



Volume 12, Issue 1, 2026, pp. 1–15

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DOI: <https://doi.org/10.65549/x2m68837>

Les comportements d'automutilation non suicidaire chez les adolescents suivis en consultation de pédopsychiatrie au CHU Mohammed VI de Marrakech : étude rétrospective descriptive de 50 cas

Période d'étude : 2021-2026

Non-suicidal self-harm behaviors among adolescents attending the child and adolescent psychiatry clinic at the Mohammed VI University Hospital in Marrakesh: a retrospective descriptive study of 50 cases

Study period: 2021–2026

Conductas de autolesión no suicida en adolescentes atendidos en la consulta de psiquiatría infantil del Hospital Universitario Mohammed VI de Marrakech: estudio retrospectivo descriptivo de 50 casos

Periodo de estudio: 2021-2026

Ibtissam Hsaini¹, Bouchra Aabbassi^{1,2}, Fatiha Manoudi³

1 University Child and Adolescent Psychiatry Team, Mohammed VI University Hospital, Marrakesh, Morocco.

2 'Health, Childhood and Development' Research Centre, Faculty of Medicine and Pharmacy, Marrakech, Cadi Ayyad University, Marrakech, Morocco.

3 Mental Health Research Team, Faculty of Medicine and Pharmacy, Marrakech, Cadi Ayyad University, Marrakech, Morocco.

Received: 02/10/2026

Accepted: [07/10/2026](#)

RÉSUMÉ

Objectif. Décrire le profil épidémiologique, clinique et psychosocial des adolescents présentant des comportements d'automutilation non suicidaire suivis en consultation de pédopsychiatrie au CHU Mohammed VI de Marrakech, ainsi que les caractéristiques des gestes, leur siège anatomique, les comorbidités psychiatriques, les facteurs psychosociaux et les modalités de prise en charge.

Matériel et méthodes. Étude rétrospective descriptive monocentrique portant sur 50 adolescents suivis en consultation de pédopsychiatrie entre 2021 et 2026. Les critères d'inclusion concernaient les patients âgés de 9 à 17 ans présentant une automutilation non suicidaire documentée. Les données ont été recueillies à partir des dossiers médicaux à l'aide d'une fiche d'exploitation standardisée et analysées de façon descriptive.

Résultats. Les 50 adolescents inclus étaient âgés de 13 à 17 ans. L'âge moyen était de $15,28 \pm 1,14$ ans et l'âge moyen de début des automutilations de $13,62 \pm 1,26$ ans. Les filles représentaient 68 % de l'échantillon. Les conduites étaient répétitives ou récurrentes chez 76 % des adolescents et un facteur déclenchant était identifiable chez 80 %. Les membres supérieurs étaient concernés chez 92 % des adolescents, avec une prédominance de l'avant-bras gauche. La fonction la plus fréquente était le soulagement d'une tension émotionnelle. Les troubles de l'humeur, les troubles du sommeil et les troubles anxieux constituaient les principales comorbidités. Les conflits familiaux et les difficultés avec les pairs étaient fréquemment retrouvés.

Conclusion. Dans cette population clinique ambulatoire, l'automutilation non suicidaire apparaît comme une conduite précoce, souvent répétitive et fortement liée aux difficultés de régulation émotionnelle.

L'évaluation doit intégrer les comorbidités psychi-

atriques et le contexte familial et relationnel. La prise en charge repose sur un accueil clinique structuré, la recherche des facteurs sous-jacents, la psychothérapie, la psychoéducation, la guidance parentale, les ateliers thérapeutiques de groupe, le traitement des comorbidités et un suivi ambulatoire rapproché adapté au niveau de risque.

Mots-clés : automutilation ; adolescent ; pédopsychiatrie ; santé mentale.

ABSTRACT

Objective. To describe the epidemiological, clinical and psychosocial profile of adolescents exhibiting non-suicidal self-harm behaviours who are being treated at the child and adolescent psychiatry clinic at the Mohammed VI University Hospital in Marrakesh, as well as the characteristics of the acts, their anatomical location, psychiatric comorbidities, psychosocial factors and treatment approaches.

Materials and methods. A single-centre, retrospective, descriptive study involving 50 adolescents treated in the child and adolescent psychiatry clinic between 2021 and 2026. Inclusion criteria were patients aged between 9 and 17 years with documented non-suicidal self-harm. Data were collected from medical records using a standardised data collection form and analysed descriptively.

