan and E. A. Kinsella, above note 6, p. 2.

10 *Protection of Civilians in Armed Conflict: Report of the Secretary-General*, UN Doc. S/2024/385, 14 May 2024 (UNSG 2024 Report), para. 48.

11 Although mental harm and psychological harm are largely seen as synonymous, the term “mental harm” is used here over psychological harm due to the Western-centric bias of the field of psychology.

reimagine the assumptions and interpretations that order the world and construct knowledge.¹²

The conceptual foundations of mental health are permeated with “European colonial and imperialist hegemony by privileging and reinforcing the perspectives of White, upper-middle class, Christian, heterosexual, male, and nondisabled individuals”.¹³ The predominant approach to mental health mirrors a Western biomedical model of psychology and psychiatry that can be traced back to French philosopher René Descartes’ dichotomization of the mind and the body.¹⁴ His Cartesian dualism – inherently a Western construct – initiated a global discourse (centred in European thought) that focuses on individual brain function and neurobiological explanations for mental ill-health.¹⁵ This paradigm often juxtaposes alternative knowledges of mental health that hold validity in diverse socio-cultural contexts.¹⁶ As Findlay summarizes, “[o]ne’s culture defines what it means to be well or unwell”;¹⁷ thus, a Western-rooted construct of mental health cannot be assumed to be universally valid in all cultures. The themes of religion and spirituality, community collectivism, relationality and interdependence, mind-body-soul unification, connection to the environment, and socio-cultural circumstances are integral to the conceptualization of mental health across many diverse cultures, including some African,¹⁸ Asian¹⁹ and indigenous communities.²⁰ For example, in general, Muslims from Rakhine State in Myanmar do not share the notion of the mind–body divide; rather, they conceptualize mental distress through complex interrelationships between the “mind-soul”, the brain and the body.²¹ Similarly, among some indigenous communities, mental distress is expressed through the notion of a “soul wound”.²² Maori

12 V. Thambinathan and E. A. Kinsella, above note 6, pp. 1–4.

13 Uma Chandrika Millner, Mihoko Maru, Aliya Ismail and Urmi Chakrabarti, “Decolonizing Mental Health Practice: Reconstructing an Asian-Centric Framework through a Social Justice Lens”, *Asian American Journal of Psychology*, Vol. 12, No. 4, 2021, p. 335.

14 Jordyn Correll, “Descartes’ Dualism and Its Influence on Our Medical System”, *Seattle University Undergraduate Research Journal*, Vol. 6, 2022, p. 49; Florence Thibaut, “The Mind-Body Cartesian Dualism and Psychiatry”, *Dialogues in Clinical Neuroscience*, Vol. 20, No. 1, 2018, p. 3; China Mills, *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*, Routledge, London and New York, 2014, p. 150.

15 Gojjam Limenih, Arlene MacDougall, Marnie Wedlake and Elysee Nouvet, “Depression and Global Mental Health in the Global South: A Critical Analysis of Policy and Discourse”, *International Journal of Social Determinants of Health and Health Services*, Vol. 54, No. 2, 2023, p. 100; *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/HRC/35/21, 28 March 2017, para. 18.

16 G. Limenih *et al.*, above note 15, pp. 103–104; *Report of the Special Rapporteur*, above note 15, para. 8; Mehta Neeta, “Mind-Body Dualism: A Critique from a Health Perspective”, *Mens Sana Monographs*, Vol. 9, No. 1, 2011.

17 Denise Findlay (Skwx wú7mesh Úxwumixw), “Gathering our Medicine: Strengthening and Healing Kinship and Community”, *AlterNative*, Vol. 2, No. 2, 2023, p. 359.

18 Jessica Horn, “Decolonising Emotional Well-Being and Mental Health in Development: African Feminist Innovations”, *Gender and Development*, Vol. 28, No. 1, 2020.

19 U. C. Millner *et al.*, above note 13.

20 L. T. Smith, above note 5; D. Findlay, above note 17, p. 360.

21 Alvin Tay *et al.*, *Culture, Context and Mental Health of Rohingya Refugees: A Review for Staff in Mental Health and Psychosocial Support Programmes for Rohingya Refugees*, Office of the UN High Commissioner for Refugees, Geneva, 2018, pp. 33, 44.

22 L. T. Smith, above note 5, p. 191.

indigenous thought emphasizes the deep interconnectedness between humans and their environment (“healing the land to heal the people”), between the physical, mental, emotional and spiritual dimensions of existence, and between individual identity and community identity (*whānau*).²³ Horn observes that some cultures in the African continent also perceive mental well-being as a shared experience predicated on the notion of *ubuntu* (a collective self and mutual interdependence).²⁴ This does not align with the Western conceptualization of mental health, which is predicated on highly individualized understandings of the self.

Similarly, community, relationality and kinship are central to the understanding of mental health among Squamish people (indigenous people of south-western British Columbia, Canada)²⁵ as well as in Filipino psychology through the concept of *kapwa* (meaning interconnectedness and a shared humanity).²⁶ Limenih *et al.* note that in some countries, cultural norms and social functioning patterns significantly influence how mental health is perceived, giving the example of how depression is comprehended within the broader socio-cultural context of the society rather than solely as a medical issue in some contexts.²⁷ The importance of socio-cultural circumstances to the understanding of mental health aligns with Fanon’s socio-diagnostic psychiatry (as interpreted by Mills), which posits that “one cannot understand psychological problems or distress outside of the conditions of oppression that lead to them.”²⁸ Evidently, conceptualizations of mental health are diverse, varying not only across but also within cultural settings.²⁹

Despite the significant variations in knowledge regarding mental health across the globe, the Western model has been systemically exported to “global South”³⁰ countries irrespective of socio-cultural context, including societies that have their own, alternative conceptualizations of mental health and where the Western ontological approach lacks coherence and validity.³¹ This transplantation

23 Joni Māramatanga Angeli-Gordon, “Whakapapa, Mauritau, and Placefulness to Decolonise Indigenous Minds”, *Genealogy*, Vol. 8, No. 4, 2024, pp. 2–3; L. T. Smith, above note 5, pp. 177, 191; V. Thambinathan and E. A. Kinsella, above note 6, p. 5.

24 J. Horn, above note 18, p. 91.

25 D. Findlay, above note 17, p. 360.

26 Carl Lorenz Gaston Cervantes, “Kaluluwa, Kapwa, and Kalikasan: Mental Health Implications of Filipino Folk Beliefs”, *Spirituality in Clinical Practice*, Vol. 12, No. 3, 2025, p. 409.

27 G. Limenih *et al.*, above note 15, p. 98.

28 C. Mills, above note 14, p. 132.

29 Anushka Patel and Brian Hall, “Beyond the DSM-5 Diagnoses: A Cross-Cultural Approach to Assessing Trauma Reactions”, *Focus*, Vol. 19, No. 2, 2021, p. 197; G. Limenih *et al.*, above note 15, p. 98.

30 The term “global South” is criticized for homogenizing diverse experiences, dichotomizing them from the “global North”, and omitting countries that do not fit neatly into either category. Nevertheless, it is still utilized in decolonial literature as a conceptual (as opposed to geographical) construct to “consolidate and empower the various social actors that consider themselves to be in subaltern(ized) positionalities of global networks of power”. The concept is therefore used here as a frame of reference that acknowledges colonial histories and the negative effects of globalization and facilitates the countering of existing global inequalities and hegemony. See Sinah Theres Kloß, “The Global South as Subversive Practice: Challenges and Potentials of a Heuristic Concept”, *The Global South*, Vol. 11, No. 2, 2017, pp. 1, 5–7.

31 Arthur Kleinman, “Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness”, *British Journal of Psychiatry*, Vol. 151, No. 4, 1987, p. 452; C. Mills, above note 14, pp. 129, 144.

of Western-centric knowledge has been labelled as a form of “cultural imperialism”,³² “modern colonisation”,³³ and “the colonization of minds”.³⁴ This ethnocentric knowledge on mental harm has been universalized through the imposition of standardized diagnostic categories for mental health “disorders”, which carry biases towards Western experiences of mental health.³⁵ The most widely used diagnostic manuals are the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM), currently in its fifth edition (DSM-5),³⁶ and the World Health Organization’s (WHO) *International Classification of Diseases* (ICD), currently in its 11th iteration (ICD-11).³⁷ Both these manuals perpetuate a Western-centric model of mental health “disorders” that relies on symptom checklists and a determination of “a clinically significant disturbance in an individual’s cognition, emotional regulation, or behaviour”.³⁸ Decolonial scholars such as Limenih *et al.* and Findlay have critiqued this transplantation of Western knowledge, arguing that it falsely assumes universal applicability or effectiveness, excludes significant variations in conceptualizations of mental health and culturally variable idioms of distress, and fails to adequately consider socio-cultural nuances in how mental health is experienced.³⁹ Consequently, these diagnostic manuals often fail to correspond with the important dimensions of community and relational experiences, the role of the soul, and connectedness to one’s environment that are focal in some cultures’ understanding of mental health.⁴⁰ For this reason, some decolonial scholars call for the assessment of mental harm to incorporate locally shaped and culturally recognizable expressions and experiences.⁴¹

Encouragingly, DSM-5 and ICD-11 acknowledge some cultural variations, including – of particular relevance to this article – cultural factors that can heighten

32 Vanessa Pupavac, “Pathologizing Populations and Colonizing Minds: International Psychosocial Programs in Kosovo”, *Alternatives*, Vol. 27, No. 4, 2002, p. 490.

33 Roei Shaul Hillel, “Decolonising Mental Health and Psychosocial Support (MHPSS) Interventions in the Humanitarian System”, *Intervention Journal of Mental Health and Psychosocial Support in Conflict-Affected Areas*, Vol. 21, No. 1, 2023, p. 21.

34 Ashis Nandy, *The Intimate Enemy: Loss and Recovery of Self Under Colonialism*, Oxford University Press, New Delhi, 1988, p. xi.

35 Moa Schafer and Alessandra Guedes, *Building Resilient Societies: The Impact of Adversity, Violence or Traumatic Experiences on Adolescent Brain, Mental Health and Psychosocial Development*, Wilton Park, June 2024, p. 8; C. Mills, above note 14, pp. 129, 144; A. Patel and B. Hall, above note 29, p. 197.

36 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed., Arlington, VA, 2013 (DSM-5).

37 WHO, *ICD-11: International Classification of Diseases 11th Revision*, 2022 (ICD-11), available at: <https://icd.who.int/en/>.

38 WHO, “Mental Disorders”, 8 June 2022, available at: www.who.int/news-room/fact-sheets/detail/mental-disorders.

39 G. Limenih *et al.*, above note 15, pp. 96, 98, 103; D. Findlay, above note 17, p. 362; A. Patel and B. Hall, above note 29, p. 197.

