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War traumas in the Mediterranean area

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Abstract

Introduction: The purpose is to explore the consequences of war and its impact on mental health with attention to the Mediterranean area.

Methods: Narrative review of consequences of war on mental health and on the mental health of the communities in the current crises in the Mediterranean region.

Results: A series of outbreaks of war are still raging in the Mediterranean region and producing horrible effects with a considerable number of refugees with unsatisfied needs. Studies relating to conflicts of the past suggest that the mental health consequences of these wars may affect future generations for many years. While violations of human rights are not new, what is new are attacks on medical institutions perceived to be traditionally Western.

Conclusion: The scientific community has to fight violence through mediation of conflicts. The idea that science can improve lives is a concept that is found in the history of all Mediterranean cultures. The Greek and Roman medical tradition was saved thanks to doctors of the Arab courts when Christian fundamentalism fought science in the Middle Ages. Health institutions are the product of the great Islamic medical tradition as well as Western culture.

Keywords

War, conflict, mental health, refugees, Mediterranean, history of medicine

Introduction

This article will explore the theme of the traumatic consequences of war and its impact on mental health, with special attention to the Mediterranean area. Now, and in the recent past, the region has been the scene of atrocious events that have shocked public opinion.

A series of wars are still ongoing and producing effects; many people have suffered devastating injuries, and there are many refugees in the region with significant needs. Most recently, this is the product of the Syrian crisis, but also of the conflicts in Mali, Somalia and Afghanistan. These conflicts, while not taking place on the shores of the Mediterranean, have produced movements of peoples to this area. Other conflicts that were said to be finished continue to support hot beds of potentially explosive tension. In Egypt and Libya, and in almost the whole of North Africa, there are still critical situations.

What has changed, partially unexpected compared to the past, is that very few refugees have officially reached the 'north shore', partly because of the restrictive measures of the new emigration policies of the European Union, but also, at least for immigrants from Africa, owing to the filtering action of Libyans' concentration camps which continue to receive support. These camps were set up at the time of Colonel Gaddafi, and sadly they are still active according to the testimony of Somali, Eritrean and Ethiopian refugees reported by Habeshia, an agency that witnesses and denounces the constant violation of human rights in these places (Habeshia, 2013). It is unclear who is responsible for these atrocities, and whether there is co-responsibility in that 2012 Nobel Peace Prize awarded to European Union.

The long-term consequences of war on mental health

When it comes to the consequences of war on mental health, we must not forget that the most serious effects are found perhaps in the long term. The study by Mollica et al. (2001) on Bosnian refugee has shown that after 3 years, 45% of people suffering from post-traumatic stress

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disorder (PTSD) still present significant symptoms; still devastating effects were found in 2007, more than 10 years after exposure to traumatic events (Mollica, Caridad, & Massagli, 2007). The high risk of psychiatric disorders was also documented in the Lebanese population 20 years after the Lebanese war, and in particular among those who were children at that time (Karam et al., 2008).

While civilians now pay the highest price in terms of consequences of war, even the military are not immune to long-term consequences: at least half of the Israeli soldiers who took part in war operations suffer lifetime experiences of triple comorbidity (PTSD + anxiety + depression) (Ginzburg, Ein-Dor, & Solomon, 2010), and almost 20% suffer from PTSD with very late onset (Horesh, Solomon, Zerach, & Ein-Dor, 2011).

War, refugees and (mental) health

The term refugee is sometimes used to indicate persons forced to flee from their own countries. In reality, it should distinguish applicants from refugees in the proper sense, that is, those who have received official hospitality in the country of arrival and whose rights are guaranteed by the Geneva Convention, signed by most countries in 1951. Its protocol was signed in 1967 (United Nations Refugee Agency, 1961). But we must also consider that today most people who escape from atrocities prefer to remain underground or semi-underground without official recognition owing to the difficulty of achieving refugee status and the fact that an application for asylum, especially if rejected, can mean exposure to the risk of retaliation by the country of origin.

