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# School bullying as a mode of presentation of psychiatric disorders in children and adolescents

## Le harcèlement scolaire comme mode de révélation des troubles psychiatriques chez l'enfant et l'adolescent

## *El acoso escolar como forma de presentación de los trastornos psiquiátricos en niños y adolescentes*

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## RÉSUMÉ

**Objectif.** Décrire les circonstances d'identification du harcèlement scolaire et les troubles psychiatriques associés chez les enfants et adolescents suivis en consultation de pédopsychiatrie à l'hôpital Ibn Nafis (CHU Mohammed VI de Marrakech), ainsi que les caractéristiques et le contexte du harcèlement, son retentissement scolaire, la chronologie par rapport au début des troubles, les facteurs de vulnérabilité et de protection, la prise en charge et la réponse de l'établissement scolaire.

**Matériel et méthodes.** Étude descriptive monocentrique portant sur 54 enfants et adolescents âgés de 8 à 16 ans, présentant un antécédent de harcèlement scolaire et ayant consulté en pédopsychiatrie. Les fiches ont été saisies du 7 juin au 17 octobre 2026 à l'aide d'une fiche de collecte standardisée et analysées de façon descriptive. Le risque suicidaire a été évalué par la C-SSRS.

**Résultats.** L'âge moyen était de 11,9 ± 1,9 ans et les garçons représentaient 66,7 % de l'échantillon. Le harcèlement était verbal chez 94 % des patients, quotidien chez 83 %, évoluant depuis plus de 12 mois chez 61 % et survenant dans l'enceinte scolaire dans 93 % des cas. Une violence intrafamiliale était associée chez 41 %. Le harcèlement n'était identifié comme facteur causal lors de la première consultation que chez 37 % des patients, les motifs de consultation dominants étant les difficultés scolaires (46 %) et le syndrome anxieux (26 %). Un diagnostic psychiatrique était retenu chez 81 % des patients (trouble anxieux 31 %, trouble dépressif 24 %, déficience intellectuelle 20 %). Le harcèlement précédait le trouble chez 70 % des patients présentant un trouble dépressif et 60 % de ceux présentant un trouble anxieux, et il était présent depuis l'entrée à l'école chez tous les patients porteurs d'une déficience intellectuelle. Aucune idéation suicidaire active n'était rapportée. La réponse de l'établissement scolaire était inexistante dans 76 % des cas.

**Conclusion.** Dans cette population clinique hospitalière, le harcèlement scolaire apparaît verbal, quotidien, durable et presque exclusivement scolaire, souvent associé à une violence intrafamiliale et à un cumul d'événements de vie stressants. Il n'est identifié comme facteur causal lors de la première consultation que dans une minorité de cas, le plus souvent derrière des difficultés scolaires ou un syndrome anxieux. Sa recherche systématique lors de toute première consultation de pédopsychiatrie, l'évaluation conjointe du contexte familial et du risque suicidaire et une liaison structurée avec les établissements scolaires s'imposent.


**Mots-clés :** harcèlement scolaire ; enfant ; adolescent ; pédopsychiatrie ; santé mentale.


## ABSTRACT

**Objective.** To describe the circumstances in which school bullying is identified and the associated psychiatric disorders in children and adolescents attending the child and adolescent psychiatry clinic at Ibn Nafis Hospital (Mohammed VI University Hospital, Marrakesh), as well as the characteristics and context of the bullying, its academic impact, its timing relative to the onset of the disorders, vulnerability and protective factors, management, and the school's response.

**Materials and methods.** A single-centre descriptive study of 54 children and adolescents aged 6 to 16 years with a history of school bullying who attended the child and adolescent psychiatry clinic. Records were entered between 7 June and 17 October 2026 using a standardised data collection form and analysed descriptively. Suicide risk was assessed with the C-SSRS.

**Results.** The mean age was 11.9 ± 1.9 years and boys accounted for 66.7 per cent of the sample. The bullying was verbal in 94 per cent of patients, daily in 83 per cent, ongoing for more than 12 months in 61 per cent and occurred on school premises in 93 per cent of cases. Intrafamilial violence was associated in 41 per cent. Bullying was identified as a causal factor at the first consultation in only 37 per cent of patients, the main reasons for consultation being school difficulties (46 per cent) and anxiety syndrome (26 per cent). A psychiatric diagnosis was made in 81 per cent of patients (anxiety disorder 31 per cent, depressive disorder 24 per cent, intellectual disability 20 per cent). Bullying preceded the disorder in 70 per cent of patients with a depressive disorder and 60 per cent of those with an anxiety disorder and had been present since school entry in all patients with intellectual disability. No active suicidal ideation was reported. The school's response was non-existent in 76 per cent of cases.

**Conclusion.** In this hospital-based clinical population, school bullying appears to be verbal, daily, long-lasting and almost exclusively school-based, often associated with intrafamilial violence and an accumulation of stressful life events. It is identified as a causal factor at the first consultation in only a minority of cases, most often behind school difficulties or anxiety syndrome. Systematic screening for

bullying at every first child psychiatry consultation, joint assessment of the family context and suicide risk, and structured liaison with schools are warranted.

**Keywords:** school bullying; child; adolescent; child and adolescent psychiatry; mental health.

## RESUMEN

**Objetivo.** Describir las circunstancias en las que se identifica el acoso escolar y los trastornos psiquiátricos asociados en niños y adolescentes atendidos en la consulta de psiquiatría infantil del Hospital Ibn Nafis (Hospital Universitario Mohammed VI de Marrakech), así como las características y el contexto del acoso, su repercusión escolar, la cronología respecto al inicio de los trastornos, los factores de vulnerabilidad y de protección, el tratamiento y la respuesta del centro escolar.

**Material y métodos.** Estudio descriptivo monocéntrico realizado con 54 niños y adolescentes de entre 8 y 16 años con antecedentes de acoso escolar, atendidos en la consulta de psiquiatría infantil. Las fichas se registraron entre el 7 de junio y el 17 de octubre de 2026 mediante una ficha de recogida de datos estandarizada y se analizaron de forma descriptiva. El riesgo suicida se evaluó con la C-SSRS.

**Resultados.** La edad media era de 11,9 ± 1,9 años y los chicos representaban el 66,7 % de la muestra. El acoso era verbal en el 94 % de los pacientes, diario en el 83 %, de más de 12 meses de evolución en el 61 % y se producía en el recinto escolar en el 93 % de los casos. En el 41 % se asociaba violencia intrafamiliar. El acoso solo se identificaba como factor causal en la primera consulta en el 37 % de los pacientes, y los principales motivos de consulta eran las dificultades escolares (46 %) y el síndrome ansioso (26 %). Se estableció un diagnóstico psiquiátrico en el 81 % de los pacientes (trastorno de ansiedad 31 %, trastorno depresivo 24 %, discapacidad intelectual 20 %). El acoso precedía al trastorno en el 70 % de los pacientes con trastorno depresivo y en el 60 % de los que presentaban un trastorno de ansiedad, y estaba presente desde el ingreso en la escuela en todos los pacientes con discapacidad intelectual. No se notificó ninguna ideación suicida activa. La respuesta del centro escolar fue inexistente en el 76 % de los casos.