40 A. Tay *et al.*, above note 21, p. 44; G. Limenih *et al.*, above note 15, p. 96; D. Findlay, above note 17, p. 362.

41 A. Patel and B. Hall, above note 29, p. 198; China Mills and Suman Fernando, “Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health”, *Disability and the Global South*, Vol. 1, No. 2, 2014, pp. 197–198; Devon Hinton and Roberto Lewis-Fernández, “The Cross-Cultural Validity of Posttraumatic Stress Disorder: Implications for DSM-5”, *Depression and Anxiety*, Vol. 28, No. 9, 2011, pp. 790, 794.

the likelihood of an attack causing mental harm. For example, ICD-11 recognizes that for some cultural groups, traumatic events affecting family members rather than the individual themselves, the desecration or destruction of religious symbols, or the inability to perform funeral rites could amount to a traumatic stressor for PTSD.⁴² The latter is also referenced as a socio-cultural factor that can cause deviations in the onset of PTSD in DSM-5.⁴³ Nevertheless, the “disorder” categories themselves and their required diagnostic elements are static and impervious to cultural variations, despite the fact that they may be fundamentally unsuitable in some contexts. Due to the necessity of cultural relativity, some countries have integrated complementary diagnostic and alternative treatment systems within or alongside centralized ICD-11-based health systems.⁴⁴ Thus, if “disorder” categories based on these diagnostic manuals are used in isolation to inform the implementation of the proportionality rule (see the section “A Decolonial Critique of Existing Interpretations of Mental Harm within Proportionality” below), the protection of this rule will be limited to mental harm reflected within the manuals.

Further, while the inclusion of some cultural considerations in these manuals is promising, they remain minimal and under-developed. Localized research into the various ways in which mental harm is inflicted and presents itself in different socio-cultural contexts should be undertaken, not only to expand the cultural variation considerations within the manuals but also, crucially, to document patterns in experiences of mental harm that may fall outside of the manuals. “Disorder” categories have been criticized for obfuscating experiences of mental ill-health that fall below diagnostic cut-offs but that are not asymptomatic;⁴⁵ for example, research evidences that prognoses for individuals with sub-threshold depression (who have clinically relevant symptoms without meeting the full criteria for the disorder) are similar to those meeting diagnostic criteria.⁴⁶ To avoid the neglect of such experiences, some authors advocate for a dimension or gradient model of mental-ill health that assesses symptom severity on a continuum instead of subject to a threshold.⁴⁷

Not only can harm to mental health on a global scale not be adequately viewed through a Western lens, but that Western lens can also reinforce epistemic injustice.⁴⁸ DSM-5 and ICD-11 are culturally constituted objects not produced in a vacuum but informed by geopolitical dynamics, historical legacies, and the deeper

42 ICD-11, above note 37, “6B40 Post Traumatic Stress Disorder”.

43 DSM-5, above note 36, p. 278.

44 WHO, *WHO Global Report on Traditional, Complementary and Integrative Medicine 2024*, Geneva, 2025, p. 5.

45 Edward D. Barker and Heidi Riley, *The Role of Trauma and Mental Health in Violent Extremism*, briefing note, XCEPT, 19 July 2022, p. 4.

46 David Fergusson, L. John Horwood, Elizabeth Ridder and Annette Beautrais, “Subthreshold Depression in Adolescence and Mental Health Outcomes in Adulthood”, *Archives of General Psychiatry*, Vol. 62, No. 1, 2005, p. 70.

47 Sami Timimi, “No More Psychiatric Labels”, *Asylum Magazine*, Vol. 19, No. 1, 2012; E. D. Barker and H. Riley, above note 45, p. 4; D. Fergusson *et al.*, above note 46, p. 70.

48 Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing*, Oxford University Press, Oxford, 2007, pp. 1–2.

ontological hegemony of the concept of mental health;⁴⁹ the need for concrete categorization is itself a “Eurocentric” ideology.⁵⁰ The use of diagnostic manuals that translate varied experiences of distress into “Western existential categories”⁵¹ will necessarily dilute and eclipse local and indigenous knowledges and furthermore will preserve underlying power disparities and privileges that influence knowledge production.⁵² It is also important to acknowledge the breadth of research evidencing the harmful impacts of taking a Western-centric approach to mental health practice or healing.⁵³ While not included here, these critiques remain pertinent as the discourse on mental harm shapes actions and thus the absorption of a Western conceptualization of mental harm into IHL norms could have a trickle-down effect into mental health interventions on the ground.⁵⁴

Mental harm from attacks in conflict

The vast and enduring mental harms caused in armed conflict have been widely evidenced, but they are often not disaggregated by the causes of the mental harm. For example, WHO’s latest estimate of the prevalence of mental health “disorders” in conflict-affected populations is 22.1%,⁵⁵ a 9.9% increase from the global mean estimate of 12.2% in 2019 – the same year WHO’s estimate was published.⁵⁶ Yet, this cannot all be attributed to attacks (defined under IHL as “acts of violence against the adversary”⁵⁷) – some mental harm is caused through other acts of violence that do not constitute an attack, such as sexual violence or torture,⁵⁸ while others may be

49 G. Limenih *et al.*, above note 15, pp. 97, 102.

50 Kenneth Nunn, “Law as a Eurocentric Enterprise”, *Law and Inequality*, Vol. 15, No. 2, 1997, pp. 334–337.

51 A. Kleinman, above note 31, p. 452.

52 Sami Timimi, “No More Psychiatric Labels: Why Formal Psychiatric Diagnostic Systems Should Be Abolished”, *International Journal of Clinical and Health Psychology*, Vol. 14, No. 3, 2014, pp. 211–212; G. Limenih *et al.*, above note 15, pp. 98–99, 103; R. S. Hillel, above note 33, p. 22.

53 See, for example, S. Timimi, above note 52; V. Pupavac, above note 32; C. Mills, above note 14; D. Findlay, above note 17; G. Limenih *et al.*, above note 15; Alex Edney-Browne, “The Psychosocial Effects of Drone Violence: Social Isolation, Self-Objectification, and Depoliticization”, *Political Psychology*, Vol. 40, No. 6, 2019; Wilton Park, *Conflict Trauma and Youth: Exploring Approaches for Recovery and Conflict Prevention in the Middle East and North Africa*, January 2025.

54 C. Mills and S. Fernando, above note 41, p. 198.

55 F. Charlson *et al.*, above note 1, p. 244.

56 Institute for Health Metrics and Evaluation, “Global Burden of Disease (2025)”, accessed via *Our World in Data*, “Share of Population with Mental Health Disorders”, 2026, available at: <https://ourworldindata.org/grapher/share-with-mental-and-substance-disorders?tab=chart>.

57 Protocol Additional (I) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3, 8 June 1977 (entered into force 7 December 1978) (AP I), Art. 49(1).

58 Susan Bartels *et al.*, “Psychosocial Consequences of Sexual Violence in South Kivu Province, Democratic Republic of Congo”, *African Journal of Gender and Women Studies*, Vol. 4, No. 8, 2019; Gabriela Távora, “Beyond Seeing and Listening: Children Born from Conflict-Related Sexual Violence”, *International Journal of Transitional Justice*, Vol. 18, No. 3, 2024, p. 501; Coleen Kivlahan *et al.*, “Long-Term Physical and Psychological Symptoms in Syrian Men Subjected to Detention, Conflict-Related Sexual Violence and Torture: Cohort Study of Self-Reported Symptom Evolution”, *eClinicalMedicine*, Vol. 67, 2024, pp. 2–3;

caused by the circumstances of war that in some cases are not causally linked to an attack, such as lack of shelter, food or water, extreme financial hardship, unemployment, displacement or inability to access health care.⁵⁹ While it has been argued that protections against civilian harm in the conduct of hostilities extend beyond harm caused through attacks to the broader category of military operations, including by virtue of Article 57(1) of Additional Protocol I to the Geneva Conventions (AP I),⁶⁰ this article will focus on mental harm caused through an attack, in line with the codified principle of proportionality. Attacks are one of the gravest causes of mental harm in conflict, either directly or as a reverberating effect. Localized studies identify war-related stressors for mental harm, including air raids, artillery fire, the death or injury of loved ones, property destruction, witnessing the destruction of local infrastructure, and witnessing death or dead bodies.⁶¹ The use of explosive weapons is evidenced as a particular direct cause of mental harm due to an acute stress reaction to the violence of the event.⁶²

Mental harm can also reverberate from physical harms caused by attacks. For example, Docherty notes that burn injuries can have long-term cognitive consequences due to the physiological state of shock caused by an extensive loss of fluids, and psychological and emotional consequences stemming from the burn incident itself and from the painful daily treatment, as well as lasting scars or disabilities.⁶³ Studies also evidence that individuals left disabled by war can experience profound psychological distress as a result, including PTSD, which was recorded at a prevalence of almost 30% among individuals with a conflict-related physical disability in Yemen.⁶⁴ Moreover, mental harm can be a cascading effect of socio-economic circumstances that result from an attack, such as family separation or economic hardship, which have been identified as mental harm triggers for children

Hiba Abu Suhaiban, Lana Ruvolo Grasser and Arash Javanbakht, "Mental Health of Refugees and Torture Survivors: A Critical Review of Prevalence, Predictors, and Integrated Care", *International Journal of Environmental Research and Public Health*, Vol. 16, No. 13, 2019.

59 Thanos Karatzias *et al.*, "War Exposure, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress Disorder among Parents Living in Ukraine during the Russian War", *Acta Psychiatrica Scandinavica*, Vol. 147, No. 3, 2023, p. 280; Nexhmedin Morina, Kimberly Stam, Thomas Polletc and Stefan Priebe, "Prevalence of Depression and Posttraumatic Stress Disorder in Adult Civilian Survivors of War Who Stay in War-Afflicted Regions: A Systematic Review and Meta-Analysis of Epidemiological Studies", *Journal of Affective Disorders*, Vol. 239, 2018, pp. 331–333.

60 See also the article by Eitan Diamond and Tsvetelina van Benthem in this issue of the *Review*: Eitan Diamond and Tsvetelina van Benthem, "Protections against Cumulative Mental Harm under International Humanitarian Law", *International Review of the Red Cross*, Vol. 108, No. 932, 2026, section on "Protections against Cumulative Mental Harm in the Conduct of Hostilities".

61 T. Karatzias *et al.*, above note 59, p. 280; N. Morina *et al.*, above note 59, pp. 331–333.

62 Article 36, *The Impact of Explosive Violence on Mental Health and Psycho-Social Well-Being*, briefing paper, September 2013, p. 2.

63 Bonnie Docherty, "They Burn through Everything": *The Human Cost of Incendiary Weapons and the Limits of International Law*, Human Rights Watch, November 2020, pp. 13–14.

