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Original articles

Profil épidémiologique des tentatives de suicide chez les adolescents : étude rétrospective au CHU Mohammed VI de Marrakech (2021-2025)

Epidemiological profile of suicide attempts among adolescents: a retrospective study at the Mohammed VI University Hospital in Marrakesh (2021–2025)

Perfil epidemiológico de las tentativas de suicidio en adolescentes : estudio retrospectivo en el Hospital Universitario Mohammed VI en Marrakesh (2021-2025)

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RÉSUMÉ

Objectif. Établir le profil épidémiologique, clinique et évolutif des tentatives de suicide chez les adolescents pris en charge au service de pédopsychiatrie du CHU Mohammed VI de Marrakech. **Matériel et méthodes.** Étude rétrospective monocentrique portant sur 131 adolescents âgés de 10 à 17 ans, hospitalisés ou suivis pour tentative de suicide entre janvier 2021 et décembre 2025. Les données ont été recueillies à partir des dossiers médicaux et analysées par le logiciel SPSS version 27. **Résultats.** L'âge moyen était de 14,71 ± 1,38 ans avec une nette prédominance féminine

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(82,4 %). Les méthodes les plus utilisées étaient l'intoxication médicamenteuse (40,5 %) et les méthodes violentes (53,4 %). Un conflit familial était le facteur déclenchant principal (63,4 %). Une dépression chronique était retrouvée dans environ 40 % des cas. La prise en charge était ambulatoire intensive dans 61,8 % des cas avec une évolution favorable dans la majorité des patients. **Conclusion.** Les tentatives de suicide chez les adolescents à Marrakech s'inscrivent dans un contexte de vulnérabilité multifactorielle dominée par les troubles dépressifs et la dysfonction familiale. Un renforcement de la prévention et de la coordination des soins est nécessaire.

Mots-clés : Tentative de suicide, Adolescent, Épidémiologie, Pédopsychiatrie, Marrakech

ABSTRACT

Objective. To establish the epidemiological, clinical and outcome profile of suicide attempts among adolescents managed in the child and adolescent psychiatry department of Mohammed VI University Hospital in Marrakech. **Methods.** Retrospective ingle-centre study of 131 adolescents aged 10 to 17 years, hospitalised or followed for a suicide attempt between January 2021 and December 2025. Data were collected from medical records and analysed with SPSS version 27. **Results.** Mean age was 14.71 ± 1.38 years with a marked female predominance (82.4 %). The most frequent methods were medication overdose (40.5 %) and violent methods (53.4 %). Family conflict was the main precipitating factor (63.4 %). Chronic depression was found in approximately 40 % of cases. Intensive outpatient care was provided in 61.8 % of cases, with a favourable outcome in the majority of patients. **Conclusion.** Suicide attempts among adolescents in Marrakech occur in a multifactorial context of vulnerability dominated by depressive disorders and family dysfunction. Strengthening primary and secondary prevention, as well as improving care coordination, is required.

Keywords: Suicide attempt, Adolescent, Epidemiology, Child and adolescent psychiatry, Marrakech

RESUMEN

Objetivo. Determinar el perfil epidemiológico, clínico y evolutivo de los intentos de suicidio en adolescentes atendidos en el servicio de psiquiatría infantil del Hospital Universitario Mohammed VI de Marrakech. **Material y métodos.** Estudio retrospectivo monocéntrico realizado con 131 adolescentes de entre 10 y 17 años, hospitalizados o en seguimiento por intento de suicidio entre enero de 2021 y diciembre de 2025. Los datos se recopilaron a partir de los historiales médicos y se analizaron con el programa SPSS, versión 27. **Resultados.** La edad media fue de 14,71 ± 1,38 años, con un claro predominio femenino (82,4 %). Los métodos más utilizados fueron la intoxicación medicamentosa (40,5 %) y los métodos violentos (53,4 %). El principal factor desencadenante fue un conflicto familiar (63,4 %). Se observó depresión crónica en aproximadamente el 40 % de los casos. El tratamiento fue ambulatorio intensivo en el 61,8 % de los casos, con una evolución favorable en la mayoría de los pacientes. **Conclusión.** Los intentos de suicidio entre los adolescentes de Marrakech se inscriben en un contexto de vulnerabilidad multifactorial en el que predominan los trastornos depresivos y la disfunción familiar. Es necesario reforzar la prevención y la coordinación de la atención sanitaria.

Palabras clave: Intento de suicidio, Adolescente, Epidemiología, Psiquiatría infantil, Marrakech

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INTRODUCTION

Adolescence is defined by the World Health Organisation as the period of life between the ages of 10 and 19(WHO, 2024) and constitutes a crucial stage in human development, marked by significant physical, cognitive, emotional and social changes. Although it offers numerous opportunities for growth and identity formation, this period also represents a time of increased vulnerability to mental health disorders(Moreau, 2024) .