**Conclusión.** En esta población clínica hospitalaria, el acoso escolar se presenta como verbal, diario, duradero y casi exclusivamente escolar, a menudo asociado a violencia intrafamiliar y a una acumulación de acontecimientos vitales estresantes. Solo en una minoría de casos se identifica como factor causal en la primera consulta, casi siempre detrás de dificultades escolares o de un síndrome ansioso. Se imponen la búsqueda sistemática del acoso en toda primera consulta de psiquiatría infantil, la evaluación conjunta del contexto familiar y del riesgo suicida, y una coordinación estructurada con los centros escolares.

**Palabras clave:** acoso escolar; niño; adolescente; psiquiatría infantil; salud mental.

## INTRODUCTION

School bullying is defined as intentional, repeated aggressive behaviour occurring within a relationship characterised by an imbalance of power between the perpetrator and the victim [1]. It can be verbal, physical, relational or take place online, and affects children and adolescents across all education systems [2]. Common and often long-lasting, it is now a public health problem whose consequences extend far beyond the school setting [3].

Beyond its academic and social repercussions, bullying is recognised as a risk factor for mental health disorders, particularly depression and anxiety [4,5,6], and may be accompanied by reduced self-esteem [7], a decline in academic performance [8] and an increased risk of suicide [9,10]. The relationship between bullying and mental health problems is, however, complex and likely to be bidirectional [11]: pre-existing mental health difficulties may leave a child vulnerable to bullying, which may in turn exacerbate these difficulties or contribute to their onset.

In clinical practice, bullying often goes unrecognised [7,12]. Children rarely disclose it of their own accord [13], and it may be masked by a variety of reasons for seeking consultation, such as difficulties at school, somatic complaints, symptoms of anxiety or behavioural problems, or it may be attributed to an underlying condition, particularly in children with neurodevelopmental disorders [14]. However, identifying it during a child and adolescent psychiatry consultation, and understanding its role in the history of the disorder, are essential for providing early and appropriate management. To our knowledge, data from child and adolescent psychiatry consultations in Morocco remain scarce.

Against this background, our work aims to better characterise school bullying amongst children and adolescents attending child and adolescent psychiatry clinics in Marrakesh, in order to clarify the circumstances under which it is identified, the associated disorders and the response provided in our practice.

## OBJECTIVE

The main objective was to describe the circumstances under which school bullying is identified and the associated psychiatric disorders in children and adolescents attending child and adolescent psychiatry consultations at Ibn Nafis Hospital (Mohammed VI University Hospital, Marrakech) who have a history of school bullying.

The secondary objectives were to describe: (1) the socio-demographic characteristics of the patients; (2) the characteristics and context of the bullying (school environment alone or associated with domestic violence); (3) its impact on school performance; (4) the clinical presentation and diagnoses at the start of consultation, including suicide risk; (5) the timeline between the bullying and the onset of depressive disorders, anxiety disorders and intellectual disability; (6) vulnerability and protective factors; (7) the management and response of the school.

## MATERIALS AND METHODS

### Study design and period

This is a single-centre descriptive study

conducted in the child and adolescent psychiatry department at Ibn Nafis Hospital (Mohammed VI University Hospital, Marrakesh). Patient records were collected from 7 June to 17 October 2026.

### Study population and inclusion criteria

Patients were included if they met the following four criteria: aged between 6 and 16 years; at least one consultation at the child and adolescent psychiatry department of Ibn Nafis Hospital; a history of school bullying; and informed consent from a parent or legal guardian for the child's participation in the study. No specific exclusion criteria were defined in advance.

### Data collection

Data were collected using a standardised data collection form, created using Google Forms and completed by a single interviewer. Where the child was unable to express themselves or was non-verbal, school bullying was reported by the parents. The variables studied included:

- Sociodemographic and school-related data: age, gender, year group, type of school, area of residence, family situation, estimated socio-economic status.
- Characteristics of the bullying: forms, duration, frequency, locations, perpetrators, disclosure to an adult, reporting, time between the start of the bullying and the first consultation, impact on school performance.
- The context of the bullying: limited to the school environment or associated with violence or belittling within the family, estimated on the basis of domestic violence reported amongst stressful life events.
- Circumstances surrounding the identification of bullying at the start of consultation: reason for consultation stated immediately by the family; reason revealed subsequently following active enquiry by the clinician; or bullying not being the reason for consultation.
- Clinical data: reasons for consultation, initial symptoms, diagnoses made according to the DSM-5 or ICD-11, personal and family psychiatric history, neurodevelopmental disorders.
- The timeline between the onset of bullying and the onset of the disorder, assessed for depressive disorders, anxiety disorders and intellectual disability based on the history of the condition as reported by the child and their parents.
- Vulnerability and protective factors: perceived family support (rated on a scale of 5, considered low when ≤ 2), a non-family adult reference figure, peer relationships prior to the bullying, self-esteem, stressful life events.
- Care arrangements, prescribed treatments, follow-up care and the school's response.

### Assessment tools

Diagnoses were made on the basis of clinical assessment, in accordance with the DSM-5 or ICD-11. Standardised scales (SCARED, PHQ-A) were used only in certain patients, where necessary to support the diagnosis, and not systematically; their scores are therefore not reported. Self-esteem was assessed clinically (low, moderate, good). Suicidal risk was assessed using the Columbia-Suicide Severity Rating Scale (C-SSRS): levels of suicidal ideation are classified from 1 to 5, ranging from a wish to be dead to the existence of a suicidal intent with a plan, and suicidal behaviours are assessed separately.

### Statistical analysis

The analysis was descriptive. Qualitative variables were expressed as frequencies and percentages. Quantitative variables were described using the mean and standard deviation where their distribution permitted, or the median and interquartile range where this was not the case. Clinical variables were described at the initial assessment (T0). No comparative analysis was carried out and no statistical associations were drawn.

## RESULTS

### 1. Sociodemographic characteristics

The sample comprises 36 boys (66.7 per cent) and 18 girls (33.3 per cent). The mean age is 11.9 ± 1.9 years. The 12–14 age group is the most represented (50 per cent), followed by the 10–11 age group (31.5 per cent). The majority of patients are in primary school (54%), followed by secondary school (35%). 76% of patients attend state schools, and 87.0% live in urban areas (data not available for one patient). The children most often live in a nuclear family (65 per cent); 24 per cent are in single-parent households. The estimated socio-economic status is average in 56 per cent of cases (**Table 1**).

### Ethical considerations and conflicts of interest

The study was conducted in accordance with the ethical principles applicable to research involving minors. Informed consent was obtained from the parent or legal guardian prior to inclusion. Data confidentiality and participant anonymity were maintained throughout the collection, processing and analysis of the information. The data were used exclusively for scientific purposes. No conflicts of interest were declared in connection with this work.

