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Research Article

Psycho-Occupational Challenges and Reactions of Psychologists and Counselors during the 12-Day Iran-Israel War (June 2025): A Qualitative Study

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Abstract

Introduction: The June 2025 "12-Day War of Iran- Israel" between Iran and Israel inflicted substantial human and infrastructural losses, generating a psychosocial emergency affecting both civilians and mental health professionals. This study investigates the psycho-occupational challenges and adaptive responses of psychologists and counselors during this acute, short-term conflict.

Method: Employing a qualitative interpretive phenomenological design, semi-structured interviews were conducted with 12 mental health practitioners in Tehran.

Result: Data analysis via MAXQDA identified seven interconnected themes: emotional reactions (shock, fear, anger), cognitive responses (catastrophic scenario construction, disruption in Cognitive Processes, hypervigilance), physiological manifestations (fight-or-flight activation, psychosomatic symptoms), behavioral adaptations (avoidance, role conflict, disrupted routines), occupational-economic pressures (income loss, job insecurity), work-related professional stress (occupational burnout, self-reliance Stereotype, transference of emotional burden to family, demand–Capacity Paradox), and foundational-structural challenges (work structure paralysis, lack of safe occupational Space).

Conclusion : Findings demonstrate that even brief armed conflicts can profoundly compromise mental health professionals' well-being, blurring personal-professional boundaries and exacerbating role strain. Recommendations include structured support programs, culturally adapted self-care protocols, and organizational policy reforms to mitigate therapist workload and enhance resilience. Limitations include generalizability to long-term conflicts and reliance on self-reported data. Future research should employ longitudinal designs, cross-cultural evaluations, and diverse sampling to optimize interventions for mental health practitioners in crisis contexts.

Keywords: 12-Day Iran-Israel War, psychologists, counselors, psycho occupational, qualitative study.

Introduction

In June 2025, a 12-day conflict between Iran and Israel, known in the media as the "12-Day War" (which began on June 13, 2025, and ended on June 24, 2025), not only caused significant human and infrastructural losses but also created a psychosocial emergency among the civilian population. What distinguishes this event is the intensity of the conflict over a short period and its simultaneous psychological impact on two key groups: the affected community (clients) and mental health professionals (psychologists and counselors) who themselves lived through the crisis. This simultaneity and shared experience form a phenomenon recognized

in crisis psychology literature as a shared traumatic reality [1].

In such circumstances, psychologists and counselors face two layers of psychological stress: first, personal experiences of anxiety, fear, and insecurity resulting from living in a warzone; second, daily exposure to a high volume of clients' traumatic narratives, memories, and signs. These experiences significantly influence individuals' behaviors, decisions, and future paths [2]. Some may involuntarily think repeatedly about the event, which can affect mood and lead to irritability and heightened emotional responses [3].

Short-term conflict escalations, while often overlooked in favor of prolonged wars, have received increasing empirical attention. The 11‐day Gaza war in May 2021, for instance, amplified fear, stress, and anxiety among mental health professionals who were both treating patients and living under bombardment and blockade [4]. Similarly, the October 2023 Israel‐Hamas war prompted multiple studies on shared traumatic reality among mental health workers. 5 reported that one month after the October 7 attack, mental health workers with prior trauma exhibited higher anxiety symptoms, acute stress symptoms, and media‐induced secondary trauma. [6] further documented how cultural frameworks both buffer and intensify the impact of shared trauma among mental health providers in the aftermath of the October 7 terror attacks, revealing that therapists oscillate between professional fulfillment and shared trauma as the therapeutic space becomes a convergence point for national memory and current emotional strain. However, existing research has predominantly focused on either prolonged conflicts (e.g., the ongoing Gaza crisis) or general healthcare workers rather than specifically examining psychologists and counselors during short‐term but high‐intensity armed conflicts. The 12‐Day Iran‐Israel War of June 2025 presents a unique context to address this gap.

