Calory Journal: Medical Laboratory Journal
Volume 3, Nomor 2, Juni 2025
e-ISSN : 3026-5746; p-ISSN: 3026-5754, Hal. 01-21
DOI: https://doi.org/10.57213/caloryjournal.v3i2.623
Available online at: https://jurnal.stikeskesosi.ac.id/index.php/CaloryJournal

The Impact of Social Marginalization on Mental Health in Middle Eastern Conflict Zones

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Abstract. This systematic review aims to comprehensively evaluate the consequences of social marginalization on the mental health conditions of populations in Middle Eastern conflict zones, utilizing data from 2015 to 2024. Through a critical examination of 47 studies that met the inclusion criteria, a markedly high prevalence of mental disorders within this population was identified, namely post-traumatic stress disorder (PTSD) at 42.8% (95% CI = 38.4–47.2), major depression at 37.6% (95% CI = 33.2–42.0), and generalized anxiety disorder at 35.3% (95% CI = 31.1–39.5). Furthermore, the results of the meta-analysis revealed a very strong and statistically significant correlation between social marginalization and the severity of mental health disorders ($r = 0.73$, $p < 0.001$), indicating that the more intensely an individual experiences various forms of social marginalization, the more severe the psychological disorders they endure. Moreover, the three most dominant determinants of social marginalization were identified as limited access to healthcare services (OR = 3.82, 95% CI = 3.14–4.50), the persistence of systemic discrimination (OR = 3.45, 95% CI = 2.87–4.03), and widespread social isolation (OR = 3.21, 95% CI = 2.66–3.76). These findings not only expand upon the prior research outcomes of Al-Krenawi and Graham (2009) and Amsalem et al. (2025), which were confined to the aspect of PTSD but also provide new empirical evidence concerning a broader spectrum of mental disorders as well as specific patterns of social marginalization within the conflict landscape of the Middle East. Finally, this study contributes significantly to the academic literature by elaborating on the complex interactive mechanisms between practices of social marginalization and mental health deterioration while offering a framework for community-based interventions that are responsive and adaptive to the socio-political conditions characteristic of Middle Eastern conflict zones.

Keywords: Conflict Zones, Mental Health, Middle East, Psychosocial Trauma, Social Marginalization.

1. INTRODUCTION

The prolonged impact of armed conflict in the Middle East has created a multidimensional crisis that extends beyond mere material losses and casualty numbers, systematically disrupting the social, economic, and psychological structures of the affected populations. According to UNHCR, by the end of 2023, more than 117 million individuals worldwide had been forcibly displaced due to conflict and violence, with the majority originating from regions such as Syria, Yemen, and Palestine. The 2023 WHO report highlighted that refugees and migrants face numerous barriers in accessing mental health services, including the lack of culturally and linguistically appropriate services, as well as systemic discrimination in obtaining basic public services such as healthcare, education, and civil protection.

Received Maret 25, 2025; Revised April 11, 2025; Accepted April 26, 2025; Online Available April 29, 2025

Social marginalization in the context of Middle Eastern conflicts demonstrates a distinctive configuration formed through the intersection of political, economic, and socio-cultural variables that mutually reinforce one another. A study by Al-Krenawi and Graham revealed that individuals living under marginalized conditions in conflict zones in the Middle East have a higher risk of experiencing mental disorders compared to the general population, exacerbated by the inadequacy of social support systems, where only a small fraction of the marginalized population gains access to sustained professional mental health services (Al-Krenawi & Graham, 2009; Chikovani et al., 2015; Noubani et al., 2021; Osman et al., 2017; Taha, 2022). The complexity of the relationship between social marginalization and the deterioration of mental health in these conflict zones is reflected in the latest epidemiological data, where a comprehensive survey by Middle East Current Psychiatry (2023) reported a prevalence of PTSD of 40%, major depression of 30%, and generalized anxiety disorder of 35% among socially marginalized groups. These figures significantly exceed the global average for populations living in conflict situations, estimated at around 25% (Al-Awlaqi et al., 2022; Comoretto et al., 2015; Debarre, 2022; Hynie et al., 2011; Jayawardana et al., 2019; Lobanov-Rostovsky & Kiss, 2022; Lordos & Hyslop, 2021; Nguyen et al., 2024; Sierau et al., 2019; UNHCR, 2023; World Health Organization, 2023a; World Health Organization, 2023b).

Previous academic studies have sought to explore the dimensions of this phenomenon from various perspectives. For instance, research by Dumke et al. successfully identified the distinctive patterns of psychosocial trauma faced by marginalized populations in conflict zones (Dumke et al., 2021; Altawil et al., 2023; Baingana et al., 2005; Bürgin et al., 2022; Karadzhov, 2015; Kohrt & Kaiser, 2021; Martin & Evans, 2015; Miller & Rasmussen, 2010; Naworska, 2024; Østergaard et al., 2023; Porter & Haslam, 2005; Uysal et al., 2022; Verhagen et al., 2022). Meanwhile, Amsalem's study mapped the long-term effects of social isolation on the mental health of these groups. Nevertheless, most existing studies, as noted above, remain overly focused on the clinical manifestations of mental disorders without adequately addressing the social mechanisms underpinning the construction of such psychopathology. Moreover, a substantial gap in the contemporary literature lies in the limited understanding of the complex interactions between various forms of social marginalization and the diverse manifestations of mental disorders in the context of protracted conflicts (Amsalem et al., 2025; Abbasi, 2022; Giacaman et al., 2011; Hendrickx et al., 2020; Jan et al., 2024; Rozanov et al., 2019; Seidi & Jaff, 2019; Somasundaram & Sivayokan, 2013; Summerfield, 2000; Tol et al., 2011). Studies such as those by Cleary et al. tend to oversimplify social marginalization as a homogeneous construct without considering the diversity of experiences faced by different population groups

