

Characteristics of Children and Adolescents Referred to a Hospital-Based Psychotrauma Unit in Morocco Following Interpersonal Violence

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Abstract

Original Research Article

Background: Interpersonal violence during childhood and adolescence is associated with substantial psychological morbidity, yet the clinical profile of patients reaching specialized psychotrauma services remains incompletely described in many settings. This study aims to characterize the sociodemographic profile, clinical presentation, and violence-related characteristics of children and adolescents referred to a hospital-based psychotrauma unit following psychological/verbal, physical, or sexual violence. **Methods:** We conducted a retrospective descriptive study of a pediatric population under the age of 18, including 56 patients referred to the Psychotrauma Unit of the child and adolescent psychiatry department of ARR-AZI University Hospital in Sale Morocco from May 2025, when the unit was established, through April 2026. **Results:** The mean age was 11.6 ± 3.4 years; 37/56 (66.1%) patients were female. Initial referral complaints were heterogeneous, with anxiety/fear/panic (25/56, 44.6%), irritability (12/56, 21.4%), sadness/depressed mood (11/56, 19.6%), and school refusal/decline/absenteeism (10/56, 17.9%) among the most frequently documented. Physical violence was recorded in 29/56 (51.8%), sexual violence in 26/56 (46.4%), and verbal/psychological violence in 8/56 (14.3%); 27/56 (48.2%) had repeated exposure. Violence perpetrated by a family member was repeated in 19/24 (79.2%) cases compared with 6/29 (20.7%) clearly extrafamilial cases. **Conclusion:** Children and adolescents referred to the psychotrauma unit presented with heterogeneous but predominantly trauma-related symptoms. Repeated exposure was common and was more frequently observed in intrafamilial violence. No clear sociodemographic or violence-related profile was associated with greater symptom burden in this sample. These findings provide a descriptive overview of the first year of activity of the unit and identify variables that may warrant further investigation in larger prospective cohorts.

Keywords: child maltreatment; interpersonal violence; psychotrauma; pediatric mental health; trauma screening; child abuse.

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1. INTRODUCTION

Interpersonal violence represents a pervasive public health, human rights, and development challenge worldwide. Its consequences extend far beyond individual victims, reverberating through families, communities, and nations, and echoing across generations. According the World Health Organization, interpersonal violence may be physical, sexual, or psychological (also referred to as emotional violence), and it may involve deprivation and neglect [1]. Mounting evidence indicates that exposure to such violence increases lifelong vulnerability to a wide range of emotional, behavioral, and physical health problems, particularly among children and adolescents.

Specialized psychotrauma services therefore occupy an important position identifying post-traumatic manifestations, providing specialized care in the coordination of mental health, social, and child-protection responses.

Therefore, data from newly established services may be particularly useful for identifying local patterns and areas in which assessment can be standardized.

The present study was designed to describe the real-world clinical population referred to a hospital-based psychotrauma unit after verbal/psychological, physical, and/or sexual violence.

Study objectives

The primary objective was to characterize the sociodemographic features, referral complaints, symptoms identified during psychiatric assessment, dissociative symptoms, and violence-related characteristics of children and adolescents referred to the unit.

Secondary analyses were exploratory: explore whether age at assessment, sex, parental marital status, personal and family psychiatric history, violence type, repeated exposure, violence types, perpetrator relationship, or perpetrator sex were associated with a higher clinical symptom burden; and explore violence-related profiles that might inform clinical vigilance.

2. METHODS

This was a retrospective descriptive study conducted in the Psychotrauma Unit of the child and adolescent psychiatry department of ARR-AZI University Hospital in Sale Morocco. The study period extended from May 2025, when the psychotrauma unit was established, through April 2026.

The data were extracted from the medical records available in the hospital's medical software.

Eligible patients were younger than 18 years and had been referred following documented exposure to at least one of the following categories: verbal/psychological violence, sexual violence, or physical including exposure to it. Records were included when sufficient clinical information was available for extraction. The final sample comprised 56 patients aged 3–17 years.