In this context, suicidal behaviour constitutes a major public health problem. A suicidal crisis is defined as a temporary and reversible process of psychological exhaustion in the individual, the progressive risk of which is the act of suicide itself (French Federation of Psychiatry [FFP], 2000).

Globally, suicide is the third leading cause of death among 15–29-year-olds (WHO, 2026).

In Morocco, data from the 2016 Global School-based Student Health Survey (GSHS) reveal a high prevalence of suicidal behaviour among adolescents: 16.0 per cent reported serious suicidal thoughts and 14.6 per cent reported a suicide plan in the past 12 months, with rates of suicide attempts being particularly concerning, especially amongst girls (Tom & Mahfoud, 2022).

National data on completed suicide remain limited; according to estimates by the World Health Organisation (WHO, 2025), the suicide mortality rate in Morocco was estimated at 3.0 per 100,000 population in 2021, but these figures are likely to be underestimated due to under-reporting linked to cultural and religious factors.The Marrakech-Safi region has a population of over 4.5 million, a significant proportion of whom are adolescents. The Mohammed VI University Hospital in Marrakech is the main centre of excellence for child and adolescent psychiatry in southern Morocco. The child and adolescent psychiatry department provides consultations, outpatient care and the assessment of child and adolescent psychiatric emergencies. To date, there is no inpatient unit dedicated to child and adolescent psychiatry in Marrakech; adolescents requiring hospitalisation are therefore referred to facilities with child and adolescent psychiatric inpatient services.

At the university child and adolescent psychiatry outpatient unit at the Mohammed VI University Hospital in Marrakech, we have observed an increase in the number of cases involving adolescents admitted following a suicide attempt. However, despite this clinical reality, few studies have been conducted locally to describe in detail the epidemiological profile of such attempts in the region. As part of this study, we chose to examine the clinical cases of adolescents whose suicidal crisis resulted in a suicide attempt.

The aim of this study is to establish the epidemiological profile of suicide attempts amongst adolescents in Marrakech, by describing their socio-demographic characteristics, the methods used, the associated risk factors, the circumstances in

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which they occurred, and the clinical and developmental aspects. This study aims to provide local data that will help improve the early identification, management and prevention of suicidal behaviour in our context.

MATERIALS AND METHODS

Study design and period

This is a single-centre, retrospective, descriptive study covering a five-year period, from 1 January 2021 to 31 December 2025.

Study population

The study included all adolescents aged between 10 and 17 years who were treated at the university child and adolescent psychiatry outpatient unit at the Mohammed VI University Hospital in Marrakesh for a suicide attempt.

The exclusion criteria were: patients aged over 17 and cases of self-harming behaviour without clear suicidal intent.

The decision to set the upper age limit at 17 reflects the organisation of care pathways at the Marrakech University Hospital: patients aged 17 and over are referred to adult psychiatric services. Adolescents aged 17–19 were therefore not included in this child and adolescent psychiatry cohort.

Data collection

Data were collected from archived medical records. A standardised data collection form was developed, comprising the following variables:

- Sociodemographic data (age, gender, educational attainment, socio-economic status, family situation);
- Personal and family history;
- Characteristics of the family and social environment (conflicts, abuse, family communication);
- Characteristics of the suicide attempt (trigger, planning, method used, perceived lethality, prior communication);
- Psychiatric diagnosis, treatment and clinical course.
- Socio-economic status was assessed qualitatively based on the information available in the case file (parents' occupation, social security cover, place of residence, explicit references to financial hardship), and classified as 'low' or 'medium'.
- Abuse was recorded where it was documented in the case file (statement by the adolescent, parents or a third party, or clinical observation).

Statistical analysis

The data were entered and analysed using SPSS version 27.0. Qualitative variables were expressed as freq s and percentages. Quantitative variables were described by their mean ± standard deviation.

Qualitative variables that could include multiple responses (notably clinical symptoms, triggering factors, history and

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types of abuse) were treated as multiple-response variables, allowing the same patient to be counted in several categories for a single variable.

No bivariate analyses were carried out due to the descriptive nature of the study.

Ethical considerations

Data anonymity and confidentiality were strictly maintained, with the consent of patients and their families for the use of clinical data for research and publication purposes. The study complied with the principles of the Declaration of Helsinki.

RESULTS

1. General characteristics of the population

Our study involved 131 adolescents aged between 10 and 17 who were treated for attempted suicide at the university child and adolescent psychiatry outpatient unit of the Mohammed VI University Hospital in Marrakesh between January 2021 and December 2025. The mean age of the patients was 14.71 ± 1.38 years, with two peaks in frequency at 16 years (35.9 per cent) and 15 years (28.2 per cent). The population was predominantly female (82.4 per cent compared with 17.6 per cent boys).
Table 1

2. Time to treatment and referring department

At the time of admission, the average time between the suicide attempt and receipt of care in child and adolescent psychiatry was 5.63 ± 11.89 days. Nearly half of the adolescents (46.6 per cent) were seen on the day of the attempt, whilst 61.1 per cent were seen within the first two days.