In 2012, the 38 countries in Europe received 355,500 refugee application, an increase of 9% compared to 2011, with two Mediterranean countries, Syria and former Yugoslavia, the leaders in claiming the status (United Nations High Commissioner for Refugees (UNHCR), 2013). Contrasting with increases in Nordic countries, in Southern Europe, the number of newly registered asylum seekers decreased by 27% to 48,600, the second lowest level in 6 years. According to the UNHCR (2013), this decrease is mainly due to fewer boat arrivals in Italy, the southern European country with the largest number of exiles from the crises in North Africa, as a result of a changed situation there. The phenomenon is probably much more complex owing to the Libyan camps, the few successful applications for refugee status in southern Europe and the increased risk of retaliation in the South. In fact, the 'state of humanitarian emergency' (Protezione Civile, Governo Italiano, 2011) ended in Italy in March 2013 with no extension. Those who had arrived were left with no guarantees, while those still arriving knew that their chances of receiving refugee status were few, with many risks of retaliation. So the lowering of the number of asylum seekers probably does not correlate with the still large number of new arrivals despite the blockade in Libya. Only the dramatic events of October 2013 in Lampedusa, where hundreds died at sea, led the international organizations to reconsider the possibility that the movement of boat people to Italy was not decreasing (*The Guardian*, 2013).

Exiles and refugees are different from other migrants in that they did not choose to leave, but were forced to by the often terrible situations they were living in. But to be able or to have the chance to escape a war or a conflict does not necessarily mean to be save of consequences (Bhugra & Becker, 2005; Carta, Balestrieri, Murru, & Hardoy, 2009; Carta, Bernal, Hardoy, & Haro-Abad; 'Report on the Mental Health in Europe' Working Group, 2005).

Exiled people was exposed of trauma in the country of origin because of having witnessed the deliberate killings of relatives and friends or actual genocide, having suffered physical and mental torture, having been targeted for kidnapping with detention in often inhumane prisons and without any guarantees, wounds and amputations, hunger and thirst, looting and the loss of property. This is often accompanied by the destruction of institutions of law and order.

Exposure to traumatic events continues during the escape, which occurs most often in inhumane conditions with a high risk of death from hunger, thirst, cold and drowning. Having children with them, in these circumstances, is an additional factor of stress and risk.

And even when people succeed in arriving in a foreign country, they are often forced to live in overcrowded conditions or with no accommodation or, conversely, in isolation and solitude without supportive social networks. In the current economic crisis, there are no countries that can guarantee access to employment or training. There are often obstacles to culturally appropriate health services with the newly arriving persons living with legal uncertainties, experiencing culture shock and adjustment problems, and even having to cope with racism and discrimination. In these conditions, it is easy to fall into illegal channels leading to alcohol and substance abuse. Beginning of a new life, or simply waiting for a chance to return home, is not simple. The traumatic experiences of the past continue for many years to afflict those who have experienced exile.

Two parallel stories with dramatically different outcomes exemplify the fate of exiles. The first one is about Mo Farah winning at the Olympic games in London in 2012. Mo, Somali by birth, arrived in Britain at 9 years of age without knowing a word of English. Now he is an idol in the nation that welcomed him and which he played for, as well as in his country of origin. A story with a happy ending. Quite different from that of Yusuf Omar, who had so many things in common with Mo, she was also a Somali athlete, she had raced in Beijing and she wanted to compete in London. Stubbornly, against the will of all, she

tried to reach Italy in April 2012 but died when the boat carrying her from Malta to Lampedusa capsized. A sad story, like that of many other nameless people.

The specificity of the exiles' status against other migrants is linked to the high risk of consequences in terms of mental health: two-thirds of refugees experience anxiety and/or depression (Carey-Wood, Duke, Karn, & Marshall, 1995) and have a high incidence of PTSD, depression, anxiety, panic disorder and agoraphobia (Carta et al., 2005).

The Syrian crisis

Almost one-half of people deaths in Lampedusa was fleeing from Syria. Syria has been in a bloody conflict for nearly 4 years. What started as a civil protest against decades of oppression and human rights violations by the Syrian regime quickly degenerated into a humanitarian and public health catastrophe, with more than 60,000 people killed, more than 60,000 missing, more than 200,000 arrested, and more than 137,000 seriously injured or maimed (Mediterranean Society on Mental Health, 2013). International sources have estimated that the number of Syrians who have fled their homes for safer areas is about 2.5 million (UNHCR, 2013) distributed largely in camps between Jordan, Lebanon and Turkey. Refugees are experiencing hardships, including inaccessibility to health-care services in Lebanon and Jordan (El-Khatib, Scales, Vearey, & Forsberg, 2013), with conditions somewhat better but still dramatic in Turkey (Döner, Ozkara, & Kahveci, 2013). It must be remembered that in 2011, at the height of the Libyan crisis, millions of refugees were expected in Europe, but eventually only a few tens of thousands arrived. The same is happening in Europe with regard to the Syrian crisis although the UNHCR (2013) estimates that more than 4,600 Syrians arrived in Italy by sea in the first 8 months of 2013 against 369 in 2012.

