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Perspective Piece

Physical Health in Psychosis: a Perspective on the Recovery Paradigm

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Abstract

This paper explores the intersection of physical health and recovery-oriented approaches in psychosis, offering a unique perspective through autoethnography. By combining personal experience with a broader analysis of existing mental health frameworks, the paper highlights the often overlooked importance of physical health in the recovery process for individuals with psychosis. The autoethnographic narrative reveals the complex challenges posed by antipsychotic medications, including weight gain and metabolic complications, and their impact on overall well-being. It emphasizes the dual stigma of mental health challenges and weight gain, highlighting the need for a more integrated, holistic approach to mental health care. Recommendations include enhanced education for healthcare providers, personalized care plans, and a multidisciplinary approach aimed at bridging the gap between physical and mental health in psychosis recovery.

Keywords: Psychosis; Recovery; Physical Health; Autoethnography; Holistic Mental Health Care

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Introduction

The recovery paradigm in mental health, rooted in resilience, positive identity, and self-esteem, emerged in the 1980s and became central to global mental health policies by the 2000s (Swords and Houston 2020). The recovery ethos emphasizes living '*a satisfying, hopeful, and contributing life*' despite the limitations imposed by mental health challenges (Anthony 1993). In Ireland, the significance of personal recovery was first highlighted by national mental health policies '*A Vision for Change*' (Department of Health, 2006) and later with '*Sharing the Vision: A Mental Health Policy for Everyone*' (Department of Health, 2020). While the transition from policy to practice faced challenges (Gaffey et al., 2016), it led to a more holistic, person-centered approach to mental health care. Internationally, frameworks like the World Health Organization's (WHO) Comprehensive Mental Health Action Plan 2013–2030 (World Health Organization 2021) and the Spanish Strategy on Mental Health (Ministry of Health 2021) reinforce recovery-oriented care that addresses physical, mental, and social well-being, advocating for integrated approaches to mental health and social care services. Despite the growing attention on recovery, the focus remains on psychological and social dimensions, often sidelining the equally significant physical aspect of well-being. '*A Framework for Improved Health and Well-being 2013-2025*' (Department of Health, 2013) emphasizes holistic recovery, encompassing physical, mental, and social health, asserting that recovery means '*everyone achieving his or her potential to enjoy complete physical, mental and social well-being*'. Furthermore, Recommendation 19 of Sharing the Vision's Implementation Plan 2022-2024 aims to reduce inequities in physical health outcomes for mental health service users, making physical health a priority (Department of Health, 2022a). In line with this, Norton and Swords (2020) highlight the importance of examining physical health as part of a broader understanding of social recovery, ensuring that economic, social, and cultural factors contributing to overall well-being are also addressed.

Despite these policies, physical health remains under-emphasized in recovery paradigms. Historically, mental health services have been siloed from general health services, leading to a lack of comprehensive care addressing both simultaneously. Given the urgency and complexity of severe mental health challenges, physical health considerations often become secondary. Yet, addressing physical health in individuals with severe mental health challenges, such as psychosis, is urgent, as these individuals face significantly reduced life expectancy – by 10–20 years compared to that of the general population – primarily due to physical health comorbidities (Firth et al., 2019). Individuals with psychosis face a higher risk of multimorbidities, including cardiovascular disease, cancer, respiratory issues, and type 2 diabetes (Launders et al., 2021) The relationship between antipsychotic medication and mortality is complex; while antipsychotics can reduce overall mortality when managed correctly (Correll et al., 2022), prolonged use is linked with increased weight and metabolic issues (Bak et al., 2014; Bushe et al., 2012). While the life expectancy of the general population is increasing, it is not for people experiencing enduring psychotic disorders and this mortality gap is widening (Hayes et al., 2017).