64 Fuad Taleb, Zakaria Mani and Asmaa Altaheri, "Beyond Survival: How Social Support and Psychological Security Protect War-Disabled Individuals from Post-Traumatic Stress in Yemen", *Conflict and Health*, Vol. 20, No. 1, 2026, p. 4.

in conflict.⁶⁵ Socio-cultural and economic circumstances can also be underlying or concomitant determinants of mental harm that exacerbate the likelihood or severity of such harm materializing from exposure to a traumatic event, as documented in ICD-11 in relation to migrant populations.⁶⁶ Additionally, damage to the environment from an attack can cause mental harm, especially for communities who rely on ecosystem services or who have deep emotional and spiritual connections to the natural environment.⁶⁷ These direct and reverberating mental harms from attack can be severe, impeding quality of life, having community-wide impacts and altering the structures of societies, with long-term, lifelong and even intergenerational effects.⁶⁸ The UN Human Rights Committee recently asserted the intergenerational nature of mental harm caused by displacement, acknowledging the transmission of trauma across generations of Mayan people.⁶⁹

A limitation of the majority of available data on armed conflict-related mental harm is that it often relates only to specific categories of mental harm as stipulated in diagnostic manuals; for example, the aforementioned WHO estimate of 22.1% is a measure of five ICD-11 “disorder” categories: depression, anxiety, PTSD, bipolar disorder and schizophrenia.⁷⁰ Further examples include Karatzias *et al.*’s study of PTSD (as stipulated in ICD-11) of parents in Ukraine⁷¹ and McEwen *et al.*’s study evidencing a high prevalence of PTSD, oppositional defiant disorder, depression, and anxiety disorders (utilizing DSM-5 criteria) among Syrian refugee children in Lebanon.⁷² The construction of these studies around “disorder” categories necessarily funnels experiences of mental harm in conflict through a Western frame; therefore, while they are indicative of the proliferation of profound mental harm, they inevitably omit mental harm that falls outside of or beneath these Western categorizations. In seeking – as this article does – not to be constrained by what Western epistemology renders as facts, attention should be drawn to literature that reports on mental harm outside of the terminology of a “disorder” and focuses instead on the manifestations of the distress. For example, Nicoll documents that for children in Gaza who have experienced and witnessed conflict, mental harm manifests

65 Timothy Williams, Alexandra Jackson and Vanessa Murphy, “Beyond the Rubble: Eight Overlooked Ways that Urban Warfare Is Affecting Children”, *Humanitarian Law and Policy Blog*, 22 August 2024, available at: <https://blogs.icrc.org/law-and-policy/2024/08/22/beyond-the-rubble-eight-overlooked-ways-that-urban-warfare-is-affecting-children/>.

66 ICD-11, above note 37, “Disorders Specifically Associated with Stress”.

67 Marine Elbakidze *et al.*, “Understanding the Impact of the War on People-Nature Relationships in Ukraine”, *Ecosystem Services*, Vol. 73, 2025.

68 Erin Bijl, Welmoet Wels and Wilbert van der Zeijden (eds), *On Civilian Harm*, PAX Protection of Civilians, 2021, p. 340.

69 UN Human Rights Committee, *Views Adopted by the Committee under Article 5.4 of the Optional Protocol in Respect of Communications Nos. 4023/2021, 4024/2021, 4025/2021, 4026/2021, 4027/2021, 4028/2021, 4029/2021, 4030/2021, 4031/2021, 4032/2021*, UN Doc. CCPR/C/143/D/4023/2021-4032/2021, 7 May 2025.

70 F. Charlson *et al.*, above note 1, p. 244.

71 T. Karatzias *et al.*, above note 59, p. 277.

72 Fiona McEwen *et al.*, “Prevalence and Predictors of Mental Health Problems in Refugee Children Living in Informal Settlements in Lebanon”, *Nature Mental Health*, Vol. 1, 2023, p. 136.

through emotional and behavioural changes such as intense fear, bedwetting and reactive mutism.⁷³ Other studies observe mental harm manifesting through fatigue, intrusive memories, aggression, hyperactivity, avoidance, estrangement and self-isolation, sleep disturbance, moral injury and somatic symptoms.⁷⁴

This evidence of the reality of mental harm resulting from attack firmly establishes the significance of such harm and thus provides both the factual and moral basis on which this article argues for the progressive interpretation and implementation of the principle of proportionality in order to stem the infliction of mental harm during the conduct of hostilities.

International legal norms preventing mental harm in the conduct of hostilities

This article focuses on the principle of proportionality, which is at the centre of the debate on mental harm prevention in attack. However, the principle of proportionality is just one aspect of the legal framework that serves to prevent harm to mental health in the conduct of hostilities, which will be set out briefly below.⁷⁵

IHL enshrines a number of provisions that prohibit the intentional infliction of mental harm in the conduct of hostilities, including violence to mental well-being such as torture through mental pain or suffering (a *jus cogens* norm), cruel or inhuman treatment and outrages upon personal dignity, in particular humiliating or degrading treatment.⁷⁶ IHL further prohibits acts or threats with the primary purpose of spreading terror.⁷⁷ These provisions hold customary international law status

73 Claire Nicoll, *Trapped and Scarred: The Compounding Mental Harm Inflicted on Palestinian Children in Gaza*, Save the Children International, 2024, p. 5.

74 Ground Truth Solutions and Arab World for Research and Development, “We Do Not Want Aid from the World. We Want to Stop the War”: *Community Priorities and Perceptions of Aid and Mutual Support in Gaza*, August 2024, p. 6; C. Kivlahan *et al.*, above note 58, p. 7; Pui-Hang Wong, “Moral Injury in Former Child Soldiers in Liberia”, *Journal of Child and Adolescent Trauma*, Vol. 15, No. 3, 2022; Abdel Aziz Mousa Thabet, Yehia Abed and Panos Vostanis, “Comorbidity of PTSD and Depression among Refugee Children during War Conflict”, *Journal of Child Psychology and Psychiatry*, Vol. 45, No. 3, 2004, p. 537; Alun McDonald, *Invisible Wounds: The Impact of Six Years of War on the Mental Health of Syria’s Children*, Save the Children UK, 2017, pp. 1–2; Atle Dyregrov, Leila Gupta, Rolf Gjestad and Eugenie Mukanoheli, “Trauma Exposure and Psychological Reactions to Genocide among Rwandan Children”, *Journal of Traumatic Stress*, Vol. 13, No. 1, 2000, p. 10; Ghayda Hassan, Peter Ventevogel, Hussam Jefe-Bahloul, Andres Barkil-Oteo and Laurence Kirmayer, “Mental Health and Psychosocial Wellbeing of Syrians Affected by Armed Conflict”, *Epidemiology and Psychiatric Sciences*, Vol. 25, No. 2, 2016, p. 132.

75 It should be acknowledged that there are further protective legal norms that serve to safeguard mental health which do not fall within this article’s focus on mental harm prevention in the conduct of hostilities, such as the protection of individuals under the power of the adverse party, the treatment of the wounded and sick, and duties to facilitate humanitarian aid and assistance.

76 AP I, Art. 75(2); Protocol Additional (II) to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609, 8 June 1977 (entered into force 7 December 1978) (AP II), Art. 4(2); Art. 3 common to the four Geneva Conventions of 1949.

77 AP I, Art. 51(2); AP II, Art. 13(2). See also international criminal law’s interpretation of this provision: International Criminal Tribunal for the former Yugoslavia (ICTY), *Prosecutor v. Stanilav Galić*, Case No. IT-98-29-A, Judgment (Appeals Chamber), 30 November 2006, para. 102.

and are applicable in both international and non-international armed conflicts.⁷⁸ International human rights law – applicable in both times of peace and conflict – provides additional protections, also prohibiting torture, cruel and degrading treatment that causes mental pain or suffering,⁷⁹ and genocide (a *jus cogens* norm) inflicted through “serious bodily or mental harm to members of the group”.⁸⁰ International criminal law bolsters these protections further by criminalizing torture, cruel and inhuman treatment and outrages upon dignity⁸¹ as well as the act of genocide.⁸² International law also contributes to the prevention of mental harm from attack through norms protecting civilian objects, essential services and critical infrastructure, cultural objects and places of worship, and the environment,⁸³ damage to which can be an underlying determinant of mental harm.

IHL provides protections against mental harm in the conduct of hostilities, even when it is inflicted incidentally. Three key provisions of IHL that enforce limits on acceptable incidental physical harm from attack have been interpreted by some to also apply to mental harm – the principles of precaution and proportionality in attack and the duty to take constant care. The principle of precaution in attack provides protections against injury to civilians,⁸⁴ even if it is not considered excessive in light of the principle of proportionality.⁸⁵ By nature of their mirrored language, the justifications for the reading of this provision to include considerations of incidental mental harm are interwoven with those for the principle of proportionality, discussed in detail below. The duty to take constant care to spare the civilian population⁸⁶ has been interpreted broadly by Schmitt and Highfill to extend to all military operations, not just attacks, and to require “military personnel to avoid any harm to civilians, not just that which qualifies as incidental injury or collateral damage”.⁸⁷ Gillard expressly interprets this provision as requiring the consideration of mental

78 Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 1: *Rules*, Cambridge University Press, Cambridge, 2005 (ICRC Customary Law Study), Rules 2, 87, 90, available at: <https://ihl-databases.icrc.org/en/customary-ihl>.

79 International Covenant on Civil and Political Rights, 999 UNTS 171, 16 December 1966 (entered into force 23 March 1976), Art. 7; UN Human Rights Committee, CCPR General Comment No. 20, “Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)”, 10 March 1992, para. 5; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1465 UNTS 85, 10 December 1984 (entered into force 26 June 1987), Art. 1.

80 Convention on the Prevention and Punishment of the Crime of Genocide, 78 UNTS 277, 9 December 1948 (entered into force 12 January 1951), Art. 2.

81 For their designations as crimes against humanity and war crimes, see Rome Statute of the International Criminal Court, 2187 UNTS 90, 17 July 1998 (entered into force 1 July 2002) (Rome Statute), Arts 7(1)(f), (k), 8(2)(a)(ii), (c)(i)–(ii).

82 *Ibid.*, Art. 6(b).

83 AP I, Arts 48, 51–55; AP II, Arts 14, 16; ICRC Customary Law Study, above note 78, Rules 1, 7; International Covenant on Economic, Social and Cultural Rights, 993 UNTS 3, 16 December 1966 (entered into force 3 January 1976), Arts 12–13.

84 AP I, Art. 57(2); ICRC Customary Law Study, above note 78, Rule 15.

85 Michael N. Schmitt and Chad Highfill, “Invisible Injuries: Concussive Effects and International Humanitarian Law”, *Harvard National Security Journal*, Vol. 9, No. 1, 2018, p. 95.

86 AP I, Art. 57(1); ICRC Customary Law Study, above note 78, Rule 15.

87 M. N. Schmitt and C. Highfill, above note 85, pp. 95–96.

health impacts.⁸⁸ While the principle of precautions in attack (if interpreted as such) and the duty to take constant care provide a degree of protection against incidental mental harm, even if fully complied with, unavoidable incidental mental harm will remain. Thus, if implemented in addition to these norms, the principle of proportionality could enhance the prevention of incidental mental harm further, acting as, according to Dorsey, “a final legal safeguard”.⁸⁹

The principle of proportionality

The principle of proportionality is at the centre of the debate on enhancing IHL’s protection against excessive incidental mental harm from attack. It is codified in Articles 51(5)(b) and 57(2) of AP I and is considered customary international law,⁹⁰ making it binding in both international and non-international armed conflicts. Further, breaches of proportionality during international armed conflicts constitute a grave breach of AP I as well as a war crime under the Rome Statute of the International Criminal Court (ICC).⁹¹ The principle of proportionality prohibits “an attack which may be expected to cause incidental loss of civilian life, injury to civilians, damage to civilian objects, or a combination thereof, which would be excessive in relation to the concrete and direct military advantage anticipated”.⁹² The three categories of harm listed in this provision (loss of civilian life, injury to civilians and damage to civilian objects), which it shares with the principle of precaution, represent the predominant understanding of civilian harm among legal scholarship.⁹³ However, it should be noted that outside of the confines of IHL, civilian harm is understood more broadly than these three categories and often includes mental harm⁹⁴ – for example, in the UN Secretary-General’s 2024 and 2025 reports on the protection of civilians.⁹⁵

88 Emanuela-Chiara Gillard, *Proportionality in the Conduct of Hostilities: The Incidental Harm Side of the Assessment*, research paper, Chatham House, 10 December 2018, p. 33.