Results. The 50 adolescents included were aged between 13 and 17 years. The mean age was 15.28 ± 1.14 years and the mean age at onset of self-harm was 13.62 ± 1.26 years. Girls accounted for 68 per cent of the sample. The behaviours were repetitive or recurrent in 76 per cent of the adolescents, and a trigger was identifiable in 80 per cent. The upper limbs were involved in 92 per cent of adolescents, with a predominance of the left forearm. The most common purpose was to relieve emotional tension. Mood disorders, sleep disorders and anxiety disorders were the main comorbidities. Family conflicts and difficulties with peers were frequently reported.

Conclusion. In this outpatient clinical population, non-suicidal self-harm appears to be an early-onset behavior,

Volume 12, Issue 1, 2026, pp. 1–15

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DOI : <https://doi.org/10.65549/x2m68837>

often repetitive and strongly linked to difficulties with emotional regulation.

The assessment must consider psychiatric comorbidities and the family and relational context. Management is based on a structured clinical assessment, identification of underlying factors, psychotherapy, psychoeducation, parental guidance, therapeutic group workshops, treatment of comorbidities and close outpatient follow-up tailored to the level of risk.

Keywords: self-harm; adolescent; child and adolescent psychiatry; mental health

RESUMEN

Objetivo. Describir el perfil epidemiológico, clínico y psicosocial de los adolescentes que presentan conductas de autolesión no suicida y que son atendidos en la consulta de psiquiatría infantil del Hospital Universitario Mohammed VI de Marrakech, así como las características de las conductas, su localización anatómica, las comorbilidades psiquiátricas, los factores psicosociales y las modalidades de tratamiento.

Material y métodos. Estudio retrospectivo descriptivo monocéntrico realizado con 50 adolescentes atendidos en la consulta de psiquiatría infantil entre 2021 y 2026. Los criterios de inclusión se referían a pacientes de entre 9 y 17 años que presentaran una autolesión no suicida documentada. Los datos se recopilaron a partir de los historiales médicos mediante una ficha de registro estandarizada y se analizaron de forma descriptiva.

Resultados. Los 50 adolescentes incluidos tenían entre 13 y 17 años. La edad media era de $15,28 \pm 1,14$ años y la edad media de inicio de las autolesiones, de $13,62 \pm 1,26$ años. Las chicas representaban el 68 % de la muestra. Las conductas eran repetitivas o recurrentes en el 76 % de los adolescentes y se pudo identificar un factor desencadenante en el 80 %. Las extremidades superiores se veían afectadas en el 92 % de los adolescentes, con predominio del antebrazo izquierdo. La función más frecuente era el alivio de la tensión emocional. Los trastornos del estado de ánimo, los trastornos del sueño y los trastornos de ansiedad constituían las principales comorbilidades. Los conflictos familiares y las dificultades con los compañeros eran frecuentes.

Conclusión. En esta población clínica ambulatoria, la autolesión no suicida se presenta como una conducta precoz, a menudo repetitiva y estrechamente relacionada con las dificultades de regulación emocional.

La evaluación debe tener en cuenta las comorbilidades psiquiátricas y el contexto familiar y relacional. El tratamiento se basa en una atención clínica estructurada, la identificación de los factores subyacentes, la psicoterapia, la psicoeducación, la orientación parental, los talleres terapéuticos en grupo, el tratamiento de las comorbilidades y un seguimiento ambulatorio estrecho adaptado al nivel de riesgo.

Palabras clave: autolesión; adolescente; psiquiatría infantil; salud mental.

INTRODUCTION

Non-suicidal self-injury (NSSI) refers to the deliberate and direct harming of one's own body, carried out without the intention to die and outside of socially or culturally accepted practices [1]. It occurs predominantly during adolescence, with a peak in frequency in the middle of this period. Among adolescent psychiatric populations, repetitive behaviours are particularly common [1,2].

