

Beyond psychological support: An integrated approach to protecting the mental health of aid workers operating in armed conflict settings

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Abstract

There is compelling evidence that humanitarian staff and volunteers face an increased risk of adverse mental health conditions due to their work, including anxiety, depression, post-traumatic stress disorder, and burn-out. This article first outlines the mental health consequences associated with working in the humanitarian sector, linking these outcomes to contextual, operational and organizational psychosocial risk factors. Building on both the evidence available and the theoretical models in mental health at the workplace, and going beyond solely offering psychosocial support interventions, we propose an evidence-based framework to guide protective actions at the individual, group, leader, organizational and overarching contextual levels (the IGLOO model), tailored to the specific challenges of humanitarian contexts. Based on our experience with the International Committee of the Red Cross, we present two examples of utilizing this framework within two interventions: (1) training managers to strengthen practices that promote and protect well-being, address psychosocial risk factors, identify individuals showing signs of distress and facilitate safe access to psychological support, and (2) applying a psychosocial response framework to support staff following critical incidents. Finally, we discuss the advantages and challenges of adopting an integrated psychosocial approach to staff care, drawing implications for policy and practice from our interventions and broader experience within the sector. We conclude that humanitarian organizations should adopt an integrated approach to duty of care, prioritizing not only treatment but also the prevention and mitigation of psychological harm among staff and volunteers operating in conflict zones, extending beyond immediate crisis support to ensure sustainable protection of mental health.

Keywords: humanitarian workers, mental health, organizational support, managers, well-being, crisis response, anxiety, PTSD, burn-out, depression, MHPSS, psychosocial support, integrated systems, IGLOO model.

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Introduction

Humanitarian workers living and operating in armed conflict-affected settings face multiple psychological challenges arising not only from their constant exposure to violence, displacement and human suffering, but also from organizational

stressors related to the way in which work is structured and delivered. Consequently, numerous studies have reported significantly elevated rates of adverse mental health conditions among this group compared with the general population,¹ including higher rates of anxiety,² depression,³ post-traumatic stress disorder (PTSD),⁴ burn-out,⁵ secondary traumatic stress,⁶ compassion fatigue,⁷ general psychological distress⁸ and suicidal ideation.⁹ The mental health consequences of their work vary and are unequally distributed across different subgroups; younger humanitarians,¹⁰ for instance, often present higher levels of stress and a reduced capacity for coping (likely due to limited experience in challenging environments), which exposes them to greater risk of burn-out and depression.¹¹ Similarly, women workers frequently experience adverse mental health consequences¹² compounded by the risk of gender-based violence,¹³ harassment and discrimination in the workplace.¹⁴ It is not surprising that local workers,¹⁵ who often share the lived experiences and challenges of the populations they serve, manifest higher levels of psychological distress and are at greater risk of PTSD, depression and anxiety compared with both international staff¹⁶ and the general population.¹⁷ Lastly, volunteer workers, who

- 1 Lily Cameron, Mary McCauley, Nynke van den Broek and Hannah McCauley, "The Occurrence of and Factors Associated with Mental Ill-Health amongst Humanitarian Aid Workers: A Systematic Review and Meta-Analysis", *PLoS One*, Vol. 19, No. 5, 2024.
- 2 Barbara Lopes Cardozo *et al.*, "Psychological Distress, Depression, Anxiety, and Burnout among International Humanitarian Aid Workers: A Longitudinal Study", *PLoS One*, Vol. 7, No. 9, 2012.
- 3 Barbara Lopes Cardozo *et al.*, "The Mental Health of Expatriate and Kosovar Albanian Humanitarian Aid Workers", *Disasters*, Vol. 29, No. 2, 2005.
- 4 Ellen Connorton, Melissa J. Perry, David Hemenway and Matthew Miller, "Humanitarian Relief Workers and Trauma-Related Mental Illness", *Epidemiologic Reviews*, Vol. 34, 2012.
- 5 Thomas Ehring, Saiqa Razik and Paul M. G. Emmelkamp, "Prevalence and Predictors of Posttraumatic Stress Disorder, Anxiety, Depression, and Burnout in Pakistani Earthquake Recovery Workers", *Psychiatry Research*, Vol. 185, No. 1–2, 2011.
- 6 Jan Ilhan Kizilhan, "Stress on Local and International Psychotherapists in the Crisis Region of Iraq", *BMC Psychiatry*, Vol. 20, 2020.
- 7 Saif Ali Musa and Abdalla Hamid, "Psychological Problems among Aid Workers Operating in Darfur", *Social Behavior and Personality: An International Journal*, Vol. 36, No. 3, 2008.
- 8 B. L. Cardozo *et al.*, above note 2.
- 9 Xiao Lu Wang, Paul S. F. Yip and Cecilia L. W. Chan, "Suicide Prevention for Local Public and Volunteer Relief Workers in Disaster-Affected Areas", *Journal of Public Health Management and Practice*, Vol. 22, No. 3, 2016.
- 10 L. Cameron *et al.*, above note 1.
- 11 B. L. Cardozo *et al.*, above note 3.
- 12 Alastair Ager *et al.*, "Stress, Mental Health, and Burnout in National Humanitarian Aid Workers in Gulu, Northern Uganda", *Journal of Traumatic Stress*, Vol. 25, No. 6, 2012.
- 13 Melanie Sauter, "AidToo, or When Situation Permits Rape: Sexual Violence among Humanitarian Aid Workers", *Journal of International Humanitarian Action*, Vol. 9, No. 1, 2024.
- 14 Alice Gritti, "Building Aid Workers' Resilience: Why a Gendered Approach Is Needed", *Gender and Development*, Vol. 23, No. 3, 2015.
- 15 Hannah Strohmeier and Willem F. Scholte, "Trauma-Related Mental Health Problems among National Humanitarian Staff: A Systematic Review of the Literature", *European Journal of Psychotraumatology*, Vol. 6, 2015.
- 16 A. Ager *et al.*, above note 12.
- 17 E. Connorton *et al.*, above note 4.

