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Correlates and persistence of OCD and related disorders: Findings from a national LMIC student survey

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Background: Although research on the epidemiology of obsessive-compulsive disorder (OCD) is growing, most studies are from high-income countries, with limited data on obsessive-compulsive related disorders (OCRDs). Whereas age of onset, persistence, and sociodemographic correlates of OCD have been well studied, much less is known about these factors in related conditions.

Aim: This study aimed to investigate age of onset, persistence, and sociodemographic correlates of OCD and OCRDs in a national student mental health survey in South Africa.

Setting: This study draws on data collected from 17 universities across South Africa.

Methods: Students completed a survey assessing OCD, body dysmorphic disorder (BDD), trichotillomania (TTM), excoriation disorder (SPD), and hoarding disorder (HD). Multivariable regression using a log-binomial model examined sociodemographic correlates. Persistence was calculated as the proportion of current cases among those with lifetime diagnoses.

Results: Among 3532 respondents (63.3% female; mean age 20.9 years), mean age of onset was 15.6 years for OCD and 14.8 years for other OCRDs. The proportional persistence median was 67% for OCD and 75% for other OCRDs. Older students were at an increased risk for OCD (relative risk [RR] 1.04), while females (RR 1.23) and white students (RR 1.37) were at higher risk for OCRDs other than OCD. Students identifying as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and others (LGBTQ+) were at increased risk for all OCRDs.

Conclusion: Despite reliance on non-validated self-report measures, this study offers the first survey data on BDD, TTM, SPD, and HD from a low- and middle-income setting.

Contribution: Results of this study highlight early onset and persistence of OCRDs, calling for greater global mental health attention.

Keywords: South Africa; university students; obsessive-compulsive disorder; OCD; obsessive-compulsive related disorders; OCRDs; age of onset; persistence.

Introduction

The incorporation of obsessive-compulsive disorder (OCD) into community surveys has facilitated research on its prevalence and correlates. There is evidence that OCD is a moderately prevalent disorder,[1] that it has a relatively early age of onset,[2] and that it is more common in women.[3] The World Mental Health survey, the largest set of community surveys of mental disorders to date, also includes several surveys from low- and middle-income countries (LMICs), and confirms that OCD is a prevalent and persistent condition, with consistent sociodemographic correlates in different countries.[4]

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Relatively little attention has been paid to the epidemiology of obsessive-compulsive related disorders (OCRDs), including body dysmorphic disorder (BDD), trichotillomania (hair-pulling disorder, or TTM), excoriation (skin-picking) disorder (SPD), and hoarding disorder (HD). A few community surveys have been undertaken in high-income countries, but to our knowledge none in LMICs.

In this article, we report the results of a national student mental health survey conducted across 17 universities in South Africa. Our aim was to estimate the age of onset, persistence, and sociodemographic correlates of OCRDs.

Research methods and design

Study design and procedures

This was a cross-sectional survey reporting on the lifetime, 12-month, and 30-day prevalence of OCRDs, including OCD, BDD, TTM, SPD, and HD in a sample of South African (SA) university students, with ages ranging from 18 years to 24 years. All of the 26 public universities in South Africa were invited to participate. Seventeen (n = 17, 65%) universities sent out emails to their undergraduate students with an invitation to complete an anonymous survey in English between April 2020 and October 2020. To reduce participant burden, the survey consisted of a main section sent out by all participating universities, combined with 1 of 4 additional sections that were randomised. In this way, a quarter of survey invitations included the main survey section combined with a section with items on OCRDs.

Measures

Sociodemographic characteristics

Participants completed the survey and responded to items asking their age, gender (female, male, and *gender non-conforming*, such as gender fluid or non-binary), group (according to the official categories in government policies and the population census, i.e., black-African, white, and black-Other [i.e., Coloured - an official term used for census data and population classification in SA, Asian, and other non-white]), parents' level of education (less than secondary education, secondary graduate, some postsecondary and university graduate) and sexual orientation (heterosexual [no same sex attraction], or a sexual minority group [i.e., lesbian, gay, bisexual, asexual or questioning]). Our inclusion of group is not intended to reify these social constructs but rather it is done with the aim of addressing ongoing health disparities.