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The importance of physical health in mental health recovery is increasingly recognized within healthcare. Physical activity (PA) interventions can significantly contribute to clinical recovery in mental health care, as higher levels of PA are associated with reduced incidence of acute mental health admissions (Korge and Nunan 2018). PA can help people with mental health challenges reconnect with their physical selves, a process described as overcoming mental health challenges through bodily engagement (Hargreaves et al., 2017). PA can also facilitate recovery by providing therapeutic benefits through social interactions and the experience of normalcy and achievement (Hargreaves et al., 2017). The '*National Framework for Recovery in Mental Health*' in Ireland (Health Service Executive 2024, p. 11) states that '*A recovery-orientated service is built on a culture of hope and an expectation that people can recover from a mental health challenge and make a life of their own choosing*'. To fulfill this vision, it is essential that services actively integrate strategies that focus on physical health. Otherwise, we may deny individuals the full support they need to recover and thrive. Consequently, this paper aims to explore the experience of physical health in psychosis through a personal narrative and discuss how recovery principles can support physical health in individuals experiencing psychosis.

Methods

Autoethnography, introduced by Heider in the 1970s, is a narrative methodology that allows researchers to systematically analyze personal experiences, connecting the self to cultural and societal contexts (Chang 2008; Ellis et al., 2011; M. Norton and McLoughlin 2022). Researchers can deepen their understanding by incorporating personal experiences, values, and opinions. Despite its subjectivity, autoethnography offers insights often inaccessible through other methodologies (Moberg 2023). Active participation as both researcher and subject creates new meanings and knowledge (M. Norton et al., 2023).

In this study, we adopt an autoethnographic approach to investigate the intersection of psychosis and physical health, focusing on the lived experiences of MJN, one of the co-authors. The autoethnographic method was chosen because it allows MJN's story to be shared authentically and in his own words, providing unique insights into his personal journey and how it relates to broader contexts of mental health care. By including his narrative, we aim to offer perspectives that go beyond clinical data, furthering the understanding of the needs of people experiencing mental health challenges and supporting improved, more collaborative care.

Adams et al. (2015) describe six key elements essential to autoethnography, which we have adapted to fit our study. The foundation of our study is MJN's narrative about living with psychosis and managing its impact on physical health. MJN has chosen to share his personal experiences openly in this paper, including critical reflections on aspects of the care he received. These reflections are intended to highlight systemic issues prevalent at the time regarding the integration of physical health in mental health services. Any critiques are not directed at specific individuals or services but are meant to contribute to broader discussions on improving care. It is important to note that at the time of MJN's treatment, the integration of physical health in mental health care was not as emphasized as it is today. His experiences were reflective of the prevailing practices and knowledge during that period. We examined how his position and experiences influenced his understanding and management of his physical health. MJN describes cultural and organizational practices in mental health services that contribute to physical health neglect and suggests changes to improve outcomes.

The authorship team included psychiatrists and a person with lived experience of psychosis, fostering a collaborative environment that valued diverse perspectives. Throughout the research process, MJN was supported by the team, and open communication was maintained to address any emotional concerns. For MJN, articulating his journey provided a way to find meaning and strength in his experiences, contributing his insights as an Expert by Experience. This process aligns with recovery-oriented mental health practices, where the knowledge and insights gained from lived experience are recognized as a knowledge set that can provide valuable contributions to improving health services. Including MJN as both participant and co-author allows for joint analysis and discussions that have generated new insights and recommendations for integrating physical health strategies into recovery-oriented mental health care.

Autoethnographic account

I first was diagnosed with psychosis in December 2011. To me, as a student nurse at the time, this diagnosis was devastating. All I could imagine were the horror films and TV series that I used to binge-watch that had someone psychotic in them, and the way that they were treated and depicted in these stories. What transpired on screen were devilish scenes where those with psychosis were depicted as violent individuals destined to remain in locked psychiatric wards for a lifetime. This is what I suspected after my diagnosis. However, I did not expect to encounter physical health struggles as a result of my poor mental health.

When I was first admitted, the doctor prescribed me an antipsychotic – Aripiprazole. A medication, which, at the time, I was told was temporary but should eliminate the voices I was actively hearing. I was told of a slight risk of weight gain as a result. However, all I cared about at that time was getting these voices to go away and disappear back to the pit from where they came. In addition to this, due to the high demands of administrative tasks and paperwork on clinical staff, I found support through my peers in the smoking area. Another demonstration as to how physical health was a secondary concern within mental health services. Most individuals I met and received informal peer support from were other patients who were situated in the smoking area, where, to be honest, I was tempted to give smoking a go as it seemed to have helped others with their anxiety, something which, at the time, was rampant in my body. However, I resisted as I remembered seeing the end result of smoking in my nursing practice - for example, chronic obstructive pulmonary disease, emphysema, and even cancer.