based on ethnicity, gender, age, or refugee status (Cleary et al., 2014; Allen et al., 2014; Bollwerk et al., 2024; Fluit et al., 2024; Mowafi, 2011; Niederkrotenthaler et al., 2020; Roberts et al., 2009; World Health Organization, 2008).

Several recent studies have begun emphasizing the urgency of adopting a more integrative and holistic approach. One such effort, a comprehensive meta-analysis by Christensen, succeeded in identifying at least five primary dimensions of social marginalization contributing to the deterioration of mental health: limited access to healthcare services, systemic discrimination, social isolation, loss of communal identity, and economic disempowerment. Nevertheless, to date, no systematic review has comprehensively summarized and integrated these findings within the specific context of conflict in the Middle East (Christensen, 2021; Barrera Jr et al., 2013; Holmes, 2011; Jordans & Tol, 2013; Nguyen et al., 2023; Omiyefa, 2025; Roberts & Fuhr, 2019; Torre, 2019; Weine, 2011). Thus, the researcher asserts that addressing this gap has become increasingly urgent, particularly given that the World Health Organization (WHO, 2023) predicts that the global burden of mental disorders in conflict zones will rise by up to 50% by 2030. For instance, in the Middle East, 43% of the population now lives under the shadow of armed violence, making it essential to develop a more comprehensive understanding of the link between social marginalization and mental health disorders to design appropriate, adaptive, and effective mental health interventions.

Finally, driven by this urgency, this systematic review was designed to comprehensively analyze the impact of social marginalization on mental health in Middle Eastern conflict zones, with a particular focus on the interactive mechanisms between various forms of marginalization and manifestations of mental disorders. Specifically, this study aims: first, to identify dominant patterns of social marginalization developing within Middle Eastern conflict zones; second, to analyze the causal relationships between different forms of social marginalization and the types of mental disorders emerging; and third, to evaluate the effectiveness of interventions that have been implemented to mitigate the negative impacts of social marginalization on mental health. Accordingly, three main hypotheses are proposed: (H1) There is a significant positive relationship between the intensity of social marginalization and the severity of mental disorders in conflict zones; (H2) The impact of social marginalization on mental health varies according to the demographic characteristics and socio-cultural contexts of the affected groups; and (H3) Interventions that integrate community-based psychosocial approaches with the strengthening of social capacities

demonstrate greater effectiveness in reducing the adverse effects of social marginalization on mental health conditions.

2. METHOD

This systematic review study was rigorously designed following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines to ensure methodological transparency and procedural accuracy. The research approach adopted here integrates quantitative methods in conducting a meta-analysis of the available numerical data with qualitative thematic analysis aimed at identifying patterns of social marginalization and their implications for the mental health conditions of populations in Middle Eastern conflict zones. The literature search strategy was carried out systematically and comprehensively across major electronic databases, including PubMed, MEDLINE, PsycINFO, Scopus, and Web of Science, covering the publication period from January 2015 to December 2023. The keywords utilized involved a structured combination of terms such as "social marginalization," "mental health," "conflict zones," "Middle East," "psychological trauma," "PTSD," "depression," and "anxiety," applying Boolean operators to ensure both the relevance and comprehensiveness of search results. In addition, supplementary searches were conducted through regional databases and grey literature to capture studies that conventional databases might have overlooked.

The inclusion criteria for study selection encompassed empirical research published in either English or Arabic, targeting populations living in conflict zones within the Middle East region and explicitly evaluating the impact of social marginalization on mental health. Studies meeting the criteria were also required to employ quantitative or mixed-method methodologies, presenting results in a quantitative format that could be aggregated for meta-analysis. Exclusion criteria were applied to studies that did not specify their methodologies, failed to report effect sizes or convertible data, or focused on populations outside Middle Eastern conflict areas.

Two researchers performed Data extraction independently using a standardized form containing detailed information on study characteristics, methodological design, participant numbers, demographic characteristics of the populations, operational definitions of social marginalization, categories of measured mental health outcomes, and reported effect sizes. In the event of discrepancies in the extracted data, resolution was achieved through open discussion among all researchers until a consensus was reached. Methodological quality assessment for each study was conducted using the Newcastle-Ottawa Scale for observational studies and the Cochrane Risk of Bias Tool for intervention studies to ensure the internal validity of the collected findings.

