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The Conceptualization of Social Distress Coping Disorders (SDCDs): Uncovering the Contemporary Salient Mental Health Threats

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Abstract

Since the history humanity, living conditions have been struggling with harsh environmental and social conditions. Stressors included extreme cold, extreme heat, heavy rain, droughts, famines and vector borne infectious diseases, wars and predators. In contemporary world some of these stressors significantly reduced their impact on the quality of life while new ones emerged including social, economic and political stressors. The complex relationship between continued exposure to these stressors, normal human biochemical and mental processes and the counteraction of the innate human defense mechanisms lead either to the suppression of the effect of these stressors or the failure to do so that cumulatively develop into physiological or mental impairments. This paper aims at the conceptualization of mental illnesses and associated somatic illnesses that result from the failure of the body's coping mechanisms to chronic stressors embedded in contemporary political systems. These diseases have been collectively called Social Distress Coping Disorders (SDCDs) and include Alcoholism (SDCD-A), Prostitution (SDCD-P), Drug abuse (SDCD-D), Alcoholism and Drugs abuse (SDCD-AD), Anxiety disorders (SDCD-X), Hypertension (SDCD-H), Mood disorders (SDCD-M), Sleep disorders (SDCD- S), Social media addiction (SDCD-SM), Gambling disorder (SDCD-G), and Psychosomatic disorders (SDCD-PS). The current approaches to these conditions undermine the politically driven chronic socio-economic stressful conditions that are triggers of the network of symptoms that maintain these mental and somatic illnesses and the fact that most of them co-occur with others as a complex multiple mental disorder (MMD). Looking at their global ever increasing prevalence, the shortcomings of the current biopsychosocial model are addressed by interventional approach as proposed by the biopsychopolitical mode

Keywords:
Biopsychopolitical model, Stress coping, Social distress, Social distress coping disorder, Mental illness.

Introduction

Today state of the art diagnostic tools and advances in biomedical sciences made it possible to accurately diagnose and classify diseases and to make choices regarding appropriate interventions. This is the case also in psychiatry where for the universality purpose; mental disorders are recorded and classified in instruments such as the International Diseases Classification International Classification of Diseases (ICD) systems or the American Diagnostic and Statistical Manual of Mental Disorders (DSM). Today the ICD is available in its eleventh edition (ICD-11) while the American DSM is in its fifth edition (DSM-5). While these instruments are subjected to regular updates, Clark et al. (2017) criticize these classification systems for being based on observable behaviors or signs and self-reported feelings and thoughts or symptoms instead of underlying causal mechanisms. Contreras et al. (2019) went further suggesting that the endeavors towards advancing the science of psychopathology and treatment of mental disorders can be hindered by the use of such insufficient diagnostic tools. The non-communicable diseases simple causal narratives based on epidemiologically studied and identified risks according to Kelly and Russo (2018) led to blaming patients for unhealthy behaviors and choices such as excessive alcohol consumption, tobacco smoking, and not sufficiently do physical exercises. I argue that even though public health communication endeavors are taken by the ministry of health or other health organizations, in most cases especially in poor countries where oppression is a common practice, political systems leave citizens with almost no choice rather than undertaking detrimental health behaviors in terms of food and beverages and other negative practices hence blaming them for their health condition doesn't make sense. Given the diversity of mental disorders, Clark et al. (2017) argue that sound categorization is a necessity for better understanding, communicating, and clinical decision making. However while there has been advances in understanding their etiology we are still far from obtaining a universal unified theory or model that capture all causal aspects. I argue that while waiting for the day of that model to arrive, reductionism has an important place in terms of understanding the causes and hence guide preventive and curative approaches in psychiatry. This paper aims at empirically conceptualize Social Distress Coping Disorders (SDCDs) as distinct class of mental and related somatic diseases that require special attention in terms of curative and preventive interventions as well as sound epidemiological investigations.

Objectives

This paper has three objectives: from the available models and theories of stress and stressors and models explaining how stress causes mental and somatic diseases; this paper present a new perspective of stress resulting from socio-economico-political stressors embedded in contemporary political systems; by retaining the invaluable principle of causality that a deeper understanding of the causes, single or complex, and the mechanisms are cornerstones in disease prevention and treatment, this paper present a new category of mental and related somatic diseases that require a special approach towards their prevention and treatment; and finally the paper also present a new model of how these diseases can be prevented and or treated.

Methods

Inspired by the ever increasing prevalence of non-communicable diseases despite efforts made in their prevention, the methodological approach used in this paper is the synthetic review of the available literature on stressors, stress and distress caused mental and somatic diseases and uncover the gap in their etiologic mechanism, link their improper categorization to the failure in formulating appropriate interventional endeavors, and suggest solutions to these issues in order to guide future researches.