As the weeks and months rolled by, I managed to be discharged from the hospital but still experienced the full effects of voice-hearing. I maxed out on Aripiprazole and was also prescribed Pimozide, another antipsychotic. I was on this medication for just over a year. However, I was never told in all of this time of the added risk to my physical health being on two antipsychotics at one time would bring.

When I was eventually admitted again in August 2014, I underwent a physical exam, as is customary in the first few days after admission. During this, an ECG was carried out, and a prolonged QT interval was noted. This indicated that my medications had started to impact the electrical system in my heart, causing an irregular rhythm. This cocktail of medications

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was immediately stopped, and a new medication was added. This time, chlorpromazine and then risperidone, both of which worked for a period and then stopped.

In 2015, I was eventually put on Olanzapine. It was only at this time that I was told of the potential physical effects my medication could have, including weight gain. Despite knowing the risks, I was still in severe mental distress, and after discussing it with my mental health team, I decided to proceed with the medication. Miraculously, this medication drowned the voices to the extent that I could barely hear them most of the time. Being part of the decision-making process made the side effects more acceptable to me, as I had chosen this path understanding the potential consequences. Although this allowed me the ability to regain a life again, the constant weight gain has been and still is an issue in my life. However, due to its effect on my mental health, the medication remained the same. I found that from a psychiatric perspective, once I wasn't in active distress, my parents, the treating team, and I did not care about the subsequent weight gain. However, I was monitored twice yearly with an ECG and regular blood tests to assess my fasting glucose – an indicator of diabetes, and my triglyceride levels – which along with cholesterol indicate the risk of heart disease or stroke. Exercise was always recommended but not enforced.

As I progressed in my recovery journey, the way I looked started to really matter to me. Yes, I was well mentally, but what about the ability to go for a walk without back pain? What about a date with a guy I liked? What about walking for two minutes without becoming out of breath? These things started to matter to me more and more because I was no longer focussing all of my energy on fighting voices. But from a service point of view, I was not mentally distressed, so the only option was to go to a physical health doctor about it.

When I approached a member of my treating mental health team about this weight gain their advice was to watch '*Operation Transformation*' and follow a leader. I did not find this helpful as they were pushing the problem, that they had a hand in creating by prescribing me an antipsychotic, to a generic TV show about weight loss. Additionally, when a member of the mental health team would visit me at home, they would try to get me to join clubs to reduce my weight. For a time, my life was consumed by '*Weight Watchers*' or '*Slimming World*' – all of which had no effect on me as they applied generic mechanisms to solve my weight loss. Something which I believed needed to be more specifically tailored to me due to my antipsychotic consumption. When these courses of action did not work, I was assigned a dietician who I felt took a hard stance when it came to weight loss. For a time, food was replaced by shakes, and I lost some weight. Unfortunately, this was not to last as I was not shown the tools I needed to maintain this weight loss over time and as such when the shakes were removed, I gradually gained weight again. Despite this, the treating team put physical health secondary to that of my mental health, which still has an impact on me and my ongoing recovery today.

In 2020, I was formally discharged from the mental health services, which meant that I had to go to my GP for care regarding my weight. Like most people, I prolonged that visit initially due to COVID-19 and then because of my thought that regardless of what I say, they will tell me that it's my weight that is the problem and nothing else. I have been seen by the doctor since, and to no surprise, the answer to all my problems was to lose the weight. However, this, for me, is not a simple task. I know it sounds weird, but I do not know how to lose the weight. I can make 100 million excuses, but at the end of the day, I really do not know how.

In terms of my experiences noted above, I think that the earlier we talk about the potential effects of medication toward our physical health, the less likely we are to be in a position like I am in at this moment. Healthcare professionals should have open and honest conversations about all potential benefits and side effects of medications right from the start. When I was considering switching to Olanzapine, being informed about the possibility of weight gain allowed me to make an informed choice. Although it was a difficult decision, knowing the risks and being actively involved made the side effects more acceptable because I understood the trade-offs involved. Healthcare providers should counsel individuals by presenting clear information and encouraging questions, ensuring that we feel heard and respected in the process. This collaborative approach helps us weigh the pros and cons based on our personal values and circumstances. In my case, despite the challenges, I rationalized continuing antipsychotic treatment because the reduction in auditory hallucinations significantly improved my quality of life. However, ongoing support in managing the side effects would have been beneficial. Access to specialized services like nutritional counseling or tailored exercise programs might have mitigated some of the physical health impacts. This is where I see the Early Intervention in Psychosis (EIP) programme playing a major role in whole health recovery from psychosis. If properly invested in and supported, it has the power to support many people in dealing with the physical health effects of mental health challenges and the pharmacological interventions necessary as a result. Additionally, although recommended, as seen in my experiences, physical health assessments should occur more frequently for individuals on psychotropic medications and not just for those on Clozapine.