Obsessive-compulsive related disorders

The survey, which has not been validated in the South African context, assessed OCD using seven items, each capturing the most common OCD symptom dimensions. These items were adapted from the OCD module of the National Comorbidity Survey and the WHO CIDI.[5,6] Respondents indicated whether they had experienced any of these symptoms for at least 1 month, across three timeframes: the past 30 days, the past 12 months, and lifetime. Items included intrusive thoughts about contamination and cleanliness, harm and superstition, order and symmetry, religion, sex, or morality, as well as related compulsive behaviours such as washing and cleaning, checking, ordering, repeating, counting, praying, or mental reviewing. In addition, the survey assessed the other OCRDs through items capturing excessive concern with minor or perceived physical flaws, leading to behaviours such as mirror checking, grooming, and reassurance seeking (BDD); repetitive hair-pulling resulting in hair loss or bald spots (TTM); compulsive skin-picking causing open sores (SPD); and persistent hoarding of items with little value, significantly impairing the use of living spaces (HD). These were followed by Likert-type items asking about the duration of these distressing or bothersome occurrences per day (with the following response options: less than 1 h, 1–4 h, 4–8 h, and 8+ h), as well as the extent of their distress, or how much these were bothersome, or interfered with work and/or studies (response options ranging from not at all, a little, some, a lot, to extremely). The age of onset of OCRDs, that is, the age at which these symptoms lasted longer than 1 h per day, causing distress or functional impairment, was also assessed.

Data analysis

We aimed to (1) establish 30-day (current), 12 month, and lifetime prevalence estimates of OCRDs in a subset of a sample of SA university students and to (2) investigate the age of onset, persistence and sociodemographic correlates of OCRDs.

The survey data were weighted to adjust for differences in response rates across the 17 participating universities, ensuring that the results accurately reflect the demographic composition of this entire student population. Specifically, adjusting for any biases in the sample, weights were calculated based on the proportion of each demographic group (i.e., age, gender, university size) within the overall student population compared to their representation in the survey sample. The weighted data were then used in all subsequent analyses to provide more generalisable findings.

Descriptive statistics were computed for all sociodemographic variables. For continuous variables (age at the time of survey completion, age of onset of symptoms), means and standard deviations were calculated. For categorical variables (i.e., gender, population group, parents' education level, and sexual orientation), frequencies and percentages were determined. We analysed data from university students aged 18 years to 24 years, as this is the age group of interest (late adolescence, early adulthood) but also because this is the age range of the majority of undergraduate students attending universities in South Africa.

Firstly, we established the proportion of students out of the total sample that endorsed the various obsessive-compulsive symptoms. Secondly, symptom duration per day, level of distress/bother/functional impairment

associated with (likely) OCD at its worst and lasting 1 month or more, were determined. Thirdly, for those who likely met criteria for a diagnosis of an OCRD, the prevalence rates, and proportional persistence (i.e., those with an OCRD over the previous 12 months, persisting to lifetime OCRD) were also analysed. In fourth place, we also plotted the co-occurrence of OCD and the other OCRDs. Finally, we conducted a multivariate regression analysis using a log-binomial model to examine the sociodemographic correlates of OCRDs. Coefficients from the model were exponentiated to estimate prevalence ratios (relative risk or RR) with 95% confidence intervals. All statistical analyses were conducted using the survey package in R, version 4.4.1. The significance level was set at $p < 0.05$ for all tests.

Ethical considerations

Ethical clearance to conduct this study was obtained from Stellenbosch University and Health Research Ethics Committee (No. N19/08/103). Institutional permission was also obtained from all participating universities. Research was conducted in accordance with the Helsinki Declaration (1989).