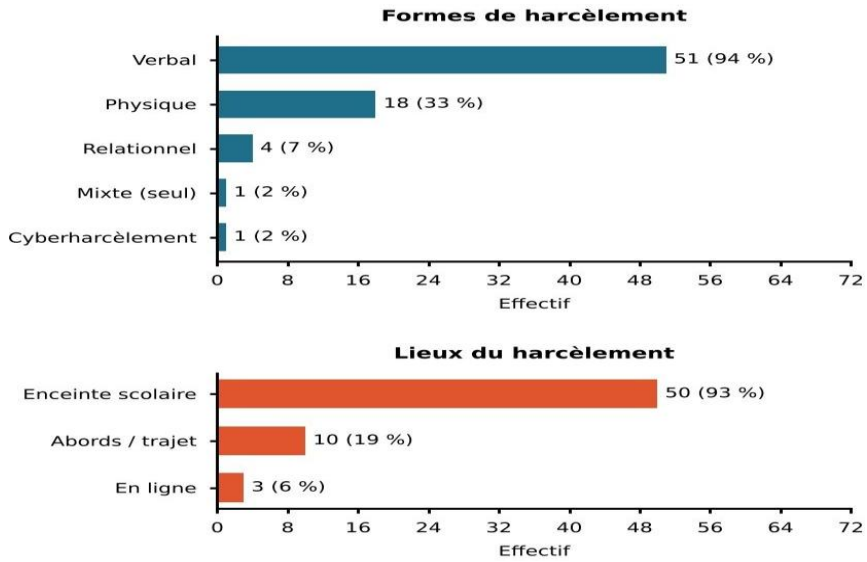
### 2. Characteristics of bullying

Harassment is verbal in 94 per cent of cases (insults, taunts), physical in 33 per cent, relational in 7 per cent, and 35 per cent of patients experience at least two combined forms. Only one case of pure cyberbullying was reported; three patients (5.6 per cent), including this case, reported incidents online, but 93 per cent of incidents took place on school premises and 19 per cent in the vicinity of the school or on the way to or from school. Groups of perpetrators were reported in 57 per cent of cases and individual perpetrators in 48 per cent (**Figure 1**).

**Table 1.** Sociodemographic characteristics (n = 54).

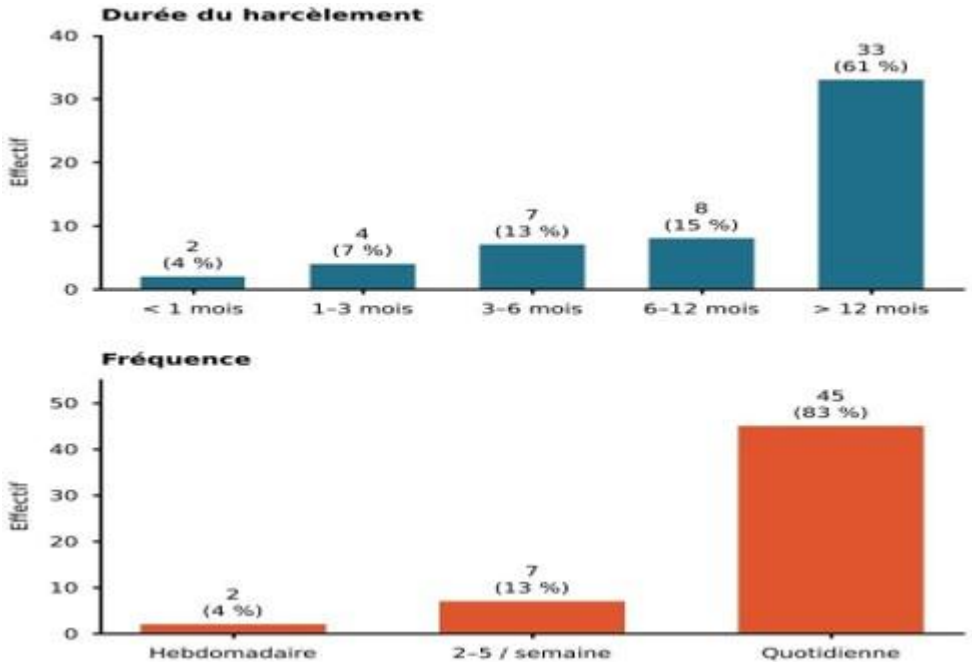
| Characteristics | Sample size (n) | Percentage (%) |
|---|---|---|
| **Gender** | | |
| **Boys** | 36 | 66.7 |
| **Girls** | 18 | 33.3 |
| **Mean age ± standard deviation** | 11.9 ± 1.9 years | |
| **Age groups** | | |
| **8–9 years** | 6 | 11.1 |
| **10–11 years** | 17 | 31.5 |
| **12–14 years** | 27 | 50.0 |
| **15–16 years** | 4 | 7.4 |
| **School level** | | |
| **Primary** | 29 | 54 |
| **Secondary** | 19 | 35 |
| **Secondary school** | 5 | 9 |
| **Not in education** | 1 | 2 |
| **Type of education** | | |
| **State** | 41 | 76 |
| **Private** | 13 | 24 |
| **Residential area** | | |
| **Urban** | 47 | 87.0 |
| **Rural** | 6 | 11.1 |
| **Not specified** | 1 | 1.9 |
| **Family structure** | | |
| **Nuclear family** | 35 | 65 |
| **Single parent** | 13 | 24 |
| **Foster care/guardianship, adoption or extended family** | 4 | 7.4 |
| **Blended family** | 2 | 3.7 |
| **Estimated socio-economic status** | | |
| **Medium** | 30 | 55.6 |
| **Low** | 22 | 40.7 |
| **High** | 2 | 3.7 |

**Figure 1.** Forms and locations of harassment (multiple responses)



The situation is chronic and severe: bullying has been going on for more than 12 months in 61 per cent of patients (76 per cent for more than 6 months) and occurs daily in 83 per cent of cases, and several times a week in 13 per cent (**Figure 2**). Eighty-five per cent of the children have spoken to an adult about it. The median time between the start of the bullying and the first consultation is 12 months (mean 17.9; interquartile range 7.5–19.5; data available for 32 patients (**Figure 2**))

**Figure 2.** Duration and frequency of bullying.




### 3. Context of the bullying: school environment alone or associated domestic violence

Bullying takes place on school premises in 93 per cent of cases. In order to determine whether school is the sole source of the child's feelings of worthlessness, the family context was assessed on the basis of domestic violence reported amongst stressful life events (**Table 2**). This was found in 22 patients (41 per cent), for whom the bullying occurred within a context of abuse or belittling at home, compared with 32 patients (59 per cent) for whom it appeared to be confined to the school environment.