1.Theoretical background

1.1. Models of stress and the link between stress and diseases

The biomedicine based medical model has long been considered orthodoxy in psychiatry, however

it was criticized for undervaluing the contribution of behavioral and social factors in the pathology of mental disorders (Hatala, 2017). Its shortcomings led Engel in 1977 to formulate his biopsychosocial model to incorporate social factors in the causal factors and in formulating interventions (Engel, 1977/2012). But at which extent does the Biopsychosocial model consider social processes? Or otherwise how social are social factors in the Engel's model? The drawback in the biopsy chosocial model is that it considers social processes as natural phenomena i.e. something inherent in a world of free man. However, in modern world, most of these social processes are results of policies, politics and political systems imposed by political elites against the will of the citizenry mainly through hegemony. Poverty, poor housing conditions, poor sanitary infrastructures, unemployment, and food insecurity among other social processes mainly in poor and developing countries result from inefficient governments and policies, corruption, and discrimination among others. Stress has been extensively studied and linked to somatic and mental changes such as mood changes, increased heart beat and increased blood pressure in different models formulated. Scott and Howard (1970) compiled eight models available at the time to explain the phenomena of stress. These include the 1962 Mechanic's model that defines stress as "the discomforting responses of persons in particular situations" and according to Mechanic, four factors will determine whether an event produces discomforting responses: the ability and capacity of a person, skills and limitations produced by group practices and traditions; the means provided to individuals by the social environment; and the norms that define where and how an individual may utilize these means. The concept of defense was advanced to mean the behavior and thoughts that are aimed at managing feelings and if the behavior is relevant to the situation is termed a coping behavior.

The Basowitz and colleagues' men in combat based stress model; was formulated based on concepts such as anxiety, stress, and stress situation. Here anxiety is defined as a conscious and reportable experience of intense dread and foreboding and rise when the integrity of an organism is threatened. Any stimuli may produce anxiety however some may be more likely than others in producing it and stress is related to those stimuli that produce anxiety. This effect is based on the differential meaning of the stimuli to the organism and the anxiety producing potential they have. Regardless of the fact that different responses may be presented by the exposed organisms, stimuli considered to be stressful are called stress situations. The Alexander (1950), Dunbar (1947), and Grinker and Spiegel (1945) psychosomatic model of stress asserts that tensions and strains that occur in one system of the body will have pathological consequences for other body systems. Anxiety and fear generated by stressing situations in one's life may not only be expressed through subjective feelings of intense dread and discomfort, but also through alterations in basic physiological processes. It is argued that also tensions will be internally dissipated from one body system to the others and produce some organic changes. A modified version of the psychosomatic model was developed by Wolff and colleagues in the 1950s and introduced the protective reaction pattern aspect of the threatened body. Accordingly, when insults to its physical integrity are experienced, a complex reaction occurs aimed at sealing off and then ridding the body of its threat. In this model, the altered feeling, bodily adjustment and behavior are simultaneous instead of a linear sequence of events.The 1956 Hans Selye's biochemical model of stress was based on the analysis of stress induced physiological and biochemical disturbances in human functioning. According to Selye, the stress is "a state manifested by a specific syndrome which consists of all of the nonspecifically induced changes within a biologic system". These nonspecifically induced changes are explained by the so called General Adaptation Syndrome (GAS), a three stages process induced by a stressor. These are alarm reaction during which a general mobilization occurs; followed by a stage of resistance characterized by a set of internal responses that stimulate tissue defense; and if the stressor is not neutralized despite the efforts made, the exhaustion stage is eventually reached. A number of pseudo-models based on the bodily

system affected were developed including the effects of stress on cardiac functioning; on mucous membrane secretion; on gastric functioning; and there are a number of studies of the relationship between stress and the genesis and onset of specific disease syndromes such as cardiovascular disorders, ulcerative colitis, dermatitis, and glaucoma. These studies are considered to be inspired by the assumptions of how stressful stimuli operate in o rganisms and how the effects of stress are manifested. Here stress is considered as an internal response to an external load by some pathogenic agent, stressor, or life crisis and this stress produces distinct pathological changes and certain typical disorders of adaptation. These pseudo -models are argued to be based on the mechanical model of stress.

In 1961, Dohrenwend modified the Selyes' physiological stress model in order to apply it to the study of the distribution and prevalence of mental illnesses in the social environment. He defined five sets of factors involved in stress reactions: the external stressors that throw the organism into an imbalanced state; factors that mediate or alleviate the effects of the stressor; the experience of stress itself, which is the product of the interaction between the stressor and the mediating factors; the adaptive syndrome, which consists of the organism's attempt to cope with the stressor; and finally the organism's response, which may be either adaptive or maladaptive. In this model, stress is defined as "a state intervening between antecedent constraints and consequent efforts to reduce constraint". Janis in 1954 developed a mode of stress based on individual psychological response to a traumatic event. His arguments were formulated based on war and warlike situations and basic elements are disaster situation, the psychological responses of individuals to disaster, and intrapsychic and situational determinants of these psychological responses. He identified three phases of danger found in what he called large-scale disasters including threat phase, the danger impact phase, and the danger-of -victimization phase. Types of reactions associated with these phases are apprehensive avoidance, stunned immobility, apathy and depression, docile dependency, and aggressive irritability. He argues that they all result in a marked drop in mental efficiency. Any of these reactions will occur depending on characteristics of the perceived danger of stimuli and situational and predispositional determinants. Regarding the weaknesses of the above main models, Scott and Howard (1970) argue that while individually they contributed to the knowledge databank, each has its own limitations and the common factor is their reductionistic attributes where each is only valid in its sphere. They identified six important points toward a unified or integrated model of stress. First are the different approaches to the definition of the stress concept itself; the second is the fact that they are field-specific; the third limitation is their consideration of events of extreme and highly traumatic nature; fourth is their incomplete nature since they do not incorporate all variables that produce stress; fifth is the incorporation of unjustified assumptions, the case of Basowitz model that assume a stressful event to one person to be stressful necessarily to another; finally some of these models do not comprehensively and entirely explain the phenomena they are intended to explain, this is the case of the Wolff's Protective Reaction Pattern model that yielded a variety of physiological responses to stress when applied to research. They also argue on six characteristics for a model to be satisfactory hence qualified of being acceptable, the one that incorporate or integrate the existing knowledge about stress into a single, unified framework. They include the clear definition of stress that distinguishes it from related phenomena; the model must be applied in different contexts without distorting the nature of any individual context; the integrated model must be able to accountfor both traumatic and nontraumatic events; the satisfactory model have to be able to explain findings of all major relevant research; it must be able to suggest new directions for research and especially research of a nonobvious nature; and finally it must be complete sothat it can determine whether or not a given stimulus leads to the experience of stress. With intent to solve the above dilemmas, Scott and Howard (1970) based on what they called analysis of human functioning