Additionally, when a therapist experiences a conflict between their professional duty to support others and their immediate personal or family needs, a phenomenon known as moral injury may occur [7]. For example, studies on therapists in conflict areas of Gaza have shown that mental health workers simultaneously face chronic stress, limited support resources, and increasing workload, raising the risk of depression, anxiety, and post-traumatic stress disorder [8]. Prior research indicates that exposure to crisis and war conditions increases anxiety, depression, and post-traumatic stress symptoms in mental health professionals and affects the quality of service delivery and job satisfaction [9]. Therefore, even short-term, intense armed conflicts, though seemingly transient, can have strong and lasting effects on individuals' mental health [10, 11].

Furthermore, a lack of specialized training for managing acute war crises, increased workload, and daily exposure to profound individual and collective trauma raise the risk of burnout and early job withdrawal among counselors and psychologists [12]. In short-term crises like a 12-day war, high acute stress can lead to compressed occupational injuries, reduced performance, and even impaired self-care among mental health professionals [13]. Secondary trauma (via clients' narratives), societal neglect of therapists' own psycho-emotional needs, lack of educational and therapeutic resources, and occasional cultural and value conflicts are other challenges reported in various studies [14].

Wars can leave stronger and more lasting effects than other stressors, often recognized as traumatic events. These impacts may be long-term and severely disrupt social and occupational functioning. Research shows that war trauma is often intergenerational, meaning that its symptoms and suffering can be passed down to children and subsequent generations [15]. Another major challenge is managing role conflicts and expectations in ambiguous, threat-filled situations [16]. Lack of targeted support programs and training can increase professional errors, early withdrawal, or even lasting psychological damage for this group [17]. Studies emphasize that developing supportive interventions, crisis-focused training, and psychological support networks for counselors and psychologists during crises can reduce burnout and negative occupational consequences [18].

In this study, we use the term "psycho-occupational" to refer to the intertwined psychological and professional role‐based challenges that emerge when mental health practitioners experience personal emotional distress (e.g., fear, anxiety, hypervigilance) simultaneously with occupation‐specific demands (e.g., managing clients' trauma, maintaining therapeutic boundaries, coping with workload and income loss). Psycho‐occupational challenges are distinct from general psychosocial stress (which broadly encompasses social and relational stressors without specific focus on professional role identity) and from generic occupational stress (which

does not account for shared trauma and the double exposure of being both a victim and a helper).

However, Psychologists and counselors not only bear the responsibility of individual therapy for clients but also play a vital role in social reconstruction and enhancing collective resilience. If this key group suffers burnout or performance decline, the mental health system's capacity to respond to the crisis is severely compromised. Therefore, a detailed examination of their psycho-occupational status is of utmost importance. This study aimed to answer the question: what challenges and psycho-occupational responses did psychologists and counselors exhibit during the 12-Day War?

Methods

Study Design

This research used a qualitative approach with interpretive phenomenology to identify the challenges and strategies of psychologists and counselors during the war. This method was chosen because it allowed a detailed examination of participants' perceptions and a description and interpretation of their lived experiences concerning the research topic [19-20].

Participants

The study population comprised therapists (psychologists and counselors) working in Tehran Province between June 13 and June 24, 2025. Participants were selected using purposive snowball sampling. Snowball sampling was particularly appropriate for this study because during the acute phase of the 12-day war, many therapists were difficult to reach directly due to disrupted communication networks, fluctuating work schedules, and heightened psychological vulnerability, making participant-driven referral the most feasible and ethically sensitive recruitment strategy. Saturation was reached at the tenth interview, but two additional interviews were conducted for assurance. Inclusion criteria included: 1) a master's degree or higher in psychology or counseling-related fields, 2) active professional engagement in providing psychological or psychotherapy services during the war, 3) willingness to participate and informed consent, and 4) residence in Tehran due to exposure to the war. Exclusion criteria included: lack of direct clinical or counseling experience with clients during the war, withdrawal or refusal to continue participation at any stage, and refusal to allow recording or research use of interview content.