Participation in the study was entirely voluntary, and all participants provided informed consent electronically prior to completing the survey. Data were anonymised and stored securely on a password-protected cloud-based server. Information about crisis and student counselling services at each of the participating universities was provided to all participants.

Results

Sample characteristics

The dataset initially consisted of 3744 respondents. Eliminating students without a full dataset on OCRDs, the final dataset consisted of responses from 3532 respondents. Participants were on average 20.9 years old (standard deviation [s.d.] 1.9), ranging between 18 years and 24 years. The sample consisted of 2235 (63.3%) female, 1288 (36.5%) male and 9 (0.3%) gender non-conforming participants. In terms of population group, the majority were black-African students (n = 2656, 75.2%), with smaller proportions representing the other groups (white or Caucasian: n = 455 [12.9%]; black-Other: n = 420 [11.9%]). More than half the sample were in their first academic year (n = 1942 [55%]). The educational levels of the parents of research participants varied widely, ranging from those below secondary level (1.2%), those that completed secondary school education (31.4%), to others who had attained a university degree (33.3%). Age of onset for OCD was 15.6 (s.d. 3.8) years, and 14.8 (s.d. 3.9) years for OCRD.

Estimated prevalences

Table 1 depicts the proportion of university students endorsing the various obsessive-compulsive (OC) symptoms assessed in the survey, lasting at least 1 month over their lifetime. Highest rates were for checking behaviours to prevent mistakes and physical harm (61%) and an obsession to order, repeat, or count things, or to do something in a precise or exactly defined way (45.5%). A third (n = 1217; 34.5%) of students endorsed 4 or more lifetime OC symptoms.

The prevalence rates and proportional persistence medians of OCRDs are depicted in Table 2 and indicate that 22.7% of the cohorts were likely to have lifetime OCD, 20.5% reported OCD in the last 12 months, and 19.6% likely experienced OCD in the 30 days prior to completing the survey. Age of onset for OCD was 15.6 (s.d. 3.8) years, and 14.8 (s.d. 3.9) years for OCRD. The proportional persistence median for OCD was 67% (95% CI 67–75; IQR 38–94), while for OCRDs other than OCD, it was 75% (95% CI 75–80; IQR 50–92). In their lifetime, 17.3% had any OCRD (other than OCD), and 15.7% reported BDD, 6.8% SPD, 5.3% hoarding disorder, and 3% TTM. Among those with OCD (Table 3), almost half had another OCRD (47%) during their lifetime, with rates of comorbid BDD (42.5%) highest.

Sociodemographic correlates of obsessive-compulsive related disorders

Findings from the multivariate regression analysis of sociodemographic correlates of OCRDs are depicted in Table 4. Older students were at increased risk for OCD (RR 1.04, 95% CI 1.0–1.08), and females (RR 1.23, 95% CI 1.00–1.50) and white students (RR 1.37, 95% CI 1.12–1.69) for OCRDs other than OCD. Being from a sexual minority group (i.e., LGBTQ+) put students at increased risk for all OCRDs (OCD: RR 1.35, 95% CI 1.15–1.59; OCRDs other than OCD: RR 1.45, 95% CI 1.21–1.51). Parental education levels were not significantly associated with any of the OCRDs.

TABLE 1: Proportion of students of the total sample (N = 3532) endorsing various obsessive-compulsive symptoms lasting at least 1 month over their lifetime.