in problem-solving terms proposed the problem -solving model of stress. According to them, the problem here is the stress stimulus and four types of problems are: problems posed to the organism from its internal physical environment; problems posed to the organism from its external physical environment; problems posed to the organism from its own psychological environment; and problems posed to the organism from its sociocultural milieu. When the threat is presented from any one or more environmental fields to an organism, it will master such threat and the mastery will depend on the available resources and these may be general like intelligence and intact neuromusculature and specific like specialized skills, pertinent knowledge, and relevant tools or materials. They argue that the way the organism responds to a problem may be an assertive response, a divergent response, and an inert response. Accordingly, when mastery to a problem occurs, there is an increase in state of that organism sothat when the problem reappears the organism will deal with it more efficiently than before and when the problem is completely resolved, the tension will eventually be dissipated and the failure to do so leads to a second-order problem which is dealing with unresolved tensions and this put an organism in a state of continuous mobilization or tension and it can be said to be experiencing a stress. Even though the problem-solving theory of stress as an integrated theory is a very good piece of work, it seems that the reductionist approaches will not be eradicated especially in guiding contextual understandings and targeted interventions. Shahsavarani et al. (2015) through their systematic literature review compiled and gave categories and classes of stress. Classes depending on the nature of stressor that include physiological stress and psychological stress; classes according to influence on individuals include positive eustress and negative distress; and classes according to the duration of the stressor include acute stress and chronic stress. According to Wheaton et al. (2013), seven categories of stimuli leading to chronic stress include threats, demands that may be expectations or duty that cannot be met; structural constraints including the lack of opportunity or necessary means to achieve ends; underreward where the output is small compared to input and comparing to the rewards of others with the same input as in lower pay for a job than others with the same qualifications; complexity as in the number of independent sources of demands or direct conflict of responsibilities across roles; uncertainty consisting the desire to have a resolution when an outcome is not available or imminent; and conflict when regularly reenacted and institutionalized in relationships and without apparent resolution. The link between stress and diseases on the other side also has been a subject of investigation. According to Williams and House (1991), stressful life events predict an increased risk of such chronic diseases such as cardiovascular diseases and cancer; they are also considered risk factors for precipitating mental illnesses such as affective disorders like depression, schizophrenia and neurotic disorders. According to Carr and Umberson (2013), studies on the mechanism and factors for stress to cause illhealth underscore the extent to which one is exposed to stress, the psychological and structural resources one has to cope with stress and the impact of stress on health vary widely based on social factors including race, socioeconomic status, gender, age, and psychological attributes including coping style. Three stages of physiological reactions to stress are alarm, resistance, and exhaustion. The outcomes of stress according to them, are considered to result from the exhaustion stage also called depletion of the body's defenses against stress and was linked to a range of physical health outcomes such as high blood pressure but also emotional and psychological adjustments, including depressive symptoms, anxiety and substance use. Carr and Umberson (2013) also explain different models that have been developed to understand the ways that stress affects health. They include the role theory (Biddle, 1979) that is grounded on the fact that everyday activities involve carrying out social roles that turn out to be the source of stress as a result of role overload or role conflict. The fundamental cause theory (Phelan, Link, & Tehranifar, 2010) formulated to

explain the effect of social class gradient on health and argue that the socio-economic status is inversely associated with nearly all indicators of health, including mortality, self- rated health, disability, most major diseases and health symptoms, and mental health. The cumulative advantage and disadvantage theory (Dannefer, 2003; Merton, 1968) which broadly proposes that adversity gives rise to subsequent adversity, whereas advantage gives rise to advantage. We have also the life course frameworks that was developed by Glen Elder in 1995 and which is argued to be a useful framework for studying the origins and impacts of stress and focuses on timing, and the stress process model (Pearlin et al., 1981) considered to be the most influential in contemporary works on stress, coping, and health. This model is built upon the premise that most stressors are rooted in roles that link individuals to social structures and that are allocated, in part, on the basis of characteristics like age, race, and gender and that exposure to stress is not randomly distributed throughout the population, but is highly structured and reflects patterns of inequality. Accordingly, the impact of a stressor on health is not universal in magnitude, and varies widely based on one's other risk factors and resources, such as social support, self-esteem and mastery.