Descriptive statistics were used to summarize the study population. Continuous variables were reported as mean and standard deviation, while categorical variables were presented as frequencies and percentages. Fisher's exact test was used to explore the association between perpetrator relationship (intrafamilial vs extrafamilial) and repeated exposure. A p -value <0.05 was considered statistically significant.

3. RESULTS

3.1 Sociodemographic characteristics

The cohort included 56 patients aged 3–17 years (mean 11.6 ± 3.4 ; median 12 years, IQR 9–14). Thirty-

seven patients (66.1%) were female and 19 (33.9%) were male. Most patients lived in an urban setting (53/56, 94.6%). Parents were recorded as married in 34/56 (60.7%), divorced in 14/56 (25.0%), separated in 5/56 (8.9%), and a widowed-parent household in 3/56 (5.4%). Recorded school levels ranged from preschool to baccalaureate-level education, and two patients were no longer attending school (Table 1).

3.2 Personal and family psychiatric history

A family psychiatric history was documented in 22/56 (39.3%) patients, while a personal psychiatric history was documented in 14/56 (25.0%).

3.3 Initial complaints and symptoms identified during assessment

The initial care giver's concerns were heterogeneous. Anxiety, fear, or panic was the most common concern (25/56, 44.6%), followed by irritability (12/56, 21.4%), sadness or depressed mood (11/56, 19.6%), school refusal/decline/absenteeism (10/56, 17.9%), and sleep disturbance excluding nightmares (9/56, 16.1%). Behavioral presentations were also observed, including aggression, oppositional behavior, and school-related impairment.

Specialist assessment through psychiatric interview with both caregivers and the patient identified a broader trauma-related symptom profile than was apparent from the initial complaint alone. Nightmares and re-experiencing were each documented in 26/56 (46.4%) patients during assessment, sleep disturbance in 21/56 (37.5%), avoidance in 14/56 (25.0%), hypervigilance in 11/56 (19.6%), appetite disturbance in 10/56 (17.9%), and exaggerated startle response in 7/56 (12.5). When initial concerns and assessment findings were combined, the most frequent manifestations were anxiety/fear/panic (42/56, 75.0%), nightmares (32/56, 57.1%), re-experiencing (27/56, 48.2%), sleep disturbance excluding nightmares (27/56, 48.2%), irritability (19/56, 33.9%), avoidance (18/56, 32.1%), and sadness/depressed mood (16/56, 28.6%), as shown in Figure 1.

Dissociative symptoms were documented in 4/56 (7.1%) patients. Given the small number of events, dissociation was described but not subjected to inferential subgroup analysis.

Table 1: Sociodemographic characteristics of the study population (N=56)

Characteristic	n	%
Age, years, mean $\pm$ SD	11.6 $\pm$ 3.4	—
Female	37	66.1
Male	19	33.9
Urban residence	53	94.6
Rural residence	3	5.4
Parents married	34	60.7
Parents divorced	14	25.0
Parents separated	5	8.9

Widowed parent	3	5.4
Preschool	2	3.6
Primary school (CE1–CE6)	27	48.2
Lower secondary school (CE7–CE9)	18	32.1
Upper secondary school (Tronc Commun/Baccalaureate)	7	12.5
Out of school	2	3.6