are commonly recruited to carry out humanitarian activities, show a higher risk of negative mental health outcomes compared with paid staff.¹⁸ While some papers suggest that these higher rates are skewed especially among expats,¹⁹ the overwhelming majority of studies list humanitarian workers as a population at risk for adverse mental health conditions,²⁰ including an increased risk of developing additional morbidities among those with pre-existing mental health diagnoses.²¹

Nevertheless, these mental health consequences can be buffered by personal experiences and factors such as the meaningfulness of one's work,²² older age,²³ having a religious faith or spirituality,²⁴ and the presence of strong social support.²⁵ Although many of these factors are personal, and some are non-modifiable, there has been increasing recognition of various organizational factors associated with psychological morbidity within the humanitarian sector. Practices related to poor leadership,²⁶ unclear communication and role ambiguity²⁷ have consistently been found to predict psychological distress and burn-out; conversely, perceived organizational support,²⁸ strong team cohesion²⁹ and empowering supervisory practices³⁰ have been shown to mitigate stress, depression and burn-out rates within staff and volunteer populations working for humanitarian organizations.³¹ Unsurprisingly, therefore, having a trust-based relationship with a manager who cares and acts

- 18 Hassan Hagh-Shenas, Mohammad Ali Goodarzi, Gholamreza Dehbozorgi and Hassan Farashbandi, "Psychological Consequences of the Bam Earthquake on Professional and Nonprofessional Helpers", *Journal of Traumatic Stress*, Vol. 18, No. 5, 2005.
- 19 Kaz De Jong, Saara Martinmäki, Hans Te Brake, Joris Haagen and Rolf Kleber, "Mental and Physical Health of International Humanitarian Aid Workers on Short-Term Assignments: Findings from a Prospective Cohort Study", *Social Science and Medicine*, Vol. 285, 2021.
- 20 E. Connorton *et al.*, above note 4.
- 21 L. Cameron *et al.*, above note 1.
- 22 Kaz de Jong *et al.*, "How Do International Humanitarian Aid Workers Stay Healthy in the Face of Adversity?", *PLoS One*, Vol. 17, No. 11, 2022.
- 23 Tarli Young and Kenneth I. Pakenham, "The Mental Health of Aid Workers: Risk and Protective Factors in Relation to Job Context, Working Conditions, and Demographics", *Disasters*, Vol. 45, No. 3, 2021.
- 24 Ozgul Ozcan, Mark Hoelterhoff and Eleanor Wylie, "Faith and Spirituality as Psychological Coping Mechanism among Female Aid Workers: A Qualitative Study", *Journal of International Humanitarian Action*, Vol. 6, No. 1, 2021.
- 25 Cynthia B. Eriksson *et al.*, "Predeployment Mental Health and Trauma Exposure of Expatriate Humanitarian Aid Workers: Risk and Resilience Factors", *Traumatology*, Vol. 19, 2013.
- 26 Sigridur Bjork Thormar *et al.*, "Organizational Factors and Mental Health in Community Volunteers: The Role of Exposure, Preparation, Training, Tasks Assigned, and Support", *Anxiety, Stress and Coping*, Vol. 26, No. 6, 2013.
- 27 Sigridur Bjork Thormar *et al.*, "The Mental Health Impact of Volunteering in a Disaster Setting: A Review", *Journal of Nervous and Mental Disease*, Vol. 198, No. 8, 2010.
- 28 Kinan Aldamman *et al.*, "Caring for the Mental Health of Humanitarian Volunteers in Traumatic Contexts: The Importance of Organisational Support", *European Journal of Psychotraumatology*, Vol. 10, No. 1, 2019.
- 29 A. Ager *et al.*, above note 12.
- 30 Áine Travers *et al.*, "Identifying Best Practice for the Supervision of Mental Health and Psychosocial Support in Humanitarian Emergencies: A Delphi Study", *International Journal of Mental Health Systems*, Vol. 16, No. 1, 2022.
- 31 Samantha K. Brooks, Rebecca Dunn, Richard Amlôt, G. James Rubin and Neil Greenberg, "Protecting the Psychological Wellbeing of Staff Exposed to Disaster or Emergency at Work: A Qualitative Study", *BMC Psychology*, Vol. 7, No. 1, 2019.

compassionately towards their team is reported as a protective factor by humanitarians,³² while the opposite appears harmful.³³

Corresponding to the concerning prevalence of adverse mental health outcomes among this population, offering psychosocial support interventions to humanitarian aid workers has been an instrumental approach to mitigate these consequences. These interventions generally include individual and group activities. At the individual level, they involve the provision of psychological first aid³⁴ after exposure to potentially traumatic situations, and access to individual psychological support,³⁵ employee assistance programmes, and external coverage for psychotherapy.³⁶ Other offered activities include mindfulness-based interventions³⁷ and resilience training, which have both shown promise in improving stress management and emotional well-being, although evaluations are often small-scale.³⁸ At the group level, psycho-educational activities³⁹ and stress management interventions⁴⁰ are often offered and have shown some positive results in protecting the mental health of humanitarians. Other suggested programmes include peer support,⁴¹ with limited evaluation reports of these programmes.

Although strong links between adverse mental health outcomes and organizational factors have been well documented, there is still a scarcity of literature examining organizational-level interventions in terms of their impact on the well-being of humanitarians.⁴² Nevertheless, several proposals emphasize the importance of training managers and supervisors to improve communication, understanding

32 *Ibid.*

33 Liza Jachens, Jonathan Houdmont and Roslyn Thomas, "Work-Related Stress in a Humanitarian Context: A Qualitative Investigation", *Disasters*, Vol. 2, No. 4, 2018.

34 Esra Bekircan, Galip Usta and Kemal Torpuş, "The Effect of Psychological First Aid Intervention on Stress and Psychological Resilience in Volunteers Participating in 2023 Earthquakes Centered in Kahramanmaraş, Turkey", *Current Psychology*, Vol. 43, No. 12, 2023.

35 Samantha K. Brooks, Rebecca Dunn, Richard Amlôt, Neil Greenberg and G. James Rubin, "Social and Occupational Factors Associated with Psychological Distress and Disorder among Disaster Responders: A Systematic Review", *BMC Psychology*, Vol. 4, No. 1, 2016.

