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Depression and Anxiety Disorders: Global Burden, Risk Factors and Management Approaches

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Abstract

Depressive and anxiety disorders are among the most prevalent and disabling mental-health conditions worldwide, accounting for a substantial proportion of years lived with disability and imposing major social and economic costs. They affect individuals across the life course, with higher burden observed among women, adolescents, and socioeconomically disadvantaged populations. Despite extensive evidence demonstrating the effectiveness of psychological and pharmacological treatments, large treatment gaps persist globally, particularly in low- and middle-income countries. This review synthesizes current evidence on the global burden and trends of depressive and anxiety disorders, examines their multifactorial risk factors—including biological vulnerability, adverse childhood experiences, social determinants, and acute environmental stressors—and evaluates evidence-based management approaches. Effective interventions span prevention and population-level strategies, integrated primary-care delivery models, task-sharing guided by the World Health Organization's Mental Health Gap Action Programme, psychological therapies such as cognitive-behavioural therapy, pharmacotherapy with antidepressants, and stepped-care and collaborative models. However, barriers including workforce shortages, inadequate financing, stigma, and weak health systems continue to limit equitable scale-up. The COVID-19 pandemic further highlighted the fragility of mental-health systems and the central role of social determinants in shaping population mental health. Reducing the global burden of depression and anxiety requires coordinated health-system reform, sustained investment, anti-stigma efforts, digital innovation with human support, and multisectoral policies addressing upstream social and economic determinants.

Keywords: Anxiety disorders, Depression, Global burden of disease, Mental health services, Task-sharing and mhGAP

Introduction

Depressive and anxiety disorders are among the most common and disabling mental-health conditions encountered in both clinical practice and community settings worldwide. Together, they affect hundreds of millions of individuals and contribute substantially to global morbidity, impaired functioning, and diminished quality of life (1, 2). Unlike many acute medical illnesses, these disorders often begin early in life, follow recurrent or chronic trajectories, and interact bidirectionally with social, economic, and physical health factors. As a result, their impact extends beyond individual suffering to impose profound societal costs, including reduced educational attainment, lost workplace productivity, increased health-care utilization, and elevated risk of premature mortality through suicide and comorbid physical illness (3, 4).

Over the past three decades, global health metrics have increasingly recognized depressive and anxiety disorders as leading contributors to non-fatal disease burden. Data from the Global Burden of Disease (GBD) Study consistently rank these disorders among the top causes of years lived with disability (YLDs) across regions, income levels, and age groups (5). While direct mortality attributable to depression and anxiety is relatively low compared with communicable diseases or cardiovascular disorders, their contribution to long-term disability is substantial and persistent (6). This distinction underscores a critical challenge for health systems: the burden of depression and anxiety is driven less by death than by sustained impairment, highlighting the need for long-term, continuous models of care rather than episodic or crisis-driven responses (7).

Despite growing recognition of their public-health importance, depressive and anxiety disorders remain underdiagnosed and undertreated in most parts of the world.

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A robust evidence base demonstrates that effective treatments exist, including structured psychological therapies, pharmacological interventions, and integrated care models (8). However, large treatment gaps persist, particularly in low- and middle-income countries, where the majority of individuals with common mental disorders receive no formal treatment (9). Even in high-income settings, access is often constrained by long waiting times, high out-of-pocket costs, workforce shortages, and fragmented service delivery (10). This disconnects between scientific knowledge and population-level impact represents a central challenge for global mental health.

The epidemiology of depression and anxiety illustrates the complexity of these conditions. Prevalence varies across regions and populations, shaped by demographic characteristics such as age and sex, as well as by broader social and economic contexts (11). Women experience higher prevalence rates of both depressive and anxiety disorders than men, a disparity influenced by biological susceptibility, psychosocial stressors, and structural inequities including gender-based violence, caregiving burden, and unequal access to economic resources (12). Adolescents and young adults represent another group of growing concern, as many depressive and anxiety disorders have their onset during this developmental period, with long-lasting consequences for education, employment, and social relationships. At the other end of the life course, older adults face distinct risk factors, including social isolation, bereavement, chronic physical illness, and declining functional capacity (13).

Recent global events have further emphasized the vulnerability of population mental health to large-scale stressors. The COVID-19 pandemic, in particular, exposed and amplified existing weaknesses in mental-health systems worldwide. Lockdowns, physical distancing measures, fear of infection, bereavement, and economic disruption were associated with a marked increase in symptoms of depression and anxiety across populations (14). Global modelling studies estimated tens of millions of additional cases of major depressive disorder and anxiety disorders attributable to the pandemic in 2020 alone. These increases were not evenly distributed; women, younger individuals, those with pre-existing mental-health conditions, and populations experiencing socioeconomic disadvantage were disproportionately affected (15). The pandemic thus highlighted how rapidly mental-health burden can escalate when social supports are disrupted and underscored the importance of preparedness and resilience within mental-health systems.

Understanding the risk factors for depressive and anxiety disorders requires a multidimensional perspective integrating biological, psychological, and social determinants. At the individual level, genetic vulnerability and neurobiological mechanisms influence susceptibility, but these factors rarely act in isolation (16). Developmental exposures, particularly adverse childhood experiences such as abuse, neglect, and household dysfunction, are among the strongest predictors of later depression and anxiety. Across the life course, cumulative exposure to stress—including interpersonal conflict, financial insecurity, discrimination, and work-related strain—can precipitate or exacerbate symptoms (17). Importantly, these individual and developmental risks are embedded within broader social and structural contexts that shape both exposure to adversity and access to protective resources.