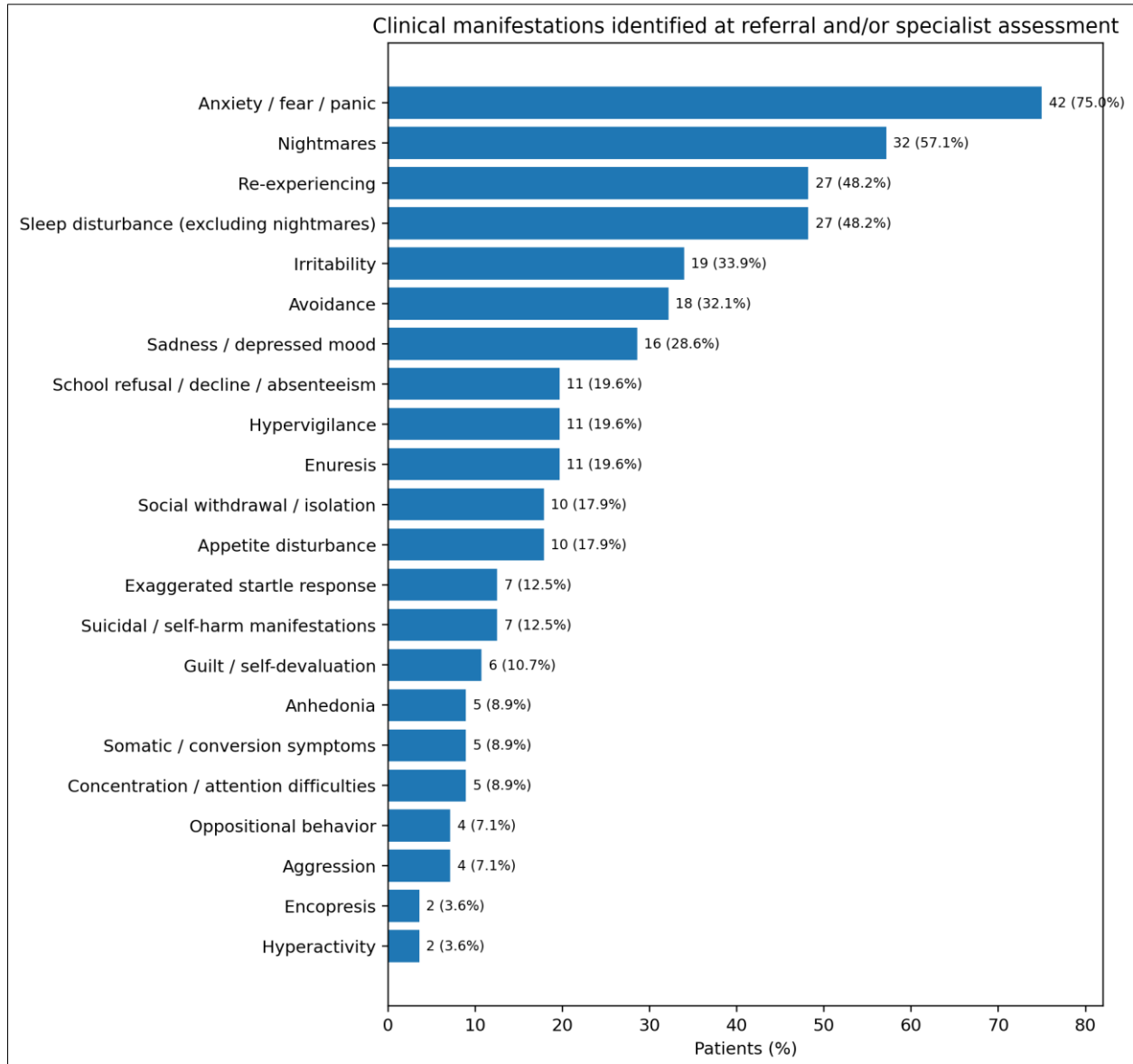


Figure 1: percentage of the Clinical manifestations

3.4 Characteristics of violence exposure

Physical violence was documented in 29/56 (51.8%) patients, sexual violence in 26/56 (46.4%), and verbal/psychological violence in 8/56 (14.3%). Seven patients (12.5%) had exposure to more than one of these violence categories.

Twenty-seven patients (48.2%) experienced repeated violence and 29 (51.8%) a single episode. The distribution of violence types is presented in Figure 2.

It's important to note, that exposure to physical violence was included in the physical violence category as it was frequently associated with it.