36 Caitlin Cockcroft-McKay and Francisco José Eiroa-Orosa, "Barriers to Accessing Psychosocial Support for Humanitarian Aid Workers: A Mixed Methods Inquiry", *Disasters*, Vol. 45, No. 4, 2021.

37 Carolyn Deans and Shannon Carter, "Evidenced Interventions Supporting the Psychological Wellbeing of Disaster Workers: A Rapid Literature Review", *International Journal of Environmental Research and Public Health*, Vol. 22, No. 9, 2025.

38 Colm B. Doody *et al.*, "Pre-Deployment Programmes for Building Resilience in Military and Frontline Emergency Service Personnel", *Cochrane Database of Systematic Reviews*, No. 2021/12, 2021.

39 June Okanoya *et al.*, "Psychoeducational Intervention to Prevent Critical Incident Stress among Disaster Volunteers", *Kitasato Medical Journal*, Vol. 45, 2015.

40 Capucine de Fouchier and Marianne S. Kedia, "Trauma-Related Mental Health Problems and Effectiveness of a Stress Management Group in National Humanitarian Workers in the Central African Republic", *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, Vol. 16, No. 2, 2018.

41 Penelope Curling and Kathleen B. Simmons, "Stress and Staff Support Strategies for International Aid Work", *Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, Vol. 8, No. 2, 2010.

42 Samantha K. Brooks *et al.*, "Risk and Resilience Factors Affecting the Psychological Wellbeing of Individuals Deployed in Humanitarian Relief Roles after a Disaster", *Journal of Mental Health*, Vol. 24, No. 6, 2015.

and their capacity to embody supportive management practices. In their *Mental Health at Work* policy brief, for example, the World Health Organization (WHO) and International Labour Organization (ILO) have identified manager and supervisor training as one of the essential pillars for protecting and promoting employees' mental health.⁴³ The guidelines contained in the policy brief highlight the crucial role of managers in recognizing psychosocial risk factors related to a team's work, identifying and responding to emotional distress, practising active listening, and promoting and advocating for mental health activities within the organizational hierarchy. Although the WHO and ILO recommendations were developed within a general context beyond the humanitarian sector, the need for such competences would be more pronounced in that sector, given the importance of their application. In the same vein, as our collective understanding of the need to protect and promote mental health for humanitarians working in emergency settings evolves, much of the current focus remains on responding to psychological needs during and after crises and on individual coping approaches for those who work or volunteer for humanitarian organizations. There is still very little emphasis on comprehensive strategies that address the prevention effort proactively and efficiently, from an organizational perspective, despite the clear impact of mental health in the workplace on productivity,⁴⁴ presenteeism, absenteeism,⁴⁵ and turnover rates.⁴⁶

Based on the arguments above, outlining risks and protective factors for the mental health of humanitarian aid workers, psychosocial support interventions at the individual and group levels alone are not sufficient to protect the mental health of humanitarians, as such interventions often miss the opportunity to address the root causes of the burden.⁴⁷ As an alternative, there is a growing interest in an integrated approach that tackles individual, group and organizational factors, and research has begun to shed light on its potential benefits.⁴⁸ In this article we propose a theoretical framework that corresponds to this approach, and provide examples of practical applications of it within our practice at the International Committee of the Red Cross (ICRC). The proposed framework is grounded in the premise that modifying organizational and contextual psychosocial risks will improve the mental health

43 WHO and ILO, *Mental Health at Work*, policy brief, Geneva, 2022.

44 Claire de Oliveira, Makeila Saka, Lauren Bone and Rowena Jacobs, "The Role of Mental Health on Workplace Productivity: A Critical Review of the Literature", *Applied Health Economics and Health Policy*, Vol. 21, No. 2, 2023.

45 Elena Grinza and François Rycx, "The Impact of Sickness Absenteeism on Firm Productivity: New Evidence from Belgian Matched Employer–Employee Panel Data", *Industrial Relations: A Journal of Economy and Society*, Vol. 59, No. 1, 2020.

46 Maria Pinheiro, Igor Ivandic and Djalma Razzouk, "The Economic Impact of Mental Disorders and Mental Health Problems in the Workplace", in Djalma Razzouk (ed.), *Mental Health Economics*, Springer, Cham, 2017.

47 Cheryl Yunn Shee Foo, Helen Verdelli and Alvin Kuowei Tay, "Psychosocial Interventions for Occupational Stress and Psychological Disorders in Humanitarian Aid and Disaster Responders: A Critical Review", in Colin R. Martin, Vinood B. Patel and Victor R. Preedy (eds), *Handbook of Cognitive Behavioral Therapy by Disorder: Case Studies and Application for Adults*, Elsevier, London, 2022.

48 Mahmood Othman, Zachary Steel, Catalina Lawsin and Ruth Wells, "Addressing Occupational Stress among Health Staff in Nongovernment Controlled Northern Syria: Supporting Resilience in a Dangerous Workplace", *Torture*, Vol. 28, No. 3, 2018.

of humanitarians, advocating a shift from reactive measures to a long-term strategy focused on the prevention and promotion of mental well-being.

Tailoring science to practice: The IGLOO framework for humanitarians' mental health

Evolving research trends in health and well-being at work have shifted from focusing on individual variables toward a summative approach to explaining occupational stress and well-being, such as the job demands–resources model⁴⁹ and the effort–reward imbalance model.⁵⁰ The job demands–resources model posits that the extent of imbalance between job demands and resources in the workplace is a salient predictor of adverse mental health outcomes. When demands exceed resources, individuals accumulate stress, putting their well-being at risk, whereas sufficient resources stimulate motivation and engagement. Particularly important for humanitarian workers, resources (e.g., social support, organizational support) can buffer the adverse impact of excessive demands on staff and volunteers' mental health and well-being,⁵¹ accordingly, within the demanding nature of this work, a workplace that provides adequate resources can have a profound preventative effect. The conservation of resources (COR) theory⁵² further explains that people's resources exist not in isolation but rather in clusters for both individuals and organizations, and thus, the ecological conditions in the workplace either nurture or limit resource maintenance.⁵³ In the context of armed conflict response, where humanitarians are exposed to extremely stressful and potentially traumatic events, available resources (such as organizational support) gain a more pronounced value than in normal situations,⁵⁴ making them crucial.

