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The Health Hexagon Model: Postulating a holistic lifestyle approach to mental health for times and places of uncertainty☆

Christian S. Chan *, Hadar Hazan

The University of Hong Kong, Hong Kong

A B S T R A C T

Professional-driven mental health services are often predicated on westernized beliefs of mental health and distress. This presumptuous view results in treatment solutions that are not suitable to (many) non-western contexts because they are neither culturally valid nor practically sufficient. Instead of promoting imported ideas of mental health, we encourage communities, including Hong Kong, from and for where the authors primarily theorize the current thesis, to turn to and strengthen the resources they employed before the medicalization of distress and suffering. Basic foundational elements in one's everyday life, which we present here as the *Health Hexagon Model,* should be promoted, especially healthy sleep, healthy diet, regular physical activity, closeness with nature, supportive kinships and friendships, and a sense of purpose, meaning, or sacredness. These elements are not novel; the importance of these basic elements has been recognized, distilled, and transmitted generation after generation. We advocate for communities to identify the missing or hampered fundamental elements in their lives and focus on finding methods that would help them adopt a lifestyle conducive to individual and collective health. This call-to-action is particularly timely as the global community fights for its survival against the coronavirus and ponders ways to cope with the seismic changes in lifestyle it has brought.

The protracted Covid-19 pandemic has claimed millions of lives worldwide and has taken a toll on the well-being of many more (Koh et al., 2021; Zhao et al., 2020). Before the Covid-19 outbreak, Hong Kong was already facing a series of political and social crises. The 2019 social unrest coupled with the ongoing pandemic have considerable mental health consequences (Hou et al., 2021; Liu et al., 2020). Even with no lockdowns, the long period of social distancing and severe disruption of daily life resulted in a 28.3% and 42.3% increase in stress and depression symptoms, respectively (Zhao et al., 2020). These figures are expected to increase mental health service requirements in Hong Kong by approximately 12% (Ni et al., 2020).

Like most places on earth, there is an ongoing shortage of professional mental health support in Hong Kong. The city, with its 7.5 million residents, has fewer than 1300 psychiatrists and clinical psychologists combined.[1] The Hong Kong government, long aware of this shortage, published in 2017 a comprehensive review that resulted in a set of new policies designed to enhance mental health services (Mentalhealth review report, 2017); it aimed to promote mental health literacy among the general public and targeted vulnerable groups through large-scale, city-wide initiatives (e.g., Joyful@HK; "Student Mental Health Support Scheme"; "Dementia Community Support Scheme"). The existing case management program and the Common Mental Disorder (CMD) clinics were further strengthened (Mentalhealth review report, 2017).

Despite the good intentions, in this paper, we argue that the proposed solutions—including the more holistic ones that are supported by multidisciplinary teams (e.g., CMD clinics)—are still fundamentally based on a problematic medical model. According to the 2017 Review, these services were adopted because of an "international trend [that] encourages community support and ambulatory services." This *international trend* does not consider the ontological framework that Hong Kong and other non-western cultures use to make sense of the social world (Ji et al., 2010). It also does not consider the crucial role of culture in the understanding of treatment and illness (Ng et al., 2009). The fact that there is a paternalistic aim to *improve mental health literacy* reflects such incompatibility, which is evident in the low acceptability of mental health services among many communities, including the Chinese people (Ju et al., 2020). Despite the increase in mental health burden and the awareness of it, Chinese people still generally prefer non-professional help to deal with mental health issues. They tend to believe they can cope by themselves or rely on their existing social networks for support (Ni et al., 2020; Shi et al., 2020). When they do seek professional help, they favor medical doctors and Traditional Chinese Medicine practitioners (for a review, see Shi et al., 2020). These

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* Corresponding author. Department of Psychology, The University of Hong Kong, Pokfulam, Hong Kong.
E-mail address: shaunlyn@hku.hk (C.S. Chan).

[1] There is no official count of the number of practicing clinical psychologists. The reported number was based on the membership of professional bodies in Hong Kong.