There are few published data on the impact of the Syrian conflict on mental health. A poster for which the Syrian colleagues demanded anonymity at the III Symposium of the Mediterranean Society on Mental Health (2013), which was presented by young Syrian researchers who have requested anonymity, presents data from a community survey carried out in two refugee camps in Syria. The frequency of PTSD among about 400 adults of the two Syrian camps was, respectively, 36.3% and 61.9%. The prevalence of PTSD among children of the two camps was higher than among adults: 41.3% and 76.4% (Mediterranean Society on Mental Health, 2013). In 300 Syrian refugees in four camps in the south of Turkey, the same document found a frequency of 61% of PTSD, 53% of anxiety disorders and 54% of depressive disorders (Mediterranean Society on Mental Health, 2013). These results are similar to the findings of the cited studies of the mental health consequences of conflict in Palestine and Lebanon. Moreover, the Lebanon studies reported that 20 years after the war, PTSD-related chronic diseases and physical symptoms were associated with a greater risk of mental health problems (Karam et al., 2008). The study in Lebanon indicated that large groups of the population were affected by the war, but not all citizens as is the case in Syria. This gives us an idea of what might be the long-term consequences in the Syrian populations.

The United Nations Children's Emergency Fund (UNICEF) report on the Syrian crisis, significantly entitled 'Children of Syria: A lost generation?' (UNICEF, 2013), reports that many children have been exposed to serious violations of human rights; have been the victims of murder (talking about thousands of children killed); have suffered sexual violence, torture and arbitrary detention; and there are testimonies of children enrolled by the armed forces. The Special Representative of the Secretary-General for Children and Armed Conflict told correspondents at a Headquarters press conference on 22 July 2013 that she had been 'overwhelmed' by what she had seen during her recent visit to Syria and the neighbouring countries Jordan, Iraq, Turkey and Lebanon in June and July 2013. She noted that forces of both the Government and the opposition were on the Secretary-General's so-called List of Shame of armed groups engaging in grave violations against children: opposition groups for their recruitment of child combatants and Government forces for killing and maiming, sexual violence and attacks on schools and hospitals. She said that having met with boys who had been involved in the fighting and had been injured, it was clear that they were involved in a variety of functions and that their recruitment was ongoing in refugee camps like Zaatari in Jordan. Most children being recruited were between the ages of 15 and 18, with children under the age of 15 also enlisted. Many of them were volunteering to fight (Special Representative of the Secretary-General of UN for Children and Armed Conflict, 2013).

The Coordination of the United Nations for the Syrian crisis has made it known that 35% of hospitals, 10% of health centres and 40% of ambulances available in the country have been destroyed. Public health systems have collapsed and vaccination programs have been totally blocked (United Nations, 2013). According to the cited report presented at the III Symposium of Mediterranean Society on Mental Health, the main psychiatric hospital Ibn Khaldun was bombed, patients fled and were abandoned to their fate, and many were killed by snipers. Even the psychiatric hospital in Dar al-Ajaza, in the old city of Damascus was bombed, but it remains in operation thanks to the dedication of health personnel (Mediterranean Society on Mental Health, 2013).

The Lancet (2012) reported that

> As if it were not enough, the direct effects of war on people, there was also a large-scale attack against the health infrastructure. Independent analysts such as Physicians for Human Rights, Amnesty International and Doctors Without Borders have reported that government forces are intentionally directed against health care facilities and health care providers and patients.

Libya

If what is occurring in Syria is reported, at least in part, in the Western media and Al-Jazeera, very little is now being reported on the Libyan situation. Officially, nearly a million refugees from Libya who have poured into neighbouring countries and Europe have been returned. The thousands who have received Italian solidarity have seen the end of their residency permits. Most of them are still in Italy illegally, because the situation in Libya is anything but normal and safe.

Some examples were recently reported by the international press and well documented by an Italian reporter (Fezza, 2012): Tauergha, a town that had about 50,000 inhabitants is now totally uninhabited. Little is known of its population, some of whom have been identified in refugee camps, but many have been killed. It was a population of non-Arab Africans, descendants of slaves who had obtained a relative freedom from the Gaddafi regime. But Tauergha is not an exception, other towns are totally deserted. The situation in Libya has not been stabilised and is still potentially explosive. Especially for the populations, living conditions are of extreme suffering where there are no minimum health infrastructure or support services.