From another angle, the current understanding of psychosocial risk factors in the workplace clearly classifies them as modifiable factors for mental health problems.⁵⁵ Therefore, recognizing and adjusting them plays an important preventive role in maintaining staff and volunteers' mental health. Particularly in crises, an approach to staff and volunteer care which considers how to recognize and modify these risk factors would arguably reduce the significant resource loss that

49 Evangelia Demerouti, Arnold B. Bakker, Friedhelm Nachreiner and Wilmar B. Schaufeli, "The Job Demands-Resources Model Of Burnout", *Journal of Applied Psychology*, Vol. 86, No. 3, 2001.

50 Johannes Siegrist, "Adverse Health Effects of High-Effort/Low-Reward Conditions", *Journal of Occupational Health Psychology*, Vol. 1, No. 1, 1996.

51 Arnold B. Bakker, Evangelia Demerouti and Martin C. Euwema, "Job Resources Buffer the Impact of Job Demands on Burnout", *Journal of Occupational Health Psychology*, Vol. 10, No. 2, 2005.

52 Stevan E. Hobfoll, "Conservation of Resources: A New Attempt at Conceptualizing Stress", *American Psychologist*, Vol. 44, No 3, 1980.

53 Stevan E. Hobfoll, Jonathon Halbesleben, Jean-Pierre Neveu and Mina Westman, "Conservation of Resources in the Organizational Context: The Reality of Resources and Their Consequences", *Annual Review of Organizational Psychology and Organizational Behaviour*, Vol. 5, No. 1, 2018.

54 S. E. Hobfoll, above note 52.

55 Anthony D. LaMontagne *et al.*, "Workplace Mental Health: Developing an Integrated Intervention Approach", *BMC Psychiatry*, Vol. 14, No. 131, 2014.

impacts humanitarians' mental health.⁵⁶ Matching the WHO and ILO policy brief, which outlines workplace mental health interventions across three interconnected strategies (preventing harm by addressing psychosocial risks, protecting and promoting mental health by raising awareness and fostering resilience, and supporting those negatively affected by ensuring appropriate channels of care),⁵⁷ we sought to mobilize a practical framework to map workplace interventions.⁵⁸ Following the suggested model for practices/resources on the individual, group, leader, organizational and overarching contextual levels, known as the IGLOO model,⁵⁹ we propose the following practices as an integrated approach to care.

- **Individual level:** Interventions at this level target personal characteristics and needs, including increasing resources available to staff and volunteers. This may include preparing them for the challenges of their work through psycho-education on common psychological reactions, and the development of skills for stress management and emotional regulation. Access to health-care services, including psychological support and specialized mental health care for those in need, is another important intervention.
- **Group level:** This level involves practices and interventions that aim to mobilize social support in the workplace, including emotional and practical support, as well as strengthening collaboration and cohesion. Examples include group psychological support activities after critical incidents, peer support programmes, reflective spaces to foster solidarity and trust, and activities that facilitate mutual learning and sharing with a focus on shared values.
- **Leader level:** Recognizing the cardinal protective role that managers and supervisors can play not only with practical considerations such as workload management or role clarity, but also in terms of creating a caring environment, the leaders' role is highlighted repeatedly. Examples of interventions at this level include equipping managers with the skills for reflective practice, empathetic communication and team workload management, as well as the ability to recognize signs of distress and facilitate access to support.
- **Organizational level:** This level involves interventions related to both policies and cultural norms within the organization, where protecting the mental health of personnel is a key component of the duty of care policy and practice.⁶⁰ Such interventions include measures to manage internal psychosocial risks such as excessive workload, as well as measures to protect staff from

⁵⁶ S. E. Hobfoll, above note 52.

⁵⁷ WHO and ILO, above note 43.

⁵⁸ Karina Nielsen, Cristina Di Tecco, Jo Yarker and Michela Vignoli, "An Integrated Approach to Managing Wellbeing in the Workplace", in Paula Brough and Gail Kinman (eds), *Wellbeing at Work in a Turbulent Era*, Edward Elgar, Cheltenham, 2024.

⁵⁹ Karina Nielsen, Jo Yarker, Fehmidah Munir and Ute Bültmann, "IGLOO – an Integrated Framework for Sustainable Return to Work in Employees with Common Mental Disorders", *Work and Stress*, Vol. 32, No. 4, 2018.

⁶⁰ Liza Jachens, "Humanitarian Aid Workers' Mental Health and Duty of Care", *Europe's Journal of Psychology*, Vol. 15, No. 4, 2019.

exposure to security risks and inappropriate behaviours, including sexual harassment.⁶¹ While wider literature highlights the role of autonomy and participation in decision-making,⁶² a special focus in humanitarian-work-adapted practices would also include proactive preparedness, informed consent on security and health risks, and robust insurance coverage.⁶³ Tailored human resources (HR) policies such as special leave after exposure to critical incidents,⁶⁴ special protocols for reintegrating those impacted with flexible work arrangements, gradual return-to-work practices and ongoing monitoring of their well-being, and rest and recuperation breaks in high-risk assignments form another important type of intervention. Given the unique demands of humanitarian work, the adaptation of standard HR management practices to accommodate these demands, rather than applying generic HR standards from other sectors, is a key factor without which engagement and trust would be jeopardized.⁶⁵ We strongly advocate for organizational policies that facilitate equity in terms of resources for volunteers and local and international staff, including equivalent insurance schemes and post-exposure support, regardless of contract type.

- **Overarching context:** As with any programme or intervention in the humanitarian sector, adapting to the specific context in which people operate is a critical element. Recognizing the diverse cultural and geopolitical settings in which organizations function and teams live and work, mental health and well-being interventions should be both context-sensitive and inclusive. Accordingly, interventions at this level should ensure cultural competence for those working in cultures different from their own.⁶⁶ This level also integrates awareness of external factors such as legal frameworks, security conditions, conflict dynamics, specific resources and capacities available within the organization, and community norms into organizational strategies for staff safety and well-being,⁶⁷ helping to ensure that protective systems are grounded in the realities of the operating environment.