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preferences reflect a discrepancy between the resources provided (e.g., services offered by mental health professionals) and what people want or need.

The offering of professional-driven mental health services is predicated on the westernized beliefs of mental health and, more fundamentally, distress and suffering. These beliefs stem from the medical model of illness, which assumes that *deviant* affect, thoughts, and behaviors are symptoms produced by underlying pathologies caused by physio-biological factors. The causes, courses, and cures of mental illness are derived from this medical model that treats mental illness as other medical illnesses (Jacobs et al., 2015; Watters, 2010).

This presumptuous view leads to treatment solutions that are not accessible, acceptable, applicable, or beneficial to those in (many) non-western cultures (Watters, 2010). For example, even after being culturally adapted, the efficacy of western psychotherapies, such as CBT, is lower among Chinese than in western populations (see Ng & Wong, 2018 for a review). Some argue that the reason for the relatively lower efficacy is due to the "lower level of mental health literacy … [which] might lead to a lowering of expectation that psychotherapy, including CBT, can be helpful … [which] might, in turn, affect the treatment effects" (p. 633, Ng & Wong, 2018). In other words, Chinese people are expected by scholars and professionals to get *educated* about mental health as defined by the west. It is expected from non-western countries to adopt practices that are supported by evidence according to the west. The *science*, upon which this view and treatments are based, is derived from contexts that are primarily *Western, Educated, Industrialized, Rich, and Democratic* (i.e., WEIRD; Henrich et al., 2010). Equally troubling, the reproducible crisis adds skepticism towards the very foundation of psychological science (Open Science Collaboration, 2015), which may further undermine the credibility of professional mental health services (Chan et al., 2022). Indeed, there is generally little trust in non-western communities towards the services provided (Ng et al., 2009). Put it simply, the pre-existing *treatment gap* between the demand and supply of mental health services, which the proponents of global mental health have enlisted themselves to fill, is embedded in and complicated by a more pervasive and fundamental *cultural gap*.

Instead of promoting imported western ideas of mental health, we—as researchers and clinicians trained in the west and now operate in a milieu that is exposed to both western and local, indigenous ethos (Ho, 1985)—echo ongoing calls (Airhihenbuwa, 1995; Kopinak, 2015; Watters, 2010) to encourage communities to turn to and strengthen the resources they employed before the medicalization of distress and suffering. We argue that basic foundational elements in one's everyday life that have known to be essential for health and well-being should be promoted and addressed systematically and concurrently; especially healthy sleep (e.g., Chapman et al., 2013; Chattu et al., 2018; Schmid et al., 2015), healthy diet (e.g., Blanchflower et al., 2013), regular physical activity (e.g., Josefsson et al., 2014; Matricciani et al., 2018; Saunders et al., 2016), closeness with nature (e.g., Bowler et al., 2010; Capaldi et al., 2014), supportive kinships and friendships (e.g., Holt-Lunstad et al., 2010; Uchino et al., 2018; Wittig et al., 2016), as well as a sense of purpose, meaning, and sacredness (e.g., Joshanloo & Jovanović, 2018; Sørensen et al., 2019). These elements are not novel, which is precisely the point; the importance of these basic elements has been recognized, distilled, and transmitted for generations to the extent they are now commonsensical. The fact that they are too obvious is the result of their universal usefulness.

Nonetheless, these elements are rarely addressed together (for an exception, see Walsh, 2011). Even with *lifestyle medicine* that is designed to improve mental health, there is generally a greater emphasis on diet, sleep, and exercise, while the other and less tangible elements the model underscore here have yet to be integrated (e.g., Forsyth et al., 2015; Naslund et al., 2018). Including aspects of closeness with nature, social relationships, and a sense of purpose, meaning, and sacredness (Walsh, 2011) is the result of going beyond the medical model and viewing humans not just as organisms that require physical maintenance but also as social and spiritual creatures who are part of the biosphere and require non-physical nourishment. In this paper, we present the *Health Hexagon Model* (Fig. 1), which integrates the aforementioned six elements. Through this model, we reiterate the importance of addressing people's needs—without pathologizing them—from a holistic standpoint that views humans as biological, social, and spiritual beings who are embedded in their natural, created, and socially constructed ecologies.

