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Suicide Attempts and Childhood Trauma: Clinical and Socioeconomic Profile and Associated Factors

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Abstract **Original Research Article**

Introduction: Suicide attempts (SA) represent a major public health concern, particularly among young adults. Childhood trauma is one of the most extensively documented risk factors in the international literature. This study aims to describe the clinical and socioeconomic profile of patients hospitalized following an SA, and to explore associations between childhood traumatic experiences, psychiatric disorders, and suicidal behaviors. ***Methods:*** A cross-sectional descriptive study was conducted on 65 patients hospitalized after an SA in the psychiatric inpatient unit of Ar-Razi University Hospital, Salé, Morocco. All patients had a confirmed diagnosis of Borderline Personality Disorder (BPD) according to DSM-5-TR criteria. Data were collected between 2022 and 2024 using a structured questionnaire covering socioeconomic and clinical variables, traumatic history, and characteristics of prior suicide attempts. ***Results:*** All 65 patients shared a diagnosis of borderline personality disorder (BPD) according to DSM-5-TR. The sample was predominantly female (73.8%), young (86.2% aged under 30 years), and single (83.1%). Depressive disorder was the leading comorbid diagnosis (81.5%). Psychiatric comorbidity with substance use disorder was found in 78.5% of patients. Childhood trauma was reported in 81.5% of cases, with sexual abuse as the most prevalent type (39.6%). Among patients with a history of SA (76.9%), the mean age at first SA was 17.3 years. Drug overdose was the most commonly used method (42.0%). Non-suicidal self-injury (NSSI) was present in 72.3% of subjects. ***Conclusion:*** This study confirms the close relationship between early traumatic experiences and suicidal behaviors in patients with BPD, and underscores the need for a clinical approach that systematically includes the assessment of traumatic history in the management of suicidal patients with borderline personality disorder.

Keywords: Suicide attempts; borderline personality disorder; DSM-5-TR; childhood trauma; sexual abuse; depression; substance use disorders; self-harm.

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1. INTRODUCTION

A suicide attempt (SA) is defined as a deliberate, self-inflicted act with a non-fatal outcome, reflecting intense psychological distress and a high risk of recurrence or completed suicide. According to the World Health Organization (WHO), more than 700,000 deaths by suicide occur annually worldwide, and for each completed suicide, an estimated 10 to 30 attempts are recorded [5]. Suicidal behaviors thus constitute a major psychiatric emergency and represent both a clinical and a public health challenge.

In low- and middle-income countries, including Morocco, the issue of suicide tends to be underestimated due to the cultural, religious, and social stigma surrounding this phenomenon. Nevertheless, available data suggest a growing prevalence of SAs, particularly among young people, women, and socioeconomically vulnerable populations.

Among the numerous risk factors identified in the literature, childhood traumatic experiences occupy a central place. Sexual abuse, physical violence, neglect, and early losses are associated with a significant increase in the risk of developing psychiatric disorders (depression, bipolar disorder, post-traumatic stress disorder), addictive behaviors, and suicidal behaviors in adulthood. The developmental stress-biology model proposes that early exposure to traumatic experiences alters neuroendocrine systems and emotional regulation circuits, rendering individuals more vulnerable to subsequent crises [2,4,6].

In Morocco, few clinical studies have systematically documented the relationship between

childhood trauma and SA in patients hospitalized in psychiatric settings, particularly among those diagnosed with borderline personality disorder (BPD). BPD, as defined by DSM-5-TR, is characterized by pervasive instability of affect, identity, interpersonal relationships, and impulse control, and is associated with markedly elevated rates of self-harm and suicidal behavior. The present study was designed with the following objectives: to describe the socioeconomic and clinical profile of patients with BPD admitted for SA, to characterize traumatic histories and past suicidal behaviors, and to explore associations between these variables.

2. MATERIALS AND METHODS

2.1 Study Design and Setting

This was a cross-sectional descriptive study conducted in the adult psychiatric inpatient unit of Ar-Razi University Hospital, Salé, Morocco. Included patients were those consecutively hospitalized following a suicide attempt and who met DSM-5-TR diagnostic criteria for borderline personality disorder (BPD). The data collection period covered the years 2022–2024.

2.2 Study Population and Inclusion Criteria

All patients under 60 years of age, hospitalized for a confirmed SA, who met DSM-5-TR diagnostic criteria for borderline personality disorder (BPD), who provided informed consent and were able to participate in a structured interview were included. Patients with severe cognitive impairment precluding communication, patients not meeting BPD diagnostic criteria, or patients with incomplete data were excluded. The final sample comprised 65 patients.