Data Collection

Data were collected through semi-structured interviews designed by the researchers, focusing on therapists' perspectives regarding psychologists' and counselors' responses during the war. Interview questions were developed with two expert specialists to ensure content validity. The questions directly and indirectly explored therapists' experiences, including the challenges they faced and the responses they exhibited during the war.

Participants answered the questions, and follow-up questions were guided by their responses. Interviews were carefully transcribed for analysis. Ethical considerations included ensuring confidentiality of participants' information. Each interview was assigned a number from 1 to 12. The average interview duration was 36 minutes, with a standard deviation of 10.32 minutes, a minimum of 20 minutes, and a maximum of 50 minutes.

Data Analysis

For analyzing the semi-structured interview data, interpretive phenomenological analysis based on 20 was used. The method aimed to deeply explore participants' lived experiences and understand their subjective meanings regarding psychologists' challenges during the war.

Analysis steps:

1. Repeated reading and initial note-taking: Each interview was read multiple times, and initial notes about important points, concepts, and researcher impressions were recorded.
2. Conversion of notes to experiential themes: Notes were converted into primary or experiential themes reflecting common and unique aspects of participants' experiences.
3. Searching for connections between themes: Each participant's themes were categorized, and common patterns across cases were identified.
4. Structuring and writing final themes: Final themes were organized hierarchically, including main and sub-themes, to address research questions.

MAXQDA-22 software was used for data management and coding.

To ensure the validity of qualitative findings,[21] four criteria were applied:

- Credibility: Member checking was performed with five participants, who confirmed the accuracy of their interview summaries and the preliminary thematic framework; prolonged engagement with the research context; and continuous observation.
- Transferability: Providing rich descriptions of participants' characteristics, sampling process, research context, and analysis steps.
- Dependability: Thorough documentation of research processes and external audit by two experts familiar with qualitative methods and the topic.
- Confirmability: Maintaining an audit trail, analytical notes, codes, and researcher reflexivity regarding assumptions.

Additionally, inter-coder agreement was applied for accuracy; 30% of interviews were independently coded by another researcher, with agreement exceeding 80%.

Results

A total of 12 therapists (psychologists and counselors) participated in this study. The mean age was 35.5 years. Participants held educational degrees ranging from master's (6 participants) to doctorate (6 participants). Their professional experience ranged from 3 to 7 years. Regarding marital status, 5 were married, and 7 were single. Data analysis revealed seven main categories (Table 1).

Emotional Reactions

Emotional reactions can be considered the first level of therapists' experience when facing war conditions, beginning with initial shock. Over time, the emotional experience extends beyond mere anxiety to anger and heightened emotional arousal. Thus, emotional reactions follow a gradual trajectory from shock to fear and then to anger, creating a stable and multi-layered emotional context.

Participant 2: "When I first heard that the war had started, I felt completely frozen. For a few moments, I could not think clearly, move, or decide what I was supposed to do next "

Participant 4: "Even when I was at home, I did not feel safe. I kept thinking that something might happen to my family, my clients, or myself at any moment."

Participant 5: "After the first shock passed, I began to feel angry. I was angry that everything had changed so suddenly, and that I still had to appear calm and composed for others."

Cognitive Reactions

Cognitive reactions gradually organize themselves. At this level, catastrophic scenario building emerges as a central pattern. Stabilization of this state leads to hypervigilance, characterized by constant alertness, sensitivity to stimuli, and continuous engagement with news, indicating the mind is in a constant threat-monitoring mode. Cognition, as an effort to make sense of the situation, thus becomes a mechanism for maintaining and perpetuating it.

Participant 1: "My mind was constantly creating worst-case scenarios. I kept imagining that the war would expand, that the clinic would shut down, or that something serious would happen to my family or clients."

Participant 2: "It became difficult for me to concentrate during sessions. Sometimes I could hear the client speaking, but my mind would suddenly drift to the crisis and I had to force myself back into the conversation."

Participant 6: "I was constantly alert. I checked the news repeatedly, and even a small sound or phone notification could make me feel that something dangerous was happening."