Variable	*n*	%	SE
An obsession about dirt, germs, or contamination, or a compulsion to repeatedly wash or clean things.	1029	29.1	0.9
An impulse to go back over things in your mind to make sure a mistake was not made, or a compulsion to check things, like locks or stoves, to prevent something bad from happening.	2154	61.0	0.9
An obsession to order, repeat, or count things, or to do something in an exactly defined way.	1603	45.5	0.9
A superstitious urge to go through specific mental rituals or perform specific acts to avoid something terrible from happening.	831	23.6	0.8
An excessive concern that you have sinned, or that God might punish you, or an excessive urge to pray over and over or ask for forgiveness.	1395	39.6	0.9
Intrusive thoughts or urges that you do not want and that you find upsetting, like thoughts about sexual things or urges to do something immoral.	1283	36.4	0.9
Any other recurrent thoughts, images, impulses, or compulsions that are either excessive, unrealistic, or very upsetting to you.	1071	30.4	0.9
Any of the above	2754	78.0	0.8
Exactly 1 of the above	466	13.2	0.6
Exactly 2 of the above	543	15.4	0.7
Exactly 3 of the above	527	14.9	0.7
Four or more of the above	1217	34.5	0.9

SE, standard error.

TABLE 2: Prevalence rates and proportional persistence median of obsessive-compulsive related disorders in the total sample (N = 3532).

Dx	Lifetime prevalence		12-month prevalence		30-day prevalence		Proportional persistence median†		
	%	95% CI	%	95% CI	%	95% CI	Median	95% CI	IQR
OCD	22.7	21.1, 24.2	20.5	19, 22	19.6	18.1, 21.1	67%	67, 75	38–94
Trichotillomania (hair-pulling) disorder	3.0	2.4, 3.6	3.0	2.4, 3.6	1.8	1.3, 2.3	-	-	-
Excoriation (skin-picking) disorder	6.8	5.9, 7.7	6.5	5.6, 7.4	5.0	4.2, 5.8	-	-	-
Body dysmorphic disorder	15.7	14.4, 17.0	14.7	13.4, 16.0	12.7	11.5, 14.0	-	-	-
Hoarding disorder	5.3	4.4, 6.1	5.0	4.1, 5.8	3.2	2.5, 3.9	-	-	-
Any lifetime OCRD	17.3	15.9, 18.6	16.2	14.9, 17.6	14.3	13.0, 15.6	75%	75, 80	50–92

OCD, obsessive-compulsive disorder; OCRD, obsessive-compulsive related disorder; CI, confidence interval; IQR, interquartile range.

†, The age of onset of individual OCRDs was not available; therefore, the proportional persistence median for the OCRDs other than OCD was not calculated.

TABLE 3: Prevalence of obsessive-compulsive related disorders among students with and without lifetime obsessive-compulsive disorder (N = 3532).

OCRD	Lifetime prevalence						12-month prevalence						30-day prevalence					
	Among students without lifetime OCD (*n* = 2732)			Among students with lifetime OCD (*n* = 800)			Among students without OCD in the past year (*n* = 2801)			Among students with OCD in the past year (*n* = 723)			Among students without OCD in the past month (*n* = 2833)			Among students with OCD in the past month (*n* = 689)		
	n	%	SE	*n*	%	SE	*n*	%	SE	*n*	%	SE	*n*	%	SE	*n*	%	SE
Trichotillomania (hair-pulling) disorder	43	1.6	0.3	63	7.9	1.1	43	1.5	0.2	62	8.6	1.2	26	0.9	0.2	38	5.5	1.0
Excoriation (skin-picking) disorder	87	3.2	0.3	152	19.0	1.6	86	3.1	0.3	143	19.9	1.7	71	2.5	0.3	105	15.2	1.5
Body dysmorphic disorder	213	7.8	0.5	340	42.5	2.0	211	7.5	0.5	308	42.6	2.1	185	6.5	0.5	265	38.7	2.1
Hoarding disorder	44	1.6	0.2	143	17.8	1.6	42	1.5	0.2	133	18.4	1.7	23	0.8	0.2	90	13.1	1.6
Any lifetime OCRD	233	8.5	0.6	376	47.0	2.0	230	8.2	0.5	342	47.3	2.1	203	7.2	0.5	300	43.9	2.2

OCRD, obsessive-compulsive related disorder; OCD, obsessive-compulsive disorder; SE, standard error.