Throughout the history of humanity, life has been a result of human interaction with harsh and stressful environment and socio-political processes. These conditions included famines, heavy rains, drought, pandemics epidemics and outbreaks of infectious diseases, wars and inter-ethnic violence, and oppressive feudalism among others. While people believe in equity and equality like in the universal declaration of human rights that human beings were created equal and that they have certain undeniable rights, the contemporary world is growing to become as authoritative and discriminatory as it used to be in ancient times. According to the Atlantic Council, Freedom and Prosperity Center's 2022 report on freedom that encompasses economic freedom (property rights, trade freedom, investment freedom and women's economic freedom); political freedom (constraints on government, political rights, and civil liberties); legal freedom (judicial effectiveness, government integrity, state capacity, order and security and regulatory effectiveness); only 23.5% of 174 surveyed countries were found to be free (Negrea & Kroenig, 2022) while the 2022 report on economic freedom by The Heritage Foundation that encompasses property rights, judicial effectiveness, government integrity, tax burden, government spending, fiscal health, labor freedom, monetary freedom, trade freedom, investment freedom and financial freedom found only 19.2% of 177 countries surveyed to be free and mostly free (Roberts et al., 2022). According to Negrea and Kroenig (2022), human prosperity is highly correlated with freedom, where the correlation coefficient R between the indexes is 0.81 ($R2=0.656$, $\beta=0.762$, p value undefined). The loss of freedom including socio-economic freedom is a result of repression, persecution, surveillance and discrimination by the administrative and political systems that when imbedded in daily lives become chronic stressors. According to the V-Dem Institute's 2022 democracy report that combine the Liberal Democracy Index, Electoral Democracy Index, Liberal Component Index, Egalitarian Component Index, Participatory Component Index, and the Deliberative Component Index; dictatorships are on the rise worldwide and harbor 70% of the world population i.e. 5.4 billion people and argue that there are signals that the nature of autocratization is changing since besides closed autocracies, electoral autocracy remains the most common regime type that harbors 44% of the world's population (Boese et al., 2022).

Purdeková (2016) reproduces the Setel et al. (2007)'s concept of scandal of invisibility as a form of structural violence where "the absence of reliable data renders most of the world's poor as unseen, uncountable, and hence uncounted." He argues that repressive regimes often both care for their citizens and target them where they deploy visibility and monitoring as repressive strategies. Contemporary authoritarian and repressive political systems as found in Laura and Marie (2015) from their work on Rwanda where they argue that developmental infrastructures are used to deepen state power and expand political control by elites.

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New weapons are created and deployed such as the Bjarnegård and Zetterberg's "autocratic genderwashing" where human rights are disguisedly promoted, the case of autocrats' use of women's rights for their self-promotion and hide their overall human rights abuse (Bjarnegård & Zetterberg, 2022). Autocrats also according to Knutsen and Rasmussen (2018) may adopt old-age pension system in their welfare approach however, they are used for political survival purposes and targeting particular groups hence constituting a special form of co-optation. I argue that these and other approaches are done to impress international community, the population inside the territory is aware of what is being done and due to the lack of freedom of speech and freedom of the press, eventually they form a kind of spider webs of chronic stressors in which they are born, live and grow; their limited resources are invested for coping and in the case of exhaustion, maladaptive diseases are initiated.

1.2. The Biopsychopolitical model of SDCDs

Different models of stress help to understand their biological and psychological mechanism and different theories were formulated to understand how the stress especially social stress causes psychological and somatic diseases. While constituting a major human threat in the contemporary world, both theories do not accom modate the intervention approach in their scope. They are informative in nature and take stress and related illnesses as part of normal human life, something that humanity have to expect any time and live with. The WHO's ICD-10 contains a chapter called reaction to severe stress, and adjustment disorders said to be a category of disease identifiable on the ground of symptomatology and either of the two causative influences namely exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued unpleasant circumstances that result in an adjustment disorder. While its acute stress reaction fully depict the personal temporary response to exceptional physical and or mental stress and which usually subsides within hours or days, its adjustment disorders are defined as "states of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (including the presence or possibility of serious physical illness)" resulting from stressors that affect the integrity of an individual's social network such as through bereavement or separation experiences or the wider system of social supports and values such as migration or refugee status.

The above scope of adjustment disorders that I call Social Distress Coping Disorders (SDCDs) undermine their position in mental illnesses arena in threefold: first due to undermining their causal networks embedded in contemporary repressive political systems, second their morbidity and third their prevalence. Contreras et al. (2019) retain the idea that making advances on the science of psychopathology and treatments of related diseases can be seriously hindered if this and other insufficient diagnostic systems continue to be used together with their criticized assumption that an underlying biological condition is the main cause of mental disorders. Thoits (2010) looked back at works done on stress and health and drew five major conclusions: when stressors are measured in a comprehensive way, their damaging impacts on physical and mental health are substantial; differential exposure to stressful experiences is a primary way that gender, racial-ethnic, marital status, and social class inequalities in physical and mental health are produced; minority group members are additionally harmed by discrimination stress; stressors proliferate over the life course and across generations hence widening health gaps between advantaged and disadvantaged group members; and the impacts of stressors on health and well-being are reduced when persons have high levels of mastery, self-esteem, and or social support. In the same context Hill et al. (2005) proposed what they called neighbourhood disorder as a result of the effect of psychophysiological distress on health. They argue that disadvantaged people live in neighbourhoods that expose them to chronic stressors such as crime, trouble, and harassment among others. The stress response that occurs in the body and brain may be, they argue,

a psychological stress response that occurs in the form of fearful anxiety and depression and the physiological stress response that occurs in the form of signs and symptoms autonomic arousal such as dizziness, chest pain, upset stomach and weakness among others. While studying the relationship between psychosocial stress and cardiovascular disease, Ronaldson (2016) coined the term "negative emotional disorders" to explain the relationship between stress induced psychological distress and cardiovascular diseases and mood disorders such as depression and anxiety. However, as usual these authors consider these conditions as resulting from natural processes and undermine the possible condemnation of some people to live in those disadvantageous conditions.