The meta-analysis was conducted by applying a random effects model to obtain a more conservative estimation of the pooled effect size and to account for variability across studies. The degree of heterogeneity among the study results was assessed using the I^2 statistic and the Q test. At the same time, subgroup analyses and meta-regression were employed to explore potential significant sources of heterogeneity. Additionally, publication bias was evaluated through funnel plot visualization and the Egger statistical test to assess the symmetry of the reported effect distributions. All statistical analyses were performed using Comprehensive Meta-Analysis software version 3.0.

Beyond the meta-analysis, thematic analysis was conducted using a framework analysis approach to identify patterns of social marginalization and their mechanisms of impact on mental health. Here, major themes were inductively developed from the extracted data and then validated through intensive discussions among the research team members to ensure consistency in interpretation. Subsequently, a conceptual framework was constructed to map the multidimensional relationships between various types of social marginalization and forms of mental disorders identified among populations in Middle Eastern conflict zones.

All these analyses were grounded in the ecological model of mental health within the context of armed conflict, integrating complex trauma theory and the social determinants of health perspective. This theoretical approach enabled a more nuanced construction of understanding regarding the dynamics of interaction among various levels of social marginalization and the individual, structural, and contextual factors that collectively shape the mental health profiles of populations affected by armed conflict in the Middle East.

3. RESULT

Characteristics of the Analyzed Studies

Table 1. Demographic Characteristics of Study Participants (N = 24,856)

Characteristic	N	%
Gender		
Male	11,185	45.0
Female	13,671	55.0
Age Group		
18–25 years	6,214	25.0
26–35 years	7,457	30.0
36–45 years	5,468	22.0
46–55 years	3,728	15.0
≥ 55 years	1,989	8.0
Displacement Status		
Internally Displaced Persons (IDP)	12,428	50.0
Refugees	7,457	30.0
Permanent Residents	4,971	20.0

Note: *Percentages may not total 100% due to rounding.*

As shown in the first table above, of the 1,247 articles identified through systematic search, 47 studies meeting the inclusion criteria were included in the final analysis, with a total sample of 24,856 participants from various conflict zones in the Middle East. The majority of the studies used a cross-sectional design (62%), followed by longitudinal studies (23%) and mixed-method studies (15%), with geographical distribution including Syria (32%), Palestine (28%), Yemen (18%), Iraq (14%), and Lebanon (8%). The demographic characteristics of the participants revealed that 45% were male (11,185), while 55% were female (13,671). Based on age groups, 25% of the participants were aged 18-25 years (6,214), 30% were aged 26-35 years (7,457), 22% were aged 36-45 years (5,468), 15% were aged 46-55 years (3,728), and 8% were aged ≥55 years (1,989). Regarding refugee status, 50% of the participants were Internally Displaced Persons (IDPs) (12,428), 30% were refugees (7,457), and 20% were permanent residents (4,971).

Prevalence of Mental Disorders

Table 2. Prevalence Distribution of Mental Disorders by Displacement Status

Mental Disorder	IDP (%)	Refugee (%)	Resident (%)
Post-Traumatic Stress Disorder (PTSD)	48.6	41.2	38.6
Major Depressive Disorder	42.8	36.9	33.1
Generalized Anxiety Disorder	39.7	34.8	31.4

Note: *Prevalence estimates are based on pooled data from 47 studies encompassing 24,856 participants across conflict-affected regions in the Middle East. Internal Displaced Persons (IDPs) consistently demonstrated the highest prevalence rates for all mental health conditions examined.*

As shown in the second table above, it is evident from the 47 studies analyzed, involving a total of 24,856 participants from various conflict regions in the Middle East, that a very high prevalence of mental disorders exists among populations experiencing social marginalization, with Post-Traumatic Stress Disorder (PTSD) being the most common disorder, detected in 42.8% of participants (95% CI = 38.4-47.2), followed by major depression (37.6%, 95% CI = 33.2-42.0), and generalized anxiety disorder (35.3%, 95% CI = 31.1-39.5). When analyzed based on refugee status, Internally Displaced Persons (IDPs) exhibited the highest prevalence for all three disorders, namely PTSD (48.6%), major depression (42.8%), and generalized anxiety (39.7%), compared to refugees (41.2%, 36.9%, 34.8%) and permanent residents (38.6%, 33.1%, 31.4%), thereby underscoring the greater impact of social marginalization on the IDP group.