**Table 2.** Relational context of bullying (n = 54).

| Context | Number (n) | Percentage (%) |
|---|---|---|
| **Bullying limited to the school environment** | 32 | **59.3** |
| **Bullying at school associated with violence or belittling within the family** | **22** | **40.7** |

This estimate is based on domestic violence and does not distinguish between verbal belittling by parents and other forms of violence; it may underestimate instances of children being belittled where no violence has been reported.

### 4. Impact on school performance

Academic performance has declined in 63 per cent of patients (moderate decline in 37 per cent, significant decline in 24 per cent, and withdrawal from school in 2 per cent) and remains unchanged in 37 per cent (Figure 3). Absenteeism was reported in 6 out of 54 patients (11 per cent), which is likely an underestimate given the frequency of school-avoidance symptoms.

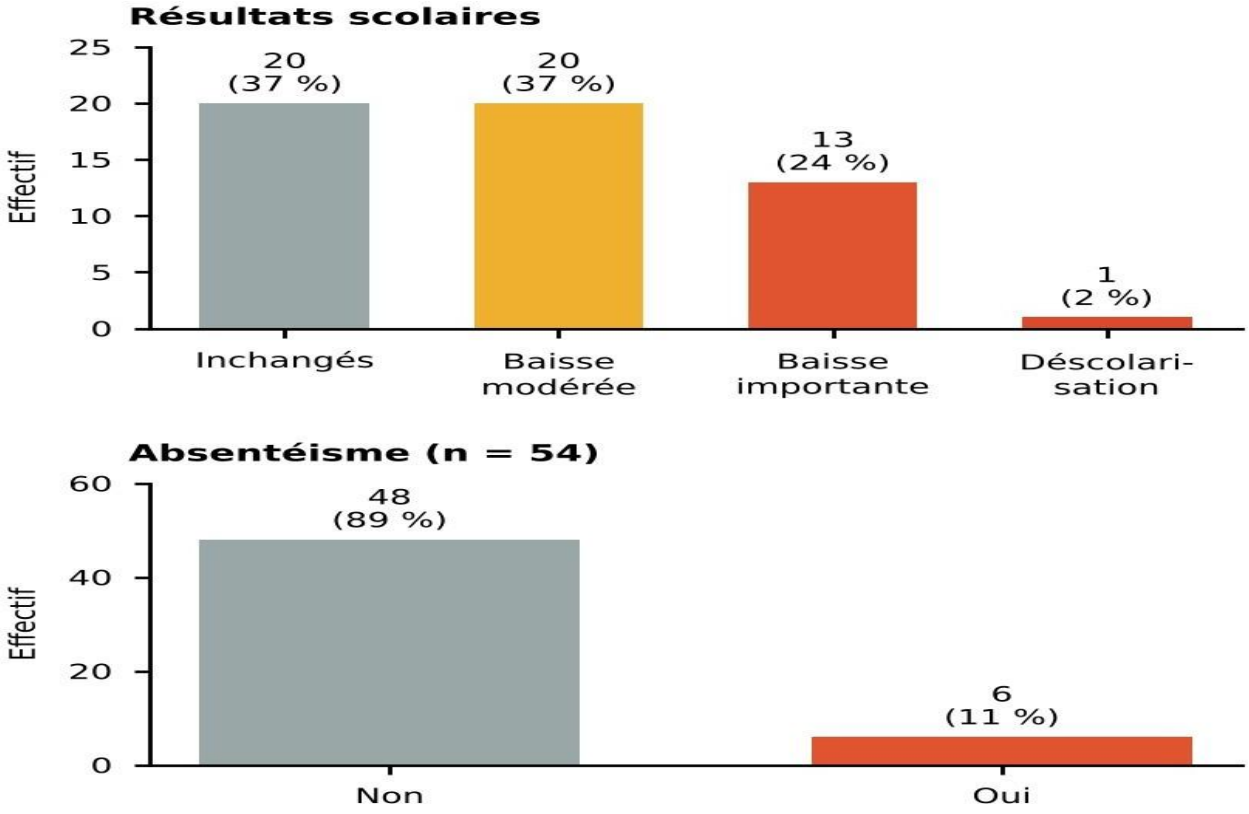



**Figure 3.** Changes in academic performance and absenteeism.

### 5. Clinical presentation at the initial consultation

***Reasons for consultation***. Academic difficulties were the most common reason (46 per cent), followed by anxiety disorder (26 per cent), depressive disorder (9 per cent) and behavioural disorders (9 per cent). One isolated case was referred due to somatic complaints, anxiety-related school refusal, suicidal ideation, abnormal movements or a referral from an external source.

***Circumstances surrounding the identifycation of bullying***. Bullying was identified as a causal factor at the first consultation in only 37 per cent of cases (n = 20) (Figure 4). It was the reason for the consultation stated by the family from the outset in 28 per cent of cases (n = 15), and was only identified subsequently, during the consultation and following active enquiry by the clinician, in 9 per cent of cases (n = 5). In 63 per cent of cases (n = 34), harassment was not the reason for the consultation.

