

# Evaluation of Suicidality in Psychiatric Outpatients: Experience of Ar-razi Hospital in Salé

N. El Moussaoui<sup>1\*</sup>, S. Bahetta<sup>1</sup>, Y. Amara<sup>1</sup>, F. Laboudi<sup>1</sup>, A. Ouanass<sup>1</sup>

<sup>1</sup>Ar-Razi University Psychiatric Hospital, CHU Rabat-Salé

DOI: <https://doi.org/10.36347/sasjm.2024.v10i09.036>

| Received: 18.08.2024 | Accepted: 23.09.2024 | Published: 28.09.2024

\*Corresponding author: N. El Moussaoui

Ar-Razi University Psychiatric Hospital, CHU Rabat-Salé

## Abstract

## Original Research Article

Suicidality, encompassing suicidal ideation, plans, and suicide attempts, is a complex phenomenon particularly prevalent among psychiatric patients. This study focuses on identifying the risk factors associated with suicidality in outpatients at a psychiatric hospital in Morocco. A total of 278 patients were evaluated using a questionnaire covering sociodemographic data, psychiatric history, and suicidal behaviors. The results show that gender, religious practices, mood disorders, substance use, particularly alcohol and benzodiazepines, and a history of suicide attempts are significant predictors of suicidality. These findings highlight the importance of a multidimensional approach to suicide assessment and prevention in this population.

**Keywords:** Suicidality, Risk factors, Psychiatric outpatients, Morocco, Suicide prevention.

Copyright © 2024 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC 4.0) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

## INTRODUCTION

Suicidality, defined as the range of thoughts and behaviors from suicidal ideation to attempts, is a major public health issue, particularly affecting populations with psychiatric disorders. Suicide, the most dramatic outcome in this spectrum of behaviors, is one of the leading causes of premature death worldwide, with approximately 800,000 deaths annually, according to the World Health Organization (WHO). Psychiatric patients, due to their increased vulnerability from underlying mental disorders, represent a particularly at-risk population. In the Moroccan context, suicidality remains a relatively unexplored subject despite alarming rates of suicide and attempts in certain specific groups. Cultural, religious, and social constraints often make it difficult to identify and treat these behaviors, requiring a multidimensional approach for their evaluation and management. This study focuses particularly on outpatients, a group often underestimated in terms of suicide risk compared to hospitalized patients. The Ar-Razi University Psychiatric Hospital in Salé, where this study was conducted, provides a unique opportunity to examine the dynamics of suicidality in an environment where cultural and religious factors play a significant role. This research aims not only to identify the specific risk factors associated with suicidality in these patients but also to propose prevention strategies adapted to this specific context.

## Objective

The primary objective of this study is to explore and identify the risk factors associated with suicidality in outpatients at Ar-Razi University Psychiatric Hospital in Salé. Specifically, the study aims to:

1. Identify sociodemographic characteristics (age, gender, marital status, education level, socioeconomic status) that may be associated with an increased risk of suicidality.
2. Examine prevalent psychiatric disorders (mood disorders, anxiety disorders, schizophrenia, substance use disorders) and their relationship with suicidality.
3. Evaluate the impact of psychosocial factors, such as social isolation, history of suicide attempts, family support, and religious practices on suicide risk.

## METHOD

The study adopted an exploratory and cross-sectional design, with data collection conducted in May 2024. The study site, Ar-Razi University Psychiatric Hospital in Salé, is a key institution for the treatment of mental disorders in Morocco, providing care to a diverse patient population.

## Participants

Study participants were recruited from outpatients at Ar-Razi Hospital. Inclusion criteria were

being aged 18 or older, having a diagnosis of a psychiatric disorder according to DSM-5 criteria, and giving informed consent to participate in the study. Patients with severe mental disorders requiring immediate hospitalization or those who refused to participate were excluded. A total of 278 patients were included in the final sample.

**Data Collection Tools**

Data were collected using a questionnaire specially designed for this study. The questionnaire included sections on sociodemographic data, psychiatric history, suicidal behaviors, and social support. No standardized psychometric scales were used in this study, distinguishing this approach from other similar studies.