89 Jessica Dorsey, “The Erosion of Human(e) Judgement in Targeting? Quantification Logics, AI-Enabled Decision Support Systems and Proportionality Assessments in IHL”, *International Review of the Red Cross*, Vol. 107, No. 930, 2025, p. 1048.

90 ICRC Customary Law Study, above note 78, Rule 14.

91 AP I, Art. 85(3)(b); Rome Statute, above note 81, Art. 8(2)(b)(iv). The Rome Statute carries stricter language than AP I, requiring the harm to be “clearly excessive”, not just “excessive”.

92 AP I, Art. 51(5)(b).

93 Samantha Holmes, “Suffering Unseen: Conceptual Boundaries of ‘Civilian Harm’ and ‘Humanitarian Need’ and Why Some Negative Lived Experiences of Armed Conflict are Neglected in Literature” (forthcoming).

94 E. Bijl, W. Wels and W. van der Zeijden, above note 68, p. 238; Sahr Muhammedally, *A Primer on Civilian Harm Mitigation in Urban Operations*, Center for Civilians in Conflict, June 2022, p. 3; Ioana Cismas, Katharine Fortin, Rebecca Sutton, Ezequiel Heffes and Anastasia Shesterinina, “The Beyond Compliance Approach: Centering Harm + Need Towards Full(er) Protection in Armed Conflict”, *Columbia Journal of Transnational Law*, Vol. 64, No. 1, 2026, pp. 20–28.

95 UNSG 2024 Report, above note 10, paras 54, 59; *Protection of Civilians in Armed Conflict: Report of the Secretary-General*, UN Doc. S/2025/271, 15 May 2025, para. 63.

Can “injury to civilians” be mental?

While the law does not provide a definition of injury for the purposes of understanding its meaning for the principle of proportionality, it is traditionally interpreted as purely physical injury.⁹⁶ As a result, excessive physical injury is prohibited while excessive mental injury is *de facto* neglected. This narrow interpretation significantly hampers the proportionality rule’s protection of civilians, yet, *prima facie*, there is nothing explicitly within the principle of proportionality that distinguishes between physical and mental harms or limits injury to the physical dimension. Further, as Bosi has shown, the drafters of IHL treaties were aware of mental harms as injuries of war, evidenced through the explicit inclusion of some mental health protections within other IHL provisions,⁹⁷ and significantly, within Article 51 of AP I itself.⁹⁸ Therefore, it is argued here that mental harm should not automatically be considered beyond the scope of the term “injury” where no express exclusion exists.

This position aligns with some experts who argue that there is no reason in principle for mental harm to be excluded from the notion of injury.⁹⁹ This view is held by Liebllich, a leading author on mental harm within the principle of proportionality, who posits that injury “could be reasonably understood to encompass also psychological harm”¹⁰⁰ and contends that such an interpretation is necessary “if IHL is to maintain its integrity”.¹⁰¹ Similarly, Knuckey *et al.* argue that in principle mental harm should be accounted for in proportionality assessments, considering extensive scientific research into mental harm since the drafting of AP I.¹⁰² An adjacent argument was raised by international experts on the conduct of hostilities attending a meeting co-organized by the International Committee of the Red Cross (ICRC) and Université Laval: they noted that IHL has been interpreted dynamically to consider new technology not known at the time of drafting, such as autonomous weapons, and thus an evolutive interpretation of IHL in line with the advanced understanding of the mental harms of war is equally justified.¹⁰³ A parallel can also be drawn between IHL’s concept of injury and its concept of the wounded and sick, as the latter has undergone an evolutionary interpretation and is now understood to encapsulate

96 S. Knuckey *et al.*, above note 4, pp. 376–377.

97 Giulia Bosi, “The Protection of Mental Health under International Humanitarian Law”, *Journal of International Humanitarian Legal Studies*, advance online version, 2025, p. 32, available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5444439. See, for example, AP I, Art. 11.

98 See, for example, AP I, Art. 51(2). See also E. Diamond and T. van Benthem, above note 60, section on “Protecting Civilians from the Dangers of Military Operations”.

99 Rebecca Sutton and Emanuela-Chiara Gillard, *Beyond Compliance: International Humanitarian Law, Humanitarian Need and Civilian Harm in Armed Conflict*, research report, PeaceRep, Edinburgh, 2022, p. 13; M. N. Schmitt and C. Highfill, above note 85, p. 92; S. Wilkinson, above note 3.

100 E. Liebllich, above note 4, p. 200.

101 *Ibid.*, p. 215.

102 S. Knuckey *et al.*, above note 4, pp. 368, 407.

103 Laurent Gisel, *The Principle of Proportionality in the Rules Governing the Conduct of Hostilities under International Humanitarian Law International Expert Meeting, 22–23 June 2016, Quebec*, ICRC and Université Laval, 2018, p. 35.

people with a mental health condition even though this was not expressly specified within the Geneva Conventions.¹⁰⁴

International criminal law jurisprudence supports the acceptance of mental harm within the notion of injury. For example, in *Prosecutor v. Lubanga*, the ICC Appeals Chamber expanded upon the definition of a victim of a crime under Rule 85(a) of the Rules of Procedure and Evidence, determining that the “harm” required to render an individual a victim includes “[m]aterial, physical, and psychological harm”.¹⁰⁵ Further, in *Prosecutor v. Prlić et al.*, the Trial Chamber of the International Criminal Tribunal for the former Yugoslavia (ICTY) included the “significant psychological impact” of the destruction of the Old Bridge of Mostar in its analysis to determine that the attack was disproportionate.¹⁰⁶ The substance of proportionality was not engaged with by the judges when the appeal of the related conviction was upheld.

The *Tallinn Manual 2.0 on the International Law Applicable to Cyber Operations* (Tallinn Manual 2.0) is a persuasive source for incorporating mental harm into the IHL notion of injury, and thus the principle of proportionality. It interprets injury to include “severe mental suffering”, which the International Group of Experts agreed was in line with IHL’s underlying humanitarian and civilian protection agenda and further supported by analogy through IHL’s concrete provisions prohibiting intentional mental harm, indicating the drafters’ intention to include norms for mental health protection.¹⁰⁷ Yet, it is also important to note that the Tallinn Manual 2.0, in addition to some scholars,¹⁰⁸ does limit its interpretation to only “severe” mental harm; thus, while it is an authoritative source for encouraging considerations of incidental mental harm within the principle of proportionality, it is not without limitation as it could give rise to ambiguity around a legally relevant threshold of severity. While this article acknowledges the inability for injury to encapsulate all forms of mental harm, including minor impairments (as doing so would render the principle of proportionality inoperable), it argues that the evaluation of the severity of the mental harm ought not to be a precursor to a proportionality assessment, but a consideration within the proportionality assessment itself. The balancing act of proportionality will necessarily afford weight to different anticipated harms based on their gravity in relation to the concrete and direct military advantage anticipated – thus, severity does not need to be a pre-emptive determination. Ultimately, the wording of AP I does not limit the principle of proportionality to severe injury to civilians, be it interpreted as physical or mental.

104 ICRC, *Commentary on the Fourth Geneva Convention: Convention (IV) relative to the Protection of Civilian Persons in Time of War*, 2nd ed., Geneva, 2025, para. 1695.

105 ICC, *The Prosecutor v. Thomas Lubanga Dyilo*, Case No. ICC-01/04-01/06-1432, Judgment (Appeals Chamber), 11 July 2008, para. 1.

106 ICTY, *Prosecutor v. Prlić et al.*, Case No. IT-04-74-T, Judgment and Opinion (Trial Chamber), Vol. 3, 29 May 2013, paras 1583–1584.

107 Michael N. Schmitt (ed.), *Tallinn Manual 2.0 on the International Law Applicable to Cyber Operations*, 2nd ed., Cambridge University Press, Cambridge, 2017 (Tallinn Manual 2.0), Rule 92(8).

108 E. Lieblich, above note 4, p. 191; S. Wilkinson, above note 3.

Scholars also argue that the exclusion of mental harm from proportionality's notion of injury might be contrary to AP I's core objective of protecting civilians against the effects of hostilities.¹⁰⁹ As is well known, it is a fundamental rule of treaty interpretation that treaties must be interpreted in good faith in light of their object and purpose;¹¹⁰ thus, a purposive interpretation of the principle of proportionality would prohibit instead of permit excessive incidental mental harm to civilians. Not following such an interpretation would undercut the humanity principle at the core of this legal norm, and of IHL more broadly.

Considerations when weighing mental harm in proportionality analyses

The proportionality assessment must weigh two values – civilian harm, including mental harm, and military advantage – against one another and determine if the anticipated civilian harm is excessive. This requires the consideration of multiple contextual factors, including the gravity and scope of the harm, the ability for the harm to be remedied in a timely fashion, the strategic importance of the military advantage, and the probability of both anticipated effects materializing.¹¹¹ Notably, the ICRC's 1987 Commentary on the Additional Protocols holds that incidental civilian harm "should never be extensive"¹¹² – a condition that supersedes whether an attack is foreseen to comply with the principle of proportionality of not.

Jus in bello proportionality is assessed *ex ante* for a specific attack, and thus is observed by some armed actors as precluding the consideration of accumulated harm that results from multiple different attacks over time.¹¹³ However, this article suggests that the fact that proportionality assessments are made in relation to specific attacks is not a barrier to the consideration of previous attacks as important contextual information to inform the analysis; rather, it argues that such considerations are required. The assessment of proportionality is inherently contextual, meaning that decisions of attack must be made considering all sources of information available to the individual at the time.¹¹⁴ This argument is supported by Gillard, who asserts that belligerents must take into account the "specific context in which an attack will take place", including damage caused by previous attacks, which may make further damage more significant.¹¹⁵ Dorsey further emphasizes that proportionality assessments demand a context-specific balancing exercise of qualitative

109 E. Lieblich, above note 4, p. 193; S. Knuckey *et al.*, above note 4, p. 368.

110 Vienna Convention on the Law of Treaties, 1155 UNTS 331, 23 May 1969 (entered into force 27 January 1980), Art. 31(1).

111 Robert Kolb, "Indirect or Reverberating Excessive Collateral Damage in Modern IHL", *Articles of War*, 13 August 2025, available at: <https://lieber.westpoint.edu/indirect-reverberating-excessive-collateral-damage-modern-ihl/>.

112 Yves Sandoz, Christophe Swinarski and Bruno Zimmerman (eds), *Commentary on the Additional Protocols*, ICRC, Geneva, 1987, para. 1980.

113 UNSG 2024 Report, above note 10, para. 59; Lawrence Hill-Cawthorne, *International Law in Extremis*, University of Bristol Working Paper Series No. 001/2025, 26 June 2025, pp. 24–25.