How chronic socio-economic stress get under the skin and cause somatic and psychic diseases has been a subject of research for many years. According to Jenkins and Cofresi (1998) the psychosomatic model in medicine and psychiatry is built on the principle that "many diseases arise at least in part due to internal responses of individual human beings to psychological and psychosocial events" and factors include genetic and biochemical makeup, cultural background and personality or psychological profile. They argue that while psychosomatic model is based on psychological and personal factors to explain the interaction between psychological processes and bodily experiences, the sociosomatic model pioneered by Kleinman is based on the interaction between social relationships and bodily experiences. The sociosomatic model is constructed based on the primacy of social events, conditions and relations; the conceptualizations of social events as productive or ameliorating factors of diseases; the role of bodily experience in relation to the social world; the role of emotion in bodily experience; the conceptualization of the self with respect to the social world; and shaping and patterning of bodily processes through the dynamic interaction of subjective experience, cultural meaning and situated context. All of these taken together may mediate the onset or course of an illness (Jenkins & Cofresi, 1998). In the sociosomatic model, three mechanisms are involved: social and physical environment interaction with either the human neuroendocrine, autonomic or immune systems. According to McEwen (2012), for these interactions to manifest biopsychological changes two phenomena play important roles: the biological imbedding of earlier experiences that determine operating ranges of biological systems and the cumulative wear and tear of the physical and social environment on the brain and body acting through the neuroendocrine, autonomic, metabolic, and immune systems. The understandings of these mechanisms are facilitated by advances in neuroendocrinology and neuroscience. Evers et al. (2010), Kiecolt-Glaser et al. (2002) and Ronaldson (2016) argue that the stress response involves the activation of the hypothalamic–pituitary–adrenal (HPA) axis and the autonomic nervous system both of which affect the immune system. According to McEwen (2012), through their negative and positive feedback mechanisms; hypothalamus, pituitary and adrenal hormones affect a number of behaviors such as mood, cognition, and self-regulatory behaviors. Their hormones work in concert with other mediators of the autonomic, immune, and metabolic hormone systems and due to their adaptive and potentially damaging capabilities they form the basis of allostasis and allostatic load or overload. Kiecolt-Glaser et al. (2002) argue that normally, cytokines are protein substances released by cells that serve as intercellular signals to regulate the immune response to injury and infection; however, emotions disturbances such as depression and anxiety were proven to enhance the production of proinflammatory cytokines such as IL-6 whose higher plasma concentrations were associated with greater distress and studies on chronic fatigue patients showed increases in IL-6 following a severe life stressor hence both physical and psychological stressors can provoke transient increases in proinflammatory cytokines. They argue that sufficient evidences support the idea that stress impedes the immune response to infectious challenges, amplifying risks for contagion and prolonged illness episodes. On the other side, emotions also provoke the release of pituitary and adrenal hormones that have multiple effects, including alterations in cardiovascular and immune function and depressed and anxious moods can activate the sympathetic-pituitary-adrenal medullary

axis and the hypothalamic-pituitary-adrenocortical (HPA) axis. According to them, many studies showed that emotion-responsive hormones including catecholamines (norepinephrine and epinephrine), adrenocorticotropin hormone, cortisol, growth hormone, and prolactin can cause quantitative and qualitative changes in immune function hence the bi-directional feedback between the endocrine and immune systems. Stressors that are resistant to behavioral coping are associated with continued elevated stress hormones such as cortisol that was found to initiate, perpetuate, or aggravate syndromal depression, depression-like behaviors, and depressive symptoms such as anxiety, insomnia, and poor memory. They argue also that both emotional distress and disease may be prompted by common genetic and constitutional variables since first -degree relatives of depressed patients who have never been clinically depressed were found to have HPA axis responses similar to their affected relatives and different from controls, this is part of the so called psychosocial genomics.

Besides the effects of stressors on human's neuroendocrine system, McEwen (2012) argue that mediators of allostasis have effect on brain plasticity or the so called neuroplasticity. They argue on the fact that acute and chronic stress-induced plasticity is reversible in young adult brains and that the overstimulation by seizures, head trauma, and ischemia among others does cause permanent irreversible damage. However, there is sufficient evidence that the aging brain loses its resilience i.e. its ability to recover from stress-induced changes as well as those changes caused by isolation and an unhealthy lifestyle. These are sufficient evidences that chronic socio-economic stressors affect the complex neuroendocrine system and the brain to cause the somatic and psychological illnesses. The combination of studies and discovery of biochemical marker or simply biomarkers and modern imaging techniques uncovered the long lasted mystery of how socio-economic stress get under the skin to cause mental and physical illnesses. By looking at the trends in global prevalence of chronic socio-economic stressors' caused illnesses; considering the facts that in large part the causative factors are imbedded in the political systems and policy adopted political elites; and retaining the sociosomatic interactions through neuro endocrinology and immune system; neuroplasticity and psychosocial genomics; social distress coping disorders are fully explained by the biopsycho political model that also guide preventive and curative interventions.