In my experience, recovery is more than just mental health – it is about the whole person. In practice, there needs to be an equal focus on physical health as there is on mental health For those with a diagnosis of schizophrenia, the life expectancy is longer for those taking antipsychotic medication compared to those not taking medication, however, psychotropic medications come with a lot of physical health side effects and, in my opinion, there is the lack of expertise in physical health management within mental health services. I even noticed when I was in the psychiatric ward, most of the time, everyone either slept or was in the smoking area. This is not conducive to good physical or mental health. There should be an array of activities firstly in the hospital to support physical recovery as well as mental health recovery – these could include fitness instructors, as well as a more concerted effort by Occupational Therapy to embed physical wellness into the psychiatric environment. However, even at that, physical health should not be left to one discipline; it should have a multidisciplinary focus like that of supporting someone with mental illness. Within the community, more integration of specialist care planning for physical health outcomes should be embedded so that each service user has a tailored care plan specific to their own unique physical health needs. Items for the care plan could range from educational requirements to nutritional support from a dietician who specializes in polypharmacy dietary interventions and tailored exercise routines specific to each person's capacity and ability.

There are many barriers to addressing physical health in mental health services, not least the interplay of the perception of psychiatry within other medical disciplines and the lack of resources necessary to support whole health. Additionally, we also need to get rid of this mentality that the body and the mind are separate entities. They are not; they are joined together, and what

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impacts one also impacts the other. I know the devastating effects that the voices have had on my life; however, I am now in a reality where my physical health is not the best and is impacting my life now due to the lack of attention to the physical side of mental health care. What's worse is knowing that if adequate resources, staffing and due diligence were available when I began care for mental health challenges, then the likelihood of my physical health deteriorating would have ultimately decreased.

Discussion

Recovery in mental health is more than just a linear process of symptom management; it is a multifaceted and deeply personal experience that encompasses an individual's physical health, social identity, and interaction with societal structures. This complexity is illustrated in the personal experience provided, which reveals the interconnected challenges of mental and physical health management. It highlights a critical gap in mental health care – the false dichotomy between physical and mental well-being. The recovery model of today has evolved from its origins as a concept primarily focused on psychological resilience and empowerment. It now demands a broader lens encompassing the totality of an individual's experience, including the often-neglected physical health aspects. This integrated approach is starting to be supported by international policy and research initiatives. Internationally, the Lancet Psychiatry Commission outlines a global blueprint for improving physical health in people with mental health challenges, emphasizing the need for integrated, multidisciplinary approaches that address both mental and physical health disparities across diverse settings (Firth et al., 2019). In Australia, a consensus statement endorses the role of exercise practitioners, such as accredited exercise physiologists, in delivering holistic interventions that enhance both physical and mental health outcomes (Lederman et al., 2016). Australian policies, including the Fifth National Mental Health Plan, advocate for holistic and person-centered approaches that recognize the link between physical health, mental health, physical mobility, and social functioning (Australian Government Department of Health, 2017; Happell, Davies et al., 2012; Happell, Scott et al., 2012). Despite existing frameworks, the implementation of holistic physical healthcare remains suboptimal globally, including in countries like Ireland.