2.3 Data Collection

Data were collected using a structured questionnaire administered by a clinician during the initial psychiatric assessment. The questionnaire covered: (1) socioeconomic variables (sex, age, educational level, occupation, marital status, area of residence, socioeconomic status); (2) clinical variables (primary psychiatric diagnosis of BPD according to DSM-5-TR, comorbidities, substance use disorder, medical and surgical history, family psychiatric history and history of SA); (3) Beck and Pierce suicide intent scale (SIS); (4) childhood traumatic experiences (type, number, and age at onset); (5) characteristics of prior SAs (number, method used, context, hospitalizations, age at first SA); and (6) presence of non-suicidal self-injury (NSSI).

2.4 Statistical Analysis

Descriptive analysis was performed with calculation of frequencies and percentages for categorical variables, and means with standard deviations for continuous variables. Analyses were conducted using Python.

3. RESULTS

3.1 Socioeconomic Characteristics

The sample comprised 65 patients. A marked female predominance was observed, with 48 women (73.8%) and 17 men (26.2%), yielding a male-to-female sex ratio of 0.35. The vast majority of patients were young: 35.4% were under 20 years of age and 50.8% belonged to the 20–30-year age group, together representing 86.2% of the study population. A very high proportion of patients were single (83.1%). Almost all patients resided in urban areas (96.9%). In terms of socioeconomic status, 64.6% belonged to a middle-income level, 23.1% to a low-income level, and 12.3% to a high-income level. Regarding educational attainment, 44.6% had secondary school education and 36.9% had university-level education. The occupational profile was characterized by the absence of paid employment, with 49.2% unemployed and 38.5% students. These findings are summarized in Table 1.

Table 1. Socioeconomic characteristics of the study population (N = 65)

Variable	n	%
Sex		
Female	48	73.8%
Male	17	26.2%
Age group		
< 20 years	23	35.4%
20–30 years	33	50.8%
31–40 years	6	9.2%
41–50 years	3	4.6%
Socioeconomic status		
Low	15	23.1%
Middle	42	64.6%
High	8	12.3%
Marital status		
Single	54	83.1%
Married	4	6.2%
Divorced	7	10.8%

Variable	n	%
Educational level		
Primary school	2	3.1%
Middle school	10	15.4%
Secondary school	29	44.6%
University	24	36.9%
Area of residence		
Urban	63	96.9%
Rural	2	3.1%
Occupational status		
Unemployed	32	49.2%
Student	25	38.5%
Civil servant	5	7.7%
Other (laborer, self-employed)	3	4.6%

3.2 Clinical Data

All 65 patients met DSM-5-TR diagnostic criteria for borderline personality disorder (BPD). Depressive disorder was the most frequent psychiatric comorbidity, identified in 81.5% of cases (n = 53). Bipolar disorder accounted for 10.8% (n = 7), followed by schizophrenia (n = 1), schizoaffective disorder (n = 1), and anxiety disorder (n = 1). Psychiatric comorbidity was present in 78.5% of patients. Substance use disorders were identified in 78.5% of the sample; the most frequently associated substances were cannabis, tobacco, alcohol, and benzodiazepines. Depression severity was assessed using the Beck Depression Inventory: 76.9% of patients had a score of 2 or 3, corresponding to moderate-to-severe depressive symptomatology. Medical or surgical history was documented in 33.8% of cases, family psychiatric history in 40.0%, and family history of SA in 4.6%. These data are presented in Table 2.

Table 2. Clinical and psychiatric data – all patients diagnosed with BPD per DSM-5-TR (N = 65)

Variable	n	%
Comorbid psychiatric diagnosis (all patients: BPD per DSM-5-TR)		
Depressive disorder	53	81.5%
Bipolar disorder	7	10.8%
Schizophrenia	1	1.5%
Schizoaffective disorder	1	1.5%
Anxiety disorder	1	1.5%
Psychiatric comorbidity	51	78.5%
Substance use disorder	51	78.5%
Medical/surgical history	22	33.8%
Family psychiatric history	26	40.0%
Family history of SA	3	4.6%
Severe BDI score (score 2–3)	50	76.9%

3.3 Childhood Trauma

Childhood traumatic experiences were reported by 81.5% of patients (n = 53). Sexual abuse was the most frequently reported type of trauma (39.6%), followed by physical violence (20.8%), bereavement (15.1%), verbal abuse (11.3%), neglect (7.5%), and abandonment (5.7%). The mean age at first traumatic experience was 11.3 years. Several patients reported having experienced multiple types of trauma during childhood. These results are presented in Table 3.