This frequency should not lead to the behaviour being trivialised. Even in the absence of suicidal intent at the time of the act, NSSI may occur during an acute emotional crisis, become repetitive, cause physical injuries, impact academic and interpersonal functioning, and be associated with psychiatric disorders as well as a subsequent risk of suicide [1,3]. Certain situations therefore require an urgent assessment of the physical severity, the level of crisis, the intent behind the act, any comorbid conditions, and the protective capacity of the individual's environment. NSSI is a multifactorial and transdiagnostic phenomenon. Emotional regulation, self-punishment and the expression of distress are among the most commonly described functions [1,3,4]. Adverse childhood experiences, family difficulties, bullying and depressive symptoms are also associated with these behaviours [5,6]. In the

same child and adolescent psychiatry unit at the Mohammed VI University Hospital in Marrakesh, non-suicidal self-harm was found in 29.8 per cent of adolescents treated for attempted suicide, illustrating the possible clinical overlap between the two phenomena [7].

Against this background, our study aims to better characterise non-suicidal self-harm observed in adolescents attending child and adolescent psychiatry clinics in Marrakech, in order to clarify its clinical characteristics, associated factors and management approaches in our practice.

OBJECTIVE

The main objective was to establish the epidemiological, clinical and psychosocial profile of non-suicidal self-harm behaviours among adolescents attending child and adolescent psychiatry clinics at the Mohammed VI University Hospital in Marrakesh.

The secondary objectives were to describe the age of onset, the repetitive nature and the anatomical site of the acts; to identify triggering factors and reported functions; to investigate the main psychiatric comorbidities and clinical dimensions; to explore family and psychosocial factors; and to describe the management approaches.

MATERIALS AND METHODS

Study design and period

This is a single-centre, retrospective, descrip-

tive study conducted at the university child and adolescent psychiatry outpatient unit of the Mohammed VI University Hospital in Marrakech, covering the period 2021–2026.

Study population and inclusion criteria

The study included patients aged between 9 and 17 years who attended paediatric psychiatry consultations and had at least one instance of non-suicidal self-harm documented in their medical records. The non-suicidal nature of the behaviour was defined as the absence of any intention to die at the time of the act. Suicidal ideation or a history of suicide attempts, where these had occurred at another point in the patient's history, were distinguished from the intention associated with the self-harming act under investigation.

Exclusion criteria

Patients aged under 9 or over 17 were excluded, as were records containing insufficient information to characterise the self-harming behaviour; self-harming behaviours involving suicidal intent at the time of the act; indirect behaviours not constituting direct, intentional bodily injury; and practices that are socially or culturally accepted.

Data collection

Data were collected from archived medical records using a standardised data collection form. The variables studied included:

- Sociodemographic and educational data: age, gender, place of residence, parental status, socio-economic status, academic performance and school absenteeism.
- Characteristics of self-harm: age at onset, duration, repetitive or recurrent nature, recent occurrence, need for

physical treatment and anatomical location.

- Triggering factors, reported functions, relief following the act, and academic or social repercussions.
- Psychiatric comorbidities and clinical dimensions: mood disorders, anxiety, psychological trauma, eating disorders, sleep disorders, impulsivity, emotional dysregulation, self-esteem and irritability
- Psychosocial factors: trauma, abuse or neglect, bullying, family conflicts, difficulties with peers, social isolation, problematic internet use and family support.
- Treatment approaches and the follow-up plan.

For the analysis of the anatomical site, the descriptions in the records were grouped into broad regions: forearm, arm, arm-forearm combination, lower limb and abdomen. Lateralisation was retained where specified.

Statistical analysis

The analysis was descriptive. Qualitative variables were expressed as frequencies and percentages. Quantitative variables were described using their mean $\pm$ standard deviation and their extremes. Where data were missing, the valid denominator was taken into account. No causal analysis was carried out.

Ethical considerations and conflicts of interest

Data anonymity and confidentiality were strictly maintained. Consent was obtained from patients and their parents or legal guardians for the use of clinical data for research purposes. The data were processed

in a fully anonymised manner. No conflicts of interest were declared in connection with this study.

RESULTS

1. General and sociodemographic characteristics

The 50 adolescents included were aged between 13 and 17, although the inclusion criteria allowed for ages ranging from 9 to 17. The mean age was 15.28 ± 1.14 years, and the age of 15 was the most common (36

%). Girls accounted for 68 per cent of the sample. Thirty-one adolescents (62 per cent) lived in an urban area in Marrakesh. In 58 per cent of cases, the parents were married or living together. The socio-economic status was average for 74 per cent. Among the completed records, poor academic performance was found in 40.4 per cent of cases and moderate or high levels of absenteeism in 56.3 %.