The main referring services were the paediatric A&E department at the University Hospital (35.1 per cent), followed by general practitioners (20.6 per cent), paediatric departments at the University Hospital (14.5 per cent), the paediatric intensive care unit (7.6 per cent), forensic medicine (3.8 per cent) and addiction services (3.1 per cent), whilst 15.3 per cent of patients came from other departments.

3. Socio-demographic profile

In socio-demographic terms, 6.9 per cent of adolescents were in primary school, 51.1 per cent in lower secondary school, 22.9 per cent in upper secondary school and 19.1 per cent had dropped out of school. Socio-economic status was considered low in 58 per cent of cases and average in 42 per cent of cases.

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Table 1. Sociodemographic characteristics

Variable	n	%
Age (years)		
10 years	2	1.5
11 years	2	1.5
12 years	7	5.3
13 years	10	7.6
14 years	26	19.8
15 years	37	28.2
16 years	47	35.9
Mean ± standard deviation	**14.71 ± 1.38**	**—**
Gender		
Female	108	82.4
Male	23	17.6
Current level of education		
Primary	9	6.9
Lower secondary	67	51.1
Secondary school	30	22.9
School drop-out rate	25	19.1
Socio-economic status (clinical assessment)		
Low	76	58.0
Medium	55	42.0
Birth order		
Eldest	52	39.7
Middle child	41	31.3
Junior	26	19.8
Only child	12	9.2
Parents' marital status		
Married parents living together	74	56.5
Divorced parents	37	28.2
Orphan (one or both parents)	12	9.2
Separated but not divorced parents	8	6.1

4. Personal and family history

Personal and family history reveals significant vulnerability. One third of adolescents (33.6 per cent) have previously made at least one suicide attempt, broken down as follows: 1 attempt (11.5 per cent), 2 attempts (12.2 per cent) and 3 attempts (9.2 per cent). Non-suicidal self-harm is present in 29.8 per cent of patients. A personal psychiatric history is found in 41.2 per cent of cases, predominantly major depressive disorder (31.3 per cent). A history of substance misuse affects 17.6 per cent of adolescents, mainly involving cannabis and tobacco. A medical history

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was reported in 8.4 per cent of cases, notably including epilepsy, hypothyroidism, diabetes insipidus or type 1 diabetes, Behçet's disease , chronic asthma, obesity and certain autoimmune diseases.

In terms of family history, a psychiatric history is present in 32.8 per cent of families, primarily maternal depression in mothers; a family history of suicide or attempted suicide is rare (2.3 per cent).

Table 2.

Table 2. Personal and family history

Variable	n	%
Previous suicide attempt		
No	87	66.4
Yes	44	33.6
Number of previous suicide attempts (among the 44)		
1	15	11.5*
2	16	12.2*
3	12	9.2*
5	1	0.8*
Non-suicidal self-harm		
No	92	70.2
Yes	39	29.8
Personal psychiatric history		
None (RAS)	77	58.8
Major depressive disorder	41	31.3
Anxiety-depressive disorder	4	3.1
Conduct disorder	4	3.1
Schizophrenia	2	1.5
Eating disorder (ED)	1	0.8
Borderline personality disorder	1	0.8
OCD	1	0.8
History of substance abuse		
No	108	82.4
Yes	23	17.6
Medical history		
No	120	91.6
Yes	11	8.4
Family history of mental health conditions		
No	88	67.2
Yes	43	32.8
Family relationship (among the 43)		
First-degree relative	34	26.0*
Uncle (paternal or maternal)	3	2.3*
Others (aunts, cousins, grandmother, sister, etc.)	6	4.6*
History of suicide attempts or completed suicide in the family		
No	128	97.7
Yes	3	2.3

** Percentages calculated for the entire cohort (N = 131).*

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5. Family and social environment

Regarding family circumstances, 56.5 per cent live with both parents who are married and living together, 28.2 per cent have divorced parents, 9.2 per cent have lost one or both parents, and 6.1 per cent have parents who are separated but not divorced. The family and social environment is severely disrupted. Parental conflicts or domestic violence are reported in 61.1 per cent of cases, occurring daily in 14.5 per cent and frequently in 40.5 per cent. Family communication is rated as poor or non-existent in 55.7 per cent of cases, average in 38.9 per cent and good in only 5.3 per cent. Parental support is perceived as insufficient by 88.5 per cent of adolescents. Relationship difficulties with peers (bullying or social isolation) affect 40.5 per cent of patients. A history of abuse, in all its forms, is very common (90.1 per cent), with a predominance of psychological abuse (91.6 per cent), physical abuse (56.5 per cent) and sexual abuse (22.1 per cent).

