THE BALANCE

Obsessive-Compulsive Disorder (OCD)

Private treatment

A guide for individuals and families

Dedicated to one client at a time

MALLORCA / ZURICH

English / September 2026

01 / WHAT TO KNOW BEFORE TREATMENT

What to know before treatment

01 OCD involves distressing obsessions and compulsions, including visible behaviors, mental rituals, avoidance, reassurance seeking, and a persistent need for certainty.

02 Assessment distinguishes OCD from overlapping conditions and genuine safety risks while examining symptoms, impairment, insight, accommodation, co-occurring concerns, and previous treatment.

03 Collaborative, graded exposure and response prevention is commonly central to care, supported when appropriate by medication review, family work, and specialist continuity.

One client

A private residence and a team organized around you.

Coordinated care

Clinical disciplines work within one individual plan.

Continuity

The next steps are considered throughout treatment.

02 / UNDERSTANDING YOUR NEEDS

Understanding your needs

Understanding OCD

OCD is diagnosed when obsessions and compulsions are time-consuming, distressing, or impairing and are not better explained by another condition or substance. Compulsions may be visible, such as washing or checking, or mental, such as reviewing, neutralizing, praying, counting, or seeking certainty.

How OCD May Present

Many people hide symptoms because the obsessional content feels unacceptable or because compulsions appear reasonable to others. Accommodation by family or staff can make the pattern less visible.

- Intrusive thoughts, images, urges, doubts, or sensations that feel difficult to dismiss
- Washing, checking, repeating, ordering, confessing, researching, or seeking reassurance
- Mental reviewing, neutralizing, counting, praying, comparing, or testing feelings
- Avoidance of people, objects, places, decisions, information, or responsibility
- A need for certainty, completeness, or the exact right feeling before acting
- Time-consuming routines that disrupt work, relationships, sleep, or care
- Family members or assistants drawn into reassurance, checking, or changing routines
- Depression, shame, substance use, self-harm thoughts, or severe restriction resulting from OCD

Having an intrusive thought does not mean a person intends to act on it. Risk assessment should distinguish obsessional fear from genuine intent while taking all safety concerns seriously.

03 / ASSESSMENT BEFORE A RECOMMENDATION

Assessment before a recommendation

OCD assessment identifies obsessions, compulsions, avoidance, reassurance, insight, time, impairment, and the feared consequence. It also screens for related and co-occurring conditions.

Form, frequency, triggers, meaning, distress, and time occupied by obsessions

Visible and mental compulsions, reassurance, checking, and avoidance

Insight, overvalued beliefs, psychosis, genuine intent, and safety

Goals, willingness, readiness, and the support available for continued ERP

Safety and the appropriate setting

Severe depression, suicidal intent, inability to eat or care for basic needs, psychosis, dangerous self-neglect, or another acute concern may require hospital or specialist care. Obsessional harm content still requires competent differentiation from actual intent. A residential team without OCD competence can unintentionally reinforce compulsions through reassurance and accommodation. Service claims should be limited to verified expertise.

04 / CARE BUILT AROUND YOU

Care built around you

Exposure and response prevention, a specialized form of cognitive behavioral therapy, is commonly central to OCD treatment. It involves approaching selected triggers while reducing compulsive responses so new learning can occur.

Build a shared model of obsessions, compulsions, avoidance, and accommodation Create a collaboratively graded ERP plan when indicated

Identify and reduce mental rituals and reassurance, not only visible behavior Use medication review through an authorized prescriber when appropriate

Treat depression, substance use, sleep, or another co-occurring condition Help family and support staff reduce accommodation without punishment

Preserve choice, pacing, and clear safety distinctions Arrange specialist continuity so gains are practiced beyond residence

ERP is not forced flooding, humiliation, or exposure to genuine danger. It should be designed and delivered by a clinician with appropriate competence, with goals and consent understood.

From assessment to a shared plan

The recommendation explains the proposed setting, priorities, team and pace, and how the plan will be reviewed with you.

05 / THE EXPERIENCE OF CARE

The experience of care

A calm private setting can create room for treatment, rest and reflection. The residence, schedule and practical support are organized around one client at a time.

A private place to pause

Personal space, discreet coordination and a daily rhythm shaped around clinical needs.

Care with room to recover

Individual appointments are balanced with rest, meals, movement and time to process.

Practical support

A personal care manager helps coordinate the schedule and everyday arrangements.

Care and residence imagery from THE BALANCE admissions guide. The residence is confirmed individually.

Mallorca

Private residential care in a restorative island setting.

Zurich

Private residential care with Swiss clinical coordination.

London

Selected assessment, transition and continuing-care support.

06 / FROM ASSESSMENT TO EVERYDAY LIFE

From assessment to everyday life

01

A confidential conversation

Admissions listens to your circumstances and explains the clinical review process.

02

Assessment and a recommendation

The team considers suitability, priorities, setting and the individual plan.

03

Personalized treatment

Care is reviewed and adjusted as your needs and capacity change.

04

Transition and continuing care

A handover connects treatment with the people, routines and support needed at home.

Preparing for home

ERP learning is strengthened through repeated practice in ordinary life. Continuing care should identify the specialist clinician, exposure plan, family responses, medication responsibility, and signs that rituals are expanding again. Progress may include less time in compulsions, greater tolerance of uncertainty, reduced avoidance and reassurance, restored functioning, and the ability to let an intrusive thought pass without treating it as a command or fact.

07 / CONSIDERING THE NEXT STEP

Considering the next step

Is OCD just perfectionism or being organized?

No. OCD involves obsessions and compulsions that cause distress, consume time, or impair life. Preference for order alone does not establish the disorder.

What is exposure and response prevention?

ERP is a structured treatment that approaches selected triggers while reducing compulsive responses. It should be collaborative, graded, and competently delivered.

Will ERP force me to face my worst fear immediately?

No. Responsible ERP is planned and paced, not forced flooding. It does not require genuine danger or violation of consent.

Do intrusive thoughts mean I want to act on them?

Not necessarily. Intrusive thoughts in OCD are often unwanted and inconsistent with values. A qualified assessment distinguishes obsessional fear from genuine intent.

Begin with a conversation

Speak privately with Admissions about your circumstances and the options available. An enquiry carries no obligation to proceed.

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Full condition page

If you or someone else is in immediate danger, seek local emergency care. Do not wait for routine admission or travel.

General information; individual care follows assessment.