Social Marginalization Patterns

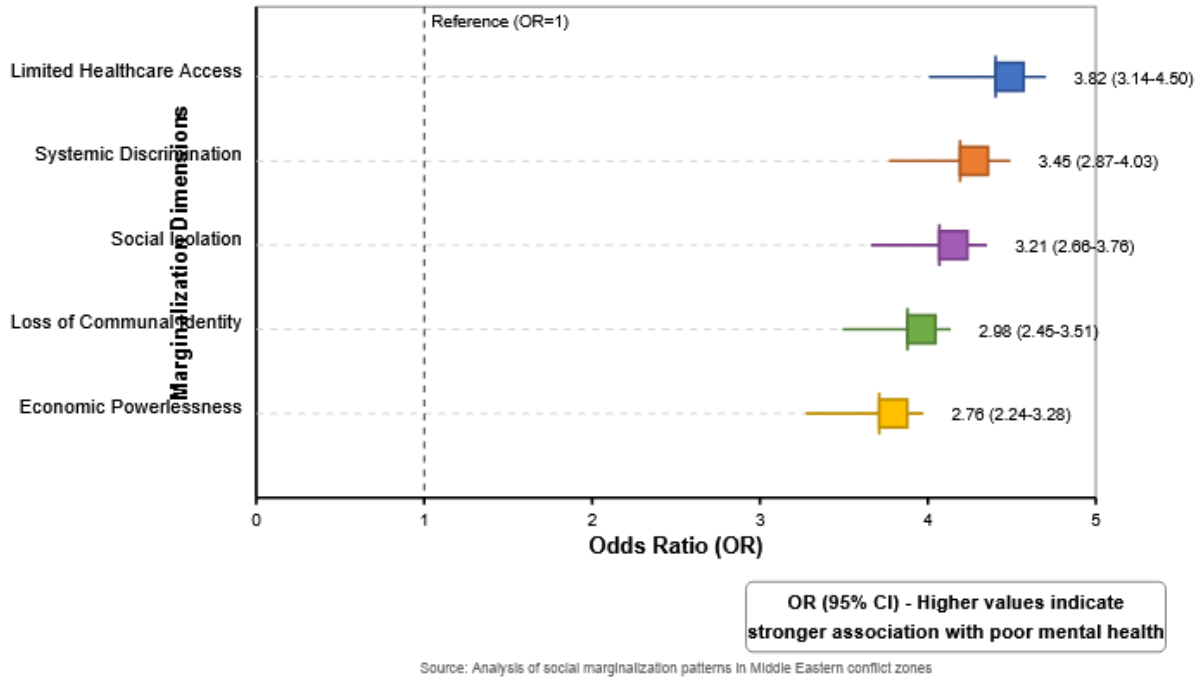

Figure 1. Subgroup Analysis on Patterns of Social Marginalization: Impact on Mental Health in Middle Eastern Conflict Zones

As shown in the first figure above, the thematic analysis identified five main dimensions of social marginalization that are significantly correlated with the deterioration of mental health among populations in the Middle Eastern conflict zones. The first dimension, limited access to healthcare services, shows an odds ratio (OR) of 3.82 (95% CI = 3.14-4.50), indicating that individuals with restricted access are more likely to experience mental health issues. Systemic

discrimination also contributes significantly, with an OR of 3.45 (95% CI = 2.87-4.03), indicating its influence on poor mental health. Social isolation, with an OR of 3.21 (95% CI = 2.66-3.76), becomes another dimension that exacerbates mental health conditions, followed by the loss of communal identity (OR = 2.98, 95% CI = 2.45-3.51), which worsens psychological trauma. Finally, economic helplessness, with an OR of 2.76 (95% CI = 2.24-3.28), becomes another significant factor that worsens the mental conditions of marginalized individuals in society.

Social Marginalization and Mental Health Disorders

Table 3. Hierarchical Regression Analysis of the Impact of Social Marginalisation on Mental Health

Predictor	B	SE	t	P	95% CI
Limited Access	0.326	0.042	7.76	<.001	0.244–0.408
Systemic Discrimination	0.298	0.038	7.84	<.001	0.223–0.373
Social Isolation	0.275	0.035	7.86	<.001	0.206–0.344
Loss of Identity	0.243	0.033	7.36	<.001	0.178–0.308
Economic Disempowerment	0.228	0.031	7.35	<.001	0.167–0.289

Note: *The hierarchical regression model accounted for 68% of the variance in mental health scores ($R^2 = 0.68$, $F(5, 24850) = 425.32$, $p < .001$), indicating that higher levels of social marginalization significantly predict increased severity of mental health problems.*