Fig. 1. The health hexagon model.

In what follows, we briefly describe some of the origins of the differences between western and non-western views of mental health[2] and underscore the literature that supports the practice of embedding these six elements into daily routines. These elements have long-and short-term influences on health and well-being (Rippe, 2013), which we briefly summarize below. The proposed model is a variant of *Lifestyle Medicine* or *Therapeutic Lifestyle Changes* (Walsh, 2011) that we maintain is suitable for urbanized, modern cities like Hong Kong, where many cultures and their idioms of distress (Kirmayer, 2007) co-exist. This model is also appropriate for the current epoch, with its complex social, political, and public health stressors. We conclude with a call for advocating lifestyle-based solutions for Hong Kong people and beyond, maintaining that it is perhaps the most practical way to tackle the mental health issues that were unveiled and exacerbated by the 2019 social unrest and Covid pandemic.

1. Western vs. non-western view of (mental) health

The Cartesian *dualism,* although long refuted, still has ramifications on western psychiatry (Ventriglio & Bhugra, 2014). The very existence of *mental* health is a case-in-point. The way illness is understood in the western (vs. non-western) cultures—its location (residing above vs. below the neck), causation (genetic-bio-medical vs. environmental), treatment (psychological vs. physical), and the relationship (and boundaries) between treatment-seeker and provider is a legacy of the Cartesian doctrine that draws a clear line between mind and body (Descartes & Cottingham, 1996/1996; Fernando, 2010). For non-western cultures, treating the mind in isolation from the body, family, society, religion, or spirituality is not perceived as valid, appropriate, or useful (Shi et al., 2020). The trends of the *mind-body integration*, holistic

[2] We continue to adopt this dichotomy solely to conform to the literature we reference.

treatment models and theories such as psychosocial/community-based interventions (e.g., Asher et al., 2017; Snider & Hijazi, 2020), or even progressive social epidemiological theories (e.g., the ecosocial theory; Krieger, 2001, 2021), only make sense to western cultures that have suffered and are recovering from theoretical and dichotomous conceptual splits.

For non-western cultures which never subscribed to these separations, integration is a non-issue. This mind-body differentiation has not been universally adopted. In many intellectual and medical traditions across the globe, a boundary between the mind and the body, between mental and physical health, had never existed (Fernando, 2014).

Historically, mentally ill people (as defined by the west) in low- and middle-income societies were relatively better treated and cared for before the spread of (western) psychiatry (Koenig, 2009; Mohit, 2001; Oskasha, 2012). In many cases, they were not institutionalized or marginalized; they were not perceived as *mad* but rather as people who were suffering from a problem in the *balance of the body-mind-spirit* (Fernando, 2014).

Even in modern times, countries that the west patronizingly refers to as *under-developed*, *third world,* or *global-south* have coped reasonably well (albeit imperfect) with what we now call mental disorders, relative to their former colonizers and occupiers from the west (Steel et al., 2014). For example, in the classic studies conducted by the World Health Organization (1973, 1979), people diagnosed with schizophrenia had better clinical (e.g., reduction in symptom severity; the amount of time spent in a psychotic episode) and social outcomes (e.g., better occupational adjustment, a greater degree of interpersonal relationships) in non-western than in western countries at a 13-year follow-up. Despite the relatively low investment in mental health care, still today, "the evidence points to a much better outcome for schizophrenia in the Third World" (p.158; Warner, 2013). In countries like Senegal, Uganda, Nigeria, and Ghana, schizophrenia and psychotic illnesses, which are considered in western psychiatry as severe forms of mental illness, seem to have a shorter duration and a spontaneous recovery compared to the west (Warner, 2013). Given the severity of these disorders, some western psychiatrists argued that the quick recovery indicates patients never really suffered from schizophrenia or that they were suffering from an organic psychosis. However, such claims have also been refuted (e.g., Haro et al., 2011).