2. Social Distress Coping Disorders (SDCDs)

SDCDs need comprehensive studies in terms of epidemiology since while they are given little attention in literature and practice, I argue that these diseases are of prime importance since they are themselves also risk factors to others mental and physical diseases as well as social violence. For example social stress and distress may trigger widespread alcoholism and prostitution that besides social violence increases the contamination rate of AIDS and other STIs. The current biomedical and psychological interventions are far from countering their ever growing global prevalences. This work is not intended to give an exhaustive list or present a comprehensive epidemiological evidences as they are found in cited references, it is a preliminary work intended to attract the global academics to turn their eyes to this underestimated threat. The below is a non-exhaustive list of SDCDs.

Alcoholism (SDCD-A)

The global prevalence of alcoholism is not well documented; however it is almost a worldwide common culture for people to appeal to glasses and bottles of alcoholic beverages whenever an unexpected stressful live event occurs. This may be of small life span for acute stressors while for chronic ones, alcohol dependence also called Alcohol Use Disorder (AUD) follows. Mossakowski (2008) has made a comprehensive literature review on the matter. She reproduced many studies arguing that heavy drinking is used as a coping strategy due to its strong association with stress while others show that heavy drinking can lead to alcohol abuse or dependence and ultimate health problems. Persistent lower socio-economic status (SES) due to unemployment and poverty creates chronic stress that leads to heavy drinking. She reproduced the Dohrenwend et al. (1992)'s social causation hypothesis that argues that the stress

of past and present socioeconomic disadvantage leads to drinking problems. In her own study, Mossakowski (2008) found that the duration of poverty has a significant association with being a heavy drinker, net of gender, age, race or ethnicity, and marital status; also that the duration of involuntary unemployment has a significant relationship with being a heavy drinker, net of demographics; and involuntary unemployment significantly predicts being a heavy drinker and frequency of heavy drinking. This is also found in Kiecolt-Glaser et al. (2002) that "distressed individuals are more likely to have health habits that put them at greater risk, including poorer sleep, a greater propensity for alcohol and drug abuse, poorer nutrition, and less exercise, and these health behaviors have cardiovascular, immunological, and endocrinological consequences".

Prostitution or Compulsive Sexuality or Sexual Addiction (SDCD-P)

While it is widely accepted that prostitution is offering sexual intercourse for money and that adultery is common in poor neighbourhoods; extravagant sexual endeavours are growing in scope and involving people of both sexes, homosexuality as well as heterosexuality, from youths to elders and especially in developing countries' areas especially inhabited by people of low SES. According to Hulland et al. (2015), among stress coping techniques, the use of passive disengagement coping strategies relative to active coping approaches is associated with engagement in more health risk behaviors and among them we have sexual endeavors with inconsistent condom use and a greater number of sexual partners. They reproduce a number of works that found adolescents with higher stress levels to be associated with increased number of sexual partners and greater likelihood of drug use during the last sexual encounter; race-related stress among African American adolescents to be associated with reporting a greater number of sexual partners; and elevated psychological distress such as perceived stress, depression, anxiety, and hostility to be associated with a greater number of sexual partners and also riskier sexual partners. Park (2021) argue that harsh environment put people in the state where they feel physical and mental tension where the stressful events force them to find ways to relieve stress when the level of tension increases and if this tension persists, it will cause physical illness or psychological maladjustment. This is the reason why for them, the tension or stress reduction theory explains addiction since addictions are used as a way of relieving stress in life, which can be described as using compensation or gains to relieve tension or stress. Among these addictions we have compulsive sexual behaviors. In their study, they found that stress has a positive correlation with lack of self-control and that lack of self-control has a positive correlation with compulsive sexual behavior disorder. They found that lack of self-control shows a relationship between pursuit of bad behavior and compulsive sexual behavior disorder.

Drug abuse (SDCD-D) and Alcoholism and Drug abuse (SDCD-AD)

Drug abuse and alcoholism may exist as independent conditions or may exist as comorbid conditions. Sudraba et al. (2015) reproduced the Wills and Shiffman (1985)'s cognitive-behavioural perspective model of stress-coping that proposes that people often use alcohol as a coping response to stress, where it is used to improve positive affect or reducing uncomfortable feelings. They argue that drinking alcohol as a coping strategy may be a short time success however; the use of alcohol to cope with chronic stressors is considered a maladaptive response. According to them, the model assume alcohol use in the absence of effective and adaptive coping strategies, and therefore individuals lacking such coping responses are at risk of engaging in problematic drinking behaviour. They argue also that to cope with negative emotion avoidant coping strategies are consistently associated with both heavy drinking and alcohol-related problems. Yanovich et al. (2018) and Balla and Nazneen (2019) argue also that lower socio-economic status people engage themselves in social avoidance behaviors such as substance abuse stress coping mechanisms. Comprehensive literature that explored the neuro-endocrinological mechanisms of drug abuse and addiction was made in Sinha (2008), Calpe-López et al. (2022) and Miczek (2008). According to Sinha

(2008), the cumulative number of stressful events was significantly predictive of alcohol and drug dependence in a dose-dependent manner and evidences from prospective and longitudinal studies show that there is substantial evidence to support the effects of stress on drug use initiation and escalation in adolescents and young adults.