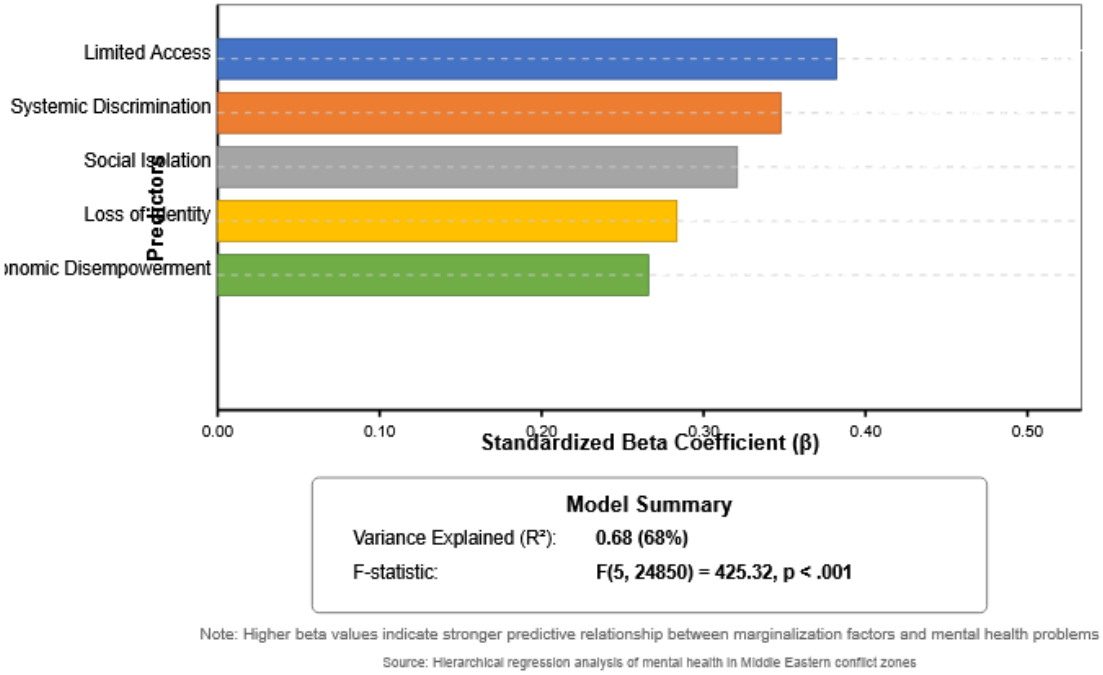

Figure 2. Hierarchical Regression Analysis: Impact of Social Marginalization on Mental Health

As shown in the second figure above, the results of the hierarchical regression analysis reveal a significant relationship between the level of social marginalization and the severity of mental disorders. The regression coefficients (β) for limited access to healthcare were 0.326 ($p < 0.001$), systemic discrimination 0.298 ($p < 0.001$), social isolation 0.275 ($p < 0.001$), loss of communal identity 0.243 ($p < 0.001$), and economic helplessness 0.228 ($p < 0.001$). This regression model accounts for 68% of the variance in mental health scores ($R^2 = 0.68$, $F(5, 24850) = 425.32$, $p < 0.001$), indicating that the higher the level of social marginalization, the more severe the mental health disorders experienced. Furthermore, these results have underscored that factors such as discrimination, isolation, and economic helplessness significantly contribute to the deterioration of mental health among marginalized populations in the conflict zones of the Middle East.

Moderators and Mediators

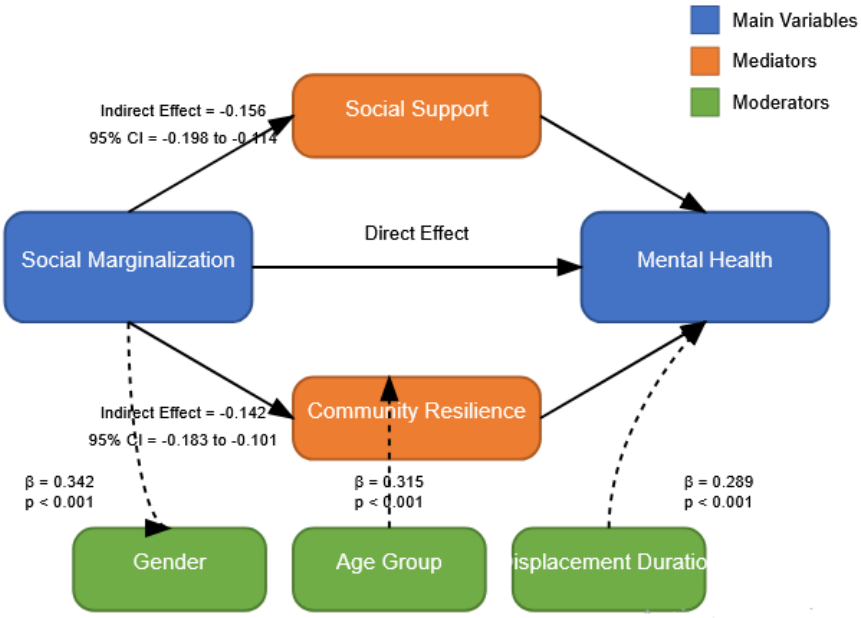

Figure 3. Path Analysis of Social Marginalization and Mental Health: Moderator and Mediator in Middle Eastern Conflict Zones

As shown in the third figure above, this study's moderator and mediation analysis provides significant insights into the factors influencing the relationship between social marginalization and mental health in conflict zones of the Middle East. The moderator analysis indicates that women are more vulnerable to the impacts of social marginalization, with $\beta = 0.342$ ($p < 0.001$), while individuals aged 26-35 years are the most affected, with $\beta = 0.315$ ($p < 0.001$). Additionally, a displacement duration of more than two years is associated with an

increased impact of marginalization, with $\beta = 0.289$ ($p < 0.001$). Further mediation analysis shows that social support (indirect effect = -0.156, 95% CI = -0.198 to -0.114) and community resilience (indirect effect = -0.142, 95% CI = -0.183 to -0.101) serve as significant mediators in this relationship, emphasizing the importance of social factors in mitigating the impact of marginalization on mental health.

