



Persistence of Hypervigilance in Iranian Society After the 12-Day War: Letter to Editor

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Dear Editor,

The 12-day war on Iran in May-June 2025, characterized by its unpredictability, drone-centered nature, and predominantly nocturnal timing, caused extensive material and human losses and profoundly affected the psychological well-being of a substantial portion of the population. During this period, many families spent nights anticipating further strikes, children were startled by sudden noises, and adults remained in a constant state of environmental scanning for danger. After the ceasefire, despite an initial return to routine activities, this heightened alertness has persisted in many individuals. Many people report misinterpreting benign sounds, such as passenger aircraft, celebratory fireworks, or thunder, as explosions; these perceptual errors can rapidly escalate anxiety. This pattern is consistent with hypervigilance as described in the psychological literature and can markedly impair daily functioning and reduce quality of life, even in the absence of other severe symptoms (1).

Within Iranian society, where a considerable share of the population, spanning major urban centers and rural communities alike, was directly or indirectly exposed to such threats, hypervigilance appears to have become a widespread collective experience. Clinical observations and field reports from mental health practitioners during and after the conflict suggest disrupted sleep patterns, reduced concentration in professional and academic settings, and strained family relationships marked by increased irritability and psychological fatigue. Although hypervigilance can represent an initial adaptive response to danger, its persistence may

lead to longer-term sequelae, including social withdrawal, reduced trust in the environment, and a diminished sense of collective security (2). Importantly, hypervigilance, as a symptom cluster distinct from, although frequently co-occurring with, post-traumatic stress disorder (PTSD), does not require direct trauma exposure; media consumption or secondary accounts alone can sustain this cycle through continual threat monitoring (3).

In this context, societal institutions, media, and support systems play a crucial role. Public media can help interrupt this cycle by reducing repetitive threat-focused content and promoting constructive narratives of recovery, resilience, and hope. In addition, psychoeducational programs targeting high-exposure groups, including children, parents, and frontline workers, can expand public access to adaptive coping strategies when delivered through community health centers, schools, and faith-based settings. Structured group sessions on relaxation and mindfulness, facilitated by trained community health workers or school counselors, have demonstrated efficacy in reducing hypervigilance-related symptoms and supporting gradual reintegration into daily life (4, 5).

Furthermore, policymakers and mental health authorities should expand community-accessible psychosocial support through nationwide toll-free counseling hotlines and evidence-based mobile health applications. The success of such initiatives may be monitored using indicators such as hotline utilization rates, self-reported sleep quality, and symptom-screening scores at follow-up. Facilitating open dialogue

about lived experiences within family, peer, or professionally facilitated support settings can alleviate emotional distress and reduce perceived isolation. These approaches contribute not only to individual recovery but also to the restoration of social cohesion and a collective identity grounded in solidarity and agency.

Ultimately, the aftermath of this brief yet consequential conflict underscores the imperative to integrate mental health and psychosocial support into national recovery and preparedness agendas, an area directly relevant to military medicine, public health, and health care system resilience. Without timely and systemic intervention, acute stress responses may crystallize into chronic psychiatric conditions, including PTSD, placing a sustained burden on health systems (6).

Several limitations of this commentary should be acknowledged. This letter is based on observational reports and published literature rather than primary empirical data. No direct measurement of hypervigilance prevalence in the Iranian population was conducted, and the absence of population-level epidemiological studies in this context limits the generalizability of these observations. The patterns described are consistent with established psychological frameworks and available practitioner reports; however, regional variation in exposure, differences in individual vulnerability, and heterogeneity in media effects mean that population-wide generalizations should be interpreted with caution. Future research using validated instruments, representative samples, epidemiological designs, and structured clinical assessments is needed to quantify the scope of post-conflict psychological impact and evaluate the effectiveness of the proposed interventions in the Iranian context.

We hope this communication stimulates rigorous interdisciplinary discourse among specialists, administrators, and policymakers and supports the design and implementation of integrated, scalable strategies to enhance societal resilience. Such initiatives are essential not only for facilitating individual recovery but also for strengthening communal cohesion and adaptive capacity in the face of future adversities.

Footnotes

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