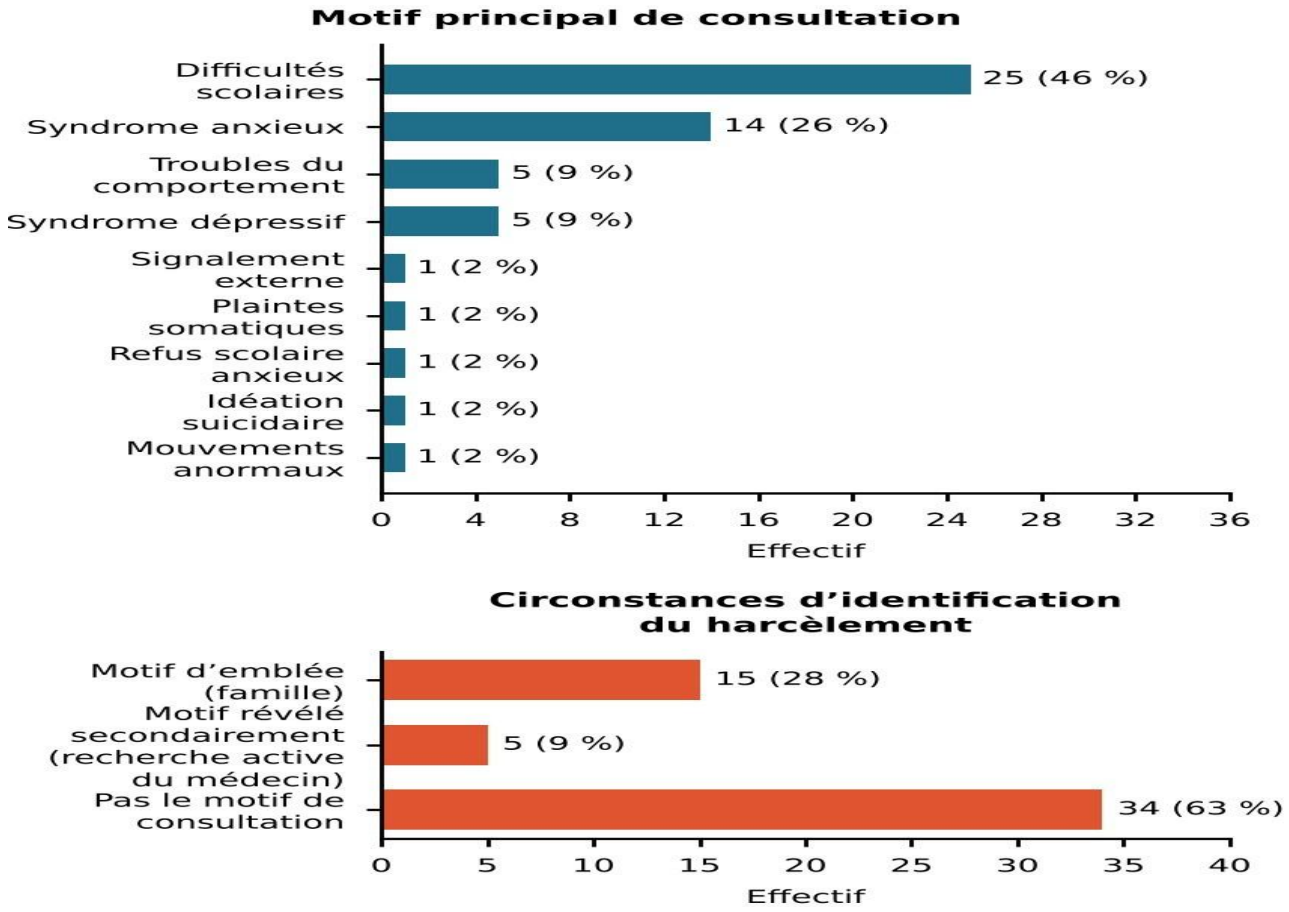



**Figure 4.** Main reason for consultation and circumstances in which bullying was identified.

Children with a confirmed neurodevelopmental disorder (21 patients) sought consultation for academic difficulties in 86 per cent of cases (18/21), compared with 21 per cent (7/33) of the others, suggesting that bullying is easily masked by academic issues in these patients.

***Suicidal risk.*** No active suicidal ideation was reported; 4 patients (7.4 per cent) had passive suicidal ideation (3 children aged 11 and one aged 12; 2 girls, 2 boys), including the patient referred for suicidal ideation. None of these four patients was receiving medication at baseline (T0).

***Diagnoses.*** At least one diagnosis was identified in 44 patients (81 per cent), and more than one in 12. The most common were depressive disorder (24 per cent), intellectual disability (20 per cent), specific learning difficulties (19 per cent) and separation anxiety (15 per cent). In total, 31 per cent of patients (17/54) had at least one anxiety disorder (separation anxiety, generalised anxiety disorder, social phobia, panic disorder), 24 per cent (13/54) had a depressive disorder and 6 per cent had post-traumatic stress disorder. Ten patients (19 per cent) had no psychiatric diagnosis.

Personal psychiatric history was virtually absent (1 case); first-degree family history was present in 30 per cent (16/54) of patients, mainly involving depressive or anxiety disorders (Figure 5).

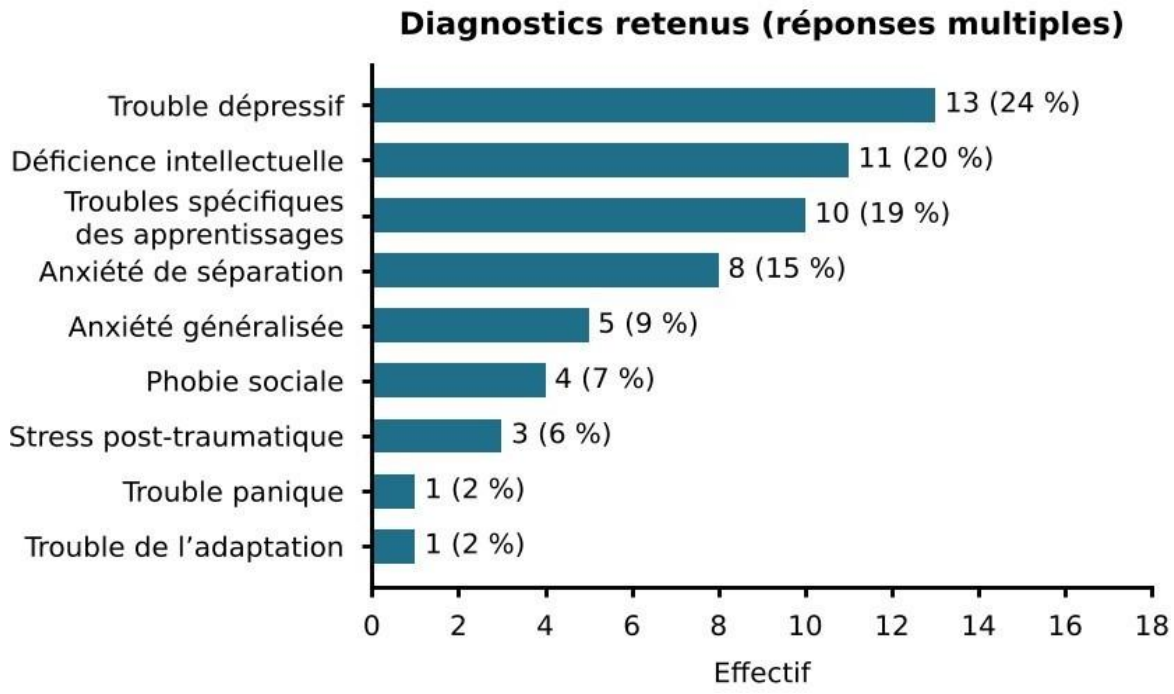



**Figure 5.** Diagnoses made following the initial assessment (multiple responses).

### 6. Timeline of the harassment and onset of the disorder according to the diagnosis

The timeline between the bullying and the onset of the disorder was examined according to the diagnosis. Among patients with a depressive disorder, the bullying preceded the onset of depression in 70 per cent of cases. Among those with an anxiety disorder, it preceded the development of anxiety in 60 per cent of cases. Among patients with an intellectual disability, all (100 per cent) had experienced bullying since starting school.

### 7. Vulnerability and protective factors

Perceived family support averaged 2.8 out of 5 and was rated as low (≤ 2) for 43 per cent of the children. A non-family support figure was present for 67 per cent; however, 74 per cent had only partial peer relationships (61 per cent) or were already isolated (13 per cent) prior to the bullying. Self-esteem is low in 30 per cent of patients (Figure 6). Concomitant stressful life events are found in 74 per cent of patients: domestic violence (41 per cent), parental separation or divorce (35 per cent), moving house or changing schools (19 per cent) **(Figure 7)**. The context is therefore frequently one of multiple adverse factors, making it difficult to attribute the symptoms solely to bullying.