Table 1. Socio-demographic and educational characteristics of the study population.

Variable	n	% / value
13 years	1	2.0
14 years	13	26.0
15 years	18	36.0
16 years	7	14.0
17 years	11	22.0
Mean age $\pm$ SE	15.28 ± 1.14	13–17 years
Girls	34	68.0
Boys	16	32.0
Marrakech urban	31	62.0
Other areas / surrounding areas	19	38.0
Married / cohabiting parents	29	58.0
Separated or divorced parents	17	34.0
Deceased parent	4	8.0
Average socio-economic status	37	74.0
Low socio-economic status	13	26.0
Low academic achievement	19/47	40.4
Moderate or high levels of absenteeism	27/48	56.3

2. Characteristics of self-harm behaviour

The mean age at onset of self-harm was 13.62 ± 1.26 years, with a range of 11 to 16 years. The mean duration was 1.44 ± 0.84 years. Self-harm within the last 12 months was reported by 88 per cent of adolescents, and a recent episode by 60 per cent. The behaviour was repetitive or recurrent in 76 per cent of cases. Medical

treatment had been required in 16 per cent of cases.

An identifiable trigger was found in 80 per cent of adolescents. Family conflict was the most common main trigger (24 per cent), followed by conflicts or break-ups with peers and romantic break-ups (14 per cent each), and then academic stress (10 per cent). The pri-

Volume 12, Issue 1, 2026, pp. 1–15

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DOI : <https://doi.org/10.65549/x2m68837>

mary function was to relieve emotional tension (34 per cent), followed by reducing anxiety or sadness (18 %).
Expressing distress and self-punishment each

accounted for 12 per cent. Temporary relief following the act was reported by 58 per cent of adolescents, and the academic or social impact was moderate or significant in 60 per cent of cases.

Table 2. Characteristics of non-suicidal self-harm behaviours.

Variable	n	% / value
Age at onset, mean $\pm$ SE	13.62 $\pm$ 1.26	11–16 years
Duration, mean $\pm$ SE	1.44 $\pm$ 0.84	0–3 years
Self-harm in the last 12 months	44	88.0
Recent episode	30	60.0
Recurrent/repeated nature	38	76.0
Somatic care required	8	16.0
Identifiable trigger	40	80.0
Family conflict as the main trigger	12	24.0
Conflict/break-up with peers	7	14.0
Romantic break-up	7	14.0
School-related stress	5	10.0
Relieving emotional tension	17	34.0
Reducing anxiety/sadness	9	18.0
Expressing distress	6	12.0
Self-punishment	6	12.0
Temporary relief after the act	29	58.0
Moderate/significant impact	30	60.0

3. Anatomical location of self-harm injuries

The upper limbs were by far the most common site of involvement. Upper limb involvement was found in 46 out of 50 adolescents (92 per cent). In 45 adolescents (90 per cent), the lesions were confined exclusively to the

arms and/or forearms. The left forearm was the most common specific site, found in 13 adolescents (26 per cent). Lesions were confined exclusively to the left upper limb in 46 per cent of adolescents, whilst bilateral lesions were present in 38 per cent.

Table 3. Distribution of the anatomical sites of self-harm.

Variable	n	% / value
Forearm only	19	38.0
Arms only	15	30.0
Arms and forearms	11	22.0
Lower limb only	3	6.0
Abdomen	1	2.0
Upper limb + lower limb	1	2.0
Injury to an upper limb, all types	46	92.0
Left forearm (specific seat)	13	26.0

4. Psychiatric comorbidities and clinical dimensions

Mood disorders were the most common confirmed comorbidity (54 per cent), followed by sleep disorders (50 per cent), anxiety disorders (38 per cent), psychological trauma/PTSD (26 per cent) and eating disorders (16 per cent). Figure 4 shows the five main comorbidities identified.

In terms of dimensions, 86 per cent of adolescents exhibited moderate or high emotional dysregulation, 82 per cent moderate or high impulsivity, 84 per cent low or fragile self-esteem and 84 per cent moderate or high irritability. Overall functioning was moderately or severely impaired in 68 per cent.