Table 3

Table 3. Family and relationship environment

Variable	n	%
Parental conflict / domestic violence		
No	51	38.9
Yes	80	61.1
Frequency of conflicts (among the 80)		
Frequent	53	40.5*
Daily	19	14.5*
Occasional	8	6.1*
Family communication		
Good	7	5.3
Average	51	38.9
Poor / absent	73	55.7
Perceived parental support		
Sufficient	15	11.5
Insufficient	116	88.5
Difficulties in relationships with peers		
No	78	59.5
Yes (bullying, isolation, etc.)	53	40.5
History of abuse (any form)		
No	13	9.9
Yes	118	90.1
Physical abuse		
No	57	43.5
Yes	74	56.5
Psychological abuse		
No	11	8.4
Yes	120	91.6
Sexual abuse		
No	102	77.9
Yes	29	22.1

** Percentages calculated for the entire cohort (N = 131).*

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6. Characteristics of the suicide attempt and initial referral

Regarding the characteristics of the suicide attempt itself, the plan was established and premeditated in 62.6 per cent of cases. Access to the method used was easy in 96.2 per cent of situations. Awareness of the lethality of the method was present in 63.4 per cent of adolescents, uncertain in 25.2 per cent and absent in 11.5 per cent. A triggering factor was identified in 77.1 per cent of cases, primarily a family conflict (63.4 per cent), followed by bullying (6.9 per cent) and relationship conflict (6.1 per cent). Suicidal thoughts are very rarely disclosed prior to the act (0.8 per cent). Psychiatric symptoms in the preceding days or weeks were dominated by irritability (35.9 per cent), withdrawal (9.2 per cent) and sadness (5.3 per cent). Serious physical consequences (coma, cardiorespiratory difficulties or neurological sequelae) are observed in 21.4 per cent of attempts. More than half of patients (52.7 per cent) are admitted to a general medical department (A&E 30.5 per cent, paediatrics or intensive care) before being referred to child and adolescent psychiatry.

The most common method is drug overdose (40.5 per cent), followed by the ingestion of toxic or caustic substances (18.3 per cent), hanging (11.5 per cent), self-inflicted bleeding or deep cuts (11.5 per cent), jumping from a significant height (9.9 per cent) and the use of a bladed weapon (4.6 per cent). A method classified as violent (any method other than pure drug overdose) was used in 53.4 per cent of cases. The stated intention was a desire to die in 55 per cent of cases, a cry for help or a message to loved ones in 17.6 per cent, and a means of putting pressure on the family in 14.5 per cent, whilst other motives were less common. **Table 4.**

Table 4. Characteristics of suicide attempts

Variable	n	%
Time from suicide attempt to admission to child and adolescent psychiatry (days)		
1 day	61	46.6
2 days	19	14.5
3 days	20	15.3
4–7 days	16	12.2
≥ 8 days	15	11.5
Mean ± standard deviation	**5.63 ± 11.90**	**—**

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Table 4. Characteristics of the suicide attempt (continued)

Referring department		
Paediatric A&E	46	35.1
General practitioner	27	20.6
Paediatrics at the University Hospital	19	14.5
Paediatric Intensive Care	10	7.6
Forensic medicine	5	3.8
Addiction medicine	4	3.1
Other	20	15.3
Method used		
Drug poisoning	53	40.5
Ingestion of toxic/caustic substances	24	18.3
Hanging	15	11.5
Bloodletting / deep cuts	15	11.5
Jump from a significant height	13	9.9
Stabbing	6	4.6
Drug overdose + jumping	2	1.5
Other (failure to take insulin, refusal to eat, throwing oneself in front of a train)	3	2.3
Method classified as violent (excluding pure drug overdose)		
No	61	46.6
Yes	70	53.4
Scenario established and planned		
No	49	37.4
Yes	82	62.6
Suicidal thoughts expressed prior to the act		
No	130	99.2
Yes	1	0.8
Easy access by		
No	5	3.8
Yes	126	96.2
Awareness of the lethality of the method		
Yes	83	63.4
Uncertain	33	25.2
No	15	11.5
Trigger identified		

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No	30	22.9
Yes	101	77.1
Continued from Table 4		
Nature of the triggering factor (out of the 101)		
Family conflict	83	63.4*
Harassment	9	6.9*
Relationship conflict	8	6.1*
Academic failure	1	0.8*
Serious physical consequences (coma, resuscitation, long-term effects)		
No	103	78.6
Yes	28	21.4
Stated intention		
Desire to die	72	55.0
Call for help / message to loved ones	24	18.3
Putting pressure on the family	19	14.5
Escaping unbearable suffering	11	8.4
Delusional state / other	5	3.8

8. Diagnosis, type of crisis (Table 5)

The type of crisis is classified as psychopathological in 57.3 per cent of cases, psychosocial in 35.1 per cent and psychotraumatic in 7.6 per cent. At the conclusion of the assessment, the most common diagnosis is chronic depression (approximately 40 per cent of cases, including many severe forms). Major depressive disorder was diagnosed in 5.3 per cent of adolescents. These depressive disorders were followed by anxiety-depressive disorders, substance-use disorders, conduct disorders and, more rarely, by schizophrenia or post-traumatic stress disorder.