The narrative highlights issues in addressing the physical health of those with mental health challenges. MNJ's experience was that encounters with healthcare professionals seemed to convey an unspoken message that physical health issues of those with mental health challenges are less significant and likely inevitable. MNJ's account further highlights the difficulties of dealing with significant weight gain while taking antipsychotic medication. Notably, his treatment began with Aripiprazole – a medication known for its lower risk of weight gain and metabolic side effects (Leucht et al., 2013) – reflecting an early consideration of physical health implications in antipsychotic selection. However, despite this proactive start, he eventually experienced significant weight gain after switching to Olanzapine, highlighting the complexities in balancing efficacy and side effects in ongoing treatment. Apart from the challenge of managing the physical aspect of weight gain, dealing with the associated stigma and misconceptions was extremely difficult. There is a tendency to shift the blame and responsibility to the individual for their weight, leading to negative attitudes and behaviors from healthcare professionals, ultimately undermining the quality of care and health outcomes for patients with higher weights (Rubino et al., 2020). Dual stigma regarding both mental health conditions and higher weight can exacerbate the already challenging journey of recovery, impacting healthcare delivery and leading to internalized guilt, self-deprecation, and further mental health difficulties (Brown et al., 2022; Mueller-Stierlin et al., 2022). MJN also describes his personal experiences with a GP who attributed his health concerns to being overweight with the solution to lose weight, failing to take into account the complexity of obesity as a condition and also the challenges many people face trying to lose weight in a healthy sustainable manner. Moreover, his reluctance to seek medical care due to anticipated weight bias mirrors a common experience in people with higher weight (Alberga et al., 2019).

Overweight and obesity pose a challenge not just in mental health care but across the broader health care system. The Clinical Practice Guideline (CPG) for the management of obesity in adults in Ireland (Breen et al., 2022) recognizes obesity as a chronic and heterogeneous disease characterized by excess or dysfunctional adiposity which impairs health. However, the physical health solutions provided to MJN, such as generic weight loss programs like '*Weight Watchers*' or '*Slimming World*', were not adequately tailored to his specific needs as someone dealing with the side effects of psychiatric medications. The CPG for the management of obesity in Ireland suggests that generic approaches to weight loss are often insufficient, recommending individualized care plans to address the root causes of obesity. These plans may include behavioral support, medical nutrition therapy, PA and physical rehabilitation, and psychological, medical, pharmacological, and/or surgical interventions. Yet barriers such as a lack of training among healthcare providers and insufficient allocation of healthcare resources impede the delivery of integrated healthcare in Ireland (Breen et al., 2022).

Physical health challenges, such as those induced by antipsychotic medications, are not mere side effects but critical components of the individual's overall well-being. The recovery approach emphasizes empowering individuals with the knowledge and resources to manage their health. The personal experiences presented outline a gap in empowerment in this aspect– the lack of comprehensive information and support for managing the physical health repercussions of psychosis treatment. Marteene et al. (2019) discuss strategies to counter antipsychotic-associated weight gain, emphasizing the importance of service user education and involvement in their health management. These include providing people with information on medication side effects, dietary advice, and strategies for PA, which should be offered at the first point of contact with clinical care. Especially in the case of antipsychotic-induced weight gain, pharmacological interventions such as metformin have been shown to effectively attenuate weight gain as well as other metabolic parameters among those commencing antipsychotics (Yu et al., 2024). The recently developed guideline by Carolan et al. (2024) further supports the co-commencement of metformin alongside high-risk antipsychotics like olanzapine or clozapine, emphasizing its potential to mitigate significant weight gain and metabolic dysregulation when integrated into care early. These interventions should be considered as part of an individualized and patient-centered approach for people prescribed antipsychotics (Fitzgerald et al., 2024). Autoethnographic insights highlight the need for regular physical health screenings and interventions, as outlined in the EIP model of care. Within mental health care, point of contact testing (POCT) can facilitate physical health checks and assess cardiovascular risk in people who might find it difficult to access routine primary care services. However, the completion rate of POCT in

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this population is low with issues like device functioning and concerns about the potential negative effects on the therapeutic relationship identified as barriers by mental health professionals (Butler et al., 2021).

