

Opinion

Beyond Symptom Relief: Rethinking Psychoactive Treatment in the Context of Social Distress

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Abstract

Psychoactive medications have been widely used to treat depression, anxiety, insomnia, pain, and other conditions that may negatively affect individuals' health and quality of life. However, psychological distress may also be influenced by social and economic conditions, including economic insecurity, unemployment, social isolation, unstable housing, and bereavement. One proposed, untested pathway is that social difficulties may contribute to symptoms for which individuals later seek care and receive psychoactive medications. Although pharmacological treatment may be appropriate and effective for reducing such symptoms, medications may not address the social conditions associated with the development of distress. Therefore, it is important to consider both individual treatment and the social conditions surrounding psychoactive medication use. This opinion paper discusses how social adversity may be associated with psychological distress and psychoactive treatment and highlights the importance of considering social interventions along with pharmacological treatment. This paper asks how psychoactive treatment can relieve symptoms while social difficulties continue and whether patients can access other forms of support.

Keywords: psychoactive medications; social distress; socioeconomic inequality

1. Introduction

Psychoactive medications have played an important role in treating a variety of psychiatric and neurological conditions [1]. Antidepressants, anxiolytics, sedatives, hypnotics, and centrally acting analgesics may reduce psychological and physical symptoms and improve individuals' functioning and quality of life. Thus, psychoactive medications are important treatment options for people experiencing depression, anxiety, insomnia, pain, and other health problems [2]. However, psychological distress does not necessarily develop only from individual biological or psychological conditions. Social and economic environments may also affect individuals' mental health. For example, unemployment may be associated with anxiety and depressive symptoms, while financial insecurity may be related to chronic stress and sleep problems [3,4]. Social isolation and bereavement may also increase the risk of loneliness, depression, and insomnia [5,6]. In addition, housing instability and other forms of socioeconomic disadvantage may negatively influence psychological well-being [7].

In this paper, 'social distress' is a descriptive term for perceived strain associated with an identifiable social adversity, such as unemployment, financial insecurity, housing instability, social isolation, or bereavement. The term does not establish that the adversity caused symptoms and is not a diagnosis. 'Psychological distress' refers to emotional



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symptoms, including anxiety or depressed mood, which may occur with or without a diagnosed mental disorder; a disorder requires separate clinical assessment. Future studies should prespecify each social exposure and measure perceived strain and symptoms with stated instruments, while assessing diagnoses against separate clinical criteria. Here, ‘psychoactive medications’ refers to prescribed, centrally acting medicines used to manage mood, anxiety, sleep, or pain, including antidepressants, anxiolytics, sedatives/hypnotics, and centrally acting analgesics. Non-centrally acting analgesics are outside this scope. The included classes have different indications and prescribing pathways; findings about one class should not be assumed to apply to the others.

Population data illustrate these differences. In the 2021 U.S. National Health Interview Survey, serious psychological distress was reported by 8.9% of adults with family incomes below the federal poverty level, compared with 2.0% of those with incomes at least four times that level [8]. Among working adults aged 18–64, the corresponding percentages were 5.4% for those who anticipated losing their job within 12 months and 2.2% for those who did not [9]. These cross-sectional comparisons describe associations and do not establish that income or job insecurity caused the distress.

A possible pathway is that social adversity contributes to psychological or physical symptoms, prompting healthcare use and, in some cases, psychoactive treatment. This sequence is a hypothesis, not an established finding. Mental health problems may also worsen employment or financial circumstances, while prior illness, access to care, and other factors may influence both social adversity and treatment [10]. This does not indicate that psychoactive medications are inappropriate for individuals whose distress is related to social conditions. Their symptoms are real and may require appropriate medical treatment. However, pharmacological treatment may reduce symptoms without changing the social conditions associated with those symptoms. For example, medication may reduce anxiety among individuals experiencing financial insecurity, but it cannot directly resolve their financial problems. Similarly, medication may improve sleep among socially isolated individuals, but it cannot provide meaningful social relationships.

Therefore, it is important to understand psychoactive medication use not only in the context of individual symptoms but also in the context of the social conditions in which those symptoms develop. This paper discusses the relationship between social adversity, psychological distress, and psychoactive treatment and considers how social interventions may complement pharmacological approaches. Rather than offering new evidence about social determinants, this paper asks readers to consider three practical questions when psychoactive medication is prescribed or continued: What symptoms need treatment, what social difficulties may continue to affect the patient, and what other help can the patient realistically access? Considering these questions together may help clinicians respond to immediate symptoms without overlooking problems that medication cannot resolve.