61 M. Sauter, above note 13.

62 Thomas Clausen, Line Rosendahl Meldgaard Pedersen, Malene Friis Andersen, Töres Theorell and Ida E. H. Madsen, “Job Autonomy and Psychological Well-Being: A Linear or a Non-Linear Association?”, *European Journal of Work and Organizational Psychology*, Vol. 31, No. 3, 2022.

63 Samantha K. Brooks, Rebecca Dunn, Richard Amlôt, Neil Greenberg and G. James Rubin, “Training and Post-Disaster Interventions for the Psychological Impacts on Disaster-Exposed Employees: A Systematic Review”, *Journal of Mental Health*, February 2018.

64 Ann Hergatt Huffman *et al.*, “The Role of Potential Traumatic Events and Work Overload on Wellbeing Outcomes: An Analysis of Four Competing Models”, *Occupational Health Science*, Vol. 9, No. 1, 2025.

65 Hamdullah Azimi, Mohammad Yusuf Saleh and Muhammad Ismail Basharmal, “Role of International Human Resource Management in International NGOs and Humanitarian Organizations”, *European Journal of Management Issues*, Vol. 33, No. 2, 2025.

66 Jorunn M. Dale and Mohammed F. Dulaimi, “Cultural Competence – a Success Factor in NGO Projects?”, *Built Environment Project and Asset Management*, Vol. 6, No. 2, 2016.

67 Kinan Aldamman, “Managerial Practices to Ensure the Well-Being of Humanitarian Volunteers: A Realist Evaluation”, PhD thesis, Trinity College Dublin, School of Psychology, 2020.

Organizational support theory⁶⁸ explains that the extent to which staff perceive support offered by their organizations, constructed as “perceived organizational support” (POS), has a strong impact on various organizational outcomes, including performance and commitment,⁶⁹ as well as employees’ well-being.⁷⁰ POS has also proven significantly relevant to humanitarian workers’ mental health.⁷¹ The IGLOO framework presented above provides a practice-based guide for interventions that also contribute to increasing POS among humanitarians, and supports a systematic approach to fostering their mental health and well-being.⁷² This offers a roadmap for an integrated, multilayered staff care approach that moves beyond crisis response to address the modifiable, prevalent psychosocial risk factors in the humanitarian workplace. The following sections offer examples of the practical utilization of these considerations.

Example 1: Managers’ training to promote healthy management practices that support staff well-being, prevent mental illness, and facilitate access to psychological support

In the preceding pages, we have provided a brief explanation of the vital role of managers in mitigating workplace stressors that lead to psychological distress among humanitarian staff and volunteers. This role yields positive results if managers understand staff mental health, are sensitive to the psychological burden of humanitarian work and are equipped with tools to prevent harm and offer support. Managers are often seen as the key representatives of their organization, embodying its values, culture and commitment to staff care. In that sense, managers and leaders are recognized as major contributors to enhancing POS.

In this context, a workshop for managers at the ICRC was developed to reinforce their skills and commitment to implementing healthy managerial practices within their scope of responsibilities. The workshop was designed with three overlapping objectives: to promote staff well-being through promotive and protective managerial practices, to equip managers to recognize signs of distress among team members and conduct supportive conversations, and to provide tools to help managers maintain their own mental health and well-being. It is delivered in three sessions, each of which lasts three hours and is focused on one of these aims. The workshop is designed for small groups (six to twelve managers), allowing for

68 Robert Eisenberger, Robin Huntington, Steven Hutchison and Debora Sowa, “Perceived Organizational Support”, *Journal of Applied Psychology*, Vol. 71, No. 3, 1986.

69 James Kurtessis *et al.*, “Perceived Organizational Support: A Meta-Analytic Evaluation of Organizational Support Theory”, *Journal of Management*, Vol. 43, No. 6, 2017.

70 Robert Eisenberger, Linda Rhoades Shanock and Xueqi Wen, “Perceived Organizational Support: Why Caring about Employees Counts”, *Annual Review of Organizational Psychology and Organizational Behavior*, Vol. 7, No. 1, 2020.

71 K. Aldamman *et al.*, above note 28.

72 Karina Nielsen, Glorian Sorensen, Nadia El-Salanti and Michael Munch-Hansen, *Designing, Implementing, and Evaluating Sustainable Interventions in Organizations: The How-To of Improving Worker Health and Well-Being*, Oxford University Press, Oxford, 2025.

interactions and mutual reflection among participants, and is delivered either online or in person by a staff psychosocial support specialist. We utilize a variety of interactive learning methods, including brief presentations, small group discussions, polls, role-plays, individual exercises and pair work, to optimize group engagement and learning.

The first session is grounded in prior theoretical work on humanitarian workers' mental health.⁷³ It includes a first section that underpins the role of managers in identifying and managing the psychosocial risks to staff mental health, and a second that explores in practical terms the practices that promote well-being (e.g., offering regular feedback and encouraging group tasks) and address risk factors for staff mental health (e.g., workload and role ambiguity). Managers then reflect on these practices in small groups, bringing their own experiences and sharing the challenges they may face while implementing them, in order to discuss potential solutions for overcoming these challenges collectively.

The second session builds on the first, introducing further competencies for identifying potential signs of distress among team members. It proposes a safe and structured method for carrying out supportive conversations with those who manifest signs of distress. The aim of these conversations is grounded exclusively in the intention to support; therefore, they are made clearly distinct from performance appraisal. Instead, supportive conversations embody a safe and confidential space marked by empathetic, active listening, and non-judgemental attitudes. Ultimately, the aim is to propose and discuss adjustment measures that support improving the situation and encourage seeking psychological support. Managers then discuss this framework in different proposed scenarios, including regular work situations, immediately after a critical incident, and upon returning to work after prolonged sick leave. We chose the scenarios based on our trending experiences of supporting humanitarian workers, focusing on internal organizational factors rather than conflict-related ones. Participants lastly role-play the situations, and groups end with feedback on each other's approach.