Anxiety disorders (SDCD-X)

According to Weems & Silverman (2013), Khan & Khan (2017), among risk factors and etiological origins for anxiety disorders we have social risk factors such as social exclusion, chronic stress and teasing in school environment. Social processes include different forms of discrimination (based on ethnicity, body physique, skin color etc.), lower socio-economic status that leads to the loss of self-esteem, and disadvantage by prejudice (belonging to a social class to which the wrong doings are attributed). While some anxiety disorders have biological origins such as genetics and developmental processes, this category of social distress coping anxiety disorders include social anxiety disorder (SAD) which is characterized by an extreme and unreasonable fear of being embarrassed or humiliated in front of others, generalized anxiety disorder (GAD) which is characterized by persistent and excessive worry about a number of events or activities, and posttraumatic stress disorder (PTSD) (Weems & Silverman, 2013).

Hypertension (SDCD-H)

Several studies have showed that chronic stress affects human circulatory system and cause cardiovascular diseases including high blood pressure or hypertension. In his comprehensive literature review, Dimsdale (2008) found evidence on the psychological stressors effect on the heart in which substantive studies confirmed the raised blood pressure after acute stressors such as earthquakes and a continued and increased blood pressure after chronic stressors such as warfare. Ronaldson (2016) reproduced the findings by Bomhof-Roordink et al. (2015) where they argue that life stress including childhood trauma, negative life events, daily hassles, and job strain to be associated with increased arterial stiffness. According to McMahon et al. (2021), substantive studies have been done and evidence support the cardiovascular reactivity (CVR) which is a physiological change in heart rate (HR), blood pressure (BP) or other measures of cardiovascular function between a resting period, and during the presence of an external stressor. Hypertension has become a health threat of global concern.

Mood disorders (SDCD-M)

This group of social distress coping mood disorders comprises major depressive disorder (MDD) and persistent depressive disorder (PDD) which consolidate the two former separated diseases chronic major depressive disorder or chronic MDD and dysthymia (DeRubeis et al., 2016). Life events that lead to hopelessness or despair such as persistent forms of social injustice in the form of preferential treatment and discrimination on in the labor market are among causes or risk factors. The neuroendocrinology and neurochemical processes of mood disorders due to sociosomatization have been explained in (DeRubeis et al., 2016; Khan & Khan, 2017; Young et al., 2000).

Sleep disorders (SDCD- S)

The relationship between work related stress and sleep disorders have been intensively studied and few examples include (Kerawati & Gayatri, 2019; Lee et al., 2021; Schiller, 2017). Other different forms of social stressors such as discrimination, perceived discrimination and inter-personal relationships among others have also been documented in Gordon et al (2017) and the neuroendocrinological implication considered in Han et al. (2012) and Gordon et al (2017). Among these disorders we have insomnia and hypersomnolence.

Social media addiction (SDCD-SM)

Researches in the area of technostress including the use of social networking sites yielded conflicting results. Some research shows that when individuals perceive their use as stressful, they often reduce the extent of use or even stop using it altogether while others show that even when individuals are stressed from using them, they continue to use them. Social media addiction as a social stress and perceived stress coping side effect has been documented in (Taş, 2022;

Zhao & Zhu, 2022). Associated health and social problems such as stress and sleep deprivation, depression, anxiety, poor work academic performance and interpersonal relationship like romance were reviewed in (Daniels et al., 2021; Satici et al., 2021; Sayed et al., 2022; Wang & Deng, 2022).

Gambling disorder (SDCD-G)

Until recently, comprehensive knowledge in the area of gambling addiction is still not fully attained. However, it is widely accepted that social distressing situations like the current COVID-19 increase its prevalence (Selarno & Pallanti, 2021); the neurochemistry, endocrine and genetic involvement considered (Yau & Potenza, 2015); and the socio-economic burden either on the side of the patient, society and governments (Quigley, 2022; Shaffer & Korn, 2002; Yau & Potenza, 2015). While Shaffer and Korn (2002) argue on the spectrum of gambling covering at-risk, problem, subclinical, pathological, probable pathological, extremely pathological, in-transition, and compulsive gambling; current approaches deal with upper extremes while failing to trace roots of the problem. With these biomedical and psychological approaches we will always be many steps behind controlling this new illness and its ever increasing prevalence worldwide. In their psychoecomonics, Shaffer and Korn (2002) argue that income, employment, and poverty are socioeconomic determinants of gambling since poverty often is associated with increased financial risk-taking and people living in poverty perceive greater potential to change their lives from a gambling win than people living in wealth. Their multidimensional approach to treatment that include combinations of psychopharmacology, psychotherapy, and financial, educational, and self-help interventions are in accord with the biopsychopolitical model of mental health interventions. What is intriguing is that sometimes what are considered causes of gambling like poverty turn out to be also among consequences! And in the pathological extreme rarely do gambling disorder occurs as a single entity, but a complex comorbid condition with personality, mood disorders and other addictive conditions (Shaffer & Korn, 2002; Yau & Potenza, 2015).

Psychosomatic disorders (SDCD-PS)

They include functional dyspepsia (FD) that was found to be affected by social stress and mood disorders (Huang et al., 2021), migraine headache and its comorbid conditions such as anxiety disorders and mood disorders like depression (Puca, 2000).