114 ICRC Customary Law Study, above note 78, Rule 14.

115 E.-C. Gillard, above note 88, p. 20.

considerations and ethical nuances.¹¹⁶ Contextual considerations will be particularly salient for weighing mental harm in proportionality analyses, as mental harm can be exacerbated through repeated attacks and attacks can compound with underlying socio-cultural and economic determinants to heighten the risk of mental harm materializing (see the section on “Acknowledging Socio-Cultural and Economic Circumstances” below). Diamond and van Benthem argue that factoring context and specific vulnerabilities of a population into proportionality assessments could enable those assessments to capture mental harm originating from multiple isolated or entwined sources, including previous attacks, displacement and malnourishment.¹¹⁷

In an alternative approach, Lubell and Cohen call for a “strategic proportionality” assessment – a higher-level assessment of proportionality that is to be conducted throughout the conflict and which balances “the overall harm against the strategic objectives”.¹¹⁸ They posit that this would enable the cumulative effects of mental harm to be considered in decisions of attack, even when the harms do not have a singular cause but result from prolonged exposure to war.¹¹⁹ This approach may enable anticipated incidental mental harm to have a greater influence on decisions of attack, but considerations of cumulative harm would be limited to that which is causally linked to a single armed actor, leaving a loophole where mental harm results through exposure to attacks by multiple parties and omitting the consideration of other contextual factors and underlying determinants that this article proposes should be taken into account. Additionally, while Lubell and Cohen’s approach allows for cumulative harm to be considered, it is to be balanced against the overall strategic aim of the use of force – thus, the scope has been widened on both sides of the proportionality equation.¹²⁰ It is hard to conceive of many circumstances in which expected overall incidental mental harm would be rendered disproportionate against the alleged high-level strategic objectives of the conflict.

Military policy on incidental mental harm

Military policy largely mirrors the language of AP I with regard to the principle of proportionality, but injury to civilians is also captured in various military manuals through alternative phrasings of “suffering”, “harm”, “harmful effect”, “affecting the civilian population” and “damage to persons”.¹²¹ Whether the broad formulation of these policies is intended to permit them to be interpreted to include mental

¹¹⁶ J. Dorsey, above note 89, pp. 1053, 1061, 1063.

¹¹⁷ E. Diamond and T. van Benthem, above note 60, section on “Reasonably Foreseeable Cumulating Causes of Mental Disorders”.

¹¹⁸ Noam Lubell and Amichai Cohen, “Strategic Proportionality: Limitations on the Use of Force in Modern Armed Conflicts”, *International Law Studies*, Vol. 96, 2020, pp. 162, 176.

¹¹⁹ *Ibid.*, p. 174.

¹²⁰ *Ibid.*, p. 194.

¹²¹ Jean-Marie Henckaerts and Louise Doswald-Beck (eds), *Customary International Humanitarian Law*, Vol. 2: *Practice*, Cambridge University Press, Cambridge, 2005, Rule 14, available at: <https://ihl-databases.icrc.org/en/customary-ihl/v2/rule14>.

harm can only be speculated. Other authors' assessments of State practice indicate that militaries generally do not factor mental harm into their considerations of proportionality of attack;¹²² however, some military policies can also be drawn upon to illustrate degrees of receptiveness to considering mental harm in judgments of proportionality. For example, the US Department of Defense's (DoD) 2023 instruction on *Civilian Harm Mitigation and Response* (CHMR DoD-I)¹²³ mandates consideration of a narrow scope of civilian harm which it defines as "civilian casualties and damage to or destruction of civilian objects".¹²⁴ A report by the US Government Accountability Office acknowledges that this civilian harm definition sought to exclude "second and third order effects, such as psychological effects".¹²⁵ However, the CHMR DoD-I also appears to partially extend its civilian harm mitigation efforts to a broader category by requiring consideration of "other adverse effects on the civilian population", albeit only requiring consideration of these effects "to the extent practicable".¹²⁶ Although the instruction does not elucidate on what other adverse effects it intends to capture, the wording is broad and thus could be interpreted to cover those harms that it excluded from its narrow conceptualization of civilian harm, notably mental harm. Nevertheless, even if the CHMR DoD-I can be interpreted to require some consideration of mental harm, it still maintains a hierarchy that prioritizes physical harms for which consideration is mandatory while "other adverse effects" – potentially including mental harm – are only required to be considered where practicable.

A second example is from North Atlantic Treaty Organization (NATO) policy, which is more explicit and progressive in its extension of IHL to incidental mental harms. In its incorporation of the principles of proportionality and precaution, NATO's 2021 revised joint targeting doctrine requires analyses of "expected collateral damage" to include estimations of "effects in the virtual and cognitive dimensions",¹²⁷ with "cognitive dimensions" expanded on as "psychological/behavioural effects".¹²⁸ However, the doctrine does acknowledge that "the risk estimate for effects in these two dimensions [virtual and cognitive] may not achieve the same level of prediction as the physical one", and it recognizes that "the integration of cognitive effects into NATO Joint Targeting is still in its infancy".¹²⁹ Although US and NATO policies can be viewed as somewhat receptive to the mitigation of excessive incidental mental harm, this analysis is based on policy language and whether mental harm

122 Simon Bagshaw, *Towards the Full Protection of Civilians*, policy briefing, Article 36, October 2024, p. 2; E.-C. Gillard, above note 88, p. 33; M. N. Schmitt and C. Highfill, above note 85, p. 83.

123 This analysis of US policy is based on publicly available materials at the time of writing (2026).

124 DoD, *Civilian Harm Mitigation and Response*, DoD Instruction 3000.17, 21 December 2023 (CHMR DoD-I), p. 49.

125 US Government Accountability Office, *Civilian Harm: DOD Should Take Actions to Enhance Its Plan for Mitigation and Response Efforts*, Report to Congressional Committees, March 2024, p. 18.

126 CHMR DoD-I, above note 124, p. 49.

127 NATO, *NATO Standard Allied Joint Doctrine for Joint Targeting*, AJP-3.9, Edition B, Version 1, 9 November 2021 (NATO Joint Targeting Doctrine), Chap. 1, Section VII, § 1.7(i).

128 *Ibid.*, Chap. 1, Section II, § 1.2.1.

129 *Ibid.*, Preface, p. XVII; Chap. 1, Section VII, § 1.7(i).

is, or could be, conceptually captured by the policies, rather than on observations of military practice.

A decolonial critique of existing interpretations of mental harm within proportionality

Having presented the current literature and policy on proportionality and incidental mental harm, this article will now evaluate mental harm within proportionality in attack through a decolonial lens, and (in the subsequent sections) explore how this critique could be overcome through suggesting what an alternative approach might look like and how it could be operationalized.

The growing literature encouraging the inclusion of incidental mental harm in the principle of proportionality gives hope towards better policy and strategic protections for mental health in conflict; however, the present article engages with a pressing challenge that has not yet been acknowledged or addressed in this debate. In interpreting the principle of proportionality to include mental harm, some scholars impose narrow parameters on the mental harm that they seek to include, and this enforces a hierarchy within types of mental harm that privileges and prioritizes Western experiences and knowledge. Two problematic conceptualizations are identified below: (1) the separation of physical and psychological harm, and (2) the utilization of Western-centric “disorder” categories. It is argued here that perpetuating these Western-centric conceptualizations of mental health diminishes other forms of knowledge and, on a practical level, could, in certain contexts, lead to skewed interpretations of proportionality that do not sufficiently consider the foreseeable mental health impacts of an attack.

For example, in their paper on whether the causation of TBIs to civilians should, under IHL, be considered in decisions of attack, Schmitt and Highfill interpret injury for the purposes of the principle of proportionality to extend, in theory, to considerations of incidental mental harm that result from a TBI.¹³⁰ However, they appear to exclude any other manifestations of mental harm from the reach of the principle of proportionality, asserting that, in light of the state of the law in 2018, the term “injury” “could not be interpreted to encompass purely psychological harm unrelated to TBI”.¹³¹

A similar conceptual separation between biological harm to the brain (requiring medical treatment) and purely psychological harm (treated through psychotherapy or psychological and behavioural interventions) was suggested within the International Law Association Study Group on the Conduct of Hostilities in the 21st Century (ILA Study Group), with some members arguing that the latter should be excluded from the principle of proportionality.¹³² However, this distinction

130 M. N. Schmitt and C. Highfill, above note 85, pp. 92–94.

131 *Ibid.*, p. 92.

132 ILA Study Group, “The Conduct of Hostilities and International Humanitarian Law: Challenges of 21st Century Warfare”, *International Law Studies*, Vol. 93, 2017, p. 360.

appears convoluted, is not a distinction made within the principle of proportionality itself, and fails to acknowledge that some manifestations of mental harm unrelated to a brain injury can still cause biological changes to the brain and result in physical symptoms.¹³³

Lieblich also restricts his interpretation of proportionality considerations to certain experiences of mental harm, although in a different way than Schmitt and Highfill.¹³⁴ He writes that “[w]hen we discuss mental harm, we naturally refer to the most serious, well studied forms of such harm, such as post-traumatic stress disorder”.¹³⁵ Knuckey *et al.* similarly limit their discussion of incidental mental harms exclusively to PTSD, although they do acknowledge cross-cultural variations of the “disorder” and the impact of confounding socio-economic variables.¹³⁶ Solomon notes that “it is wrong to only associate civilian mental harm with PTSD”, but explains that PTSD is used by legal scholars due to its ability to translate mental harm into the legal sphere.¹³⁷

Crucially, these authors’ interpretations of the principle of proportionality and its required mental harm considerations largely rest on the Western-centric “disorder” categories of TBI and PTSD, as coded and classified in ICD-11 and DSM-5. The aforementioned concerns over the cross-cultural validity of these diagnostic manuals should not be overlooked by those seeking to envelop “disorder” categories into the application of the principle of proportionality.¹³⁸ While these authors encourage greater consideration of incidental mental harm in decisions of attack than is currently undertaken in practice, they limit incidental mental harm considerations to standardized “disorder” categories that depict only certain forms of mental suffering as legible,¹³⁹ and their approaches would therefore omit the broader landscape of lived experiences of mental harm in conflict that do not fit neatly into “disorder” categories from the protective scope of the principle of proportionality.¹⁴⁰ Such an interpretation does not align with WHO’s definition of mental health as “more than the absence of mental disorders”.¹⁴¹ The International Criminal Tribunal for Rwanda (ICTR) took a different approach to interpreting the necessary severity of serious mental harm for the crime of genocide: it held that the mental harm must include “more than minor or temporary impairment of mental faculties” but need

133 See, for example, A. McDonald, above note 74, p. 14.

134 E. Lieblich, above note 4, p. 205.

135 *Ibid.*, p. 191.

136 S. Knuckey *et al.*, above note 4, pp. 381, 396–397.

137 Solon Solomon, “Why Should the Innocent Suffer? Mental Harm as Disability and the Establishment of a Post Bellum Duty of Care for Enemy Civilians”, *Fordham International Law Journal*, Vol. 48, No. 1, 2024, p. 168.

138 Martyn Pickersgill, “Debating DSM-5: Diagnosis and the Sociology of Critique”, *Journal of Medical Ethics*, Vol. 40, No. 8, 2014, p. 522; G. Limenih *et al.*, above note 15, p. 98.

139 G. Limenih *et al.*, above note 15, p. 96.

140 A. Patel and B. Hall, above note 29, p. 197.

141 WHO, “Mental Health”, available at: www.who.int/data/gho/data/themes/theme-details/GHO/mental-health.

not be “permanent or irremediable”.¹⁴² Following this approach to incidental mental harm considerations in decision of attack would permit the necessary flexibility to embrace cultural diversity in lived experiences of mental harm, rather than using disorder categories as thresholds of severity for mental harm to be considered and ultimately mitigated.