9. Therapeutic management

Given the lack of a specialist child and adolescent psychiatry inpatient unit in Marrakesh, intensive outpatient care was provided for 61.8 per cent of adolescents. This care is based on an integrative approach combining supportive psychotherapy, psychoeducational interventions and family support, in line with current recommendations for the prevention of recurrent suicidal behaviour in adolescents, and is organised in the form of therapeutic sessions every 24 hours at the day hospital. The frequency is then adjusted according to the response during the acute phase (appointments every 48–72 hours during the first four weeks).

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Adolescents classified as high-risk according to the Risk–Urgency–Danger (RUD) assessment – accounting for 38.2 per cent of cases – were referred to child and adolescent psychiatric inpatient services located outside the city.

Table 5. Diagnosis, type of crisis, management and outcome

Variable	n	%
Type of seizure		
Psychopathological	75	57.3
Psychosocial	46	35.1
Psychotraumatic	10	7.6
Primary diagnosis (grouped)		
Chronic depression (all forms)	≈ 52	≈ 40
Major depressive episode (MDE)	7	5.3
Environmental/psychosocial disorder	≈ 33	≈ 25
Troubled adolescence	9	6.9
Post-traumatic stress disorder (PTSD)	≈ 4	≈ 3
Conduct disorder	4	3.1
Schizophrenia	2	1.5
Other (anxiety-depression, OCD, borderline, bipolar, etc.)	≈ 20	≈ 15
Referral via a general medical department before child and adolescent psychiatry		
No	62	47.3
Yes	69	52.7
Care setting		
Intensive outpatient care	81	61.8
Inpatient care	50	38.2

** Percentages calculated for the entire cohort (N = 131).*

Overall, 61.8 per cent of cases were managed on an outpatient basis, whilst hospitalisation was required in 38.2 per cent of cases. In outpatient care, treatment almost always combines psychotherapy (97 per cent of cases) with pharmacological treatment.

Fluoxetine (20 mg) is prescribed as first-line treatment for major depressive episodes, sometimes in combination with risperidone at an average dose of 0.5 to 1 mg, or with other antidepressants such as sertraline.

Furthermore, a group psychotherapy workshop dedicated to managing suicidal crises is organised following the acute phase. This workshop, now offered systematically to all patients, constitutes a structured approach aimed at strengthening adolescents' skills in emotional regulation, identifying triggers and developing coping strategies. It forms part of a strategy for secondary prevention and reducing the risk of repeat suicide attempts.

This intensive outpatient care has led to **clinical stabilisation** and a return to normal

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psychosocial functioning in the majority of adolescents receiving outpatient care

10. Outcome

At the end of the follow-up period, the outcome was favourable in the majority of cases, with the crisis resolving on average within 3 to 4 weeks and a return to normal functioning observed in many adolescents. However, 6.9 per cent of patients were lost to follow-up. Furthermore, a few patients required referral for hospitalisation due to an unfavourable course of the condition, a resurgence of suicidal ideation or a suicide attempt (observed in 2 per cent of cases).

DISCUSSION

Suicide attempts represent a major medical and psychological emergency and one of the most pressing public health issues worldwide. Their high prevalence, combined with the severity of their consequences, makes them a phenomenon that cannot be addressed without collective, multi-sectoral action.

Adolescence is a period of particular vulnerability, marked by identity, emotional and neurobiological upheavals that expose young people to an increased risk of acting on suicidal thoughts. Impulsivity, a characteristic trait of this age group, plays a decisive role in suicidal behaviour, shortening the time between suicidal thoughts and the act itself, and making prevention all the more urgent and complex.

Given the scale of this phenomenon, rigorous assessment and awareness-raising are essential at all levels: in schools, within families, in society at large, amongst GPs—who are often the first point of contact—and, finally, within specialist mental health services, which ensure appropriate and coordinated care.

Age and gender:

The average age of 14.71 ± 1.378 years, with two peaks in frequency at 15 and 16 years, is consistent with national and international data. It is similar to the findings of the study by Khaloui et al. (2025) in Casablanca, which reported an average age of 15.03 ± 1.35 years. This age group corresponds to a period of high vulnerability linked to the changes of puberty, academic pressures and the emergence of mood disorders. However, another Moroccan study had reported a lower mean age (12 and a half years) (Salimi et al., 2013).

A clear predominance of females was observed in our series (82.4 per cent, female-to-male sex ratio = 4.68), which is consistent with data from the national and international literature, which recognise that females predominate among those who attempt suicide (Khaloui et al., 2025; Abderrahmane et al., 2022; Ay et al., 2025; Rhodes et al., 2014).