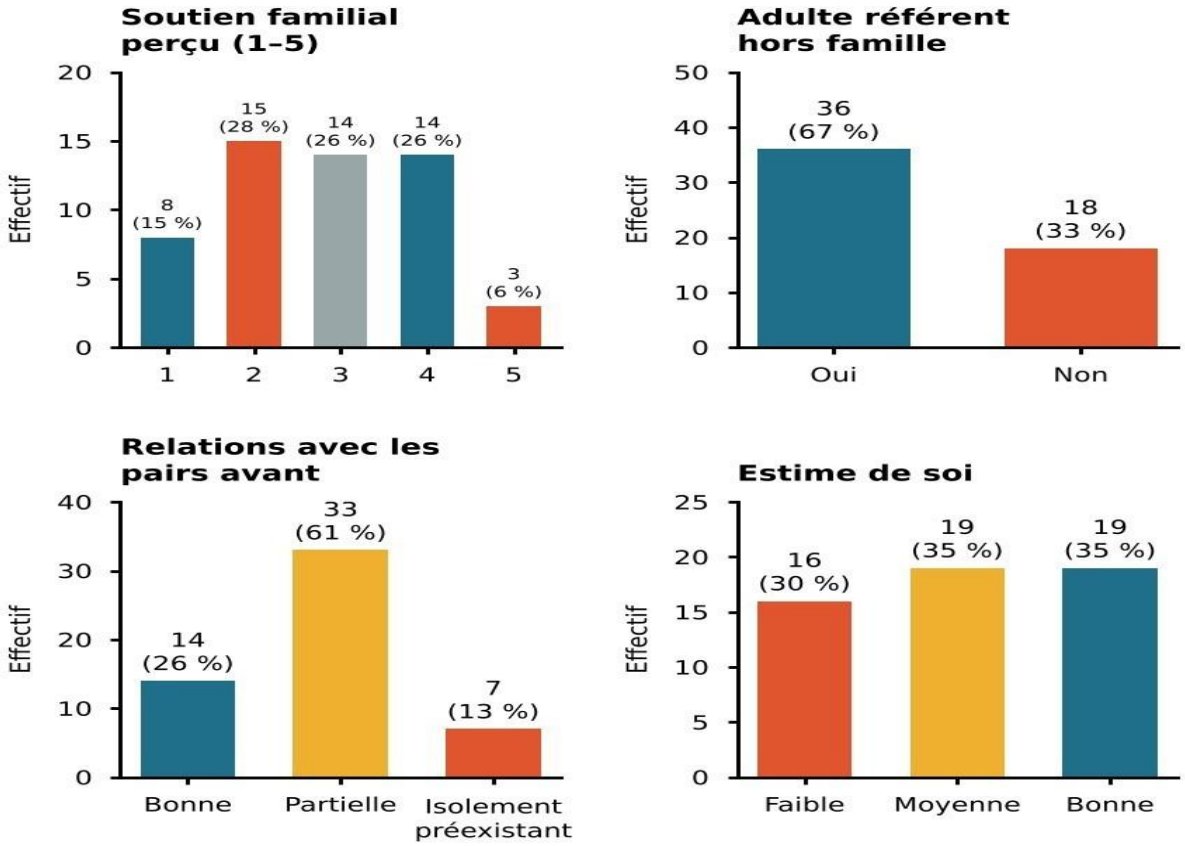



**Figure 6.** Family support, primary adult caregiver, peer relationships and self-esteem.

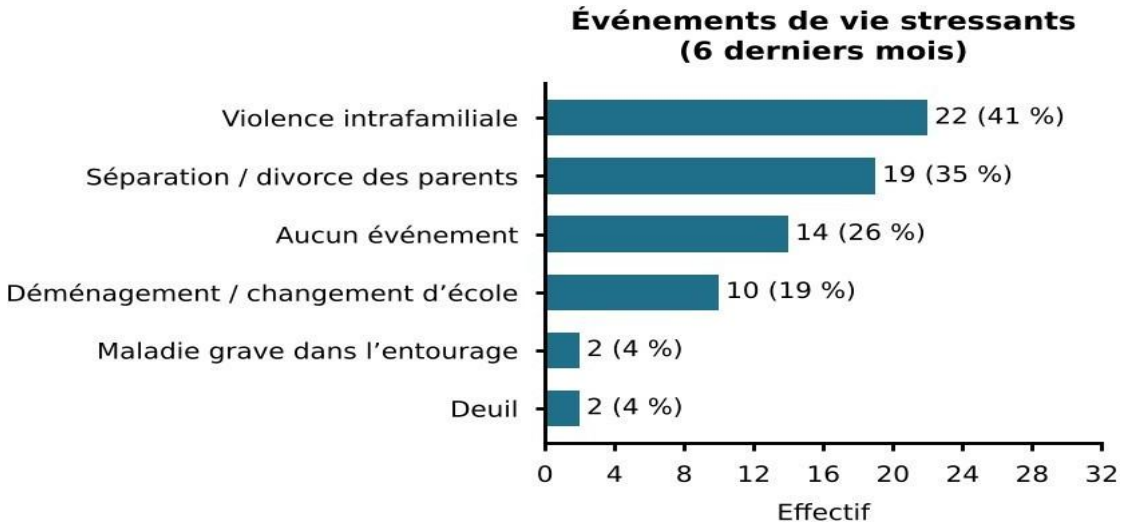



**Figure 7.** Stressful life events in the last 6 months.

## 8. School-based care and response

Individual psychotherapy was initiated for 98 per cent of patients and psychoeducation for 76 per cent. Ten patients (19 per cent) received medication: an SSRI antidepressant (8 patients: fluoxetine or sertraline), one of whom was also prescribed low-dose risperidone, or hydroxyzine (2 patients). Structured liaison

with the school (RASED) and family therapy were re ly reported for only one patient each (**Figure 8)**, whilst a referral was made in 67 per cent of cases (**Figure 9**).