**Procedure**

Patients were invited to participate in the study during their regular outpatient consultations. After receiving detailed explanations about the study's objective and signing informed consent, they were asked to complete the questionnaire. Interviews were

conducted by mental health professionals to ensure that the responses were complete and accurate.

**Statistical Analysis**

Data were analyzed using SPSS software (version 25). Descriptive statistics were used to characterize the sample. Associations between sociodemographic, clinical variables, and suicide risk were evaluated using chi-square tests for categorical variables and t-tests for continuous variables. Logistic regression models were used to identify independent predictors of suicidality.

**RESULTS**

Among the 278 patients included, 60% were women, and 40% were men, with a mean age of 35 years (standard deviation: 12.4 years). Mood disorders were the most frequent, diagnosed in 45% of patients, followed by anxiety disorders (30%) and substance use disorders (20%). (See Tables 1 and 2)

**Table 1: Sociodemographic Data**

	Total (n=278)	History of SA (n=60)	No History of SA (n=218)	P-value
<b>Gender</b>				P=0.0092
Female (n, %)	167 (60.1%)	34 (56.7%)	133 (61.0%)	
Male (n, %)	111 (39.9%)	26 (43.3%)	85 (39.0%)	
<b>Age range</b>				P=0.5376
18-25 (n, %)	89 (32.0%)	16 (26.7%)	73 (33.5%)	
26-35 (n, %)	78 (28.1%)	20 (33.3%)	58 (26.6%)	
36-45 (n, %)	58 (20.9%)	14 (23.3%)	44 (20.2%)	
46-55 (n, %)	32 (11.5%)	7 (11.7%)	25 (11.5%)	
56-65 (n, %)	21 (7.6%)	3 (5.0%)	18 (8.3%)	
<b>Marital Status</b>				P=0.7654
Single (n, %)	154 (55.4%)	31 (51.7%)	123 (56.4%)	
Married (n, %)	84 (30.2%)	20 (33.3%)	64 (29.4%)	
Divorced (n, %)	35 (12.6%)	7 (11.7%)	28 (12.8%)	
Widowed (n, %)	5 (1.8%)	2 (3.3%)	3 (1.4%)	
<b>Education</b>				P=0.3485
No education	16 (5.8%)	5 (8.3%)	11 (5.0%)	
Primary level	21 (7.6%)	6 (10.0%)	15 (6.9%)	
Secondary level	155 (55.8%)	33 (55.0%)	122 (56.0%)	
University level	86 (30.9%)	16 (26.7%)	70 (32.1%)	
<b>Professional status</b>				P=0.0724
Unemployed (n, %)	111 (39.9%)	30 (50.0%)	81 (37.2%)	
Permanent job (n, %)	78 (28.1%)	11 (18.3%)	67 (30.7%)	
Occasional job (n, %)	45 (16.2%)	8 (13.3%)	37 (17.0%)	
Retired (n, %)	12 (4.3%)	4 (6.7%)	8 (3.7%)	
Student (n, %)	32 (11.5%)	7 (11.7%)	25 (11.5%)	
<b>Loneliness</b>				P=0.4723
Yes (n, %)	145 (52.2%)	31 (51.7%)	114 (52.3%)	
No (n, %)	133 (47.8%)	29 (48.3%)	104 (47.7%)	
<b>Religious practice</b>				P=0.0104
Practitioner	154 (55.4%)	24 (40.0%)	130 (59.6%)	
Non-practitioner	124 (44.6%)	36 (60.0%)	88 (40.3%)	

### Sociodemographic Characteristics

Analysis revealed that single or divorced patients were at increased risk of suicidality compared to married patients. Additionally, a low level of education and precarious socioeconomic status were also associated with a higher risk of suicidality.

### Psychiatric Disorders and Suicidality

Patients with major depression were significantly more likely to have suicidal ideation or attempts. Anxiety disorders, although less strongly associated than depression, also showed a positive correlation with suicidality.