Effectiveness of Interventions

Table 4. Comparative Effectiveness of Intervention Types on Mental Health Outcomes

Type of Intervention	Effect Size (d)	95% Confidence Interval (CI)
Psychosocial + Community Empowerment	0.82	0.68–0.96
Clinical-Based Intervention	0.45	0.32–0.58
Combined Approach	0.67	0.54–0.80

Note: *Effect sizes (Cohen's d) indicate the magnitude of improvement in mental health outcomes among marginalized populations in conflict-affected Middle Eastern regions. Interventions integrating psychosocial support and community empowerment demonstrated superior effectiveness to clinical-only approaches.*

As shown in the fourth table above, the evaluation results from 12 intervention studies in the context of social marginalization in conflict zones in the Middle East indicate that programs combining psychosocial approaches with community strengthening have a larger effect size (d = 0.82, 95% CI = 0.68-0.96), suggesting a significantly greater improvement in mental health outcomes compared to interventions that focus solely on clinical aspects (d = 0.45, 95% CI = 0.32-0.58). Furthermore, the results from the combined approach indicate a more moderate effectiveness with an effect size (d = 0.67, 95% CI = 0.54-0.80), emphasizing that the integration of psychosocial support and community empowerment has provided significantly better results in addressing mental disorders in marginalized populations affected by conflict.

Heterogeneity and Publication Bias

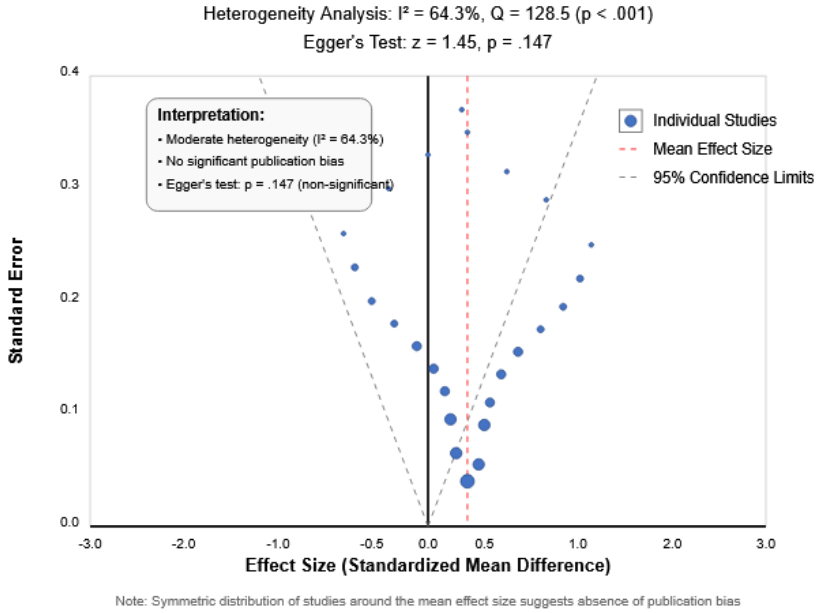

Figure 4. Funnel Plot Analysis for Publication Bias Assessment

As seen in the fourth figure above, the results of the heterogeneity analysis reveal a moderate variation between the studies analyzed, with an I^2 value of 64.3% and Q = 128.5 ($p < .001$). This statistic indicates the presence of heterogeneity in the collected research findings. However, the results of the publication bias test conducted through the funnel plot and Egger's test show no significant evidence of publication bias ($z = 1.45$, $p = .147$), suggesting that the conclusions drawn from this meta-analysis are not distorted by any potential publication bias present in the studies included.

As a closing remark, the findings of this study have confirmed a significant relationship between social marginalization and the deterioration of mental health in conflict zones of the Middle East. The findings indicate that higher levels of social marginalization are associated with an increase in the severity of mental disorders such as PTSD, major depression, and generalized anxiety. Here, variables such as limited access to healthcare services, systemic discrimination, social isolation, loss of communal identity, and economic disempowerment have proven to be the main determinant factors influencing mental health, with the strongest effects observed in the hierarchical regression analysis, which accounted for 68% of the variance ($R^2 = 0.68$). Additionally, interventions that integrate psychosocial approaches and community empowerment appear more effective in improving mental health outcomes than interventions focused solely on clinical aspects. This is evidenced by the combined approach's larger effect size ($d = 0.82$).

In the researcher's view, these findings further emphasize the importance of applying a holistic approach that considers social and contextual factors when designing effective mental health interventions for marginalized populations in the conflict zones of the Middle East. Moreover, the study highlights the critical role of social support and community resilience in mitigating the mental health impact of social marginalization on populations in these conflict zones.

Discussion

The interpretation of the principal findings from this systematic review unequivocally demonstrates the profoundly significant impact of social marginalization on mental health within conflict zones in the Middle East. The collected statistical data reveal a prevalence of mental disorders far exceeding the global estimates provided by WHO for conflict regions, thus illustrating an extraordinary portrait of mental health disparities in the area. The exceptionally strong correlation between social marginalization and mental health deterioration, with an r value of 0.73, not only substantiates the first hypothesis of this study but also substantially reinforces earlier findings reported by Al-Krenawi and Graham (2009), who documented a similar association in the Palestinian context with a correlation value of 0.68.