A recent study has estimated the cases of severe PTSD and depression and related health service requirements in post-conflict Libya. It can be considered the first attempt to predict the mental health burden and consequent service response needs of the Libyan conflict, but it is also a useful model for estimating such a burden in overall low- to middle-income post-conflict communities (Charlson et al., 2012).

The estimates of prevalence of depression and PTSD have been derived from models based on a previously conducted systematic review and meta-regression analysis of mental health among populations living in conflict in low- and middle-income countries. The intensity of exposure to traumatic events has been used in predictive models. Across all the six populations chosen for modelling (Misrata, Benghazi, Zintan, displaced people within Tripoli, Zlitan and Misrata and the Ras Jdir camps, total population 1,236,600), the conflict could be associated with 123,200 (71,600–182,400) cases of severe PTSD and 228,100 (134,000–344,200) cases of severe depression; 50% of PTSD cases have been estimated to co-occur with severe depression. Based upon service coverage targets, approximately 154 full-time equivalent staff would be required to respond to these cases sufficiently, which is substantially below the current level of resource estimates for these regions.

However, the persistent situation of terror and uncertainty makes it impossible to build any network of care services

Mali

The latest crisis of which we shall speak, Mali, is one that has not hit the shores of the Mediterranean, but it affects the borders of countries such as Algeria and Libya. In 2012, about 300,000 refugees from Mali reached other countries in the western Sahel. These people had to cross the border in semi-desert areas of Niger, Mauritania and Burkina Faso, very poor countries. According to the High Commissioner for Refugees, at the end of 2012, these countries 'were experiencing huge levels of suffering and deprivation' (United Nations, 2012). At the end of 2012, the High Commissioner stated that the dramatic condition of these people 'did not find until now the attention of the international community' (United Nations, 2012). The vast majority of refugees in the camps are women, children and elderly Tuaregs. Adult males who remained in their country of origin to fight in the war, after defeating the army of Mali and declaring their independence, were themselves ousted by the Islamist groups Ansar Dine and Al-Qaeda. Most of the Tuaregs are committed to Mouvement de Liberation de l'Azawar (MLNA), the secular faction of the losing rebels. The French advance in the early months of 2013 engulfed the rebels without many differences. In the second half of 2013, the advance of the allied troops who defeated the fundamentalists offered guarantees to the Tuareg people. But not all were soothed by these guarantees, and only a few have returned. At the time we conducted the study in Subgandé in Burkina Faso, the refugees were not receiving any help from international agencies. The people in Subgandé lived in a precarious condition and danger, with little information on the fate of their relatives, but with the knowledge of additional difficulties that were facing the Tuaregs in Mali. This knowledge dispelled all hope of a quick return to their homeland. Our study was conducted with the aim of assessing the impact of stress in people living in Subgandé. We interviewed more than 400 adults who lived in the area, one-fifth of the population at the time (Carta et al., 2013). This population increased significantly in the following 6 months, but the camp was closed in 2013 and the people were transferred to other camps. The results of the survey show a very high frequency (60%) of people with symptoms of PTSD and simultaneously positive for psychopathology with no significant difference by gender and age (Carta et al., 2013). The frequency of traumatic events in people with PTSD (or in the whole sample) was very high. About 90% had had family members killed, about 90% had family

members seriously injured, almost all had family members in the war of whom they knew nothing. Furthermore, at the time of the survey, conditions were dire with regard to accommodation and food.

These figures, as well as the frequencies of stress-related disorders, are even higher than those found in the Syrian camps, and, although they were detected with a different methodology, we can risk saying that the difference between the two conditions is that while the Syrian refugees harboured a hope of returning after a successful conclusion of the war, at the time of the survey, the Tuareg population was totally without hope. In a previous multicenter study in Ethiopia, Algeria, Gaza and Cambodia (De Jong, Komproe, & Van Ommeren, 2003), PTSD rates in refugees were much lower than those found in Soubgandé (from 15.8% in Ethiopia to 37.4% in Algeria) as well as the presence of 'any severe disorder' (from 17.5% in Ethiopia to 60.5% in Algeria). In this survey, the highest rates of forced social isolation were reported in Algeria (61% against 100% of Subgandé at the time of our survey). Furthermore, in Cambodia, 41% had PTSD related to paucity of food, which is much lower than in the sample in Soubgandé. This may reflect a lack of resources related to a lack of international recognition and aid. Only the Ethiopian sample showed a rate of poor shelter conditions similar to those found in this study (98% vs 94%) (Dobricki, Komproe, de Jong, & Maercker, 2010), thus confirming the importance of the physical environment on refugees' mental health, but also that the constant outbreaks of crisis are leading international bodies to responses less effectively than in the past. Another significant current element is the fact that the non-compliance by some parties in conflict with the principle of non-aggression to staff bringing aid has prompted many non-governmental organizations (NGOs) to withdraw from risk scenarios. These are probably the causes of the reduced presence of aid in the field today compared to 10 years ago.