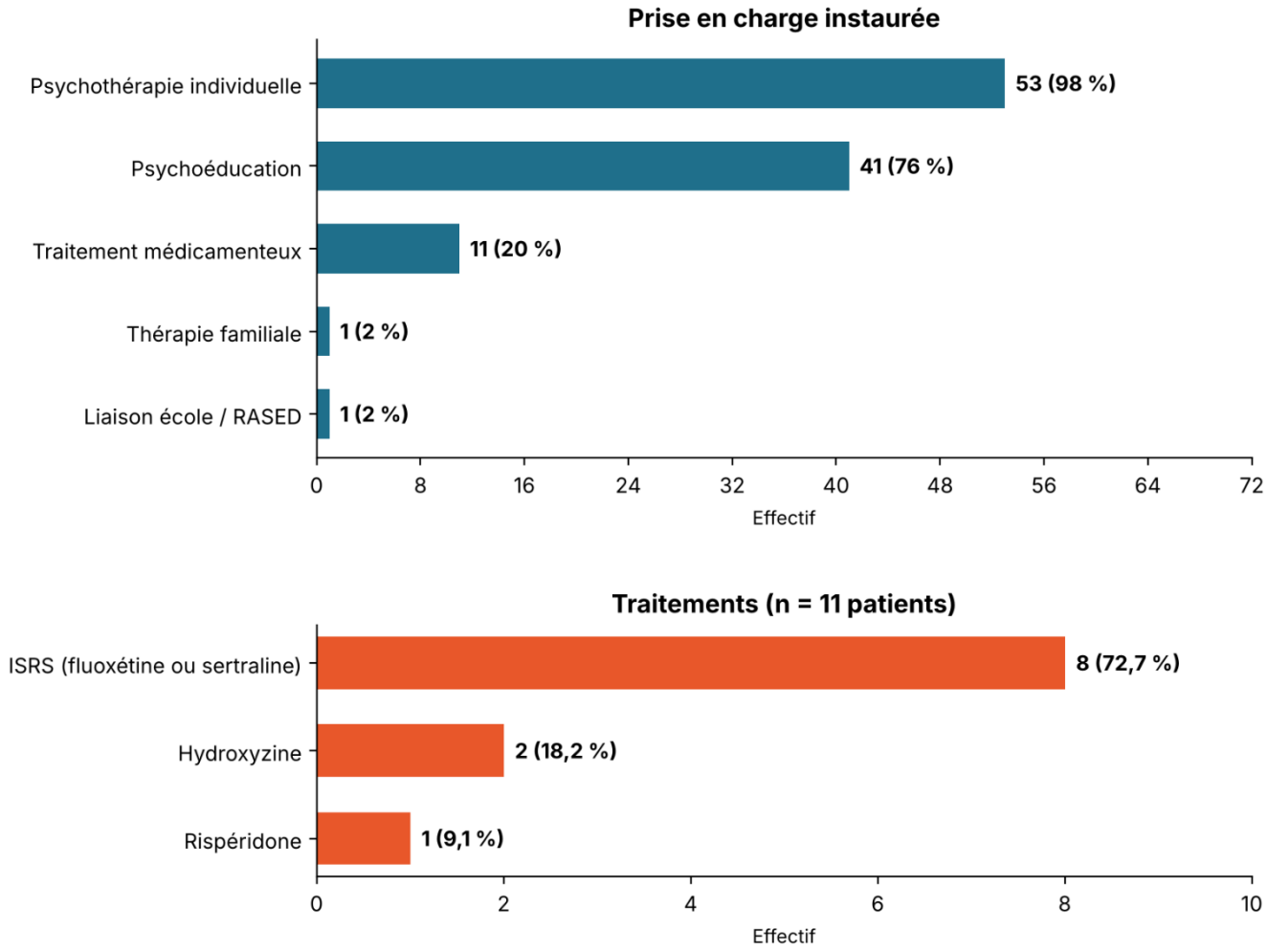



**Figure 8.** Types of care initiated at T0 and prescribed treatments.

An official referral or consultation with the teaching staff takes place in 67 per cent of cases; it is not deemed necessary in 17 per cent of cases and is refused or hindered by the family in 17 per cent of cases. There is no response from the school in 76 per cent of cases (n = 54); adjustments to the school environment are secured in 11 per cent of cases and a change of school is arranged in 13 per cent of cases. Follow-up is maintained for 57 per cent of patients (31/54), 35 per cent are lost to follow-up (19) and 7 per cent are absent with a known reason (4).

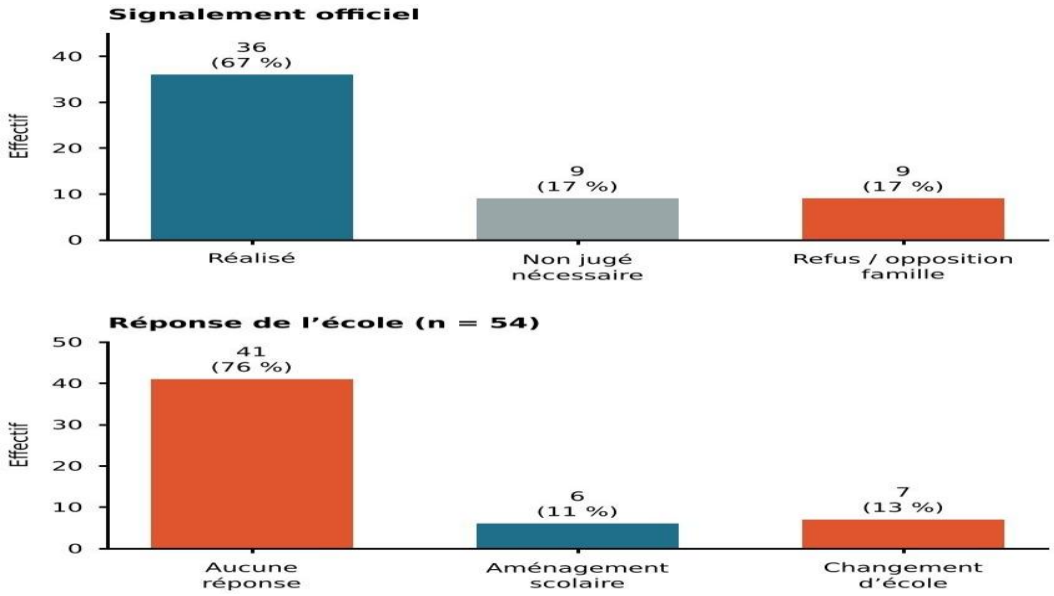



**Figure 9.** Official notification and school response.

## DISCUSSION

Our study, conducted amongst 54 children and adolescents receiving child and adolescent psychiatric care due to a history of school bullying, highlights five key findings: bullying that is almost exclusively school-based, verbal, daily and long-term; a frequent accumulation of family adversities; a polymorphic clinical presentation in which bullying is identified as a causal factor at the first consultation in only 37 per cent of cases; the bullying preceded the onset of the disorder in 70 per cent of cases of depressive disorders and 60 per cent of anxiety disorders, and had been present since the child started school in all patients with an intellectual disability; and a lack of response from the school in three out of four cases.

### Patient characteristics

The predominance of male cases (66.7 per cent; sex ratio of 2) is consistent with international analyses [2], less so with data from Fez, where prevalence rates are similar between the sexes [15], and differs from a psychotherapy practice where the victims were more often girls [12]. This is undoubtedly due as much to the recruitment process of a child and adolescent psychiatry service – where neurodevelopmental disorders are common (39 per cent) and associated with increased exposure to bullying [14] – as to an actual difference in exposure. The proportion of primary school pupils (54 per cent) differs from Moroccan data on the school-age population, where victims are more numerous at secondary school level [16]; it may reflect the recruitment method, particularly as at least six children aged 12 and over are still attending primary school, which suggests academic delays. The profile—urban, state school and of medium or low socio-economic status—is consistent with the weak association between low socio-economic status and victimisation [2].