Table 4. Main confirmed psychiatric comorbidities.

Variable	n	% / value
Confirmed mood disorders	27	54.0
Confirmed sleep disorders	25	50.0
Confirmed anxiety disorders	19	38.0
Confirmed psychological trauma/PTSD	13	26.0
Confirmed eating disorders	8	16.0

5. Psychosocial factors

Significant family conflicts and difficulties in peer relationships were found in 46 per cent of adolescents in each case. A traumatic event was documented in 34 per cent, social isolation in 36 per cent, problematic internet use in 38 per cent, school bullying or

cyberbullying in 20 per cent, and abuse or neglect in 18 per cent. Family support was rated as poor in 32 per cent, moderate in 40 per cent and good in 20 per cent of adolescents; it was not assessed in 8 per cent of cases.

Table 5. Main psychosocial factors identified.

Variable	n	% / value
Traumatic event	17	34.0
Documented abuse/neglect	9	18.0
Bullying at school/cyberbullying	10	20.0
Serious family conflicts	23	46.0
Relationship difficulties with peers	23	46.0
Social isolation	18	36.0
Problematic internet use	19	38.0
Low family support	16	32.0

6. Treatment

A family intervention was proposed or carried out for 44 per cent of adolescents, and medication was prescribed for 42 per cent. Psychotherapy combined with a family intervention was the main follow-up plan for 24 per cent, close outpatient monitoring for 22 per cent, and individual psychotherapy for 20 per cent. Referral to hospital or an urgent assessment was indicated for 16 per

cent of adolescents.

In our practice, family intervention is not limited to a one-off consultation: depending on needs, it combines consultations with parents, family psychoeducation, parenting guidance and work on communication within the family and the factors that trigger or perpetuate the behaviour.

Table 6. Treatment approaches documented in the case files.

Variable	n	% / value
Family intervention	22	44.0
Medication	21	42.0
Hospital admission indicated / urgent referral	8	16.0
Psychotherapy + family intervention	12	24.0
Close outpatient monitoring	11	22.0
Individual psychotherapy	10	20.0
Hospitalisation / urgent assessment under the scheme	10	20.0
Follow-up + medication	5	10.0
Multidisciplinary care	2	4.0

DISCUSSION

Our study highlights non-suicidal self-harm behaviours emerging in early adolescence, which are often repetitive, predominantly seen in females and overwhelmingly localised to the upper limbs. These behaviours occur within a context of significant emotional dysregulation, psychiatric comorbidities and common family and relational factors. These findings support a holistic clinical approach, focusing on the act itself, its function and the psychopathological context.

Age and female predominance

The mean age of 15.28 years and the mean age at onset of 13.62 years are consistent with data indicating that NSSI peaks in mid-adolescence [1,2] and with a median age at onset of 14 years reported in clinical populations [3]. This period corresponds to a phase of high emotional reactivity, identity restructuring, physical changes and a process of self-autonomisation that is not yet complete. When the ability to verbalise and regulate emotions is insufficient, turning to the body can become an immediate means of managing tension that is difficult to tolerate. Thus, early and mid-adolescence constitute a particularly important period for early detection.

Girls accounted for 68 per cent of our sample. A predominance of females is regularly observed in clinical populations [1,3]. This could be linked to the higher prevalence among adolescent girls of internalised symptoms such as depression, anxiety,

rumination and certain difficulties with emotional regulation, but also to differences in the ways in which distress is expressed and care is sought [6]. Conversely, more externalised behaviours in some boys may be less readily identified as self-harm. This interpretation remains hypothetical: our clinical series does not allow us to estimate a difference in prevalence between the sexes in the general population. Thus, the observed female predominance should be understood as a clinical characteristic of our population rather than as a general epidemiological conclusion.

Repetition of behaviours and anatomical site

Repetitive or recurrent behaviour was observed in 76 per cent of adolescents. The temporary relief observed after the act in 58 per cent of cases may help to reinforce the behaviour: when an act rapidly reduces tension, even briefly, it can become a strategy that is reused during subsequent crises. Repetition therefore appears not only as a marker of severity, but also as a reflection of the gradual establishment of a dysfunctional emotional regulation strategy [1,3]. This finding justifies early intervention to promote alternatives to acting out before the behaviour becomes a habitual response to distress.