Similar conclusions have been drawn for other less severe mental disorders (Steel et al., 2014). For example, a systematic review (Nortje et al., 2016) showed that traditional forms of healing practiced in non-western cultures are effective in relieving distress and improving mild symptoms in CMDs (e.g., depression, anxiety, somatization). In these countries where the primary studies were conducted, traditional healers provide a form of psychosocial interventions that resonate with the values and beliefs of their clientele. Consistency between the system of beliefs and the system of treatment can lead to higher perceived efficacy of the traditional treatment; this effect does not seem to be weakened by the presence of conflicting scientific evidence (van der Watt et al., 2018).

However, through globalization, western attitudes to mental health and illness have spread worldwide (Watters, 2010), especially the view of the mind as an object that can and should be readily isolated and subjected to empirical inquiries. This view assumes that the human experience can be quantified and reduced to a list of perceived and inferred signs (e.g., flat affect; anhedonia) and symptoms (e.g., delusion) (Jaspers & Hamilton, 1963/1963). Such a form of scientific approach, which lies at the core of the main nomenclatures of mental disorders, does not resonate with non-western cultural systems that have a different collective perception of reality (Castillo, 1997) and explanatory models (Kirmayer, 2007).

In Traditional Chinese Medicine, psychiatric symptoms are understood as an integral part of medicine. The source of mental (and physical) illness is attributed to an imbalance between bodily forces. As such, a harmonious, healthy life requires a proper balance among these forces (Tseng, 1973). Emotions (or emotional forces) are also understood as such; they are neither "positive" nor "negative"; a healthy emotional life is one of equilibrium among the different emotions. In fact, treatment of excessive emotions can entail eliciting a counter-emotion to balance it out (Zhang, 2012).

Similarly, some cultures in the African continent see a need to unify the spiritual and material worlds as a way of understanding mental problems (Castillo, 1997). For example, in Ethiopia, behavioral disturbances are seen as a result of bad, good, or ugly spirits (Fekadu, 2012). In West Africa, supernatural forces are believed to cause suffering and illness, while the absence of well-being is believed to be the result of an evil eye—a curse caused by the malevolent glare of someone (Ayonrinde & Okulate, 2012). In the Middle East during early Islam, the human mind was regarded as a complex, multifaceted entity that was the product of continuous interaction of many inter-related spheres such as body, soul, society, the past, and even the collective memories in mythology (Mohit, 2001). In Egypt, mental disorders were considered part of physical ailments as early as 5000 years ago (Oskasha, 2007). In these cultures, mental problems—their cause and consequences—are understood as part of a larger system. To ease the burden of (mental) disease worldwide, we need to consider the cultural context in which it occurs (Gopalkrishnan, 2018). We need to re-incorporate into its care the same elements of protective and remedial factors that have helped cultures overcome calamities and civilization thrive for centuries—long before the rise and spread of modern psychiatry. Our proposed Health Hexagon Model is one such example.

2. Health Hexagon Model: Six components of health

The *Health Hexagon Model* centers on six elements. The first three elements, namely, diet, sleep, and exercise, have long been considered the main pillars of a healthy lifestyle (e.g., Hosker et al., 2019; Zhao et al., 2021). An overwhelming body of evidence suggests that sleep (duration, quality, synchronization with the environment), nutrition, and physical activity are vital components of individual health (Matricciani et al., 2018). Insufficient sleep is associated with a range of medical (e.g., high blood pressure, obesity, diabetes, neurological disorders; Cappuccio et al., 2011; Chapman et al., 2013; Chattu et al., 2018) and mental problems (e.g., depression, anxiety, poor motivation, irritability; Saunders et al., 2016; Schmid et al., 2015). Strong evidence suggests a causal link between insomnia and the onset and maintenance of an array of mental disorders (e.g., Hertenstein et al., 2019), including psychotic experiences (Freeman et al., 2017), depression (Williams et al., 2020), and post-traumatic stress (Richards et al., 2020).