### Psychosocial and Behavioral Factors

Contrary to expectations, social isolation did not show a significant correlation with suicidality in this sample. However, religious practice emerged as a protective factor, with a significant reduction in suicide risk among patients who regularly practiced a religion. On the other hand, the use of certain substances, particularly psychoactive substances, was strongly associated with an increased risk of suicidality, highlighting the importance of considering this factor in risk assessment.

**Table 2: Psychiatric and Addictive Assessment Data**

	Total (n=278)	History of SA (n=60; 21.5%)	No History of SA (n=218; 78.4%)	P-value
<b>Family history</b>				P=0.4
Yes (n, %)	11 (4%)	4 (6.6%)	7 (3.2%)	
No (n, %)	267 (96%)	56 (93.3%)	211 (96.7%)	
<b>Psychiatric disorders</b>				
Schizophrenia (n, %)	45 (16.2%)	14 (23.3%)	31 (14.2%)	P=0.1783
Depressive disorder (n, %)	56 (20.1%)	18 (30.0%)	38 (17.4%)	P=0.0492
Anxiety disorder (n, %)	24 (8.6%)	8 (13.3%)	16 (7.3%)	P=0.1654
Personality disorder (n, %)	18 (6.5%)	7 (11.7%)	11 (5.0%)	P=0.0721
Bipolar disorder (n, %)	17 (6.1%)	5 (8.3%)	12 (5.5%)	P=0.4725
Brief psychotic disorder (n, %)	4 (1.4%)	1 (1.7%)	3 (1.4%)	P=0.7945
<b>Psychiatric hospitalization</b>				P<0.0001
Yes (n, %)	45 (16.2%)	18 (30.0%)	27 (12.4%)	
No (n, %)	233 (83.8%)	42 (70.0%)	191 (87.6%)	
<b>Substance use</b>				
Tobacco (n, %)	185 (66.5%)	45 (75.0%)	140 (64.2%)	P=0.0935
Cannabis (n, %)	129 (46.4%)	33 (55.0%)	96 (44.0%)	P=0.1142
Alcohol (n, %)	121 (43.5%)	40 (66.7%)	81 (37.2%)	P=0.0002
Benzodiazepine (n, %)	74 (26.6%)	27 (45.0%)	47 (21.6%)	P<0.0001
Cocaine (n, %)	35 (12.6%)	9 (15.0%)	26 (11.9%)	P=0.5263
Amphetamines (n, %)	12 (4.3%)	3 (5.0%)	9 (4.1%)	P=0.7365

## DISCUSSION

The results of this study highlight significant factors influencing suicidality in psychiatric outpatients. Regarding gender, a slightly higher proportion of men among those with a history of SA was observed, although the majority of participants were women. This observation is consistent with several studies suggesting that, although women are more likely to attempt suicide, men often have more severe attempts and are more likely to have a history of completed SAs. For instance, a study by Schrijvers *et al.*, demonstrated that men have more lethal attempts than women, although women more frequently report a history of SAs [1].

As for age, the analysis indicates that the 26-35 age group is most represented among those with a history of SA. This corresponds to the literature that often identifies young adults as an at-risk group. A study by Nock *et al.*, revealed that the prevalence of suicide attempts is higher among young adults, particularly in

this age group, due to stress factors related to entering adulthood [2].

Regarding marital status, although no significant relationship was found between this factor and SA history, the literature is divided. Some studies, such as Stack's, show that single individuals are more at risk of SA, primarily due to social isolation and a lack of emotional support [3]. However, other research finds no significant link, consistent with these results.

Results on education and employment status are also interesting. The lack of statistical significance for education level is consistent with the work of Knipe *et al.*, who found that education is not an isolated factor for SA, but may interact with other elements such as economic status and employment [4]. Conversely, the observed trend between unemployment and SA is supported by several studies. For example, Blakely *et al.*, demonstrated that unemployment is a major risk factor

for suicide, likely due to the psychological stress associated with economic instability [5].

The significant association found between religious practice and SA history aligns with the findings of Dervic *et al.*, who highlighted that religiosity can play a protective role against suicide. They observed that practicing individuals are generally less likely to have a history of SA, likely due to social support and moral values promoted by religion [6].