### Characteristics of bullying

The predominance of verbal bullying (94 per cent) is consistent with international [2] and Moroccan [16] data. The frequency of physical bullying (33 per cent) is similar to that reported among Moroccan primary school pupils [16], although the definitions

are not comparable; by contrast, the low frequency of relational bullying (7 per cent) differs from international data [2]. Cyberbullying, which is infrequent here (three patients, or 5.6 per cent), is lower than that reported in Fez [15] and amongst young people with mental health or neurodevelopmental disorders [14], which may be due to the relatively young age of our sample. Bullying takes place on school premises in 93 per cent of cases, with multiple perpetrators involved in 57 per cent: the school is both the setting where it occurs and the place where a response can be organised, which argues in favour of school-wide interventions. The duration of the bullying (more than 12 months in 61 per cent of patients) and its daily frequency (83 per cent) significantly exceed those reported in school-based surveys [2] and suggest that the children seeking consultation are those most severely affected; the repetition and persistence of exposure increase the risk of anxiety and depressive disorders [5]. The median duration of 12 months reflects prolonged exposure prior to the first consultation.

## Recognition of bullying

Eighty-five per cent of the children had spoken to an adult about it, a higher proportion than that observed in the school population [13], which is likely due to clinical recruitment and data collection from parents in the case of non-verbal children. However, bullying was recognised as a causal factor at the first consultation in only 37 per cent of cases, the predominant reasons being academic difficulties (46 per cent) and anxiety disorder (26 per cent). The obstacle therefore does not seem to be solely the child's silence, but rather the link established by adults between what the child says and the symptoms that prompted the consultation. This finding is consistent with the literature, which indicates that bullying is not routinely assessed in mental health settings [7,12], and argues in favour of systematically asking about peer relationships and school experiences during any initial consultation. Among children with a neurodevelopmental disorder, academic difficulties were the reason for the consultation in 86 per cent of cases (18/21), compared with 21 per cent (7/33) of the others: academic performance tends to mask bullying, as the disorder alone is sufficient to explain the difficulties [14].

### Family context and impact on school performance

Domestic violence is reported in 41 per cent of patients, consistent with the established link between abuse and peer victimisation [19], with multiple forms of victimisation being associated with greater distress [20]. For these children, neither school nor home may offer a safe haven, which could deter them from seeking help [7]: care must therefore include an assessment of domestic violence and child protection. Academic performance declines in 63 per cent of patients, consistent with the association between bullying and poorer academic achievement [8].

### Suicidal risk and diagnoses

No active suicidal ideation was reported, which differs from the literature establishing a link between victimisation and suicidal ideation [9,10], although the strength of this link varies across studies [9]. The presence of passive suicidal ideation in four children, who were not receiving treatment, warrants regular reassessment of risk (C-SSRS). The prevalence of anxiety disorders (31 per cent) and depressive disorders (24 per cent) is consistent with systematic reviews [4,5] and clinical samples [12,21]. low rate of

post-traumatic stress disorder (6%) differs from the literature [12,22,23], perhaps because bullying is not explicitly included in criterion A, a point of debate. The 19% of patients without a diagnosis may reflect distress below the diagnostic threshold: the assessment should not be limited to seeking a specific diagnosis.

### Timeline of the harassment and onset of the disorder

Harassment precedes the disorder in 70 per cent of patients with depression and 60 per cent of patients with anxiety, in line with longitudinal data [4,5,6], and the duration of the harassment makes it plausible that it plays a triggering or aggravating role [5]. However, this precedence is not consistent, which is consistent with the bidirectional relationship between victimisation and internalised disorders [11,24]; pre-existing vulnerability (family history in 30 per cent of cases, limited peer relationships or isolation in 74 per cent of cases) may have contributed to both the bullying and the disorder. Among patients with an intellectual disability, bullying has been present since starting school in all cases, consistent with the high levels of victimisation described in this population [14,25]. As bullying cannot cause a developmental disability, the relevant question concerns the early onset and duration of exposure, which warrants vigilance from the start of schooling.

### Vulnerability and protective factors

Low levels of family support (43 per cent), fragile peer relationships prior to the bullying (74 per cent) and low self-esteem (30 per cent) are consistent with the moderating factors described in the literature [5,7]. A non-family adult support figure is present for 67 per cent of children, which contrasts with the very limited response from the school. The accumulation of stressful life events (74 per cent) makes it difficult to attribute symptoms solely to bullying, but does not exonerate bullying: it necessitates investigating and addressing it alongside the other factors [3].

### Management and the school's response

Management prioritises individual psychotherapy (98 per cent) and psychoeducation (76 per cent), with the use of medication remaining limited (19 per cent), in line with recommendations for individual psychological support [7]; interventions focused on bullying in a clinical setting still need to be developed [12]. Given the prevalence of domestic violence (41 per cent) and the lack of family support (43 per cent), the very limited use of family therapy is an area for improvement. A report is made to the relevant authorities or work is carried out with the school staff in 67 per cent of cases (refused or hindered by the family in 17 per cent, an obstacle that warrants qualitative exploration), but there is no response from the school in 76 per cent of cases, whilst bullied pupils rarely confide in school staff [13] and school programmes reduce victimisation [26], particularly amongst those most severely victimised [17]. This finding calls for a protocol to liaise between the counselling service and schools. Finally, the fact that 35 per cent of patients are lost to follow-up undermines continuity of care and highlights the need to strengthen links with families.

### Strengths and limitations

This study provides local data on a phenomenon that has been little documented in child and adolescent psychiatry in Morocco, utilising standardised data collection, consent from

legal guardians and an assessment of suicide risk using a validated scale ( C-SSRS). It remains a single-centre, descriptive study with a limited sample size (n = 54). Follow-up (T1) will enable us to study the clinical and academic progress of these children, and a comparative study including children attending consultations with no history of bullying would allow us to test whether academic performance masks bullying in children with a neurodevelopmental disorder.

## CONCLUSION

In this series of 54 children and adolescents attending paediatric psychiatry consultations at Ibn Nafis Hospital, school bullying appears to be verbal, daily, persistent and almost exclusively school-related, often associated with domestic violence (41 per cent) and a combination of stressful life events. It is identified as a causal factor at the initial consultation in only 37 per cent of cases, most often masked by academic difficulties or an anxiety disorder, and the school's response is non-existent in three out of four cases.

Bullying precedes the disorder in 70 per cent of patients with a depressive disorder and in 60 per cent of those with an anxiety disorder, and has been present since starting school in all patients with an intellectual disability. It must therefore not be trivialised: even when it is not the reason for the consultation, it forms part of the history of the disorder.

These descriptive findings, specific to a hospital-based population, argue in favour of systematically investigating bullying during any initial child and adolescent psychiatry consultation, for the joint assessment of the family context and suicide risk, and for the establishment of a structured liaison with schools. Comparative and longitudinal studies are needed to clarify the links between bullying and psychiatric disorders in the Moroccan context.

## CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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