Discussion

Key findings of this study were that OCRDs have a relatively early age of onset and are persistent conditions. Notably, older students were at an increased risk for OCD, females and white students were at increased risk for OCRDs other than OCD, and being from a sexual minority group (i.e., LGBTQ+) put students at increased risk for OCD as well as related conditions.

In terms of prevalence, it should be noticed that in our sample, the most common OCRD other than OCD was BDD, a finding that is consistent with the typically increased concerns about appearance, body image, and heightened self-awareness and social comparison in this age group.[7] Of note also is that our lifetime rates of BDD, and comorbid BDD in OCD, appear much higher than in the general population and in university students elsewhere.[7] However, our findings regarding prevalence should be interpreted in the context of several key limitations. In particular, although the questions here were based on DSM-5 criteria, concerns have been raised about the clinical validity of community survey diagnoses (e.g., see the Epidemiological Catchment Area [ECA] validation study),[8] and indeed we did not conduct a clinical validation. Participants were self-selected and are not representative of the broader community. Nonetheless, this is one of the first surveys of the epidemiology of OCRDs in an LMIC setting.

Our finding of relatively early age of onset for OCD and related disorders, aligns with previous work suggesting that OC symptoms, such as body shape concerns, hair-pulling, and skin-picking, typically emerge in adolescence.[2,9,10,11] The findings also indicated that the OCRDs are highly persistent conditions; nearly 70% of respondents with lifetime OCD reported experiencing current symptoms, and three quarters (75%) of those with a lifetime OCRD (other than OCD) had persistent symptoms.

Modest to moderate associations of OCRDs with sociodemographic variables were found, with higher risk for OCD among older students, for OCRDs other than OCD among females and white students, and all OCRDs among sexual minority students relative to heterosexual students. The underlying reasons for these observed associations remain unclear, and further investigation is warranted to explore potential explanatory factors. Future research should examine the sociocultural, psychological, and biological mechanisms that may contribute to these differential risks across demographic groups. Finally, the finding that students from a sexual minority group were 35% – 45% more likely to present with lifetime OCD or any other OCRD compared to heterosexuals aligns with previous work suggesting a stable pattern of associations with mental difficulties in the LGBTQ+ community, irrespective of the specific disorder.[12,13,14,15]

In conclusion, key limitations of these data include the use of self-report measures that have not been validated in the South African context. Nevertheless, this study provides some of the first survey data on BDD, TTM, SPD, and HD, from a low- and middle-income setting. A notable strength is its broad national reach, with data collected from students across multiple provinces, thereby enhancing the representativeness of the findings. The results emphasise the early onset and persistence of these conditions, underscoring the need for greater attention from the field of global mental health.

TABLE 4: Mutivariate regression analysis of sociodemogrpahic correlates of of OCD and OCDR among students 24-years and younger (n = 3,532).