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Delay in access to child and adolescent psychiatry and referral services

In our study, the average time between the initial referral and the start of care in child and adolescent psychiatry was 5.63 ± 11.89 days, with 46.6 per cent of patients seen on the same day. This time is shorter than that reported by Khaloui et al. (8.91 days) (Khaloui et al., 2025). The pathway to care continues to be predominantly via the paediatric A&E department at the University Hospital (35.1 per cent) and somatic departments, highlighting the need for better coordination with child and adolescent psychiatry to ensure early assessment, which significantly reduces the risk of repeat suicide attempts (Apicella et al., 2023; Fontanella et al., 2020). The delay observed in our series highlights a frequent delay in consultation with a child and adolescent psychiatrist following the initial referral by the somatic doctor. From a clinical perspective, this delay prompts reflection on psychosocial factors such as shame and guilt felt by the patient and/or their family, as well as the possible trivialisation of the act by those around them, which may contribute to postponing the request for or acceptance of specialist care.

Socio-economic status

A low socio-economic status was observed in 58 per cent of cases, which is consistent with the literature (Khaloui et al., 2025; Abderrahmane et al., 2022; Tom & Mahfoud, 2022). However, this finding must be interpreted with caution due to a possible recruitment bias, as our university facility primarily treats patients who are financially disadvantaged and from precarious social backgrounds.

Family and psychosocial factors

Family and relational factors are of particular concern: parental conflict or domestic violence (61.1 per cent), poor family communication (55.7 per cent), perceived insufficient parental support (88.5 per cent) and a history of abuse (90.1 per cent, including psychological abuse at 91.6 per cent). These findings are consistent with recent literature confirming the major role of family dysfunction (OR ≈ 1.94) and abuse in suicidal behaviour among adolescents (Pu et al., 2025; Arias et al., 2025; Chia et al., 2025).

Personal and family history

One third of adolescents (33.6 per cent) had previously made at least one unsuccessful suicide attempt, 29.8 per cent exhibited non-suicidal self-harm, and 41.2 per cent had a personal psychiatric history, predominantly major depressive disorder (31.3 per cent). These figures are consistent with those from other studies (Khaloui et al., 2025; Ay et al., 2025; Baldini et al., 2025).

A family history of psychiatric disorders (32.8 per cent) also constitutes a significant vulnerability factor (Pu et al., 2025). Delayed diagnosis of depression and a lack of treatment represent a major aggravating factor in suicide risk, and a suicide attempt not followed by a referral to a child and adolescent psychiatrist exposes the

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adolescent to a risk of recurrence of approximately 30 per cent within the same year, with the use of potentially more lethal methods (Ligier et al. 2016). These findings highlight the high vulnerability profile of the adolescents in our series and emphasise the need for thorough assessment, close monitoring and targeted secondary prevention in patients with a history of attempted suicide and/or major depressive disorder.

Characteristics of the suicide attempt

The predominance of family conflict as a triggering factor (63.4 per cent**)** is not surprising in the Moroccan socio-cultural context. Intrafamilial tensions, whether linked to parental conflicts or academic pressures, constitute a major source of distress that is often trivialised by those around them. These findings fully justify the systematic inclusion of family therapy in our management protocol.

These findings are consistent with the international literature, which highlights the central role of family conflicts and early-life adversities (Ligier et al., 2016; Miller et al., 2013; Chen et al., 2026). They argue in favour of a structured assessment of suicide risk from the very first point of contact, particularly by GPs.

The exceptionally low rate of prior disclosure of suicidal thoughts **(**0.8 per cent**)** is particularly worrying. It reflects the silence surrounding the suicide crisis in our context, linked to stigma, fear of family judgement and the lack of appropriate spaces for adolescents to speak openly. This finding highlights the urgent need to develop awareness programmes in schools and within families, to enable adolescents to express their distress before they act on their thoughts.

Furthermore, the high proportion of violent methods **(**53.4 per cent**)** and serious physical complications **(**21.4 per cent**)** is comparable to data from Casablanca (6). These results highlight the severity of suicide attempts in this population and reinforce the need for early, multidisciplinary intervention.

Diagnosis and management

The prevalence of major depressive disorder as the primary diagnosis (≈ 40 per cent) illustrates the diagnostic delay frequently observed in our practice. Indeed, depression in adolescents is often overlooked, trivialised or confused with ‘behavioural difficulties’ or ‘troubled adolescence’. This leads to suicidal behaviour without any prior psychiatric intervention having been initiated. This finding is consistent with the literature, which indicates that only one third of adolescents with depression receive appropriate treatment (Walter et al., 2023). The predominance of intensive outpatient care (61.8 per cent) in our series primarily reflects a structural constraint linked to the absence of a dedicated child and adolescent psychiatric inpatient unit in Marrakesh. Although not a deliberate choice, this approach has proved effective in our practice, provided it is underpinned by a rigorous organisation of follow-up (frequent initial appointments,

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multidisciplinary coordination and active family involvement). This outpatient approach is favoured whenever the adolescent's suicide risk and level of functioning allow it, with hospitalisation being reserved for severe or high-risk cases (Aabbassi & Manoudi, 2026).