A balanced diet, as well as regular exercise, have also been found to be indispensable to health and well-being; poor diet and physical inactivity are responsible for a large portion of mortality in the US, for example (~15%; Mokdad et al., 2004, 2005). These elements are also associated with various outcome measures such as depression, anxiety, sleep quality, and quality of life (Blanchflower et al., 2013; Josefsson et al., 2014; Lahart et al., 2019). A rapidly growing body of literature suggests that food may affect people's physical and mental health via the gut microbiome (Firth et al., 2020). The gut microbiome interacts with the brain in a bidirectional pathway affecting mood, anxiety, cognition, and pain (Cryan & Dinan, 2012; Osadchiy et al., 2011). In the Health Hexagon Model, diet is beyond what we ingest. Borrowing traditional pearls of wisdom backed by emerging empirical evidence, a healthy diet entails regularity of meals (e.g., when and how often), sensitivity to seasonal changes and gut culture (e.g., when to eat or not eat what), and social aspects of food consumption (e.g., whom do we eat with and where; Pereira & Van der Bilt, 2016).

The importance of sleep, exercise, and diet is common sense confirmed—but not discovered—by modern scientific inquiries. Practitioners are trained to inquire about abnormalities in sleep and eating patterns; these lifestyle components are assessed as potentially symptoms (or disorders in themselves, e.g., sleep or eating disorders). While a

consensus exists regarding their value to health and mental health (e.g., Alvaro et al., 2013; Firth et al., 2019; O'Neil et al., 2014), healthy sleep, exercise, and diet are seldom considered as a possible first-line solution for people's (mental) health problems. Recent calls to incorporate these lifestyle factors into formal diagnostic assessment and treatment planning is promising (e.g., Firth et al., 2019; Malhi et al., 2015; Noordsy, 2019).

Close social relationships, sometimes conceptualized as *perceived social* support (Lakey & Orehek, 2011), *social connections* (Pietromonaco & Collins, 2017), or *social capital* (Norstrand & Xu, 2012), are known across disciplines as having various mental and physical health benefits such as reducing stress (Wittig et al., 2016), depression (Ross, 2000), mortality rates (Holt-Lunstad et al., 2010), disease etiology (Uchino et al., 2018), and increasing overall well-being (Gabriel et al., 2020; Ross, 2000). According to a meta-analytic review, poor social relationships are a risk factor that is comparable with other biomedical risk factors such as obesity, physical inactivity, and smoking (Holt-Lunstad et al., 2010). Beyond the benefits associated with being on the receiving end of social relationships, a considerable amount of evidence points to the positive sequelae of being the *giver*, caretaker, and shouldering responsibility and honoring commitments in relationships and communities (e.g., Brown et al., 2003). Social isolation brought upon by the Covid-19 pandemic further underscores the importance and relevance of social relationships to mental health (Brooks et al., 2020).

In western psychiatry, poor (or "disorganized") social relationships are viewed within the context of a disorder (e.g., schizotypal, schizoid, borderline personality disorders) or a risk factor (e.g., low social support, low social capital). The absence of close social ties is conceptualized as the result of an underlying pathology rather than a possible cause for it. In some models of treatment, social ties and connection to the community are part of the treatment plan. However, these interventions are usually offered to long-term patients who have come to rely heavily on the health system, rather than to new patients that might need community support. In some contexts, community interventions are not used as a preventive measure for those with mild symptoms or early interventions but rather viewed as a last resort solution for those who are perceived as *patients for life* or chronically ill. For example, in Hong Kong, many community interventions are only offered after serial episodes of hospitalizations (Mentalhealth review report, 2017). This is despite the toll living in a highly urbanized, dense, fast-paced environment like Hong Kong can take on the quality and quantity of social relationships, which in turn, can contribute to mental health issues of its residents (Wang et al., 2018). This is especially true in the time of a pandemic where physical interaction can become a threat to one's health, or when people are forced into isolation in the name of public safety. If mental health is to be viewed as more than just the absence of diseases or disorders, it must include the ability of and opportunities for people to maintain meaningful and constructive relationships with others (Scheid & Brown, 2010).