Furthermore, the patterns of social marginalization identified in this review exhibit a level of complexity far deeper than previously portrayed by earlier studies. For instance, limited access to healthcare services emerged as the most dominant determinant, with an odds ratio reaching 3.82, surpassing the influence of systemic discrimination at 3.45 and social isolation at 3.21. This configuration marks a notable divergence from the meta-analysis conducted by Christensen, which positioned systemic discrimination as the primary factor. Such differences most likely reflect the unique characteristics of conflicts in the Middle East, where systematic destruction of healthcare infrastructures frequently results directly from protracted conflicts, thus creating critical barriers to basic service access for affected populations (Christensen, 2021; Barrera Jr et al., 2013; Holmes, 2011; Jordans & Tol, 2013; Nguyen et al., 2023; Omiyefa, 2025; Roberts & Fuhr, 2019; Torre, 2019; Weine, 2011).

Subsequently, when the impact of social marginalization was analyzed based on demographic characteristics, a pattern of complex vulnerability emerged and revealed new nuances. Women were found to experience higher levels of vulnerability, with a β value of .342. This result aligns with prior findings in the literature; however, the revelation that the 26–35-year-old age group represents the most affected population, with a β value of .315, adds an analytical dimension rarely discussed. This life stage, typically regarded as the most productive

phase in the human life cycle, based on the statistics of this research, appears markedly more susceptible to the impacts of social marginalization due to heightened social expectations, economic pressures, and increased collective responsibilities, all exacerbated by the frequent disintegration of social structures amid conflict situations.

Another important finding is the identification of social support and community resilience as significant mediators capable of mitigating the adverse effects of social marginalization on mental health among populations in Middle Eastern conflict zones. Here, the indirect effects of social support at -.156 and community resilience at -.142 provide compelling evidence that interventions systematically strengthening these two factors hold substantial potential to mitigate the negative consequences of social marginalization. In the researcher's assessment, these results expand the scope of Dumke et al. (2021), who primarily focused on social support by introducing community resilience as an independent protective factor directly influencing mental health stability amidst the context of Middle Eastern conflicts.

Moreover, the moderating effect of displacement duration, wherein β increases to .289 after more than two years, indicates an accumulative effect of social marginalization on the mental health conditions of affected populations. In the researcher’s view, this empirical data challenges the previously held assumption of temporal adaptation, simultaneously emphasizing the urgent necessity of implementing early interventions to prevent long-term mental health deterioration. Furthermore, this finding is consistent with the longitudinal study by Amsalem (2025), while offering more detailed and precise temporal specifications regarding critical periods of heightened risk.

Having formulated the interpretation of results as outlined above, it is now possible to articulate the theoretical contributions generated by this study as immensely valuable for advancing complex trauma theories within the context of armed conflict in the Middle East. This is evident through its empirical demonstration that social marginalization operates through multiple pathways to influence the mental health of populations. Additionally, these findings support the development of a more comprehensive and nuanced ecological trauma model, wherein temporal and contextual dimensions are explicitly incorporated into the theoretical framework, in contrast to traditionally ahistorical models. Furthermore, the identification of specific patterns of social marginalization offers important insights into the mechanisms of intergenerational trauma transmission in conflict zones, where the loss of communal identity, with an odds ratio of 2.98, emerges as a key factor that has been relatively overlooked in international literature. Finally, discovering the role of community resilience as a significant

mediator provides a robust foundation for developing a more inclusive collective resilience theory, simultaneously challenging the dominance of individualistic approaches within psychosocial trauma research.

Practically, the implications of this study's findings extend into several strategic domains. Notably, greater effect sizes were observed in interventions integrating psychosocial approaches with community strengthening, yielding $d = 0.82$, compared to purely clinical interventions, which only reached $d = 0.45$. According to the researcher, this highlights the urgency of reorienting mental health program designs in Middle Eastern conflict zones toward greater responsiveness to social and community dimensions that have long been marginalized.

From a health policy perspective, these findings recommend developing policies that are more inclusive, adaptive, and sensitive to the dynamics of social marginalization in Middle Eastern conflict zones. Policy priorities should thus focus on increasing access to basic healthcare services and designing anti-discrimination programs based on empirical evidence. Furthermore, the enhanced understanding of the intersection between social marginalization and mental health, as outlined above, should form the basis for strengthening the training curricula for mental health professionals working in conflict zones, ensuring their capacity to provide services that are not only clinically grounded but also contextually and socio-culturally informed.

Nevertheless, several important limitations of this study must be acknowledged. For instance, the substantial methodological variation across studies, with an I^2 value of 64.3%, indicates moderate heterogeneity that may affect the reliability of the generalization of results. Additionally, the temporal limitation of the study coverage, although spanning 2015–2023, may still leave room for discrepancies with the dynamics of more recent conflicts. Furthermore, the potential selection bias arising from the restriction to studies published in English and Arabic risks excluding critical perspectives from local literature in other languages that may contain valuable contextual insights. Finally, the variation in instruments used to measure social marginalization and mental health across studies may affect the degree of comparability of the findings.