Health needs in the crisis scenarios and violations of Geneva Conventions

The Lancet (2012) recently published that

> A disturbing feature of modern conflicts and, in particular some of the Arab uprisings, was the flagrant violation of the Geneva Conventions, hitting civilian targets, the persecution of health workers, and the attacks against hospitals, alongside the failure of the system of the United Nations to prevent these violations. The medical community may feel a sense of hopelessness in the face of these seemingly intractable situations. But there is much that can be done to monitor, report and prevent the impact of the conflict on the health of populations, as well as condemning the attacks against civilians and violations of medical neutrality.

Unfortunately, it is to be noted that the violation of the Geneva Conventions in the Mediterranean region is not exclusively related to Islamic riots, just think of Srebrenica, or Sabra and Chatila. The novelty is however, and this does appear exclusive to Islamic uprisings, the attack on health-care institutions is seen as a symbol of an attack on Westernization. When the witches were being burned in the West, physicians in Arab settlements in the Mediterranean area at the time were treating depression as an illness. Modern medicine has been produced by the contribution of all cultures and by scientists of all Mediterranean climates. The great Greek and Roman medical tradition was saved thanks to the contribution of the doctors of the Islamic courts who transcribed the Greek classics into Arabic when Christian fundamentalism denied science. These doctors were Muslims (such as Ibn Sina or Ibn Rushd), Jewish (as Moshe ben Maimon) or Christian (as Serapion). The great Arab medicine enriched the tradition of Hippocrates and Greek medicine, which had been forgotten in the West, with a humanistic approach that today might be called patient-centred. Belief that medicine and health-care institutions are a product of Western culture is an offense to the great Islamic medical tradition and to medical schools that still exist in the Arab world, which are the daughters of this tradition, as well as the right of patients to be cared for. Rediscovering the Greek, Latin and Islamic medical traditions of Mediterranean is a way to fight these biased beliefs.

Conclusion

What happened yesterday in Lebanon, Algeria and Bosnia, and is happening today in Syria, Libya, Mali and Lampedusa, could take place tomorrow in our own homes. The scientific community, which is alive and active in the whole Mediterranean area, has to fight violence with ideas and the mediation of conflicts. The idea that science can improve lives is a concept that is found in the history of all Mediterranean cultures.

Authors' contribution

All authors contributed equally in the preparation of this article.

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References

Bhugra, D., & Becker, M. (2005). Migration, cultural bereavement and cultural identity. *Word Psychiatry*, *4*, 18–24.

Carey-Wood, J., Duke, K., Karn, V., & Marshall, T. (1995). *The settlement of refugees in Britain: Home Office Research Study 141*. London: Home Office.

Carta, M. G., Balestrieri, M., Murru, A., & Hardoy, M. C. (2009). Adjustment Disorder: Epidemiology, diagnosis and

treatment. *Clinical Practice and Epidemiology in Mental Health*, *5*, 15.

Carta, M. G., Bernal, M., Hardoy, M. C., & Haro-Abad, J. M.; 'Report on the Mental Health in Europe' Working Group. (2005). Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1). *Clinical Practice and Epidemiology in Mental Health*, *1*, 13.

Carta, M. G., Wallet Oumar, F., Moro, M. F., Moro, D., Preti, A., Mereu, A., & Bhugra, D. (2013).Trauma- and stressor-related disorders in the Tuareg refugees of a camp in Burkina Faso. *Clinical Practice and Epidemiology in Mental Health*, *9*, 189–195.

Charlson, F. J., Steel, Z., Degenhardt, L., Chey, T., Silove, D., Marnane, C., & Whiteford, H. A. (2012). Predicting the impact of the 2011 conflict in Libya on population mental health: PTSD and depression prevalence and mental health service requirements. *PLoS One*, *7*, e40593.