Table 3. Distribution of childhood trauma types (among the 53 patients with trauma history)

Type of Trauma	n	%
Sexual abuse	21	39.6%
Physical violence	11	20.8%
Verbal abuse	6	11.3%
Bereavement	8	15.1%
Neglect	4	7.5%
Abandonment	3	5.7%
Total (with trauma)	53	81.5%

3.4 Characteristics of Suicide Attempts

A history of SA was documented in 76.9% of patients (n = 50). The mean age at first SA was 17.3 years (minimum: 9 years, maximum: 29 years). The most frequently used method was drug overdose (42.0%), followed by phlebotomy (22.0%), hanging (12.0%), defenestration (12.0%), jumping from a height (4.0%), ingestion of rodenticide (4.0%), and other methods (drowning, jumping in front of a train). The context at the time of the SA was predominantly a depressive episode (70.0%), with 30.0% occurring in an impulsive context. Non-suicidal self-injury (NSSI) was reported by 72.3% of patients (n = 47). These results are summarized in Table 4.

Table 4: Characteristics of suicide attempts and self-injurious behaviors (N = 65)

Variable	n	%
History of SA	50	76.9%
Method used		
Drug overdose	21	42.0%
Phlebotomy	11	22.0%
Hanging	6	12.0%
Defenestration	6	12.0%
Jumping from height	2	4.0%
Rodenticide/toxic ingestion	2	4.0%
Other (drowning, train…)	2	4.0%
Context of SA		
Depressive episode	35	70.0%
Impulsive context	15	30.0%
Non-suicidal self-injury (NSSI)	47	72.3%
Mean age at first SA	17.3 years	—
Minimum age at first SA	9 years	—

4. DISCUSSION

The female predominance observed in our study (73.8%) is consistent with the international literature, which consistently reports a sex ratio favoring women for SAs, whereas men have higher rates of completed suicide. This discrepancy, often referred to as the "gender paradox," is partly explained by differences in the lethality of methods chosen, modes of expressing distress, and health-seeking behaviors [3,5].

The young age of our population is particularly striking: 86.2% of patients were under 30 years of age, and one-third were under 20. These findings confirm that adolescence and early adulthood represent critical periods of vulnerability for suicidal behaviors. In France, suicide remains the second leading cause of mortality among individuals aged 15–24; in Morocco, epidemiological data suggest a similar trend, although likely underreported [3].

Single marital status (83.1%) and unemployment (49.2%) emerged as major socioeconomic vulnerability factors in our sample. Social isolation and the absence of a professional role are well-established risk factors, as they reduce protective resources such as social support, a sense of purpose, and daily structure. The predominance of a middle socioeconomic level (64.6%) indicates that suicide risk is not confined to economically disadvantaged populations [5].

The predominance of comorbid depressive disorder (81.5%) is consistent with the well-established literature on BPD, in which major depressive episodes represent one of the most frequent and clinically significant comorbidities. In patients with BPD, depressive symptoms are often characterized by profound emptiness, abandonment-related dysphoria, and affective instability, which compound the already elevated suicidal risk. The diagnosis of bipolar disorder in 10.8% of patients further highlights the complexity of mood dysregulation in BPD, particularly the risk of misdiagnosis between BPD and bipolar disorder given their overlapping affective features [10].

The very high prevalence of substance use disorders (78.5%) warrants particular attention. In BPD, impulsivity — a core diagnostic feature — is strongly associated with substance misuse, which in turn amplifies suicidal risk by lowering inhibitions, intensifying dysphoria, and impairing judgment. The multiplicity of substances used (cannabis, alcohol, benzodiazepines, cocaine, MDMA, opioids) reflects a pattern of polydrug use that worsens psychiatric prognosis in BPD. The uncontrolled prescription of benzodiazepines represents an additional risk factor, as these agents are frequently used as the means of SA [7,10].

The high prevalence of family psychiatric history (40.0%) is consistent with genetic and familial data on vulnerability to psychiatric disorders and suicidal behavior. This history serves both as an indicator of hereditary risk and as a reflection of a family environment that may be detrimental to the child's psychoaffective development [5].