Time spent in nature, or exposure to nature, was a non-issue until modernity. Modern life has created a disconnection—both physical and psychological—between humans and the natural world. This disconnection, or even deprivation (Soga & Gaston, 2016), has been receiving increasing theoretical and empirical attention in recent years, despite not being acknowledged by psychiatry as either a problem or its reversal as a remedy. Studies indicate that various forms of exposure to nature, such as viewing nature from a window, gardening, exercising in a green environment, or even exposure to virtual nature (Browning et al., 2019), are associated with improved health (e.g., cardiovascular, endocrine, immune function; Bowler et al., 2010), cognition (e.g., attention), and well-being (e.g., happiness, stress reduction, positive emotions; Capaldi et al., 2014). Some studies have even shown a causal relationship between time spent in nature and reduction in depression and anxiety. Korpela et al. (2016) used nature walks to treat depression and found a decrease in depression and an increase in positive mental well-being during the three-month study. During city-wide lockdowns, having a view of nature from one's home was a protective factor against psychological distress (Soga et al., 2021). However, incorporating nature as part of a preventive initiative or treatment has yet to be adopted by mainstream psychiatry.

Meaning, purpose, and scaredness are collectively considered as the sixth component in our model. This component is an old basic human need that has been explored and discussed since antiquity. The impact of meaning and purpose on mental health has received ample treatment by psychologists, including in the form of humanistic and existential psychotherapies (Frankl, 1984/1984; Rogers, 1967), as well as in more contemporary models such as Acceptance and Commitment Therapy (Hayes et al., 2009). The positive impact of religion—including through meaning-making—has strong empirical support (see Koenig & Larson, 1998). A sense of sacredness as a fundamental need is also gaining traction in mainstream scientific arenas (Gabriel et al., 2020).

The meaning-health connection, in particular, has been consistently demonstrated in empirical research. A systematic review and meta-analysis study revealed small-to-moderate effect sizes between meaning and health indicators (Czekierda et al., 2017; Guerrero-Torrelles et al., 2017; Wang & Lin, 2016). Meaning was also found to correlate with positive mental health outcomes, quality of life (Sørensen et al., 2019), hedonic and eudemonic well-being (Joshanloo & Jovanović, 2018), even after accounting for personality traits (Halama & Dedová, 2007). The importance of meaning and transcendence is particularly apparent in the wake of disasters and calamities (Park, 2016), both personal (Altmaier, 2013) and communal (Haynes et al., 2017). The nature of modern life, in which materialism and consumerism have become the new religion (Eckersley, 2006; Kurenlahti & Salonen, 2018), provides people with many distractions from their non-materialistic yet fundamental needs. Viewing mental health issues as the manifestation of a need for meaning beckons serious consideration of non-professional mental health services as treatment (or at least a part of it).