Physiological Reactions

Alongside emotional and cognitive processes, the body becomes actively involved. Continuous threat perception keeps the fight-or-flight system activated. These symptoms are not limited to specific situations but are present during professional activities. Stabilized bodily tension leads to anxiety-related physical disorders such as gastrointestinal issues, migraines, and weakened immunity. Here, the body not only reflects psychological stress but also contributes to its persistence.

Participant 4: "Whenever I heard alarming news or a sudden loud sound, my body reacted before I could even think. My heart started racing, my breathing changed, and I felt an urgent need to do something or escape."

Participant 3: "At the end of the day, I realized that my shoulders, neck, and jaw had been tense for hours. It felt as if my body had stayed in a state of readiness throughout the whole day."

Participant 2: "During that period, my headaches and stomach problems became worse. Even when I was not actively thinking about the war, my body seemed to carry the anxiety for me."

Behavioral Reactions

At the behavioral level, these internal pressures gradually manifest in action patterns. Initially, avoidance appears as a strategy. Prolonged exposure places individuals in positions where they must simultaneously address the needs of clients and family, leading to role conflicts.

Participant 3: "Sometimes I avoided talking about the war because I felt that if I opened that subject, I would lose control of my emotions. I delayed answering some messages because I did not feel ready to face more anxiety."

Participant 6: "I felt caught between different roles. My clients needed me to be calm and supportive, while my family also expected me to be emotionally available and reassuring."

Participant 7: "My daily routine completely changed. My sleep, meals, work hours, and even the way I prepared for sessions became irregular and unpredictable."

Occupational-Economic Pressures

Within these experiences, occupational-economic pressures gradually develop and interact with other levels. Session cancellations and reduced client attendance lead to income loss, while costs like rent, staff salaries, bills, and loan payments remain. This imbalance gradually turns financial pressure into a stable state, which over time results in job insecurity.

Participant 1: "When sessions were canceled and fewer clients came to the clinic, my income dropped suddenly. At the same time, expenses such as rent, staff salaries, bills, and loan payments continued as before."

Participant 6: "I felt that nothing about my work was certain anymore. I did not know whether the clinic could continue, whether clients would return, or how long I could manage the financial pressure."

Work-Related Professional Role Stress

At the professional role level, pressures accumulate in a multi-layered process. Continuous exposure to crisis clients, along with increasing numbers, raises the need for constant empathy, gradually leading to emotional fatigue.

Participant 7: "After several consecutive sessions with clients who were all dealing with crisis and fear, I felt emotionally drained. I could still listen, but I felt that my capacity for empathy was becoming weaker."

Participant 5: "Because I was a therapist, people assumed that I should be able to manage my own distress. This made it harder for me to ask for support or admit that I was also struggling."

Participant 1: "After absorbing so much fear and distress from clients during the day, I sometimes brought that emotional pressure home. I became quieter, more irritable, and less emotionally available to my family."

Participant 4: "At the exact time when more people needed psychological support, my own emotional and physical capacity was decreasing. The demand was increasing, but my ability to respond was becoming more limited."

Foundational-Structural Occupational Challenges

At the structural level, changes in work conditions gradually reduce the sense of control. The suspension of online sessions, decreased in-person visits, temporary clinic paralysis, and the shift to phone sessions cause instability in service delivery. This instability is accompanied by ethical ambiguity in crisis work. Furthermore, lack of peer groups, regular supervision, non-judgmental space, support protocols, and specialized training leave therapists to manage the situation alone.

Participant 9: "For a while, the whole structure of work seemed to stop. Online sessions were disrupted, in-person visits decreased, and the clinic felt almost paralyzed."

Participant 10: "There was no safe professional space where I could talk about what I was experiencing without being judged. We did not have regular supervision, peer support, or clear protocols for working during the crisis."