The perpetrator was a family member in 24/56 (42.9%) cases, a neighbor in 10/56 (17.9%), a stranger in 10/56 (17.9%), a peer/classmate in 5/56 (8.9%), and school staff in 4/56 (7.1%). Two patients (3.6%) had both family and non-family perpetrators, and the relationship was not disclosed in one case (1.8%). These categories are shown in Figure 3.

Perpetrators were male in 39/56 (69.6%) cases and female in 15/56 (26.8%); one case involved both male and female perpetrators and one did not disclose the perpetrator's sex. Among sexual-violence cases, 24/26 (92.3%) involved a male perpetrator; among physical-violence cases, 16/29 (55.2%) involved a male perpetrator, 12/29 (41.4%) a female perpetrator, and one involved both sexes. Among verbal/psychological-

violence cases, 6/8 (75.0%) involved a female perpetrator.

Repeated exposure was, however, strongly associated with perpetrator relationship. Among clearly intrafamilial cases, 19/24 (79.2%) were repeated, compared with 6/29 (20.7%) of clearly extrafamilial cases (OR 14.57, 95% CI 3.84–55.26; Fisher's exact $p < 0.001$). (Table 2).

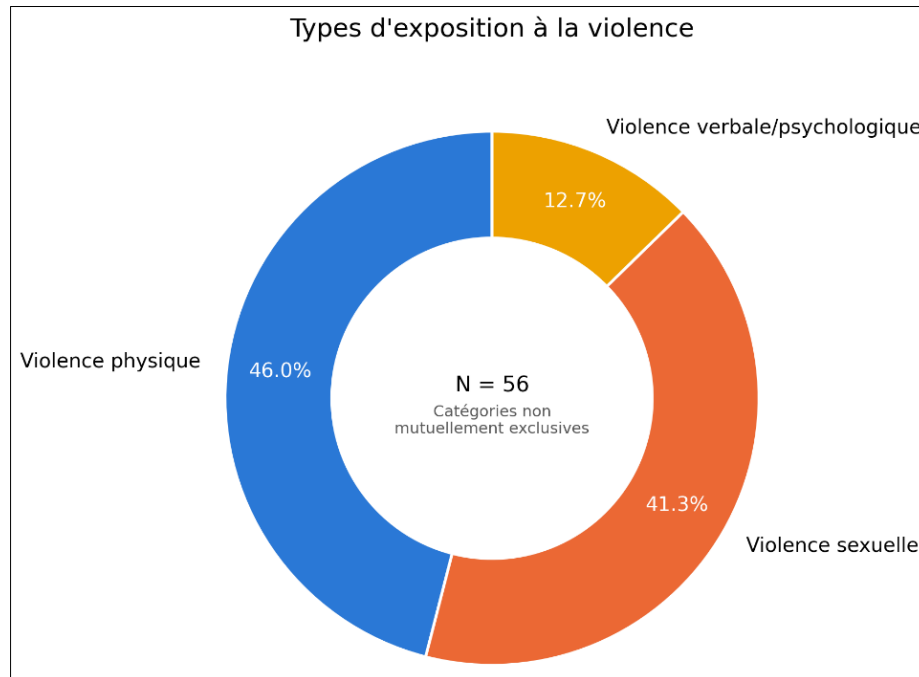


Figure 2: Types of violence exposure in the study population

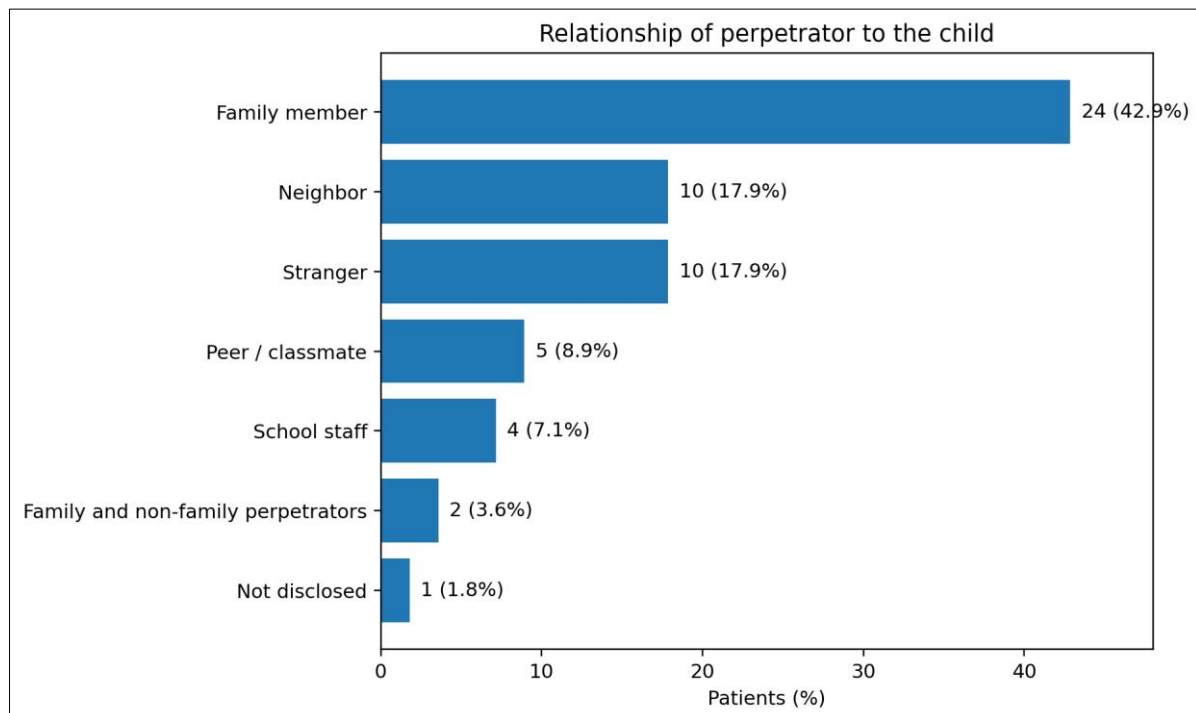


Figure 3: Relationship of the perpetrator to the child

Table 2: Repeated exposure according to perpetrator relationship

Perpetrator relationship	Repeated exposure, n/N (%)
Family member	19/24 (79.2)
Neighbor	2/10 (20.0)
Stranger	2/10 (20.0)
Peer / classmate	1/5 (20.0)
School staff	1/4 (25.0)
Family and non-family perpetrators	2/2 (100.0)
Not disclosed	0/1 (0.0)
Total	27/56 (48.2)

4. DISCUSSION