	Lifetime OCD		12-month OCD		30-day OCD		Lifetime TTM		Lifetime SPD		Lifetime HD		Lifetime BDD		Any OCRD (not OCD)		Any OCD/OCRD	
	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI	RR	95% CI
Age	1.04	(1.00, 1.08)	1.03	(0.99, 1.07)	1.03	(0.99, 1.08)	1.08	(0.96, 1.21)	1.00	(0.94, 1.07)	1.01	(0.93, 1.10)	0.98	(0.94, 1.02)	0.99	(0.95, 1.03)	1.01	(0.98, 1.04)
Gender																		
Male																		
Female	0.89	(0.76, 1.04)	0.88	(0.75, 1.04)	0.87	(0.74, 1.04)	0.86	(0.54, 1.37)	1.65	(1.12, 2.43)	0.91	(0.62, 1.31)	1.29	(1.04, 1.6)	1.23	(1.00, 1.5)	1.03	(0.90, 1.18)
Gender non-conforming	0.85	(0.40, 1.81)	0.93	(0.43, 1.99)	0.99	(0.46, 2.11)	2.02	(0.53, 7.71)	1.62	(0.51, 5.13)	1.23	(0.31, 4.97)	1.32	(0.58, 3.0)	1.14	(0.5, 2.56)	0.83	(0.42, 1.63)
Population group																		
Black-African																		
White	0.91	(0.74, 1.12)	0.91	(0.73, 1.14)	0.86	(0.68, 1.09)	1.39	(0.78, 2.47)	2.48	(1.82, 3.38)	0.82	(0.52, 1.31)	1.31	(1.05, 1.63)	1.37	(1.12, 1.69)	1.10	(0.94, 1.29)
Black-other	1.13	(0.93, 1.38)	1.15	(0.93, 1.42)	1.12	(0.90, 1.40)	1.45	(0.82, 2.57)	1.51	(1.05, 2.17)	1.04	(0.68, 1.60)	1.26	(1.00, 1.58)	1.22	(0.98, 1.52)	1.11	(0.94, 1.31)
Parent education																		
Less than secondary																		
Secondary graduate	1.00	(0.80, 1.24)	1.00	(0.79, 1.27)	0.99	(0.78, 1.25)	0.72	(0.40, 1.29)	0.87	(0.57, 1.34)	1.35	(0.73, 2.49)	1.04	(0.78, 1.39)	0.99	(0.75, 1.31)	0.98	(0.81, 1.17)
Some postsecondary	0.93	(0.74, 1.19)	0.93	(0.72, 1.2)	0.90	(0.69, 1.18)	0.70	(0.35, 1.4)	0.80	(0.51, 1.27)	1.25	(0.66, 2.38)	1.06	(0.78, 1.45)	1.01	(0.75, 1.35)	0.96	(0.79, 1.17)
University graduate	0.94	(0.75, 1.17)	0.94	(0.74, 1.19)	0.89	(0.70, 1.13)	0.60	(0.33, 1.07)	0.77	(0.51, 1.18)	1.22	(0.64, 2.30)	1.02	(0.76, 1.36)	0.98	(0.75, 1.29)	0.89	(0.73, 1.07)
Sexual Orientation																		
Heterosexual																		
Sexual minority group	1.35	(1.15, 1.59)	1.35	(1.13, 1.61)	1.34	(1.12, 1.61)	1.75	(1.10, 2.76)	1.94	(1.44, 2.60)	1.69	(1.18, 2.41)	1.41	(1.16, 1.71)	1.45	(1.21, 1.74)	1.35	(1.19, 1.54)

Note: The model used here is log binomial. i.e. binomial regression with log link to estimate prevalence ratios/risk ratios.

OCD, obsessive-compulsive disorder; OCRD, obsessive-compulsive related disorder; RR, relative risk; SPD, excoriation disorder; CI, confidence interval.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article. The author, D.J.S., serves as an editorial board member of this journal. The peer review process for this submission was handled independently, and the author had no involvement in the editorial decision-making process for this manuscript. The authors have no other competing interests to declare.

Authors' contributions

All authors contributed to the article, discussed the results, and approved the final version for submission and publication. C.L - Conceptualisation; Methodology; Formal analysis; Investigation; Writing- original draft; Resources; Writing- review and editing; Supervision. R.S. - Methodology; Formal analysis; Investigation; Software; Writing- review and editing. J.R. -Conceptualisation; Methodology; Project administration; Software; Resources; Writing- review and editing. W.S.- Methodology; Investigation; Project administration; Writing- review and editing R.N. -Investigation; Writing- review and editing. E.B. - Conceptualisation; Methodology; Investigation; Project administration; Software; Data curation; Resources; Writing- review and editing. K.R. - Formal analysis; Investigation; Writing- original draft; Writing- review and editing. D.J.S.-Conceptualisation; Methodology; Investigation; Resources; Writing- review and editing; Supervision: Funding acquisition. J.B. - Conceptualisation; Methodology; Investigation; Software; Data curation; Resources; Writing- review and editing; Supervision: Funding acquisition.

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Data availability

The data that support the findings of this study are available from the corresponding author, C.L. upon reasonable request.

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