The limitations of forcing lived experiences of mental harm through rigid “disorder” categories can be illustrated through the example of PTSD, a diagnosis constructed partly in response to the mental suffering of US veterans returning from the Vietnam War.¹⁴³ Scientific research into PTSD is mostly consumed by the experience of trauma by Western soldiers,¹⁴⁴ but it goes without saying that the civilian and combatant experiences will be very different. Patel and Hall find that PTSD symptoms are “culturally malleable” and observe that for Cambodian refugees the local idiom of “thinking a lot” was a more prominent trauma reaction than any of the symptoms prescribed for PTSD in DSM-5.¹⁴⁵ Research has shown that even in socio-cultural contexts where PTSD is a commonly accepted diagnostic construct and its symptomology holds validity, its clinical utility can be limited – such as in Afghanistan, where compared to culturally specific and indigenous expressions of distress, PTSD has a lesser substantive impact on people’s daily functioning.¹⁴⁶ The impermeability of the construct of PTSD to cultural nuances has led some mental health experts to reject its pertinence to their population. For example, the chair of the Palestinian Ministry of Health’s Mental Health Unit, Dr Samah Jabr, critiques the clinical definition of PTSD for failing to fully capture the experience or reactions of Palestinians experiencing collective and continuous trauma.¹⁴⁷ Horn critiques the highly medicalized discourse of PTSD as a “Northern orthodoxy” that is “predicated on a privileged idea that the world is fair and just in the first place”;¹⁴⁸ indeed, cultural relativists would challenge the applicability of PTSD anywhere outside of the culture where the concept was constructed.¹⁴⁹ Confining mental harm considerations for proportionality analyses to “disorder” categories like PTSD could result in inaccurate assessments of the proportionality of an attack that omit culturally nuanced trauma responses.

142 See, for example, ICTR, *The Prosecutor v. Juvénal Kajelijeli*, Case No. ICTR-98-44A, Judgment (Trial Chamber), 1 December 2003, para. 815.

143 Maria Helbich and Samah Jabr, “A Call for Social Justice and for a Human Rights Approach with Regard to Mental Health in the Occupied Palestinian Territories”, *Health and Human Rights Journal*, Vol. 24, No. 2, 2022, p. 308.

144 S. Knuckey *et al.*, above note 4, p. 393.

145 A. Patel and B. Hall, above note 29, p. 198.

146 Kenneth Miller *et al.*, “The Validity and Clinical Utility of Post-Traumatic Stress Disorder in Afghanistan”, *Transcultural Psychiatry*, Vol. 46, No. 2, 2009, pp. 232–233.

147 Olivia Goldhill, “Palestine’s Head of Mental Health Services Says PTSD is a Western Concept”, *Quartz*, 13 January 2019; Bethan McKernan, “Chronic Traumatic Stress Disorder: The Palestinian Psychiatrist Challenging Western Definitions of Trauma”, *The Guardian*, 14 April 2024.

148 J. Horn, above note 18, pp. 87, 89–90.

149 A. Patel and B. Hall, above note 29, p. 199.

In addition to omitting experiences that fall outside of Western-constructed parameters, relying on “disorder” categories when anticipating incidental mental harm from an attack requires a distinction between different types of mental harm. Not only does the codified law for the principle of proportionality not require distinctions between types of civilian injuries, but current practice and collateral damage estimate (CDE) methodologies also do not categorize or typologize foreseeable incidental physical harms.¹⁵⁰ Thus, through analogy, it can be argued that distinction between different types of mental harm is not required in law either.

Responding to the decolonial critique: A culturally and contextually sensitive approach to mental harm within proportionality

A decolonial evaluation illustrates the need for a localized, socio-culturally sensitive interpretation of mental harm within the principle of proportionality. This section will explore practical suggestions for interpreting and implementing the principle of proportionality in order to overcome concerns highlighted through a decolonial lens. While not reflecting current prevailing practice, this approach would respond (at least in part) to the above decolonial critique, but it also holds value beyond (post-)colonial contexts, representing the best practice of centring lived experiences in the principle of proportionality, applicable in all conflict situations where IHL applies. The following key features are explored below, alongside suggestions for how they could be concretely applied to the principle of proportionality: (1) centring localized and culturally appropriate notions of mental harm, and (2) acknowledging socio-cultural and economic circumstances.

Centring localized and culturally appropriate notions of mental harm

Proportionality could be interpreted in a manner that recognizes epistemological diversity on mental health and the need for cultural humility,¹⁵¹ for example by ensuring that diverse cultural understandings of mental harm are not ignored. This article has identified that community collectivist values and interdependence, mind–body–soul unification and connection to the environment are key features of mental well-being in some cultures (see the above section on “Mental Harm through a Decolonial Lens”). Cultural nuances in the conceptualization of mental health and mental harm could be incorporated into research that might inform proportionality analyses, ensuring that relevant lived experiences and perspectives shape the future implementation of proportionality in attack. Encouragingly, progression towards this culturally nuanced approach is nascent. NATO’s 2021 revised joint targeting

150 L. Gisel, above note 103, p. 36.

151 A. Patel and B. Hall, above note 29, p. 200; C. Mills and S. Fernando, above note 41, p. 198; D. Findlay, above note 17, pp. 362–363.

doctrine acknowledges how, in some cultures, mental health is indivisible from community interconnectivity or environmental connection. In the context of “CDE for effects in the virtual and cognitive dimensions”, it states that “commanders and their staffs should manage the risk by making efforts to understand the human environment”, within which it includes “how all humans interact with their environment, especially with each other”.¹⁵²

Research could also embrace local languages and idioms of distress relevant to particular conflict contexts, such as the term *waushanti* (meaning sad or restless mind), used by conflict-affected communities in Rakhine State in Myanmar,¹⁵³ or the Afghani concept of *jigar khun* (meaning a state of dysphoria or melancholy), used widely to describe war-related experiences.¹⁵⁴ The prominence of local idioms of distress in an individual’s trauma response is emphasized in parts of ICD-11,¹⁵⁵ representing a positive advance toward cultural adaptation of “disorders” within diagnostic manuals. Embracing local knowledge and beliefs on mental harm in these suggested ways would respond to the aforementioned decolonial critique that rejects the Western framing of mental health in favour of “home-grown” culturally authentic and contextually appropriate conceptualizations and frameworks of mental suffering that are grounded in the realities of affected communities and “privileg[e] the knowledge of those with lived experience of distress”.¹⁵⁶ Centrally, making localized and culturally nuanced information on mental harm accessible to armed actors would facilitate its consideration in future proportionality assessments, ensuring that incidental mental harm considerations are shaped by relevant lived experiences and not limited to those which align with Western notions of mental harm.

Acknowledging socio-cultural and economic circumstances

Another key feature in identifying mental harm for proportionality in attack compliance, proposed by this article, is the consideration of socio-cultural and economic circumstances of the war-affected community at risk of mental harm. Two complementary avenues through which this could be improved are explored here. Firstly, some attacks which cause or exacerbate underlying socio-cultural and economic determinants of mental harm (such as extreme financial hardship, food insecurity, displacement and a lack of access to health care¹⁵⁷) could be captured within the remit of the principle of proportionality through the notion of reverberating effects. The prevailing view among legal scholars is that IHL requires reverberating harms to be considered in proportionality analyses, provided they are an

152 NATO Joint Targeting Doctrine, above note 127, Chap. 1, Section VII, § 1.7(i).

153 A. Tay *et al.*, above note 21, p. 30.

154 K. Miller *et al.*, above note 146, pp. 225, 232.

155 See for example, ICD-11, above note 37, “Disorders Specifically Associated with Stress”.

156 M. Schafer and A. Guedes, above note 35, p. 9; A. Patel and B. Hall, above note 29, p. 200; C. Mills, above note 14, p. 149.

157 T. Karatzias *et al.*, above note 59, p. 280; N. Morina *et al.*, above note 59, pp. 331–333.

expected consequence of the attack,¹⁵⁸ however, there remains some disagreement as to which reverberating harms must be considered. For example, while State policy and practice appear to interpret reverberating harms as necessary considerations in proportionality assessments, the material scope of the reverberating incidental harm appears limited in some policies, such as the US *Law of War Manual*'s exclusion of some reverberating economic harms from determinations of proportionality.¹⁵⁹ Scholars have called for incorporating more detailed information regarding characteristics and vulnerabilities of civilian infrastructure and services for the purpose of improving reverberating harm mitigation,¹⁶⁰ thus illustrating a willingness to place greater reliance on socio-cultural and economic circumstances within proportionality assessments. However, the UN Secretary-General has observed that the reverberating effects of conflict on "individual mental and societal trauma" are not factored into proportionality analyses by some parties to conflict.¹⁶¹ Ongoing debate regarding the scope of this obligation and the point at which a reverberating effect becomes confidently predictable enough to be considered¹⁶² could be an obstacle to the uptake of this approach.

Secondly, socio-cultural and economic circumstances that may heighten the risk of mental harm being inflicted, should be considered when determining whether an attack is proportionate. As argued above, the assessment of proportionality is inherently contextual, and decisions of attack must be made considering all sources of information available to the individual at the time.¹⁶³ Gillard gives the example of the capacity of local health facilities as a contextual factor that should be considered in proportionality assessments.¹⁶⁴ Some military policies do consider cultural factors when weighing up the proportionality of an attack: for example, the US *Law of War Manual* affords "greater consideration" to incidental damage of cultural property than to ordinary property.¹⁶⁵ Aforementioned cultural factors identified in ICD-11 and DSM-5 that can heighten the risk of PTSD – such as religious beliefs that can result in mental harm when religious symbols are destroyed –

158 ICRC, *International Humanitarian Law and the Challenges of Contemporary Armed Conflicts*, Geneva, October 2015, para. 266; Isabel Robinson and Ellen Nohle, "Proportionality and Precautions in Attack: The Reverberating Effects of Using Explosive Weapons in Populated Areas", *International Review of the Red Cross*, Vol. 98, No. 901, 2016, pp. 108–109; ILA Study Group, above note 132, p. 353; Tallinn Manual 2.0, above note 107, Rule 113. See also the section on "Causal Attribution" below.

159 DoD, *Law of War Manual*, June 2015 (updated July 2023) (US Manual), § 5.12.1.3. On State policies' approach to reverberating harms, see, for example, Henderson and Reece's review of State practice: Ian Henderson and Kate Reece, "Proportionality under International Humanitarian Law: The 'Reasonable Military Commander' Standard and Reverberating Effects", *Vanderbilt Law Review*, Vol. 51, No. 3, 2021, pp. 848–850.

160 Michael Talhami and Mark Zeitoun, "The Impact of Attacks on Urban Services II: Reverberating Effects of Damage to Water and Wastewater Systems on Infectious Disease", *International Review of the Red Cross*, Vol. 102, No. 915, 2020, p. 1318.

161 UNSG 2024 Report, above note 10, para. 59.

162 I. Henderson and K. Reece, above note 159, pp. 850–855.

163 ICRC Customary Law Study, above note 78, Rule 14.

164 E.-C. Gillard, above note 88, pp. 20, 34.

165 US Manual, above note 159, § 5.12.1.1.

serve as an example of how cultural context can inform proportionality assessments, even within the confines of “disorder”-based approaches.