This study describes the first 56 children and adolescents referred to a newly established hospital-based psychotrauma unit over its first 12 months of activity. The cohort was predominantly female (66.1%), with a mean age of 11.6 years. This female predominance is strikingly similar to the 66.5% reported by Racine *et al.*, in a Canadian child advocacy mental health sample [2]. The present population was also overwhelmingly urban, which may reflect the hospital's referral catchment and accessibility rather than the underlying distribution of violence exposure.

A central finding was the difference between what initially prompted consultation and what emerged during specialist assessment. Caregiver concerns were dominated by anxiety/fear, irritability, sadness, school difficulties, and sleep complaints. In contrast, further psychiatric assessment frequently identified nightmares, re-experiencing, avoidance, hypervigilance, appetite changes, guilt, and anhedonia that had not been documented as the initial reason for referral. This pattern is clinically important because pediatric trauma may be expressed through broad emotional, behavioral, school, or somatic manifestations rather than through an explicitly trauma-labeled complaint. Trauma-screening guidance recommends inquiry not only about intrusive and avoidance symptoms but also anger, behavioral problems, depression, anxiety, and developmentally specific manifestations [5,6] as trauma symptoms may be developmentally difficult to verbalize, and can be perceived differently by children and adults. Shemesh *et al.*, found that child self-reported post-traumatic symptoms were more closely related to clinician-determined PTSD status than parent-reported symptoms in a pediatric outpatient sample [7,8].