The upper limbs were affected in 92 per cent of cases, with a predominance of the left forearm. Accessible areas, particularly the arms, are frequently described in self-harm [1,3]. The forearm is easily accessible, allows for relatively precise control of the movement and can be concealed under clothing. The predominance of the left side could correspond to the use of the dominant right

hand, but as handedness was not recorded, this hypothesis cannot be verified. The choice of this area may also reflect an ambivalence between the desire to conceal the injury and the possibility that it might become visible as an indirect expression of suffering that is difficult to put into words. Thus, the forearm appears to be a preferred site due to its ease of access, the control it allows and the possibility of concealment.

Functions of self-harm and comorbidities

Relieving emotional tension was the most common primary function, whilst 86 per cent of adolescents exhibited moderate or high levels of emotional dysregulation. These findings are consistent with functional models in which NSSI serves to rapidly reduce negative emotional states [1,3,4]. Self-punishment and the expression of suffering may also arise in a context of guilt, low self-esteem or an inability to communicate distress directly. These findings reinforce the need for psychotherapy to focus on the identification, verbalisation and regulation of emotions, as well as on alternative strategies to self-harm.

Mood and anxiety disorders were common, but the diagnostic diversity confirms that NSSI is not specific to any one disorder [3]. It can be understood as a cross-sectional marker of difficulties with emotional regulation and psychological distress. The assessment must therefore not stop at the injury itself: it must look for depression, anxiety, psychological trauma, high impulsivity, low self-esteem and other comorbidities likely to perpetuate the behaviour. In practice, treating the associated disorder is a key strategy for reducing the vulnerability underlying self-harming behaviour.

Family, traumatic and relational factors

Family conflicts and difficulties with peers each affected 46 per cent of our study population. Family relationships and the quality of communication between parents and adolescents are consistently identified as factors associated with NSSI [4]. In the same unit, a study on suicide attempts had also highlighted a high prevalence of parental conflicts and relationship difficulties [7]. The family can therefore act as both a vulnerability factor and a therapeutic resource. This observation justifies the significant emphasis placed on family counselling, psychoeducation and parental guidance in our care programme.

A traumatic event was reported in 34 per cent of cases, and abuse or neglect in 18 per cent. A recent meta-analysis found an association between various forms of childhood abuse and NSSI, particularly emotional and sexual abuse [5]. However, as our study did not include a control group, these past experiences cannot be interpreted as causes. Bullying and digital behaviour also need to be explored, as victimisation is associated with profiles combining self-harm and depressive symptoms [6]. Thus, the clinical interview must look beyond the behaviour itself and explore the adolescent's entire family, school, relational and digital environment.

Clinical features: crisis, severity and the risk of trivialisation

Self-harm is sometimes trivialised by the adolescent, their family or those around them because the immediate aim of the act is not to die. However, this trivialisation can delay the decision to seek help. The repetition of such acts, their impact on daily functioning, physical injuries, the intensity of

emotional dysregulation and the possible co-occurrence of suicidal ideation over time necessitate a thorough assessment [1,7]. In practice, each episode must be considered within the context of the crisis: the intensity of the distress, behavioural control, triggering factors, available resources and monitoring capabilities. Thus, the 'non-suicidal' nature of the act does not imply a lack of seriousness and never precludes an assessment of suicide risk.

Management in our unit

Treatment begins by welcoming the adolescent into a supportive, non-judgemental and safe environment. This initial stage aims to establish a therapeutic alliance and to assess the functional signs: frequency and repetition of the acts, location, circumstances, triggering factors, intended function, impact, physical severity and level of crisis. A suicide risk assessment is carried out systematically in order to distinguish self-harm from a suicidal act and to determine the necessary level of safety measures.

In a second stage, the team investigates the clinical cause or, more specifically, the associated, underlying or perpetuating factors: depressive or anxiety disorders, emotional dysregulation, impulsivity, psychological trauma, low self-esteem, family difficulties, bullying, and difficulties at school or in relationships. This approach ensures that treatment addresses not only the symptom but also the mechanisms that contribute to its recurrence.

Psychotherapy forms the core of the treatment. Depending on the clinical presentation, it may combine supportive psychotherapy with a cognitive-behavioural, psychodynamic or interpersonal approach. Symptom-

tom-focused work centres on identifying and expressing emotions, learning alternative strategies to self-harm, and preventing relapses. Work addressing underlying factors explores associated disorders, traumatic experiences and family or interpersonal difficulties.