3. The interventions guidelines in SDCDs

Thoits (2010) proposed policy implications guiding interventions to reduce the negative effects of stress on the quality of life. First, in the reduction of negative effect of social distress, effective coping and social support interventions should be identified and implemented; second, the structural conditions that put people "at risk of risks" such as discrimination, poverty, residential segregation, inadequate schools, and unemployment should be the focus of ameliorative social programs and policies; and third, in order to reduce health disparities over the life course, policies and programs should target children who are at long-term health risk due to early exposure to poverty, inadequate schools, and stressful family circumstances. I argue that we no longer have negative effects of stress on the quality of life instead a life threatening class of psychological and somatic diseases with socio-economic stress as causative agent and whose contribution to the global burden of diseases increases year after year. These policy recommendations are covered and strengthened in the biopsychopolitical model of mental illnesses that recognizes and emphasizes on the contribution of politics to the social determinants of mental health. The biopsychopolitical model recognizes that the Thoits' risk of risks may be results of social processes and that in contemporary world where they are most prevalent, they are results of politics and that the same political systems have to come out with a goodwill to solve problems resulting from their own doing for the sake of humanity. Health systems and political systems will have to play complementary roles in preventive and curative endeavors. The political systems will focus on the risks of risks or the upstream social determinants of mental health such as reduction of poverty and promoting non-discriminatory socio-economico-political milieu for all citizens to prosper. On the other side the health systems will work on downstream social determinants of mental

health and cure mental illhealth.

Discussion of the findings

The link between stressors, stress, distress and mental disturbances has been studied extensively and models and theory formulated. This led Engel to include social factors in his model of mental disorders, the biopsychosocial model. In 2021, the World Health Organization publicized its Comprehensive mental health action plan 2013–2030 that recognizes good mental health as fundamental for humanity being productive and materialize their full potential. This action plan is based on four major objectives: "more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research" (World Health Organization, 2021). While the action plan seems to emphasize on the effectiveness of the health systems, it recognizes also other interventions such as poverty reduction. Are we succeeding in these endeavors? Absolutely not! In 2015, Ann Case and Ryan Deaton published a paper in which they coined the term "deaths of despair" for what they saw as excess deaths associated with suicide, unintentional drug overdose, and alcohol use and intoxication. Beseran et al. (2022) carried out a review of the literature to find the social determinants of deaths of despair found among them low socioeconomic position, lower education levels, working in jobs with high insecurity, unemployment, and living in rural areas as the most relevant social determinants of diseases of despair. In their attempt at the epidemiology of these disorders, Na et al. (2022) coined the term "lives of despair", the lives characterized by the complete loss or absence of hope, and estimated that in the US 7.2 million adults had both lifetime Substance Use Disorder (SUD) and suicide attempt and 78.8 million had either. Contrary to the expectations of the World Health Organization that improved health systems will improve mental health, I argue that regardless of efforts continued to be made, the contrary results will be obtained as long as the real roots or causes of despair, these shameful conditions that leads to lives of despair, are addressed. What is the origin of these living conditions? Natural processes or artificially created conditions? The rise in dictatorship, economic inequality, human rights abuse, restriction of freedom of speech and freedom of the press, discrimination among others are the real causes of lives of despair that lead to unhealthy choices and practices and cause mental disturbances and somatic diseases. These are not natural phenomena in contemporary world, they are man-made; they are embedded in political systems.A proper categorization of these diseases has advantages of attracting attention to academicians for deeper studies, health organization and human rights activists and other interested parties to stand and call for political changes and endeavors that address socio-economic inequality and social injustice in general. The terminology such as "diseases of despair" undermine the roots or causes of the that despair hence I collectively put these diseases of despair and other mental and somatic disorders as presented in this paper in a category of politically driven social distress caused diseases that I call "Social Distress Coping Disorders (SDCDs)" that require special mainly politically grounded interventions as explained by the new biopsychopolitical model of mental health and illhealth.

Conclusion

Despite the efforts made to understand the mechanisms through which stress and distress cause health impairments especially a large number of non-communicable diseases and the global awareness and well-structured policy recommendations to tackle their contribution to the global burden of diseases; it seems that through the lenses of their ever increasing share, the way we are approaching them is not working. More importantly, these diseases are also risk factors to other health threatening conditions making their true share to the total deaths , Years lived with disability (YLD),

and Disability-adjusted life years (DALYs) even higher. For example, alcoholism is considered a necessary underlying cause for more than 30 conditions including infectious diseases, cancer, diabetes, neuropsychiatric diseases, cardiovascular disease, liver and pancreas disease, and unintentional and intentional injury (Rehm, 2011). According to Sobierajski et al. (2022), risk factors for arterial hypertension include heart failure, heart attack, stroke, aortic aneurysm, kidney failure, atherosclerosis, and eye diseases. According to Monteso-Curto et al. (2018) depression is a risk factor for a number of diseases such as cardiovascular disease, metabolic syndrome, biochemical alterations, diabetes, dementia, cognitive impairment, Alzheimer's disease, somatization and chronic pain, asthma, arthritis, and hyperlipidemia. Instead of considering these diseases as a passive class in international classification systems such as ICD-10 and ICD-11, I suggest strong emphasis to be put on this special class that I call "Social Distress Coping Disorders" in terms of comprehensive epidemiologic studies and their risk factors that are argued to be imbedded in currently increasing repressive, authoritarian and dictatorial political systems. Interventional approaches should be restructured to conform to the practices as indicated in the biopsychopolitical model.

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