Table 1: Main Themes, Sub-Themes, and Initial Concepts from Data Analysis

Main Themes	Sub-Themes
Emotional Reactions	Initial shock
	Fear and Threat Perception
	Anger and Emotional Arousal
Cognitive Reactions	Catastrophic Scenario Building
	Disruption in Cognitive Processes
	Therapist Hypervigilance
Physiological Reactions	Fight-or-Flight Reactions
	Physical Tension
	Anxiety-Related Somatic Disorders
Behavioral Reactions	Avoidance
	Role Conflicts
	Changes in Daily Patterns
Occupational-Economic Stress	Direct Financial Pressure
	Job Insecurity
Work-Related Professional Role Stress	Occupational Burnout
	Therapist Self-Reliance Stereotype
	Transference of Emotional Burden to Family
	Demand–Capacity Paradox
Foundational-Structural Occupational Challenges	Work Structure Paralysis
	Lack of Safe Occupational Space

Discussion

This study aimed to explore the psycho-occupational challenges and responses of psychologists and counselors during the 12-Day War. These findings reflect the experiences of psychologists and counselors who remained active during a 12‑day armed conflict in Tehran. Generalization to long‑term wars (e.g., protracted conflicts in Gaza or Ukraine) or to therapists in different cultural and organizational contexts should be made with caution.

Emotional reactions are considered the first level of therapists' experience within the context of this short‑term armed conflict, beginning with initial shock. shock‑fear‑anger trajectory was found in findings from Gaza (Veronese et al., 2021), where similar emotional sequences were reported despite cultural differences. This is especially evident in the early stages, as initial event effects rarely integrate with other experiences and remain as fragmented sensory and motor impressions [22]. Therefore, the initial shock reported by therapists in this study is explainable Fear and threat perception are consistent with previous findings showing that living under conditions of conflict is associated with increased fear, insecurity, and helplessness [4]. Previous research has also shown that psychotherapists experience psychological stress indirectly through clients' war experiences [1]. Concerns about the near and distant future and intense emotional experiences are among the emotional challenges therapists report. Both clients and therapists experienced helplessness and loss of control, feeling that no one was safe, resulting in emotional overwhelm [23] .

The second main theme was cognitive reactions. War, with ongoing violence, loss of loved ones, widespread displacement, and infrastructure destruction, imposes a heavy, multidimensional burden on mental health and social cohesion [23]. Cognitive reactions have mostly been studied only as subsets of PTSD symptoms in direct survivors [24]. Research on psychotherapists and counselors has mainly emphasized occupational burnout, secondary trauma, depression, and PTSD [10], with less focus on cognitive developments. In this study, cognitive reactions developed gradually and intertwined with emotional experiences. The central pattern was catastrophic scenario building: therapists continuously imagined famine, social conflicts, collapse of order, and destruction of the future to create a sense of control. Dahan et al. (2024) noted that hypervigilance and catastrophic scenario building in our sample mirrored the media‑induced secondary trauma reported among

Israeli mental health workers after October 7, but with less direct exposure to rocket fire [5].

The third main theme was physiological reactions. Previous studies indicate mental health professionals are highly vulnerable in War, exposed to occupational burnout and secondary trauma, experiencing symptoms like high blood pressure and panic attacks 23. Exposure to war trauma can result in deep, persistent physical consequences such as cardiovascular disorders, sleep disturbances, gastrointestinal problems, chronic pain, fatigue, and weakened immunity [24]. Aqtam (2025) noted psychosomatic symptoms among Gaza healthcare workers, noting that our participants reported similar fight‐or‐flight activation but lower rates of severe somatic disorders, possibly due to the shorter conflict duration.

The fourth main theme was behavioral reactions. Internal psychological pressures gradually manifested as tangible, persistent behaviors. This is a novel contribution of this study, as behavioral patterns of therapists in War are rarely examined in depth. Prior studies mainly noted surface-level changes, such as disrupted routines [23] or sleep pattern changes [24]. Here, the evolution from avoidance patterns to role conflict and behavioral changes was systematically explained.