The last session of the workshop is dedicated to the managers' own mental health and well-being, including reflective exercises on managing work-related stress, addressing work-life conflicts, understanding and preventing burn-out, and developing and implementing mental health self-care plans.

We implemented multiple tracks of the workshop through our staff psychosocial team, targeting volunteer managers. These were delivered in diverse settings, including mixed organizational structures and both online and offline modalities, with the overarching aim of mobilizing humanitarian managers in a holistic psychosocial model to protect staff mental health and well-being. We also managed to gather feedback from those who participated in order to measure their perceptions and experiences of the participation. Out of the seventy-three responses we have already analyzed, participant satisfaction rate was high (8.82/10), and the participants reported that they would strongly recommend the workshop to other

73 K. Aldamman, above note 67.

Table 1. *Perceived knowledge gain indicators reported by participants of the managers' workshop (n=73)*

Indicator	Mean value (out of 5)
Understanding risks to staff mental health and well-being	4.32
Exploring managerial methods for promoting/addressing risks to team mental health and well-being	4.26
Identifying signs of distress among team members	4.27
Conducting supportive conversations with team members in distress	4.22
Getting ideas and inspiration for self-care	4.38

managers (9.21/10). Furthermore, when assessing the perceived knowledge gain across five indicators using a five-point Likert scale (1 = not at all, 5 = very much), results indicated a substantial positive impact, with average scores consistently above 4.20/5 (see Table 1). According to the same feedback, the workshops have served as a very appropriate channel for gaining knowledge and practice reflections; however, many managers pointed out the difficulties they face in scheduling time to attend three different sessions, and the insufficiency of this training for sustained supportive managerial action in the face of organizational complexities and a lack of consistent investment in the matter.

Example 2: Mitigating the impact of security incidents – the IGLOO model in action when teams are confronted with threats

In this section we provide two cases to illustrate the utilization of the IGLOO framework in crises, as supportive workplace practices, including social and leadership support, are increasingly recognized as being among the most effective means of facilitating recovery following potentially traumatic and extremely stressful situations in the workplace.⁷⁴ In our experience, minimizing the psychological harm to humanitarian teams in critical situations requires mainstreaming psychosocial considerations into the crisis management response rather than relying on a solo psychological intervention. In the previous sections, we linked resource loss and well-being based on COR principles. Expanding on the same concepts, Hobfoll and colleagues identified the essential psychosocial resources that can mitigate mental

74 Francine Watson *et al.*, “Managing Trauma in the Workplace: Evolving Workplace Mental Health Practices for a Changing World”, *National Forum for Health and Wellbeing at Work*, Alliance Manchester Business School, Manchester, 2026.

health risks for those affected by potentially traumatic and extremely stressful situations.⁷⁵ We have mainstreamed the promotion of these resources of safety, calming, individual and collective efficacy, connectedness, and hope, throughout the security management framework and via all responders. Management, security focal points, human resources, peers and other functions can all contribute to mitigating the impact of workplace trauma by promoting these resources wherever they operate within the IGLOO framework.

The first of the two cases examined in this section was an incident that took place during an aid activity resulting in serious casualties. In the second case, a team was confronted and detained by an armed group for several hours, during which a commander showed unpredictable and humiliating behaviour, threatening the team with a longer detention, kidnapping or even a fatal outcome. In both situations, staff felt that their humanitarian mission and organization were severely disrespected.

As is well recognized, preparedness⁷⁶ is critical because mitigating the impact starts long before an incident takes place, and is a key organizational responsibility. In the first case, the management team and the other support functions that had to respond to the death of staff who came under shelling had recently participated in a crisis management exercise. They felt prepared and were able to respond swiftly and with mastery, which reduced their own stress. Key support functions, including staff health doctors, the psychosocial support team, trained family liaison officers and the human resource manager, were ready to be deployed to the site where the affected team and families were gathered. The staff psychosocial support team was included in the response discussions and actions, aiming to integrate the Hobfoll essential elements into its actions; this resulted in the response being perceived as very supportive by the wider affected team in a subsequent evaluation. The efficient and swift response in managing the aftermath of the crisis increased the sense of safety and collective efficacy for the affected teams. This integration was highlighted as very caring and supportive.

Another key organizational practice in this case was the application of a special leave policy, allowing the affected staff to take days off to rest and recover in acknowledgement of their difficult experiences.⁷⁷ This policy was applied following the logic of circles of impact, recognizing that it is not only those directly affected by the violent event who are affected, but also those who have to manage the aftermath.⁷⁸

Group support was highlighted as a key element in the recovery of the teams affected, as groups play a key role in providing social support and hope.⁷⁹

75 Stevan E. Hobfoll *et al.*, "Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence", *Psychiatry*, Vol. 70, No. 4, 2007.

76 S. K. Brooks *et al.*, above note 63.

77 A. H. Huffman *et al.*, above note 64.

78 Cynthia B. Eriksson, Hendrika Vande Kemp, Richard Gorsuch, Stephen Hoke and David W. Foy, "Trauma Exposure and PTSD Symptoms in International Relief and Development Personnel", *Journal of Traumatic Stress*, Vol. 14, No. 1, 2001.

79 Courtney Welton-Mitchell *et al.*, "Empowering Ukrainian Healthcare and Humanitarian Aid Workers: Cocreating a Peer Support Staff Wellbeing Curriculum", *Frontiers in Public Health*, Vol. 13, 2025.

Injured staff members received messages and visits of support from their peers, and teams appreciated the care and support provided to the families of their deceased colleagues – staff positively highlighted the commemoration initiatives carried out by the management team and the logistical support provided to those who wanted to attend the funerals, allowing for collective moments of bereavement and support, which increased the sense of community. Similarly, in the second case, the team recovering from detention by an armed group was received by their colleagues, who had organized a welcoming breakfast the day after their arrival, accompanied by warm messages displayed on a board. This peer support reinforced a sense of belonging and connectedness in the workplace.⁸⁰ It was also instrumental in building bonds between teams, sharing the fear and frustration they had experienced, and exchanging knowledge of the job and the context. This opportunity for sharing is not something that everyone dares to have even in family or more intimate circles in such difficult situations, and was therefore invaluable.