Our multimodal therapeutic approach combines psychoeducation, parental guidance, psychotherapies (psychodynamic, cognitive-behavioural and interpersonal) and pharmacotherapy where indicated. Psychoeducation for families, a central component of our intervention, has helped to improve treatment adherence and reduce environmental vulnerability factors, confirming the evidence in the literature on the effectiveness of early multidisciplinary approaches (Baldini et al., 2025; Morcillo et al., 2025; Verlenden et al., 2024).

The dropout rate (6.9 per cent) is mainly attributable to the persistent stigma surrounding psychiatric disorders, socio-economic difficulties limiting access to care, geographical distance, and a sense of early improvement leading to discontinuation of follow-up. However, the lack of follow-up after a first suicide attempt significantly increases the risk of recurrence within the year, often involving more lethal methods (Ligier et al., 2016). This finding argues in favour of implementing active strategies to maintain the therapeutic relationship, notably through systematic telephone contact and enhanced coordination with GPs.

CONCLUSION AND OUTCOME

Suicide attempts among adolescents often occur within a context of multifactorial vulnerability characterised by depressive disorders, family dysfunction, abuse, precarious living conditions and many other factors. This highlights the urgent need to strengthen prevention (school-based screening, raising awareness amongst families and young people about mental health and suicidal behaviour), to improve the coordination of care and to develop specialised crisis units. Prospective, multicentre and qualitative studies are needed to better adapt prevention strategies to the Moroccan context, focusing on the identification of at-risk populations and the development of multidisciplinary strategies for holistic healthcare in paediatric patients.

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REFERENCES

OMS. Santé des adolescents (2014) [Internet]. [Cité 9 mai 2026]. Disponible sur: https://www.who.int/fr/health-topics/adolescent-health#tab=tab_1

Antoine Moreau. La narration dans la crise suicidaire de l'adolescent : l'exemple du manga. Médecine humaine et pathologie. 2024. ⟨dumas-04918837⟩

Fédération Française de Psychiatrie. (2000). La crise suicidaire : reconnaître et prendre en charge : Texte court. https://www.sfmu.org/upload/consensus/cc_crise_suicidaire_court.pdf

Organisation mondiale de la Santé. (2026, 28 août). Suicide. https://www.who.int/news-room/fact-sheets/detail/suicide

Tom, A., & Mahfoud, Z. R. (2022). Factors associated with suicidality among school attending adolescents in Morocco. Frontiers in Psychiatry, 13, 885258. https://doi.org/10.3389/fpsyt.2022.885258

World Health Organization. (2025). *Suicide worldwide in 2021: Global health estimates*. https://www.who.int/publications/i/item/9789240110069

Khaloui, G., Mabkhout, A., Rachidi, L., & Benjelloun, G. (2025). Clinical and epidemiological profile of adolescent suicide attempters in Morocco: A 10-year retrospective study from the adolescent psychiatric inpatient unit in Casablanca. Middle East Current Psychiatry, 32, 66. https://doi.org/10.1186/s43045-025-00560-8

Salimi, S., Bouhdadi, S., Rachid, A., Atlas, R., & Dehbi, F. (2013). Tentative de suicide chez l'enfant et l'adolescent : Une expérience marocaine. Journal de Pédiatrie et de Puériculture, 26(1), 6–10. https://doi.org/10.1016/j.jpp.2012.10.001

Abderrahmane, A., Kharbach, A., Azzine, H., Lkoul, A., Bouchriti, Y., Cherrat, Z., et al. (2022). Suicide attempts in Morocco: A systematic review. Revue d'Épidémiologie et de Santé Publique, 70(5), 243–251. https://doi.org/10.1016/j.respe.2022.05.006

Ay, B., Balatacı, U., & Ay, A. (2025). Sociodemographic and clinical characteristics of adolescents following suicide attempts: A single-center study from Türkiye. Psychiatry Investigation, 22(12), 1350–1357. https://doi.org/10.30773/pi.2025.0169

Rhodes, A. E., Boyle, M. H., Bridge, J. A., Sinyor, M., Links, P. S., Tonmyr, L., Skinner, R., Bethell, J. M., Carlisle, C., Goodday, S., Hottes, T. S., Newton, A., Bennett, K., Sundar, P., Cheung, A. H., & Szatmari, P. (2014). Antecedents and sex/gender differences in youth

JOURNAL OF CHILD AND ADOLESCENT PSYCHIATRY AND PSYCHOLOGY

ISSN 1578-1062

Volume 12, Issue 1, 2026, pp. 1–19

DOI: https://doi.org/10.65549/hgh1mj52

suicidal behavior. *World Journal of Psychiatry, 4*(4), 120–132. https://doi.org/10.5498/wjp.v4.i4.120

