Harm OCD Risk Assessment Checklist

An educational aid for clinicians, supervisors, and trainees

The OCD Clinic · Justin La Rose, RP · theocdclinic.ca/harm-ocd/risk-assessment-for-clinicians

Not a validated instrument. This checklist is an educational synthesis of the clinical and research literature (Veale et al., 2009; Purdon, 2004), intended as a prompt for structured thinking. It does not replace clinical judgement, local safeguarding or child-protection policy, formal risk assessment where indicated, or specialist consultation. No single item is diagnostic; the overall pattern is what matters.

1. Establish the phenomenology first

- ☐ Is the thought unwanted, intrusive, and ego-dystonic (repugnant, against the person's values)?
- ☐ Are there compulsions, overt or entirely covert (mental checking, review, reassurance, neutralising)?
- ☐ Is the distress driven by the appraisal of the thought, not the content itself? (Intrusive thoughts, including violent ones, are near-universal.)

2. Primary vs secondary risk

- ☐ Primary risk (the feared act in the obsession): almost always only apparent. No recorded cases of a person with OCD carrying out their obsession.
- ☐ Secondary risk (assess actively): depression, hopelessness, severe avoidance/restriction, self-harm to prevent imagined harm to others, substance use, functional decline, emotional unavailability to dependants.
- ☐ Is the urge the obsession, or a response to it? (e.g. self-harm to prevent feared harm to others.)

3. Factors suggesting OCD rather than intent (pattern, not any single item)

- ☐ Ego-dystonic; no history of behaviour consistent with the thought; no voluntarily generated fantasies.
- ☐ Avoidance of triggers rather than approach; efforts to suppress, neutralise, or atone.
- ☐ Very frequent/constant intrusions; dominant emotion is fear, guilt, or disgust, not gratification or indifference.
- ☐ Concern is for the potential victim, not self-interest (e.g. getting caught); strong motivation to seek help.
- ☐ Additional obsessive-compulsive symptoms in other domains.
- ☐ Where genuine doubt remains: forensic assessment and specialist consultation. Self-reported arousal is an unreliable indicator.

4. Self-harm and suicide

- ☐ Are self-harm/suicide thoughts ego-dystonic obsessions, or genuine intent? Assess independently.
- ☐ Complete a standard suicide-risk assessment regardless. OCD raises suicide risk (Torres et al., 2006: at least a quarter had attempted).
- ☐ Consider comorbid depression, hopelessness, personality disorder, and self-harm used as a compulsion.

5. Ask directly about covert compulsions

- ☐ Mental checking of intentions; reviewing memories/movements for evidence; silent reassurance and self-argument.
- ☐ Neutralising an image with a good thought or prayer; confession; reassurance-seeking from others or online.

6. Avoid these assessment errors

- ☐ Do not conduct an overcautious or unduly lengthy risk assessment; it increases doubt, avoidance, and compulsions.
- ☐ Do not provide reassurance; rationalising and reassuring are covert compulsions you would be reinforcing.

- [ ] Do not pursue or accept a demand for 100% certainty; target the appraisal, not the truth of the obsession.
- [ ] Do not open with confidentiality-breach warnings that shut down disclosure; use gentle, normalising, multiple-choice inquiry.
- [ ] Do not mistake obsessions (incl. overvalued ideas, transformation obsessions) for psychosis. Poor insight does not exclude OCD.

7. Consider specialist OCD consultation when

- [ ] Diagnostic uncertainty, poor insight, comorbid depression/suicide risk, children or the postnatal period, or non-response to treatment.
- [ ] Evidence-based treatments: ERP (a form of CBT) and SSRIs.

References: Veale D, Freeston M, Krebs G, Heyman I, Salkovskis P (2009). Risk assessment and management in OCD. Advances in Psychiatric Treatment 15(5):332-343. · Purdon C (2004). Cognitive-behavioral treatment of repugnant obsessions. J Clin Psychol 60(11):1169-1180. · Rachman S, de Silva P (1978). Abnormal and normal obsessions. Behav Res Ther 16(4):233-248. · Torres AR, et al. (2006). Am J Psychiatry 163(11):1978-1985.