In order to centre localized and culturally appropriate notions of mental harm, the implementation of proportionality in attack should include the consideration of further contextual and circumstantial factors, such as the accessibility of mental health-care services, mental harm caused by previous attacks or natural disasters and socio-cultural and economic factors that indicate likely mental harm triggers. As an illustration, attacks that may have been deemed proportionate in the first week of a conflict may fail the proportionality test after two years of the community being exposed to numerous mental harm triggers, because such contextual considerations – which indicate a higher risk of mental harm – would, through the utilization of this article’s approach, be absorbed into the proportionality analyses provided they are reasonably foreseeable. Notably, this proffered contextual approach would not limit armed actors to considerations of how their own previous military actions have affected the community; rather, it would require them to consider how all existing mental health impacts or triggers for which information is available – regardless of who or what inflicted them (such as another armed actor or a natural disaster) – could compound the foreseeable mental harm of their attack.

Solomon and Bayer show progression towards greater contextualization of *jus in bello* proportionality. They evidence that socio-economic circumstances can shape the materialization and intensity of mental harm resulting from rocket attacks, which supports their argument for a contextual approach to incidental mental harm, with proportionality assessments taken on a case-by-case basis without predetermined assumptions.¹⁶⁶ Solomon and Bayer criticize the horizontal approach to mental harm in IHL that falsely premises that war is experienced equally by all.¹⁶⁷ Their position takes crucial steps towards a holistic approach to incidental mental harm that aligns with decolonial calls for mental harm not to be siloed from socio-cultural and economic circumstances and determinants.

These two key features embrace alternative knowledges that view socio-cultural and economic circumstances as crucial to understandings of mental harm and would account for the intersecting, compounding and cumulative nature of conflict exposure, the conflict’s longevity and daily stressors. Embracing these features in the implementation of the principle of proportionality would thus respond to the UN Secretary-General’s call for an approach that “takes into account the complexity and cumulative nature of the full range of civilian harm”.¹⁶⁸

166 Solon Solomon and Ya’akov M. Bayer, “Is All Mental Harm Equal? The Importance of Discussing Civilian War Trauma from a Socio-Economic Legal Framework’s Perspective”, *Nordic Journal of International Law*, Vol. 92, No. 4, 2023, pp. 528, 531, 540–541.

167 *Ibid.*, pp. 531, 547.

168 UNSG 2024 Report, above note 10, para. 70.

Operationalizing a culturally and contextually sensitive approach to mental harm within proportionality

How the above-stipulated approach to incidental mental harm may shape the implementation of the principle of proportionality will vary across different conflict contexts, different identities of affected communities, and different military advantages pursued. The absorption of localized knowledge on the manifestation of mental harm would enable proportionality analyses to consider a more truthful representation of the types and gravity of incidental mental harm likely to result from a particular attack. Such insight may add weight to the civilian protection side of the proportionality balance and could, theoretically, shift the balance of proportionality; for example, a broader interpretation of mental harm that goes beyond Western “disorder” categories could capture a greater proportion of foreseeable mental harm resulting from a military attack. Considerations could include collective experiences of mental harm, mental harm that falls just below or outside of current “disorder” categories, or mental harm emanating from the destruction of or damage to social relationships, cultural heritage or the environment. Depending on the anticipated military advantage, this could require, in practice, alterations to the means and methods of attack in order to mitigate or prevent the foreseeable mental harm.

The commonly cited operational challenges to considering mental harm in *jus in bello* proportionality are foreseeability, measurability, causal attribution and feasibility,¹⁶⁹ although some authors have made strong rebuttals against these perceived barriers.¹⁷⁰ This section briefly summarizes these concerns and their rebuttals and undertakes an initial analysis of how the proffered culturally and contextually sensitive approach to mental harm may intersect with, exacerbate or ease existing operational challenges, and how those challenges could be surmounted. Although it is key to be aware of the practical hurdles of embracing this approach, they should not be used to justify the continued ignorance of mental harm in decisions of attack, or indeed the perpetuation of a Western-centric approach to incidental mental harm. Rather, these challenges highlight areas where further research is needed to ameliorate and overcome these operational concerns and build confidence in the utility of a culturally and contextually sensitive approach for improving civilian protection in war.

Foreseeability

The codified test of the principle of proportionality requires incidental civilian injury to be considered in decisions of attack, if the attack “may be expected to cause” the injury. This means that those involved in determining the proportionality of an attack would not be expected to predict all possible harms (mental or physical),

169 S. Knuckey *et al.*, above note 4, pp. 394–403; L. Gisel, above note 103, pp. 35–36.

170 E. Liebllich, above note 4; S. Wilkinson, above note 3; R. Sutton and E.-C. Gillard, above note 99.

only those reasonably foreseeable by a person who is reasonably well informed.¹⁷¹ Schmitt and Highfill observe that reasonable foreseeability is based on rational inferences and probabilities but excludes conjecture and speculation.¹⁷² Scholars have raised concerns as to the foreseeability of incidental mental harm by armed actors, military strategists and policy-makers due to its heightened subjectivity in comparison to physical harm.¹⁷³ The subjectivity critique is emboldened when mental harm is viewed through a decolonial lens, as it invites consideration of socio-cultural and economic factors and determinants. Nevertheless, it does not make foreseeing incidental mental harm an impossibility; indeed, the principle of proportionality already deals with highly subjective harms. Firstly, many manifestations of physical harm are non-homogeneous (for example, age, disability, gender and many other factors can impact the infliction of physical harm) and thus can be difficult or impossible to predict, such as determining who might be struck, and where on their body they might be struck, by shrapnel which could lead to diverse harms ranging from minor to fatal.¹⁷⁴

Secondly, as noted above, the incorporation of reverberating harms in proportionality assessments is increasingly accepted in State practice,¹⁷⁵ including, notably, the US and UK military manuals, which both give examples of reverberating harms that ought to be considered in decisions of attack.¹⁷⁶ Anticipating reverberating harm can similarly be highly complex and subjective to local circumstances and socio-cultural and economic factors. Like mental harm, reverberating effects can only be considered insofar as they are reasonably foreseeable. The fact that some reverberating harms are not reasonably foreseeable is not a barrier to the determination that the law obliges expected reverberating harms to be taken into account in proportionality assessments, and nor should that be the case for mental harm. While foreseeability may limit some mental harms from being considered, it is not a valid justification *per se* for excluding mental harm as a category of injury from the principle of proportionality. Concerns regarding the foreseeability of mental harm (especially when socio-cultural and economic factors are engaged with) could be further eased by using Talhami and Zeitoun's "precautionary approach" to foreseeing reverberating harm. This approach "assumes causal links and chains" within military operational planning processes to address the inevitable uncertainty in predicting the harm that may

171 ICRC, above note 158, para. 267; ILA Study Group, above note 132, p. 353; M. N. Schmitt and C. Highfill, above note 85, p. 84.

172 M. N. Schmitt and C. Highfill, above note 85, p. 85.

173 R. Sutton and E.-C. Gillard, above note 99, p. 13.

174 S. Knuckey *et al.*, above note 4, p. 403.

175 I. Henderson and K. Reece, above note 159, p. 848–850.

176 US Manual, above note 159, § 5.12.1.3 (death or injury due to the loss of power to a hospital caused by the destruction of a power plant); UK Ministry of Defence, *The Manual of the Law of Armed Conflict*, 2004, § 5.33.4 (an attack on a military fuel storage depot causing burning fuel to flow into a civilian residential area and injure civilians).

result from an attack.¹⁷⁷ It would also aid issues of causal attribution (discussed below).

Not all socio-cultural and economic factors or individual circumstances that could enhance the likelihood of mental harm materializing from an attack will be reasonably accessible to decision-makers, but some contextual information will be obtainable or even publicly available and therefore should be considered when anticipating incidental mental harm. Indeed, information already collected in attack planning in order to comply with IHL norms on the conduct of hostilities may be useful for foreseeing mental harm. Information on foreseen civilian injuries could help predict mental harm that may result, for example, in war-disabled individuals, while estimates of foreseen civilian deaths could inform mental harm predictions through the impacts that these deaths may have on family units and broader communities. Further, the identification of civilian objects within the operating environment, including no-strike entities such as cultural, religious or historical sites,¹⁷⁸ can be used to anticipate mental harm that may result from attacks near to these sites. Population density estimates for civilians in the operating area at specific times,¹⁷⁹ as well as local demographics,¹⁸⁰ could prove particularly useful, especially for identifying children, who have a heightened susceptibility to mental harm.¹⁸¹ Finally, the foreseeability of mental harm could be improved through the utilization of information regarding underlying social-cultural determinants of mental harm (such as the culture, history, welfare and social structure of the civilian population within the operating environment) that is collected by some armed actors as part of their efforts to understand the “human environment”,¹⁸² as well as mappings of crucial civilian services such as water and electricity.¹⁸³

More empirical data on how contextual factors alter the infliction of mental harm from an attack could also be collected and made available to decision-makers to enhance the foreseeability of mental harm. Pivotal to this will be battle damage assessments, including manifestations of mental harm from previous attacks that can inform future proportionality analyses, both to improve foreseeability and to ensure that considerations of compounding harm are included. Rigorous research including granular anthropological studies that evidence localized experiences of mental harm and how diverse socio-cultural factors intersect with the manifestation of mental harm could be undertaken. In addition, large-scale quantitative studies that map data on mental harm resulting from previous attacks to information about conflict typology, location, and means and methods of warfare could be used to establish

177 M. Talhami and M. Zeitoun, above note 160, p. 1320.

178 Loren Voss, “The Overlooked Importance of Intelligence Analysis in IHL”, *International Review of the Red Cross*, Vol. 107, No. 928, 2025, pp. 299, 303, 305.

179 *Ibid.*, p. 305.

180 NATO, *Protection of Civilians: ACO Handbook*, 11 March 2021, p. 15, available at: <https://shape.nato.int/resources/3/website/ACO-Protection-of-Civilians-Handbook.pdf>.

181 T. Williams, A. Jackson and V. Murphy, above note 65.

182 NATO, above note 180, pp. 15, 19.

183 L. Voss, above note 178, p. 309.

various mental harm probabilities. Such research could shape mental harm prediction models that can be embedded into existing incidental civilian harm assessment algorithms or calculations (that must accompany and not replace qualitative human reasoning),¹⁸⁴ as suggested by Liebllich in relation to PTSD.¹⁸⁵ Crucially, this further research should not be contoured around rigid mental health “disorder” categories to ensure that it does not exclude aforementioned experiences of mental harm which do not align with those categories.

Foreseeability could also be strengthened by drawing robust inferences with accepted legal categories of intentional mental harm, such as psychological torture and acts of terror. For example, depending on the intensity of the suffering inflicted, sleep deprivation can be recognized as either psychological torture or inhuman treatment under international human rights law,¹⁸⁶ and thus it is foreseeable that military attacks which will result in persistent sleep disturbance could cause mental harm.

Measurability

The perceived intangible nature of mental harm is commonly quoted as a barrier to its measurability and thus a justification for its exclusion from proportionality analyses. This has been convincingly rebutted by Liebllich and others, who observe the intangibility of some physical harms and the fact that mental harm is sufficiently tangible to be considered in other international and domestic legal provisions, including parallels drawn from tort law.¹⁸⁷ Other concerns over the measurability of anticipated mental harm rest on the challenge of assigning weight to it to balance it against a concrete and direct anticipated military advantage. Such concerns are rebutted by Gillard, who notes the equal difficulty of assigning weight to physical harm.¹⁸⁸ The weighing and balancing inherent within the principle of proportionality is not an exact science and will always be flawed since the values it seeks to compare (military advantage and civilian harm) are not directly commensurable. The opacity in weighing anticipated mental harm is therefore not unique to mental harm but is linked to the principle of proportionality itself. Notably, the ICRC’s 1987 Commentary on the Additional Protocols asserts that when there is “hesitation” over whether an attack would be disproportionate, “the interests of the civilian population should prevail”.¹⁸⁹

184 S. Wilkinson, above note 3. On the need for proportionality assessments to remain rooted in qualitative human reasoning, see J. Dorsey, above note 89, p. 1071.