2. From Social Adversity to Psychoactive Treatment

A variety of social conditions may influence psychological and physical well-being. Economic hardship, unemployment, social isolation, caregiving burden, bereavement, neighborhood disadvantage, and housing instability may increase stress and negatively affect mental health [3–7]. Individuals exposed to these conditions may experience anxiety, depressive symptoms, sleep problems, chronic stress, pain, or difficulty managing everyday life [3–7]. When these symptoms become severe or persistent, individuals may seek healthcare. Healthcare professionals may then assess the symptoms and provide appropriate treatment, including psychoactive medications [1,11]. These observations suggest a possible pathway from social adversity to distress, healthcare use, and medication; its sequence and strength require empirical testing.

Healthcare systems generally focus on the symptoms presented by individuals [11]. Individuals with depressive symptoms may receive antidepressants, while those experiencing anxiety or insomnia may receive other appropriate psychoactive medications. Such treatment may improve health and functioning. However, the social conditions associated with the symptoms may remain unchanged. Individuals who experience anxiety related to financial insecurity may receive effective treatment for anxiety while continuing to experience financial difficulties. Similarly, individuals experiencing insomnia associated with caregiving responsibilities or social isolation may benefit from treatment, even though the circumstances contributing to their sleep problems remain. Therefore, improvement in symptoms does not necessarily indicate that the conditions associated with the development of distress have been resolved. It is important to distinguish between treatment of symptoms and intervention in the social conditions that may contribute to those symptoms.

3. Individual Treatment and Social Distress

Healthcare services generally provide treatment at the individual level. Individuals seek healthcare, receive diagnoses, and are provided with treatment based on their symptoms and health conditions. However, some factors associated with psychological distress exist beyond the individual level [11]. For example, employment conditions, housing environments, economic resources, and opportunities for social participation are influenced by broader social and institutional conditions. These factors may have important effects on mental health but cannot be changed through pharmacological treatment.

When individuals experiencing socially related distress enter the healthcare system, attention may naturally focus on reducing their symptoms. This is an important function of healthcare. However, focusing primarily on symptoms may provide an incomplete understanding of why the distress has developed or continued. This issue should not be interpreted as suggesting that socially influenced psychological problems are less serious or that psychoactive medications should not be provided. Social adversity may result in severe psychological problems that require medical treatment [12]. Therefore, individuals should receive appropriate pharmacological treatment when it is necessary. However, individual treatment and social intervention have different functions. Psychoactive medications may help reduce depression, anxiety, insomnia, or pain, whereas social policies and services may address unemployment, economic insecurity, unstable housing, or social isolation. Thus, one type of intervention cannot necessarily replace the other. It is therefore important to consider the social context of psychoactive treatment. If social conditions continue to influence an individual's distress, pharmacological treatment alone may not fully address the factors associated with the problem.

4. Social Differences in Psychoactive Treatment

The relationship between social adversity and psychoactive treatment may differ depending on individuals' circumstances and the type of social difficulty they experience [13]. Social isolation and bereavement, for example, may be associated with depression, anxiety, and sleep disturbance [5]. Economic insecurity and unemployment may contribute to chronic stress, worry, and depressed mood [3,4]. Housing instability may also negatively affect sleep, mental health, and continuity of healthcare [7]. In addition, individuals may have different resources available to cope with these difficulties. People with greater economic resources may have better access to psychotherapy, specialist mental health services, exercise programs, recreational activities, and other forms of non-pharmacological support [14]. Conversely, individuals with fewer socioeconomic resources may experience barriers to these services because of financial costs, limited transportation, long waiting periods, or lack of available healthcare providers. Therefore, socioeconomic inequality may

also influence how psychological distress is treated. Individuals with fewer resources may be more highly exposed to stressful social conditions while having fewer alternatives to pharmacological treatment.

This does not mean that psychoactive medications are necessarily provided more frequently or inappropriately to socioeconomically disadvantaged populations. Rather, the availability of treatment alternatives may differ across socioeconomic groups [15]. When psychotherapy, community services, social activities, or other forms of support are difficult to access, medication may become one of the more readily available treatment options. Thus, psychoactive medication use should not always be understood only as an individual treatment decision. Social and economic resources may influence both individuals' exposure to distress and the types of treatment available to them. More attention should therefore be paid to socioeconomic differences in the relationship between social distress and psychoactive treatment.

5. Combining Pharmacological and Social Interventions

Recognizing the importance of social conditions does not mean that pharmacological treatment and social interventions should be considered competing approaches. Individuals experiencing significant psychological symptoms should receive appropriate treatment regardless of whether social factors contributed to those symptoms [11]. For example, individuals who develop severe depression following unemployment may still need treatment for depression. Similarly, individuals who experience persistent insomnia because of caregiving responsibilities may need appropriate treatment for their sleep problems. It would not be appropriate to delay necessary treatment until the underlying social problem is resolved. Therefore, pharmacological and social approaches should be considered together. Healthcare providers may assess important social stressors along with psychological and physical symptoms. When appropriate, psychoactive treatment may also be connected with other forms of support, such as financial counseling, employment services, housing assistance, bereavement support, community programs, and interventions targeting social isolation.