This heterogeneity has practical implications for detection. Caregivers may seek help because of irritability, opposition, aggression, school refusal, sleep disturbance, anxiety, or somatic symptoms rather than because they recognize a trauma-specific syndrome. Trauma-informed assessment therefore requires active inquiry into both exposure and a broad range of emotional and behavioral reactions [5,6].

Sleep-related manifestations were particularly prominent. Nightmares were present in 57.1% and other sleep disturbances in 48.2% of patients. A systematic

review and meta-analysis by Schønning *et al.*, found significant associations between childhood maltreatment and insomnia symptoms, shorter sleep duration, and nightmares [9].

A family psychiatric history was recorded in 39.3% of patients and a personal psychiatric history in 25.0%. Racine *et al.*, reported parental mental health difficulties in 52.3% of referred maltreated children [2]. However, the constructs are not identical and our study lacks a non-exposed comparison group, so these figures should be viewed as clinical context rather than evidence of a specific familial risk association.

The violence profile was heterogeneous. Physical violence was documented in 51.8%, sexual violence in 46.4%, and verbal/psychological violence in 14.3%; 12.5% had more than one of these recorded categories. The proportion of multiple violence types was considerably lower than the 53.4% multiple-maltreatment rate reported by Racine *et al.*, [2]. This difference should be interpreted cautiously because the Canadian study captured a broader range of maltreatment and adversity, including neglect and domestic violence exposure, whereas our study was limited to three violence categories and we included exposure to physical violence in the physical violence category as it was very frequently associated with it.

Perpetrators were male in 69.6% of the total sample, close to the 72.7% reported in the Canadian child advocacy cohort [2]. Male perpetrators predominated especially in sexual-violence cases (92.3%), whereas female perpetrators were more represented in physical and verbal/psychological violence in this dataset. These distributions are descriptive and should not be generalized beyond the referred population.

Almost half of the cohort (48.2%) had repeated exposure to violence. Repetition was particularly concentrated in intrafamilial cases: 79.2% of intrafamilial cases were repeated compared with 20.7% of extrafamilial cases. A pediatric emergency department study of sexual abuse similarly found that 59.2% of children had experienced more than one incident before presentation [10]. Earlier clinical literature also suggests that extrafamilial sexual abuse is more often a single episode, whereas sustained access to a child can facilitate recurrence in some intrafamilial contexts. Our finding is

clinically relevant because chronicity and perpetrator relationship are dimensions of trauma exposure that may influence symptom burden and safety planning [3,11].

Dissociative symptoms were identified mostly through routine psychiatric assessment without a standardized age-adapted instrument. Their frequency should be interpreted cautiously, particularly in younger children, in whom dissociative manifestations may be difficult to recognize during clinical interviews [12].

The exploratory analyses did not identify clear associations between the number of documented symptom domains and the demographic or violence-related variables examined.

This study has several strengths. It describes a real-world pediatric psychotrauma population and captures clinically useful exposure dimensions that are often omitted from purely diagnosis-focused reports, including perpetrator relationship, perpetrator sex, and repetition. Taken together, these findings provide an initial description of the population referred during the first year of activity of the psychotrauma unit.

5. LIMITATIONS

This study has several limitations. First, it's a relatively small sample. The results therefore describe a selected clinical population and cannot be used to estimate the prevalence of violence or trauma-related symptoms in the general pediatric population.

Second, the dataset did not include other metrics that could be useful as the age at onset, exact duration of violence, delayed psychiatric care or a comprehensive inventory of other victimization types such as neglect. This likely limited assessment of chronicity and polyvictimization and may partly explain the low proportion of multiple violence types.