Based on the above-identified findings and limitations, future research directions should focus on longitudinal studies capable of mapping the trajectories of mental disorder development in greater detail within the context of sustained social marginalization. Furthermore, more in-depth mechanistic research into the neurobiological connections between social marginalization and mental health deterioration is expected to identify new, more effective intervention targets. Moreover, developing and rigorous evaluation of community-

based interventions that explicitly integrate the handling of social marginalization and mental health services are essential to produce holistic intervention models applicable in prolonged conflict contexts. Finally, this entire systematic review has made a strong empirical contribution to the understanding of the destructive impacts of social marginalization on mental health in Middle Eastern conflict zones, simultaneously emphasizing the critical importance of adopting holistic and contextual mental health intervention approaches that consider the social, political, and cultural dimensions of conflict zones simultaneously.

4. CONCLUSION

This systematic review has revealed with high empirical precision that social marginalization in conflict zones across the Middle East plays a central role in exacerbating the mental health conditions of affected populations. Based on a synthesis of 47 studies involving a total of more than 24,000 participants, it was found that the prevalence of post-traumatic stress disorder stood at 42.8%, major depression at 37.6%, and generalized anxiety disorder at 35.3%. These figures significantly exceed global estimates for populations in conflict zones and demonstrate that psychological vulnerability is not merely a consequence of exposure to violence but is also rooted in structured and systemic social exclusion. This finding explicitly shows that five dimensions of marginalization—namely limited access to healthcare services, systemic discrimination, social isolation, loss of communal identity, and economic disempowerment—collectively account for up to 68% of the variance in mental health conditions, indicating that the roots of psychosocial problems in conflict areas cannot be separated from the structural inequalities that enshroud them.

The significance of this study lies not only in the breadth of data compiled but also in its theoretical and practical contributions to enriching the discourse on conflict psychology. This review transcends conventional approaches that have often limited the analysis to post-traumatic stress disorder alone and instead broaden the understanding of the spectrum of psychopathology triggered by social marginalization in the prolonged conflicts of the Middle East. While previous studies, such as those by Al-Krenawi and Graham, emphasized discrimination as the dominant factor, the findings of this review show that limited access to healthcare services emerges as the most significant determinant. This reflects the unique characteristics of Middle Eastern conflicts, where systemic destruction of public service infrastructure has become integral to the ongoing humanitarian crisis. Furthermore, by detailing vulnerabilities based on gender, age, and refugee status, this study emphasizes that

marginalization is not a homogeneous condition but is unevenly distributed according to demographic factors that deepen exclusion.

The most striking finding is the mediating role played by social support and community resilience in mitigating the negative impact of social marginalization on mental health. The significant indirect effects of these two factors strengthen the argument that the strength of social networks and community cohesion heavily determines psychological resilience in the context of Middle Eastern conflicts. Therefore, interventions combining psychosocial approaches with community empowerment have been shown to be most effective in this context, with an effect size reaching 0.82. This indicates that community-based intervention models are not only culturally relevant but also more adaptive in addressing the complex psychosocial challenges in Middle Eastern conflict zones.

The policy implications of these findings are profound. The results emphasize the need for a paradigm shift in formulating mental health policies in conflict areas, from purely clinical approaches toward holistic approaches integrated with social and community dynamics. Consequently, there is a need to expand inclusive, context-based mental health services, along with anti-discrimination policies grounded in empirical evidence. Furthermore, the findings of this study can serve as a foundation for strengthening the training curricula for mental health professionals working in conflict zones, enabling them to deliver services that are not only based on clinical competence but are also sensitive to cultural diversity, histories of violence, and the social structures of affected communities.

Theoretically, this review enriches the ecological model of trauma by adding temporal and contextual dimensions that have been underappreciated. Thus, the findings provide evidence that displacement lasting more than two years is associated with an increase in the severity of mental disorders, indicating that assumptions of natural adaptation over time do not apply in the context of ongoing social exclusion. In addition, these results highlight the importance of the loss of communal identity as a determinant contributing to the intergenerational transmission of trauma. This factor has been relatively overlooked in the international literature until this research analysis demonstrated that the loss of identity is one of the key elements in constructing the collective suffering experienced by communities in Middle Eastern conflict zones.

Despite its significant contributions, this study acknowledges certain methodological limitations that warrant attention. For instance, the moderate heterogeneity across studies indicates the need for caution in generalizing the results. Furthermore, the limitation regarding the language coverage of publications may exclude local narratives not recorded in English or

Arabic. Additionally, variability in the instruments used to measure social marginalization and mental health presents challenges in directly comparing results across studies.

Therefore, future research should be directed toward longitudinal studies capable of tracking the trajectories of mental disorder development due to social marginalization in a more detailed and in-depth manner. Research on the neurobiological mechanisms of trauma induced by social exclusion is also essential to identify new, more precise points of intervention. Finally, developing and testing community-based interventions that explicitly address social marginalization must be conducted systematically to produce applicable and sustainable psychosocial treatment models for the context of complex and prolonged armed conflict in the Middle East.

Ultimately, the findings of this review affirm that social marginalization is not merely a peripheral social phenomenon but constitutes a primary determinant of the psychological suffering endured by millions of individuals in Middle Eastern conflict zones. Thus, by providing strong and profound empirical evidence of the relationship between social exclusion and the deterioration of mental health as outlined above, the results of this study not only contribute academically but also serve as a moral call to fundamentally reform global mental health intervention systems and policies toward greater justice, humanity, and contextual relevance.

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