3. Intersectionality and integration

There is an abundance of evidence that demonstrates the independent benefits of each of the six components of the Health Hexagon Model. While it is readily conceivable that these elements can be highly interconnected (Nudelman et al., 2019), thus far, they have been mostly studied in isolation. Even studies that take a more holistic approach and acknowledge the inseparability of the physical and psychological aspects of mental health still neglect the other components (Kelly et al., 2020). To the best of our knowledge, despite well-articulated arguments to do so (Walsh, 2011), few studies have evaluated or implemented these elements together, especially in the form of daily habits, as opposed to a *packaged* or manualized treatment, which seems to offer little long-lasting gains (Kemp et al., 2009). The fact that these elements are often treated and studied as *separate active ingredients* may render the same myopia that got us to ignore them in the first place. These elements should be promoted or addressed in connection with each other (Walsh, 2011). For example, people might take care of their physical well-being (e.g., eating a balanced diet, exercising, sleeping well) but not spend time outdoors, maintain relationships, or pursue meaningful and valued actions. We take this further to suggest that these six elements need to intersect and not be viewed in isolation. For example, some places in nature we visit should be treated as sacred and are therapeutic (Frumkin, 2003); some meals we partake collectively are primarily to cultivate relationships (Delormier et al., 2009); some physical exercises are better done outdoor than inside an air-conditioned gym (Plante et al., 2006); connection with others makes people feel less alone and facilitate a sense of meaning (Lund et al., 2019). Contrary to the current paradigms of lifestyle medicine that focus almost exclusively (for an exception, see Anderson & Fowers, 2020) on the physical aspects of health (e.g., physical activity, diet, alcohol intake, drug use, and smoking; Dale et al., 2014), our model suggests addressing concurrently the body, mind, and the transcendental. Going beyond the medical model in part means that health should not be understood as physical *or* mental, personal *or* collective, depositional *or* environmental.

4. Conclusion: Strengthen the weak links

Lifestyle medicine maintains that people are not just mentally unwell because they have a mental illness; some might be unwell because they have been neglecting one or more of these basic lifestyle aspects in their lives. It is very easy to do so in both impoverished and wealthy communities alike, albeit for different reasons. Low-income people may find it challenging to take care of their diet, sleep, and exercise as they struggle to make ends meet. Financially affluent individuals, with more leisure time and money, may prioritize materialistic, consumption, and competition-based activities, at the expense of meaning, non-instrumental relationships, and exposure to nature (For socioeconomic status and health behaviors, see Nudelman et al., 2019). A person who has good sleep and diet, exercises, visits the outdoors regularly, has meaningful relationships, and pursues meaning in life is most likely able to cope with difficulties in life, including the diagnosis their psychiatrists may give them.

To be sure, we are not arguing against the entire enterprise of modern psychiatry and psychology (Kirmayer, 2007; Watters, 2010). We are questioning their remedies as the first line of defense, especially in the non-WEIRD world or places where the supply of professional mental health practitioners is scarce or even non-existent. Perhaps in some cases, if not most, they should be regarded as the last resort. In contexts that have not suffered from the legacy of the Cartesian mind-body split or the reach of a commercial interest-driven global mental health, there may still be functional solutions, albeit imperfect, to the various stressors in life that have withstood the test of time. These solutions are almost by-definition culturally appropriate and are widely accepted; there is no need to first *destigmatize* them before their application and dissemination. In other words, rather than using a medicalized language of—and a medicalized approach to—mental health, which alienates people and does not resonate with some cultures, we can use the language of unhealthy, unbalanced lifestyles as an explanation for people's prolonged suffering. Instead of re-educating entire societies by introducing new, ever-changing terms, terminologies, and definitions, we can use their cultural jargon to offer solutions.

More practically, a patient's problem should be viewed from a holistic perspective and in relation to the elements the proposed model ascribes. Is the person regularly eating a healthy diet that is appropriate to where they live and the season? Is the person adjusting her sleep cycle in accordance with the season and climate? Is the person spending time with family and those whose lives are intertwined with his or her? Is the person spending time outdoors and in nature? What does his or her daily life look like? The routine/habitual aspect plays an important role; we think these six facets require regular, if not daily, maintenance for them to count, as opposed to being offered as a manualized, time-limited treatment. Collectively, they weave a safety net for everyone's inevitable fall. Such cultivation takes time and perseverance; it by no means is a quick fix.

We believe that reducing the burden of disease should not only require decreasing the ratio of mental health professionals to patients or increasing their accessibility to psychiatric remedies. Instead, we should first advocate for people and communities to identify the missing or hampered fundamental elements in their lives and focus on finding methods that would help them adopt a lifestyle—including daily habits—conducive to cultivating health. This call-to-action may be particularly timely and relevant as the global community fights for its survival against a virus and ponders ways to cope with the seismic changes in lifestyle it has brought.

Declartion of competing interest

The authors report no conflict of interest.

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