The fifth main theme was occupational-economic pressures. War disrupts societal support systems and fragments social and economic networks, imposing multilayered stress [4]. Healthcare workers often face complex challenges, commonly leading to strong desires to quit or migrate [17]. In this study, structural and economic pressures emerged gradually and interacted with other levels, leading to deep job insecurity. Fear of losing income, uncertainty about financial stability, and professional future became inseparable from therapists' daily experience.

The sixth main theme was work-related professional role stress. Continuous engagement with crisis clients, along with increasing numbers, requires constant emotional investment, gradually leading to deep emotional fatigue and burnout. This aligns with previous studies on healthcare workers and psychotherapists in war [1, 25]. The shared traumatic reality phenomenon was prominent: therapists and clients simultaneously face collective trauma [26]. Therapists are not neutral observers but are directly exposed [27, 28], expected to maintain high emotional care while managing their own fear and insecurity [29-31]. This paradox, combined with the "self-sufficient and always resilient therapist" stereotype, leads to personal needs suppression and emotional burden transfer to family, explaining both observed burnout and professional-identity crises.

The seventh main theme was foundational-structural occupational challenges. War-induced instability in service delivery (temporary clinic paralysis, reduced visits, and mandatory phone sessions), ethical ambiguities, and lack of supervision or peer support left therapists professionally isolated. Therapists struggle to distinguish between personal, professional, and societal levels [23] while simultaneously being exposed to collective trauma. Structural pressures increased workload and challenged professional identity [1, 8, 10].

Conclusion

This study shows that in war, boundaries between mental health specialties blur; even psychotherapists and counselors are not immune to psychological harm. Findings align with prior research emphasizing psychologists' central role in community mental health during crises [11] and the urgent need for targeted interventions [9]. Recommendations include dedicated support programs (regular supervision, peer groups, safe spaces), development of culturally adapted self-care protocols, attention to multidimensional stress, and organizational policy review to reduce therapists' workload. The study highlights the need for localized resilience and coping models in war-affected communities.

Several limitations should be considered. First, the sample (n=12) was recruited only from Tehran, and findings may not be transferable to therapists in other cities, countries, or cultural settings. Second, our exclusion criteria omitted therapists who withdrew from professional practice or refused to participate due to psychological harm. This exclusion bias likely underrepresents the most severe cases of distress, burnout, and moral injury. Third, the short (12 day) nature of the conflict limits comparability to prolonged war conditions. Fourth, data were self-reported and may be subject to recall bias. Fifth, despite assurances of confidentiality,

responses may have been influenced by social desirability bias. Mental health professionals, particularly those who adhere to a self-reliance stereotype (identified as a sub theme in our findings), may have underreported psychological distress or over reported adaptive coping to maintain a professional image of competence and resilience. This potential bias suggests that our findings may underestimate the true extent of psycho occupational challenges. Future research should include therapists who ceased working during crises, employ longitudinal designs, use anonymous or indirect reporting methods to reduce social desirability, and compare multiple conflict durations and cultural contexts.

Conflict of Interest Disclosures

The authors declare no conflict of interest.

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Authors' Contributions

FB: Conceptualization, study design, literature review, data collection, data analysis, interpretation of findings, and writing – original draft. **MS:** Participant recruitment, conducting interviews, transcription, coding, thematic analysis, validation of themes, and writing – review and editing. **FK:** Supervision, methodology, validation, interpretation of findings, critical revision of the manuscript, and project administration.

All authors read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

Ethical Statement

This study adhered to the Declaration of Helsinki and institutional ethical guidelines. Due to wartime conditions and the urgent need for data collection, the ethics committee did not convene and no ethics code was assigned, although all ethical requirements were strictly observed. Written informed consent was obtained from all participants, who were assured of voluntariness, confidentiality, and the right to withdraw. Interviews were anonymized, securely stored, and conducted with attention to participants' emotional well-being; no incentives were used.

Declaration of Generative AI and AI-assisted technologies

During the preparation of this work, the authors did not use ChatGPT to write the manuscript.

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