As mentioned before, dissociative symptoms were identified mostly through routine psychiatric assessment without a standardized age-adapted instrument which could explain the low numbers presenting this symptom.

6. CONCLUSION

Interpersonal violence in childhood is associated with a wide and heterogeneous range of psychological, behavioral, and functional manifestations that may vary according to developmental stage, characteristics of the exposure, and the child's environment.

The present study illustrates this clinical diversity within a specialized pediatric psychotrauma setting, while also highlighting the frequency of repeated exposure and the importance of considering the relationship to the perpetrator. Beyond the specific findings of this cohort, this study only established an

initial clinical profile of the population reaching the service and a baseline for future prospective using standardized and developmentally adapted assessment.

Conflict of Interest Statement: The authors declare that they have no conflicts of interest.

REFERENCES

1. World Health Organization. *Violence against children*. World Health Organization. Available from: <https://www.who.int/news-room/fact-sheets/detail/violence-against-children>
2. Racine N, Dimitropoulos G, Hartwick C, Eirich R, van Roessel L, Madigan S. Characteristics and Service Needs of Maltreated Children Referred for Mental Health Services at a Child Advocacy Centre in Canada. *J Can Acad Child Adolesc Psychiatry*. 2021;30(2):92–103. PMID: 33953761.
3. Hodgdon HB, Spinazzola J, Briggs EC, Liang LJ, Steinberg AM, Layne CM. Maltreatment type, exposure characteristics, and mental health outcomes among clinic referred trauma-exposed youth. *Child Abuse Negl*. 2018;82:12–22. doi:10.1016/j.chiabu.2018.05.021.
4. Gindt M, Fernandez A, Zeghari R, *et al.*, A 3-year retrospective study of 866 children and adolescent outpatients followed in the Nice Pediatric Psychotrauma Center created after the 2016 mass terror attack. *Front Psychiatry*. 2022;13:1010957. doi:10.3389/fpsy.2022.1010957.
5. National Child Traumatic Stress Network. *Trauma Screening*. National Child Traumatic Stress Network. Available from: <https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-screening>
6. National Child Traumatic Stress Network. *Trauma-Informed Mental Health Assessment*. National Child Traumatic Stress Network. Available from: <https://www.nctsn.org/treatments-and-practices/screening-and-assessments/trauma-informed-mental-health-assessment>
7. Shemesh E, Newcorn JH, Rockmore L, *et al.*, Comparison of parent and child reports of emotional trauma symptoms in pediatric outpatient settings. *Pediatrics*. 2005;115(5):e589. doi:10.1542/peds.2004-2201.
8. Meiser-Stedman R, Smith P, Glucksman E, Yule W, Dalgleish T. Parent and child agreement for acute stress disorder, post-traumatic stress disorder and other psychopathology in a prospective study of children and adolescents exposed to single-event trauma. *J Abnorm Child Psychol*. 2007;35(2):191–201. doi:10.1007/s10802-006-9068-1.
9. Schønning V, Sivertsen B, Hysing M, Dovran A, Askeland KG. Childhood maltreatment and sleep in children and adolescents: A systematic review and meta-analysis. *Sleep Med Rev*. 2022;63:101617. doi:10.1016/j.smrv.2022.101617.

10. Lee MHM, Ganapathy S, Low SM, Chua CLQ, Chong SL, Ma E, Wong PCY. A review of child sexual abuse cases presenting to a paediatric emergency department. *Ann Acad Med Singap.* 2021;50(7):527–535. doi:10.47102/annals-acadmedsg.2021127.
11. Loinaz I, Bigas N, de Sousa AM. Comparing intra and extra-familial child sexual abuse in a forensic context. *Psicothema.* 2019;31(3):271–276. doi:10.7334/psicothema2018.351.
12. Diseth TH, Christie HJ. Trauma-related dissociative (conversion) disorders in children and adolescents—an overview of assessment tools and treatment principles. *Nord J Psychiatry.* 2005;59(4):278–292. doi:10.1080/08039480500213683.