Leaders and managers play a critical role, as we have highlighted above. In the first case, the rapid, regular and transparent communication about the circumstances and how the ICRC was responding to support the affected staff and their families contributed to re-establishing the feeling of safety and the perceived support in teams present in the country, not only in the affected site. Likewise, in the second case, staff who had been detained highlighted the importance of their manager on their return to the base; informed by his previous training in the managers' workshop discussed in our first example, his welcoming attitude, marked by a listening and observant approach towards their immediate needs, was crucial. The manager's willingness to schedule an operational and supportive space intended for sharing emotional experiences the following day, the invitation to the staff psychosocial team to be involved, and the manager's openness during these spaces to listen and provide clarifications on the decision-making criteria all contributed positively to the team regaining a sense of safety and trust.⁸¹ Team members felt that the difficulties they had faced were recognized, and they gained a better understanding of their manager's challenges as well. They valued the way their manager encouraged them to take care of themselves and activated the special leave for all to recover, endorsed by the organization's policy. With this thorough management approach, the psychosocial risk factors associated with the situation were carefully identified and addressed.

While the practices above showed a greater effect of mitigating the impact on the individuals affected, nonetheless, due to various factors such as personal circumstances, levels of exposure and previous history,⁸² some affected staff were in need of and benefited from individual psychological support. An initial intervention

80 Elvira Cicognani, Luca Pietrantonio, Luigi Palestini and Gabriele Prati, "Emergency Workers' Quality of Life: The Protective Role of Sense of Community, Efficacy Beliefs and Coping Strategies", *Social Indicators Research*, Vol. 94, No. 3, 2009.

81 Cheryl Y. S. Foo, Helen Verdelli and Alvin Kuowei Tay, "Humanizing Work: Occupational Mental Health of Humanitarian Aid Workers", in Tony Wall, Cary L. Cooper and Paula Brough (eds), *The SAGE Handbook of Organizational Wellbeing*, SAGE Publications, London, 2021.

82 L. Cameron *et al.*, above note 1.

by a mental health specialist provided an opportunity to assess their specific needs, risk factors and immediate reactions. In both of the cases detailed above, this led to several referrals for specialized mental health support. The availability of quality-checked services before the incidents and the financial coverage needed for treatment were key factors in avoiding unnecessary delay. Access to safe and confidential⁸³ psychological support remains a minimum essential response to mitigate the impact of violence on staff, as in our post-feedback analysis of support perceptions, this access was strongly highlighted as useful not only for those who used it but also for others, who felt relieved that their affected colleagues had this opportunity available to them. Managers and crisis responders also appreciated the guidance received from the staff psychosocial team in the response to these situations; the extended availability of individual psychological support to cover them was highlighted as extremely helpful.

Lastly, the overarching context required the response to be adapted to the labour laws of each setting. In one of the cases, the incident had to be declared to the national labour risk insurance office, and a medical assessment was carried out for the local staff, ensuring compliance with national law. In both cases, the community norms around support during such situations (e.g., commemoration and gathering practices) were carefully considered and utilized, allowing staff to express and process their experiences within their native cultural frameworks.⁸⁴

Integrated psychosocial approach: Stitching real wounds versus creating cuts to practice stitching!

Everyone would appreciate a doctor who stitches a wound resulting from an accident – but consider the same situation when the wounds are caused by the “doctor” for the sole sake of practising stitching. This would clearly be a harmful practice. Similarly, while offering psychosocial support interventions to humanitarian workers is imperative, providing such support without integration into organizational culture and practices may lead to several negative outcomes, including reduced effectiveness of the support, low service uptake, and increased stigma.⁸⁵ Stand-alone psychosocial support without proper integration can also result in a fundamental misrecognition of psychosocial risk factors within an institution, leaving humanitarian staff and volunteers repeatedly struggling with the same challenges despite existing support mechanisms. We therefore offer the following comparison between stand-alone and integrated approaches to highlight those that best protect and promote the mental health of humanitarian workers.

83 Garry J. Stevens, Asra Sharma and Kelsey Skeoch, “Help-Seeking Attitudes and Behaviours among Humanitarian Aid Workers”, *Journal of International Humanitarian Action*, Vol. 7, No. 1, 2022.

84 K. Aldamman, above note 67.

85 G. J. Stevens, A. Sharma and K. Skeoch, above note 83.

Integration versus isolation

A holistic, integrated approach mainstreams staff psychosocial well-being into the very fabric of organizational life. Recognizing that humanitarians are a population at risk for mental health conditions due to their profession indicates that protecting their mental health should be part of their profession, including its design, environment and available resources. This requires a multilayered approach involving individuals, managers, peers, institutions and mental health professionals (IGLOO). By contrast, stand-alone interventions such as group sessions, workshops, counselling, psychotherapy or awareness campaigns are often time-bound, one-off services – they won't create intended outcomes when operating in isolation from the organization's core practices, despite their importance.⁸⁶

Addressing root causes versus managing consequences

An integrated approach to staff mental health and well-being means identifying and reducing the underlying organizational psychosocial stressors rather than solely offering means to manage the resulting strain. The systematic assessment of potential psychosocial risks (e.g., security risks, workload, unclear roles) and the implementation of measures to address them, in addition to promoting a supportive working environment, would undoubtedly bring more value to both organizations and humanitarian staff and volunteers.⁸⁷ By contrast, stand-alone psychosocial interventions that focus on helping individuals to cope with distress once it has already occurred might not address the conditions that caused it. Such a siloed approach can also create further unintended vulnerabilities for individuals, such as when cause factors are related to harassment or racism in the workplace,⁸⁸ and may ultimately result in additional unfavourable outcomes like decline in staff motivation, productivity and commitment.