Apicella, M., Serra, G., Trasolini, M., Andracchio, E., Chieppa, F., Averna, R., Iannoni, M. E., Infranzi, A., Moro, M., Guidetti, C., Maglio, G., Raucci, U., Reale, A., & Vicari, S. (2023). Urgent psychiatric consultations for suicide attempt and suicidal ideation before and after the COVID-19 pandemic in an Italian pediatric emergency setting. Frontiers in Psychiatry, 14, 1135218. https://doi.org/10.3389/fpsyt.2023.1135218

Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. JAMA Network Open, 3(8), e2012887. https://doi.org/10.1001/jamanetworkopen.2020.12887

Tom, A., & Mahfoud, Z. R. (2022). Factors associated with suicidality among school attending adolescents in Morocco. Frontiers in Psychiatry, 13, 885258. https://doi.org/10.3389/fpsyt.2022.885258

Pu, M., Guo, L., Cheng, P., Gao, Q., & Zhu, H. (2025). Family dysfunction and risk of suicidal behavior in adolescents: A systematic review and meta-analysis. Journal of Affective Disorders, 370, 427–433. https://doi.org/10.1016/j.jad.2024.11.025

Arias, P., Arqueros, M., Suárez-Soto, E., García-Ramos, A., Ayad-Ahmed, W., Ovejero-Ruiz, A., et al. (2025). Early life adversity and suicide: The role of childhood trauma and risk factors in adolescent suicidal behavior. Children and Youth Services Review, 179, 108648. https://doi.org/10.1016/j.childyouth.2025.108648

Chia, A. Y. Y., Hartanto, A., Wan, T. S., Teo, S. S. M., Sim, L., & Kasturiratna, K. T. A. S. (2025). The impact of childhood sexual, physical and emotional abuse and neglect on suicidal behavior and non-suicidal self-injury: A systematic review of meta-analyses. Psychiatry Research Communications, 5(1), 100202. https://doi.org/10.1016/j.psycom.2025.100202

Baldini, V., Gnazzo, M., Varallo, G., Di Vincenzo, M., Scorza, M., Franceschini, C., et al. (2025). A comprehensive approach to adolescent suicide prevention: Insights from a narrative review perspective. Frontiers in Psychology, 16, 1612067. https://doi.org/10.3389/fpsyg.2025.1612067

Pu, M., Guo, L., Cheng, P., Gao, Q., & Zhu, H. (2025). Family dysfunction and risk of suicidal behavior in adolescents: A systematic review and meta-analysis. Journal of Affective Disorders, 370, 427–433. https://doi.org/10.1016/j.jad.2024.11.025

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DOI: https://doi.org/10.65549/hgh1mj52

Ligier, F., Kabuth, B., & Guillemin, F. (2016). MEDIACONNEX: A multicenter randomised trial based on short message service to reduce suicide attempt recurrence in adolescents. BMC Psychiatry, 16, 251. https://doi.org/10.1186/s12888-016-0965-8

Miller, A. B., Esposito-Smythers, C., Weismoore, J. T., & Renshaw, K. D. (2013). The relation between child maltreatment and adolescent suicidal behavior: A systematic review and critical examination of the literature. Clinical Child and Family Psychology Review, 16(2), 146–172. https://doi.org/10.1007/s10567-013-0131-5

Chen, Y., Black, M., Bennett, D., McGovern, R., Sharp, H., Rehkopf, D., Taylor-Robinson, D. C., & Adjei, N. K. (2026). Multiple trajectories of family adversity and poverty and adolescent self-harm and suicide attempts: Findings from the UK Millennium Cohort Study. Child and Adolescent Psychiatry and Mental Health, 20, 75. https://doi.org/10.1186/s13034-026-01023-6

Walter, H. J., Abright, A. R., Bukstein, O. G., Diamond, J., Keable, H., Ripperger-Suhler, J., et al. (2023). Clinical practice guideline for the assessment and treatment of children and adolescents with major and persistent depressive disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 62(5), 479–502. https://doi.org/10.1016/j.jaac.2022.10.001

Aabbassi, B., & Manoudi, F. (2026). L'évaluation diagnostique et la prise en charge de la dépression de l'adolescent « en cinq étapes ». Journal de Pédiatrie et de Puériculture, 39(3), 159–163. https://doi.org/10.1016/j.jpp.2025.10.008

Verlenden, J. V., Fodeman, A., Wilkins, N., Jones, S. E., Moore, S., Cornett, K., Sims, V., Saelee, R., & Brener, N. D. (2024). Mental health and suicide risk among high school students and protective factors—Youth Risk Behavior Survey, United States, 2023. *MMWR Supplements, 73*(4), 79–86. https://doi.org/10.15585/mmwr.su7304a9

Morcillo, V., Ferrer-Ribot, M., Mut-Amengual, B., Bagur, S., & Rosselló, M. R. (2025). Mental health and suicide attempts in adolescents: A systematic review. *Healthcare, 13*(9), 1039. https://doi.org/10.3390/healthcare13091039