This individual support is complemented by weekly group therapy sessions organised within the department: a workshop on managing emotions, a workshop focusing on suicidal crises, and a workshop on adolescence. These sessions provide an opportunity to work on recognising and expressing emotions, triggers, coping strategies, self-esteem, peer relationships and identity issues specific to adolescence.

Psychoeducation is offered to the adolescent and their family to explain the possible functions of self-harm, the triggers, the signs of worsening symptoms and the appropriate courses of action. Parental guidance aims to improve communication within the family, reduce both trivialisation and overreaction, strengthen parenting skills and help parents recognise warning signs. Family intervention therefore includes discussions with parents, psychoeducation, parental guidance and, where necessary, joint work on family conflicts and interactions.

Medications target comorbid conditions rather than self-harm itself. In our clinical practice, sertraline at a dose of 50 mg/day may be used when medication is indicated for an anxiety disorder, whilst fluoxetine at a dose of 20 mg/day may be prescribed for depressive disorders. The choice of treatment, dosage and duration of treatment are tailored to the clinical assessment, tolerance

and clinical course of each adolescent.

Where the situation allows for outpatient management, follow-up may be more frequent, with a reassessment after 48 hours. Complex cases are discussed during regular clinical supervision sessions with the professor in charge of the unit, in order to reassess the diagnosis, the level of risk, the therapeutic indication and the intensity of follow-up.

Referral for hospitalisation is indicated when safety cannot be ensured on an outpatient basis, particularly in cases of a high Risk-Urgency-Danger (RUD) level, significant risk of suicide, extreme agitation, severe psychopathological disorganisation, serious physical illness, or where family supervision is not possible. The lack of a dedicated child and adolescent psychiatric inpatient unit in Marrakesh therefore leads to referral to a suitable facility [7].

Consequently, the care provided in our unit follows a step-by-step approach: admission and stabilisation, assessment of functional symptoms, identification of underlying factors, psychotherapy, psychoeducation, parental guidance, treatment of comorbidities, group workshops, close monitoring and supervision. This approach aims to reduce the recurrence of self-harm whilst improving the adolescent's emotional regulation skills and overall functioning.

Strengths and limitations

This study provides local data on a phenomenon that remains poorly documented in Marrakesh and describes the characteristics of self-harm, its anatomical location, comorbidities, psychosocial factors and management approaches. However, its ret-

rospective nature means that data may be missing and the findings depend on the quality of the medical records. The sample size of 50 adolescents, the single-centre nature of the study and the absence of a control group limit the generalisability of the findings and any causal interpretation. The specific method of self-harm was not systematically documented. Finally, the distinction between NSSI and suicidal behaviour relies on the quality of the documentation regarding intent at the time of the act.

CONCLUSION

Non-suicidal self-harm behaviours observed in adolescents attending child and adolescent psychiatry clinics at the Mohammed VI University Hospital in Marrakesh appear at an early age, are often repetitive and predominantly affect girls. The upper limbs, particularly the forearms, are the most common site of self-harm, probably due to their accessibility, the ability to control the action and the ease with which they can be concealed.

Emotional regulation plays a central role in these behaviours, in a context characterised by the prevalence of mood disorders, anxiety, emotional dysregulation and family or relationship difficulties. Such behaviour should therefore not be trivialised: even when it is non-suicidal, it may reflect a significant psychological crisis and form part of a pattern of vulnerability.

Care must be comprehensive and tailored to the individual. In our unit, this combines initial assessment and clinical evaluation, identification of underlying factors, individual psychotherapy, therapeutic group workshops,

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DOI : <https://doi.org/10.65549/x2m68837>

psychoeducation, parental guidance, treatment of comorbid conditions, close outpatient follow-up with the option of reassessment within 48 hours, and clinical supervision. Hospitalisation is reserved for situations where safety cannot be guaranteed on an outpatient basis. This approach aims to re-

duce self-harm whilst strengthening the emotional regulation skills and resources of the adolescent and their family.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.



Volume 12, Issue 1, 2026, pp. 1–15

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DOI : <https://doi.org/10.65549/x2m68837>

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