Regarding psychiatric comorbidity, the results show a strong association between depressive disorders and SA, which is well documented in the literature. Hawton and van Heeringen identified depression as the main risk factor for suicide attempts, with a high prevalence among depressed individuals with a history of SA [7]. The lack of statistical significance for other psychiatric disorders in this study may reflect an insufficient sample size or lower prevalence of these disorders in the studied population, although other studies have also found weaker associations for disorders such as anxiety or schizophrenia.

Psychiatric hospitalization as a significant factor in this study is supported by the literature. For example, Qin *et al.*, found that hospitalization for psychiatric disorders significantly increases the risk of SA, particularly in the weeks following discharge, due to increased vulnerability during this critical period [8].

Finally, the analysis of substance use is consistent with what is often reported in the literature. Alcohol and benzodiazepines are frequently associated with SA due to their disinhibiting effect, as shown by Sher's studies [9], while tobacco and cannabis, although often used by at-risk individuals, do not always show a direct relationship with SA in some studies [10].

In summary, these results corroborate several well-established aspects in the literature, including the association between gender, employment status, religious practice, depression, psychiatric hospitalization, and substance use with suicide attempts. These findings reinforce the idea that suicide attempts are a complex phenomenon, influenced by a multitude of interrelated factors.

#### Limitations of the study:

1. Sample size: A sample of 278 patients may limit the detection of certain associations.
2. Cross-Sectional Design: The lack of longitudinal follow-up makes it difficult to establish clear causal relationships.
3. Lack of Standardized Scales: The use of non-validated tools hinders comparison with other studies.
4. Reporting Bias: Social stigma may lead to underreporting of suicidal behaviors and substance use.

5. Omission of Contextual Factors: Important elements such as recent life events and social support were not assessed.

## RECOMMENDATIONS

1. Use validated tools to assess suicidality and enhance the comparability of results.
2. Adopt a longitudinal approach to track the evolution of suicidal behaviors over time.
3. Expand the study to other hospitals to obtain a more representative view of psychiatric patients in Morocco.
4. Incorporate contextual factors such as life events and social support.
5. Train clinicians to recognize risk factors and intervene early, particularly regarding substance use.

## CONCLUSION

In conclusion, this work has highlighted the importance of various factors in understanding suicide attempts within the studied population. Gender, religious practice, depression, psychiatric hospitalizations, as well as the use of substances such as alcohol and benzodiazepines, prove to be crucial elements in assessing the risk of SA. The results obtained are in line with existing literature, reinforcing the notion that suicide prevention must be approached holistically, taking into account the multiple dimensions influencing this complex phenomenon.

## REFERENCES

1. Schrijvers, D. L., Bollen, J., & Sabbe, B. G. (2012). The gender paradox in suicidal behavior and its impact on the suicidal process. *Journal of affective disorders*, 138(1-2), 19-26.
2. Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic reviews*, 30(1), 133.
3. Stack, S. (2000). Suicide: a 15-year review of the sociological literature part I: cultural and economic factors. *Suicide and Life-Threatening Behavior*, 30(2), 145-162.
4. Knipe, D. (2017). Socioeconomic position and suicide risk in rural Sri Lanka: a prospective cohort study of 168,000+ people. *Soc. Sci. Med*, 193, 88-95.
5. Blakely, T. A., Collings, S. C., & Atkinson, J. (2003). Unemployment and suicide. Evidence for a causal association?. *Journal of Epidemiology & Community Health*, 57(8), 594-600.
6. Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. *American journal of psychiatry*, 161(12), 2303-2308.
7. Hawton, H., van Heeringen, K. (2009). «Suicide». *The Lancet*, 373(9672), 1372-1381.
8. Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of

- 
- completed suicide and psychiatric disorders: a nested case-control study based on longitudinal registers. *The Lancet*, 360(9340), 1126-1130.
9. Sher, D. (2006). Psychological theories of suicidal behavior, *Psychiatr. Ann.*, 36(90), 656-664, 2006.
10. Borges, G., Bagge, C. L., Cherpitel, C. J., Conner, K. R., Orozco, R., & Rossow, I. (2017). A meta-analysis of acute use of alcohol and the risk of suicide attempt. *Psychological medicine*, 47(5), 949-957.