In this paper, 'social interventions' refers to actions at three distinct levels: clinical care (asking about social needs, care navigation, and referral), community services (employment, housing, bereavement, and social-connection support), and policy (income support and measures affecting housing or employment). Clinical referrals connect patients with services; community programs provide direct support; policies may change the resources and conditions available to larger populations. Their reach and outcomes should be assessed separately rather than treating them as one intervention.

In practice, clinicians could ask patients, with their consent, about housing, finances, employment, caregiving, and social connections alongside their symptoms [11]. When a need is identified, a social worker or care navigator could help arrange a referral to a relevant service and check at follow-up whether the patient was able to access it [11]. Follow-up could also review symptom changes and remaining social needs, while medication decisions continue to be guided by clinical assessment and patient preferences. Healthcare organizations could maintain updated referral pathways and assess where patients encounter barriers to support.

The evidence for these services depends on the intervention and the outcome measured. A review of employment interventions reported that supported employment improved competitive employment compared with psychiatric care alone; studies of Housing First reported greater housing stability [11]. These findings do not establish that every service listed above improves mental health or reduces medication use. Evidence for the

mental health effects of broader income and housing policies is still limited and often of low quality [16].

One possible approach is to pair indicated treatment with a referral for a specific unmet need. For example, a patient treated for depression after job loss could, with consent, be connected to supported employment by a designated social worker. The clinical and social-service teams would agree who makes the referral and check at follow-up whether the patient reached the service [11]. Feasibility depends on local program capacity, eligibility, transport, waiting times, staff availability, and funded coordination time. Clinics should assess these costs and barriers and monitor referral completion and patient outcomes rather than assume that referral alone is sufficient.

However, healthcare professionals cannot independently resolve many of the structural conditions associated with psychological distress. Policies could expand housing assistance and unemployment insurance and improve employment conditions, although evidence for population-level mental health effects remains limited [16]. Thus, greater collaboration may be necessary among healthcare systems, social services, community organizations, and public policies. Such an approach may allow individuals to receive treatment for their immediate symptoms while also receiving support for the social conditions affecting their well-being. When treating psychological distress, it is therefore important to consider not only which treatment may reduce symptoms but also which social conditions may contribute to the symptoms and whether these conditions can be addressed.

6. Conclusions

Psychoactive medications provide important treatment for individuals experiencing depression, anxiety, insomnia, pain, and other psychological or physical problems. This paper does not suggest that pharmacological treatment should be reduced simply because social conditions may influence psychological distress. This paper proposes, but does not establish, a possible pathway from social adversity through distress and healthcare use to psychoactive treatment. Reverse causation and shared influences, including prior illness and access to healthcare, also need to be considered. These medications may effectively reduce symptoms. However, they may not directly address the social conditions associated with the development or continuation of distress. Therefore, greater attention should be paid to both individual treatment and social intervention. Individuals experiencing psychological distress should have access to appropriate psychoactive treatment, while social and public policies should also address the conditions that negatively affect psychological well-being. Psychoactive medications can play an important role in treating individuals, but they cannot independently resolve unemployment, poverty, unstable housing, loneliness, or social disconnection. A more comprehensive approach to psychoactive care should therefore consider both the treatment of individuals and the social environments in which their distress occurs.

7. Future Directions

A prospective cohort could recruit adults with and without recent job loss or housing instability from community and primary-care settings, including people without current prescriptions. Baseline questionnaires would record each adversity, perceived social strain, validated psychological distress and sleep scores, prior diagnoses, pain, income, and access to care. Repeat questionnaires at 6 and 12 months, linked with consent to electronic health records and pharmacy dispensing records, would track changes in circumstances and symptoms, healthcare visits, and new prescriptions. The primary outcome would be initiation of medication by class within 12 months, with indication checked against clinical records; secondary outcomes would be symptom change and healthcare use. Time-ordered

analyses would examine whether adversity precedes later symptoms and prescribing and whether symptoms precede later hardship, adjusting for baseline health, socioeconomic circumstances, and access to care. This observational design could test temporal patterns but would not establish causation.

A separate pragmatic trial could randomize primary-care clinics to usual care or usual care plus structured social-needs screening, a designated care navigator, and referral follow-up. The population would be adults reporting both clinically relevant distress and at least one unmet social need. Change in a validated distress score at 6 months would be the primary outcome. Referral logs, service-provider confirmation, clinical records, and staff-time records would provide secondary measures of referral completion, actual service uptake, medication initiation by class and indication, and coordination cost. The trial would also record local service availability to interpret differences in implementation.

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