Shared ownership versus departmental responsibility

When psychosocial support for humanitarians is integrated, it becomes part of the shared organizational culture and is therefore reflected in the institution's values. Everyone, from senior and middle leaders to front-line responders, has a role in maintaining it (IGLOO). This approach creates a sense of accountability and commitment across different institutional levels. A stand-alone psychosocial approach, on the contrary, would be owned by a specific department or even an outsourced provider. This external ownership leads to fragmentation of accountability, resulting in situations where the service is treated as a "tick-the-box", an "employment benefit" or "not my business".

⁸⁶ *Ibid.*

⁸⁷ S. K. Brooks *et al.*, above note 42.

⁸⁸ S. E. Hobfoll *et al.*, above note 53.

Position on stigma

A holistic, integrated approach reflects an organizational culture that recognizes aid workers as being equally exposed to adversity as the populations they serve, thereby normalizing the narrative around mental health consequences as a common experience among humanitarian workers operating in armed conflict settings. In this approach, mental health consequences are not treated as a “lack of competence”, “personal failure” or “lack of strength”, statements usually used to reinforce stigma.⁸⁹ A stand-alone psychosocial approach might be stigma-free for those practising and using it, but if not integrated into the culture and norms of the organization, particularly within the long-standing heroic culture of the humanitarian sector, it can feed loops of stigma for those experiencing adverse mental health consequences.⁹⁰

When responding to crises

Responding to crises is complex and requires coordinated organizational action. In our examples above, if psychosocial aspects had not been considered by managers, responders and the organization, impacted staff could have been unrecognized, a negative perception of organizational support could have developed within the institution, or affected individuals might have experienced additional emotional harm, thereby increasing their vulnerability despite the availability of stand-alone psychological interventions.

Based on our experience, stand-alone psychological interventions for humanitarian staff and volunteers exposed to potentially traumatic events should be embedded within a wider organizational support framework to strengthen their value. While the effectiveness⁹¹ of stand-alone psychological interventions in the aftermath of traumatic experiences remains debatable in the literature,⁹² a holistic and integrated psychosocial approach ensures both (1) the fulfilment of the physical and psychosocial needs of those affected and (2) the mobilization of intra-organizational support, both of which have been identified as protective factors against adverse mental health outcomes.

89 Daniella Vento and Dirk-Jan Koch, “How to Care for Carers: Psychosocial Care for Local Staff of Aid Agencies”, *Disasters*, Vol. 48, No. 4, 2024.

90 S. K. Brooks *et al.*, above note 31.

91 Neil P. Roberts, Neil J. Kitchiner, Justin Kenardy, Catrin E. Lewis and Jonathan I. Bisson, “Early Psychological Intervention Following Recent Trauma: A Systematic Review and Meta-Analysis”, *European Journal of Psychotraumatology*, Vol. 10, No. 1, 2019.

92 Jo Billings *et al.*, “Post-Incident Psychosocial Interventions after a Traumatic Incident in the Workplace: A Systematic Review of Current Research Evidence and Clinical Guidance”, *European Journal of Psychotraumatology*, Vol. 14, No. 1, 2023.

Wider considerations and challenges

While the arguments above might appear straightforward in practice, we recognize the complexity and challenges that many practitioners and policy-makers might encounter when trying to adapt them. The first challenge is obviously related to the rapid demands within humanitarian organizations, which often do not allow for thorough staff preparedness and managers' training. We recommend that humanitarian organizations incorporate staff mental health and well-being considerations in the multilayered IGLOO model as early as possible and build on their expertise as it develops, rather than dismissing this call. The second challenge is related to evaluating these complex integrated approaches, which makes it difficult to spotlight their impact on staff and volunteers' mental health. Mainstreaming managers' training on staff and volunteers' mental health and well-being aspects, as well as offering systematic follow-up on their practices, remains a significant third challenge. In our experience with the managers' workshop discussed above, we often receive questions from those who participated on how to engage leaders who do not prioritize staff mental health. We share this concern. The wider International Red Cross Red Crescent Movement has developed an online module on the International Federation of Red Cross and Red Crescent Societies (IFRC) Learning Platform that could be a good way to start.⁹³

The fourth challenge concerns the extremely difficult moment for humanitarian funding in which we currently find ourselves, forcing humanitarian organizations to reduce operations and cut jobs and services available for staff. We strongly call on decision-makers to include staff mental well-being considerations while making these decisions, as recent trends⁹⁴ have marked mental health support, including for staff, as particularly prone to being cut.⁹⁵ The last point worth recording is that building such a holistic system requires expertise encompassing mental health, organizational psychology and implementation science. We strongly recommend retaining these areas of expertise when moving toward an integrated approach.

Conclusions

In light of the current understanding of the mental health consequences of humanitarian work for staff and volunteers, this article has presented arguments in favour

93 See IFRC, "It Starts With You – Promoting Mental Health and Wellbeing as a Manager", *IFRC Learning Platform*, available at: <https://ifrc.csod.com/ui/lms-learning-details/app/curriculum/614fed64-8b9b-4e7c-a8bb-da3b71552b7f> (available to all Red Cross and Red Crescent staff and volunteers, requires registration) (all internet references were accessed in March 2026).

94 Felicity Butterly, "Resilience Is Not a Substitute for Mental Health Support", *The New Humanitarian*, 19 August 2025, available at: www.thenewhumanitarian.org/opinion/2025/08/19/resilience-not-substitute-mental-health-support.

95 Global Mental Health Action Network, "An Uncertain Future – the Impacts of United States and Other Government Funding Cuts on Global Mental Health Services", 9 June 2025, available at: <https://gmhan.org/news/impact-of-funding-cuts>.

of integrated mental health and psychosocial support approaches over stand-alone ones. We have outlined a roadmap for an integrated, multi-layered staff care approach that incorporates individual, group, leader, organizational, and overarching context considerations (IGLOO), moving beyond crisis response to address root causes, mitigate risks and sustain both well-being and performance over time. We have provided examples of this approach in action, including training managers and responding to crises affecting staff. In conclusion, we urge humanitarian organizations to adopt a holistic approach to the duty of care, prioritizing not only the treatment but also the prevention and mitigation of psychological harm among staff and volunteers operating in armed conflict zones, as such approaches fulfil the moral and legal duty of care and at the same time strengthen operational effectiveness.