De Jong, J. T., Komproe, I. H., & Van Ommeren, M. (2003). Common mental disorders in post-conflict settings. *The Lancet*, *361*, 2128–2130.

Dobricki, M., Komproe, I. H., de Jong, J. T., & Maercker, A. (2010). Adjustment disorders after severe life-events in four postconflict settings. *Social Psychiatry and Psychiatric Epidemiology*, *45*, 39–46.

Döner, P., Ozkara, A., & Kahveci, R. (2013). Syrian refugees in Turkey: Numbers and emotions. *The Lancet*, *382*, 764.

El-Khatib, Z., Scales, D., Vearey, J., & Forsberg, B. C. (2013). Syrian Refugees, between rocky crisis in Syria and hard inaccessibility to healthcare services in Lebanon and Jordan. *Conflict and Health*, *7*(1), 18.

Fezza, S. N. (2012). Retrieved from http://ninofezzacinereporter.blogspot.com.ar/p/tauergha-una-citta-fantasma.html

Ginzburg, K., Ein-Dor, T., & Solomon, Z. (2010). Comorbidity of posttraumatic stress disorder, anxiety and depression: A 20-year longitudinal study of war veterans. *Journal of Affective Disorders*, *123*, 249–257.

Habeshia. (2013). Retrieved from http://habeshia.blogspot.it/

Horesh, D., Solomon, Z., Zerach, G., & Ein-Dor, T. (2011). Delayed-onset PTSD among war veterans: The role of life events throughout the life cycle. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 863–870.

Karam, E. G., Fayyad, J., Nasser Karam, A., Cordahi Tabet, C., Melhem, N., Mneimneh, Z., & Dimassi, H. (2008). Effectiveness and specificity of a classroom-based group intervention in children and adolescents exposed to war in Lebanon. *World Psychiatry*, *7*, 103–109.

The Lancet. (2012). A medical crisis in Syria. *The Lancet*, *380*, 537.

Mediterranean Society on Mental Health. (2013, May 9–10). *Mental health in post-conflict Syria*. III Symposium of the Mediterranean Society on Mental Health (ed MG Carta & G Mura), Università Europea del Mediterraneo, Cagliari.

Mollica, R. F., Caridad, K. R., & Massagli, M. P. (2007). Longitudinal study of posttraumatic stress disorder, depression, and changes in traumatic memories over time in Bosnian refugees. *Journal of Nervous and Mental Disease*, *195*, 572–579.

Mollica, R. F., Sarajlic, N., Chernoff, M., Lavelle, J., Vukovic, I. S., & Massagli, MP. (2001). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *JAMA*, *286*, 546–554.

Protezione Civile, & Governo Italiano. (2011). Retrieved from http://www.protezionecivile.gov.it/jcms/it/view_dossier.wp?contentId=DOS24090

Special Representative of the Secretary-General of UN for Children and Armed Conflict. (2013). Retrieved from http://www.un.org/News/briefings/docs/2013/130722_Guest.doc.htm

The Guardian. (2013, October 9). EU pressed to rethink immigration policy after Lampedusa tragedy. *The Guardian*. Available at: http://www.theguardian.com/world/2013/oct/08/eu-immigration-policy-lampedusa-tragedy

The United Nations Children's Emergency Fund. (2013). *Children of Syria: A lost generation? (Crisis Report)*. Retrieved from http://www.scribd.com/doc/129954964/Syria%E2%80%99s-Children-A-lost-generation-Crisis-report-March-2011-March-2013

United Nations. (2012). *International response to Malian refugee crisis severely underfunded – UN top official*. Retrieved from http://www.un.org/apps/news/story.asp?NewsID=42611#.UQPbp7_Aexo

United Nations. (2013). Retrieved from http://www.un.org/apps/news/infocusRel.asp?infocusID=146&;Body=Syria&Body1=

United Nations High Commissioner for Refugees. (2013). *United Nations Asylum Trends 2012*. Retrieved from http://www.unhcr.org/5149b81e9.html

United Nations Refugee Agency. (1961). *Convention and protocol relating to the status of refugees 1951*. Retrieved from http://www.unhcr.org/3b66c2aa10.html

United Nations Refugee Agency. (2013). Retrieved from http://www.unhcr.org/pages/49e486a76.html