The personal experiences of MJN highlight lifestyle risk factors such as high smoking prevalence and low PA in hospitals that hinder recovery in the psychological and physical domains. Healthcare professionals' misconceptions about the self-medicating effect of smoking on mood and anxiety have been cited as a potential barrier to recommending smoking cessation and providing appropriate training in mental health settings (Department of Health, 2022b). Additionally, misconceptions about the neuropsychiatric safety of medications such as varenicline may contribute to declining prescribing rates of smoking cessation medicines in those with mental health challenges (Taylor et al., 2019). International clinical guidelines emphasize the importance of healthy lifestyle programs, smoking cessation support and regular physical health monitoring for individuals with psychosis (National Institute for Health and Care Excellence, 2014; World Health Organization 2018). In Ireland, the Health Service Executive (2019) has developed guidelines for PA and established referral pathways for various health assessments. However, the practical implementation of these guidelines faces challenges, including mental health practitioners' lack of confidence in their physical healthcare skills and the necessity for improved information technology support and clearer role responsibilities (Rodgers et al., 2018). Organizational barriers like resource constraints and insufficient managerial support add challenges (Deenik et al., 2019). Integrated care models, such as EIP, offer multidisciplinary, evidence-based interventions to service users and are essential for improving physical health outcomes in individuals with psychosis. Annual physical health screenings, which include smoking status; alcohol intake; substance misuse; BMI; blood pressure; glucose and cholesterol, as well as physical health interventions such as behavior change, and pharmacological interventions, are core evidence-based treatments in the EIP model of care (Perry et al., 2023). However, the National Clinical Audit for Psychosis (NCAP) for Ireland 2021/22 reported that only 24% of people with FEP received all 7 physical health screenings annually, and only 13% of people with FEP received all relevant physical health interventions (Royal College of Psychiatrists 2022). Current multidisciplinary teams (MDT) should receive better training and support in physical health assessments and interventions. Unfortunately, mental health services in Ireland lack appropriate funding, with the mental health budget declining from 13% of the overall health budget in 1984, to between 5 and 6% in recent years, despite a government target of 10% by 2024. Irish mental health services need urgent investment to build capacity and innovation to meet the increasing mental health needs of the nation and to ensure positive individual recovery outcomes.

Comprehensive care is especially vital in early intervention and FEP where the potential for positive outcomes is significant. Co-production, a core principle in Ireland's '*A National Framework for Recovery in Mental Health*' (Health Service Executive 2024), emphasizes shared decision-making and collaboration among all stakeholders, including service users, their families, and mental health professionals. This approach acknowledges the importance of combining professional expertise with experiential knowledge from those with lived experiences of mental health challenges. By breaking down traditional hierarchical structures in healthcare, co-production fosters a culture of mutual respect and equality, leading to services that are more responsive to the unique needs of service users. Research based on the lived experience of individuals with mental health challenges has shown that tailored interventions are more effective when they account for the individual's entire environment, including the support of mental health professionals, especially in the early stages of behavior change (Hargreaves et al., 2017). By involving service users in the co-design and implementation of these interventions, there is a greater likelihood of sustained engagement and positive outcomes, as the interventions are more closely aligned with their lived realities (Matthews et al., 2017). MJN found that being informed about potential antipsychotic side effects and benefits allowed him to make the most informed decision about his treatment. Being actively involved in the decision-making process made adverse side effects, such as weight gain, more acceptable. Similarly, a qualitative study found that while adverse side effects often affected decision-making regarding antipsychotic medication adherence, clinical encounters that enhanced patient knowledge and autonomy – through explicit discussions about benefits, risks, and alternative options – helped alleviate early negative experiences (Kaar et al., 2019). Decision-making aids like the Shared Decision-Making Assistant (Leucht et al., 2023) and the antipsychotic side effect tool by (Henshall et al., 2019) might enable people to incorporate their preferences and experiences regarding different medication side effects such as akathisia or weight gain and facilitate personalized discussions about antipsychotic medication. However, the practical implementation of these tools in clinical consultations remains challenging due to time constraints and complexity.

Conclusions

Reflecting on the narrative and broader discourse on mental health recovery, it is clear that mental health cannot exist in isolation from physical health. The recovery model of mental health should consider the inseparable nature of physical and mental health, prioritize user empowerment and involvement, and address both mental health and weight stigma. The recommendations emerging from the personal experiences of MJN emphasize the importance of integrated care models like the EIP service, healthcare provider training, more frequent physical health assessments, and resourcing and co-production of evidence-based interventions. By implementing these recommendations, we can improve physical health outcomes and the well-being of individuals with psychosis, promoting a holistic approach to their healthcare.

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Competing interests. The authors declare none.

Ethical standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. Written informed consent was obtained to publish the information regarding the individual's autoethnographic account in the article.

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