185 E. Liebllich, above note 4, p. 214.

186 European Court of Human Rights, *Ireland v. The United Kingdom*, Case No. 5310/71, Judgment, 18 January 1978, paras 167–168.

187 E. Liebllich, above note 4, pp. 204–205, 212–213; S. Wilkinson, above note 3; Emanuela-Chiara Gillard, “Joint Symposium: Chatham House Report on Proportionality in the Conduct of Hostilities – Some Key Elements”, *EJIL: Talk!*, 28 January 2019, available at: www.ejiltalk.org/joint-symposium-chatham-house-report-on-proportionality-in-the-conduct-of-hostilities-some-key-elements/.

188 E.-C. Gillard, above note 88, p. 33.

189 Y. Sandoz, C. Swinarski and B. Zimmerman, above note 112, para. 1979.

A culturally and contextually sensitive approach to mental harm raises additional challenges for measurability due to the diverging tension between quantification and contextualization. Quantitative studies (as called for above) will be key to informing prediction models for anticipating mental harm, but the quantification of harm has been criticized by Glasman, among others, for its decontextualization, individualization and erasure of collective or relational social experiences¹⁹⁰ – crucial considerations highlighted in this article. Other critics also observe how the construction of quantitative knowledge is shaped by conceptual and epistemological particularities and the interpretive creation of categories, as a result of which it does not necessarily entirely reflect reality.¹⁹¹ Thus, it is argued here, the quantification of mental harm in research intended to inform decisions of proportionality must be accompanied by localized qualitative information. To ensure that measuring mental harm does not come at the expense of contextualizing lived experiences, policy-makers, military strategists and armed actors can rely on the wealth of research that already exists regarding localized approaches to mental and emotional well-being. Of particular importance are the likes of Rasmussen *et al.*'s systematic review of diverse cultural concepts and idioms of post-traumatic stress that sit outside of standardized “disorder” categories.¹⁹² Ultimately, a balance must be struck between the contextualization and cultural sensitivity of mental harm on the one hand, and on the other, the need for robust data to inform prediction models and enable confidence in the anticipation of mental harm.

Causal attribution

As the principle of proportionality seeks to capture harms that result from a single attack, it requires a foreseen causal relationship between the planned attack and the anticipated incidental harm. The causation requirement is an *ex ante* assessment of whether an attack “may be expected to cause” harm, not an assessment of factual causation; hence, anticipation that mental harm would result from an attack, and the expectation that it would not occur but for the attack, is sufficient evidence of causation.¹⁹³ Nevertheless, the issue of causal attribution is a frequently cited obstacle to considering incidental mental harm in proportionality assessments, often justified on the basis that mental harm does not always have a clear, sole cause:¹⁹⁴ for example, when prolonged exposure to hostilities erodes mental well-being incrementally over

190 Joël Glasman, *Humanitarianism and the Quantification of Human Needs: Minimal Humanity*, 1st ed., Routledge, London, 2020, p. 249.

191 Christiane Wilke and Mohd Khalid Naseemi, “Counting Conflict: Quantifying Civilian Casualties in Afghanistan”, *Humanity: An International Journal of Human Rights, Humanitarianism, and Development*, Vol. 13, No. 2, 2022, pp. 199–203; Sally Engle Merry, *The Seductions of Quantification: Measuring Human Rights, Gender Violence, and Sex Trafficking*, University of Chicago Press, Chicago, IL, and London, 2016, p. 14.

192 Andrew Rasmussen, Eva Keatley and Amy Joscelyne, “Posttraumatic Stress in Emergency Settings Outside North America and Europe: A Review of the Emic Literature”, *Social Science and Medicine*, Vol. 109, 2014.

193 E.-C. Gillard, above note 88, pp. 18–19.

194 *Ibid.*, p. 32; N. Lubell and A. Cohen, above note 118, p. 174; L. Gisel, above note 103, p. 36.

time, it can be hard to pinpoint one attack as the cause or rule out potential intervening causes.¹⁹⁵ Solomon notes that this issue is subverted by scholars who limit their assessment of incidental mental harm to PTSD, due to its diagnosis requiring a triggering traumatic event¹⁹⁶ – something that is relatively easy to anticipate in an active conflict.¹⁹⁷ However, this article has suggested that anticipating the incidental mental harm of an attack should not rely exclusively on rigid “disorder” categories, and thus it cannot benefit from the causal clarity of PTSD, and nor can other “disorders” that do not contain clear criteria on the causal event triggering the harm. Two central features of the principle of proportionality are relied on here to appease concerns regarding causation: its acceptance of indirect causation and its inherently contextual nature.

First, the principle of proportionality allows for indirect causation, which in turn may accommodate some of the often convoluted causes of mental harm. As codified in AP I, the principle contains no requirement for the anticipated harm to be caused directly by the attack (unlike the anticipated military advantage, which does need to be direct). Therefore, causation can be satisfied through a chain of anticipated events, with no limit on the number of causal steps indicated in AP I.¹⁹⁸ This reverberating dynamic is particularly amenable to a culturally and contextually sensitive approach to mental harm as it allows for harm to be causally attributable to an attack even if it is not geographically or temporally proximate,¹⁹⁹ such as mental harm caused indirectly through the infliction of underlying determinants (see the above section on “Acknowledging Socio-Cultural and Economic Circumstances”). Here proportionality assessments could be aided by further research, including the aforementioned large-scale quantitative studies exploring patterns of mental harm in previous attacks, with the added focus of mapping the specific causal chains and relationships to a sufficient granularity necessary to inform prediction models; this should include longitudinal studies to capture experiences of mental harm that may not be temporally proximate to the causal attack. Second, the highly contextual nature of the principle of proportionality (see the above section on “Considerations When Weighing Mental Harm in Proportionality Analyses”) makes it easier to satisfy causation for incidental mental harm as it requires armed actors – as argued in this article – to consider other underlying social, cultural or economic factors or vulnerabilities that elevate the risk of their attack causing mental harm.

Feasibility

Criticisms of including incidental mental harm in proportionality assessments often centre on feasibility, such as the critique that it would warrant members of armed

195 E. Diamond and T. van Benthem, above note 60, Introduction.

196 DSM-5, above note 36, p. 271.

197 S. Solomon, above note 137, p. 169.

198 E-C. Gillard, above note 88, p. 18.

199 I. Henderson and K. Reece, above note 159, p. 839.

forces or groups to possess unrealistic psychiatric expertise.²⁰⁰ However, in operationalizing incidental mental harm considerations in proportionality analyses, this article has proposed further research that can be utilized in prediction models. These models could be incorporated into existing incidental civilian harm assessment algorithms or calculations, thus negating expectations of medical expertise for armed actors with sophisticated civilian harm estimation technology and for pre-planned attacks. Decisions made in the heat of battle will benefit less from this.

It could also be argued that a culturally and contextually sensitive approach would invite a flood of minor mental harm considerations into proportionality analyses that could paralyze military activities since targeting decisions often need to be made rapidly during conflict. However, the act of balancing to determine proportionality will necessarily set aside minor mental harms in the face of concrete military advantages, just as minor physical harms are, in most conceivable scenarios, unlikely to alter armed actors' planned attacks. In requiring the consideration of incidental mental harm, it does not follow that said harm must be mitigated or prevented, but rather that operational adjustments towards avoiding or in any event minimizing the harm should be explored.²⁰¹ Nevertheless, non-mitigatable mental harms, including those that fall outside of or beneath Western "disorder" categories, ought to still be acknowledged as lived experiences of conflict, and not ignored.

Criticisms of incorporating mental harm into proportionality assessments often hyperbolize the uncertainty surrounding mental harm and juxtapose it to the predictability of physical harm without acknowledging that *jus in bello* proportionality is, by design, saturated with uncertainty and "famously vague".²⁰² Neither side of a proportionality equation can be predicted without a margin of error. Lieblch provides a crucial reminder that proportionality is "intrinsically woven with the notion of 'feasibility'",²⁰³ thus, reasonable foreseeability of incidental mental harm, in light of what is feasible, is all that is required.

Finally, arguably the greatest hurdle relevant to feasibility is the will of the armed actor to include considerations of mental harm in decisions of attack. Currently, armed actors appear to demonstrate little political will to include incidental mental harm considerations, and it could be that the proffered culturally and contextually sensitive approach challenges political will even further due to its perceived complexity and the limited capacities of armed actors on the ground. As much of IHL does, implementation will rely on the armed actor's willingness to interpret treaties in good faith.

200 E. Lieblch, above note 4, p. 211.

201 S. Wilkinson, above note 3; Solon Solomon, "Bringing Psychological Civilian Harm to the Forefront: Incidental Civilian Fear as Trauma in the Case of Recurrent Attacks", *EJIL: Talk!*, 25 April 2018, available at: www.ejiltalk.org/bringing-psychological-civilian-harm-to-the-forefront-incidental-civilian-fear-as-trauma-in-the-case-of-recurrent-attacks/.

202 E. Lieblch, above note 4, p. 211.

203 *Ibid.*

Conclusion

The mental health toll of war cannot continue to be pushed aside, nor forced into unmalleable Western categorizations that obscure some lived realities. This article's analysis of the principle of proportionality in attack and its implementation observes a weakness in the form of the continued hierarchization of physical harms. Yet, mental harms caused by war are just as prevalent and destructive as physical harms. Excluding excessive incidental mental harm from the principle of proportionality leaves civilian objects such as cars and animal livestock better protected than human mental health,²⁰⁴ and risks hollowing out the principle and skewing its delicate balance between military necessity and humanity. This article does not call for legal reform; rather, it argues that a dynamic and culturally and contextually sensitive interpretation of the principle of proportionality, supported by further research, can fill the gap and stem the currently under-regulated infliction of excessive incidental mental harm in conflict.

This article is the first to invite reflections from the decolonizing global mental health agenda into the ongoing discussions about incidental mental harm and proportionality in attack. It has shown that efforts encouraging considerations of mental harm within decisions of attack in war must not be complicit in reinforcing a hegemonic universalization that privileges the experiences, theories and concepts of some at the expense of others. Rather, alternative knowledges and diverse conceptualizations of mental harm that hold relevance for the affected community themselves must be embraced. Knowledge of the socio-cultural deviations in how mental harm is experienced should be deepened and continually integrated into mainstream mental health dialogues – including those around the principle of proportionality in attack.

The present discussion provides a step towards addressing decolonial critiques of how incidental mental harm is engaged with for the purpose of the principle of proportionality in attack. The suggested culturally and contextually sensitive approach seeks to re-centre the lived experiences of affected communities in both law and practice. It hopes to encourage armed actors, policy-makers, researchers, and all those working in the conflict sphere to work towards the goal of integrating mental harm into the implementation of *jus in bello* proportionality in a way that is more coherent with a wider range of lived experiences of conflict and which will ultimately improve mental health protections in war.

204 *Ibid.*, p. 193.