The most salient finding of our study is the high prevalence of childhood trauma (81.5%), with sexual abuse as the most common type (39.6%). These data are situated within a robust body of research establishing a strong link between adverse childhood experiences (ACEs) and the development of BPD, as well as subsequent suicidal behaviors. The biosocial theory of BPD (Linehan, 1993) posits that the disorder emerges from the interaction between biological emotional sensitivity and an invalidating environment, often including childhood abuse and neglect. The ACE Study by Felitti *et al.,* (1998), conducted on more than 17,000 subjects, demonstrated a dose-response relationship between the number of ACEs and the risk of suicide attempt in adulthood [2,4,11].

Sexual abuse in particular has been associated with a two- to five-fold increase in the risk of SA in the international literature. The underlying mechanisms include emotional dysregulation, attachment disturbances, shame, guilt, and the development of dissociative symptoms, all of which heighten vulnerability to suicidal crisis. The early onset of traumatic experiences (mean age: 11.3 years) amplifies their deleterious impact on psychoaffective development [4,6].

The frequent co-occurrence of multiple types of trauma in the same patient (polyvictimization) is also associated with a more severe clinical profile and an elevated risk of suicidal recurrence in BPD. This clinical complexity calls for an integrative therapeutic approach that simultaneously addresses BPD core symptoms, psychiatric comorbidities, substance use disorders, and traumatic sequelae. Evidence-based interventions specifically validated for BPD — such as Dialectical Behavior Therapy (DBT) and Mentalization-Based Treatment (MBT) — should be prioritized in the management of these patients [6].

The mean age at first SA of 17.3 years confirms the early onset of suicidal behaviors in our population, with some patients having made their first attempt as early as age 9. Early onset is a poor prognostic factor, associated with increased risk of recurrence and death by suicide throughout the lifespan [3,5].

Drug overdose was the most commonly used method (42.0%), followed by phlebotomy (22.0%). The predominance of methods considered less lethal (compared with hanging or firearms) may partly explain the high survival rate; however, this should not lead to an underestimation of risk, as the lethality of an act depends not only on the method but also on intent and context. Hanging and defenestration, each reported by 12% of patients, are high-lethality methods that indicate a marked degree of suicidal intentionality [5,7].

The very high prevalence of NSSI (72.3%) is a particularly concerning finding and is consistent with the diagnostic criteria of BPD, in which recurrent suicidal behaviors and self-mutilating behaviors constitute a core clinical feature (DSM-5-TR criterion 5). Although NSSI (e.g., cutting, burning) is conceptually distinct from SA in its primary intent (i.e., to regulate emotional distress rather than to die), it is nevertheless associated with an increased risk of subsequent SA in BPD patients and reflects the severe emotional dysregulation and chronic internal suffering that characterize this disorder [8,10].

This study has several limitations. The sample size (n = 65), while sufficient for descriptive analysis, limits the statistical power of comparative analyses. The monocentric design may introduce selection bias. The retrospective collection of certain data, particularly regarding childhood trauma, may be subject to recall bias. Furthermore, the absence of a control group precludes any causal inference.

5. CONCLUSION

This cross-sectional descriptive study of 65 patients with borderline personality disorder (DSM-5-TR) hospitalized for a suicide attempt at Ar-Razi University Hospital, Salé, identified a characteristic clinical profile: young, female, single, unemployed individuals with comorbid depressive disorder and addictive comorbidity who experienced traumatic events during childhood, predominantly sexual abuse. The near-universal prevalence of childhood trauma (81.5%), the early onset of first SAs (mean age: 17.3 years), and the high frequency of NSSI (72.3%) — a hallmark feature of BPD — underscore the severity and chronicity of suffering in this patient population.

These findings give rise to several clinical recommendations: (1) systematic screening for BPD using DSM-5-TR criteria in any psychiatric evaluation of a suicidal patient; (2) systematic assessment of childhood traumatic history in BPD patients; (3) integrated management of BPD, psychiatric comorbidities, and substance use disorders using evidence-based therapies (DBT, MBT); (4) development of prevention programs targeting adolescents and young adults at risk; (5) training of healthcare professionals in the early detection of abuse victims and BPD; and (6) implementation of post-hospitalization follow-up protocols to reduce the risk of recurrence.

Prospective studies with control groups and multivariate analyses are needed to better characterize the interactions among risk factors and to identify the most effective therapeutic interventions in this vulnerable population.

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