Social determinants of mental health play a central role in explaining the unequal distribution of depression and anxiety across and within countries. Poverty, unemployment, low educational attainment, insecure housing, and social exclusion are consistently associated with higher prevalence, greater severity, and poorer outcomes. These determinants not only increase exposure to stressors but also reduce access to care, reinforce stigma, and limit recovery opportunities. Consequently, mental-health inequalities often mirror—and perpetuate—existing social and economic inequalities (18). Addressing depression and anxiety at a population level therefore requires strategies that extend beyond the health sector to include education, labor, housing, and social protection policies.

Clinical presentation and course further complicate the management of depressive and anxiety disorders. Comorbidity between the two conditions is common, with many individuals presenting with mixed symptom profiles that do not align neatly with diagnostic categories. In addition, high rates of comorbidity with chronic physical illnesses such as cardiovascular disease,

diabetes, and chronic pain contribute to poorer outcomes, increased disability, and higher health-care costs. These bidirectional relationships underscore the importance of integrated models of care that address mental and physical health simultaneously rather than in isolation (19).

From a treatment perspective, substantial progress has been made in identifying effective interventions. Psychological therapies—particularly cognitive-behavioural therapy (CBT)—have demonstrated efficacy across a range of depressive and anxiety disorders in multiple meta-analyses. Pharmacological treatments, including selective serotonin reuptake inhibitors and other antidepressants, are effective for many individuals with moderate to severe illness (20). Combined treatment approaches often yield superior outcomes for patients with chronic or recurrent conditions. Alongside these clinical advances, health-system innovations such as stepped-care models, collaborative care, and task-sharing approaches have shown promise in improving access and outcomes, particularly in resource-limited settings (21).

Nevertheless, implementation of these interventions at scale remains uneven. Persistent barriers include workforce shortages, inadequate financing, limited integration of mental health into primary care, and ongoing stigma surrounding mental illness. In many settings, mental-health services remain concentrated in urban tertiary facilities, leaving rural and marginalized populations underserved (22). Digital mental-health interventions and community-based delivery models offer opportunities to expand reach, but they also introduce challenges related to quality assurance, equity, privacy, and sustainability (23).

Given these complexities, there is increasing consensus that reducing the global burden of depressive and anxiety disorders requires a comprehensive, multisectoral approach. Such an approach must combine evidence-based clinical interventions with population-level strategies addressing social determinants and promoting mental well-being across the life course. Equity must be central to these efforts, ensuring that advances in care benefit populations currently facing the greatest unmet need (24).

In this context, a comprehensive synthesis of current evidence is essential. This review aims to summarize contemporary data on the global burden of depressive and anxiety disorders, examine established and emerging risk factors, and critically evaluate management approaches with attention to both clinical effectiveness and real-world implementation challenges. By integrating epidemiological, clinical, and health-system perspectives, this article seeks to inform clinicians, researchers, and policymakers about pathways to reduce the burden of these highly prevalent and disabling conditions.

Global Burden and Trends

Mental disorders—of which depressive and anxiety disorders are the most prevalent—account for a major share of global disability. Estimates from the Global Burden of Disease (GBD) and World Health Organization (WHO) indicate that hundreds of millions of people worldwide live with depression or anxiety, and mental disorders collectively remain leading causes of years lived with disability (YLDs). The COVID-19 pandemic was associated with sharp increases in the prevalence of major depressive disorder and anxiety disorders in 2020, adding tens of millions of additional cases and materially increasing DALYs attributable to these conditions. Current WHO fact sheets similarly report that globally hundreds of millions of people experience depressive or anxiety disorders and that many do not receive adequate care (25, 26).

Risk Factors: Multifactorial Causation

Risk for depressive and anxiety disorders arises from interacting determinants operating across multiple levels, including biological, psychological, interpersonal, and structural domains. These determinants influence mental health through shared processes such as chronic stress activation, neurobiological dysregulation, inflammation, and cumulative social adversity.

Biological and Individual Vulnerability

Genetic predisposition, sex differences (higher prevalence in women), neurobiological pathways (monoaminergic function, HPA axis dysregulation), and temperamental traits (e.g., neuroticism) contribute to individual susceptibility. Biological factors interact with environmental exposures to shape risk (27).

Developmental and Psychosocial Factors

Adverse childhood experiences (abuse, neglect), insecure attachments, and early-life deprivation increase lifetime risk for depressive and anxiety

disorders. Cumulative exposure to stressors across the life course amplifies vulnerability (28).

Social Determinants and Structural Drivers

Poverty, unemployment, low educational attainment, social isolation, discrimination, and exposure to violence are consistently associated with higher prevalence and poorer outcomes. Population-level factors—economic crises, forced displacement, and weak social safety nets—elevate population risk (29).

Acute Environmental Shocks and Epidemics

The COVID-19 pandemic illustrates how infection, containment measures (lockdowns, reduced mobility), and economic disruption can increase population prevalence: modelling and meta-analytic work estimated substantial excess cases of both depression and anxiety attributable to the pandemic in 2020. Younger people and women were often disproportionately affected (30).

Clinical Presentation and Comorbidity

Depressive disorders range from single episode major depression to recurrent and chronic forms; anxiety disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, phobic disorders, and others. Comorbidity between depression and anxiety is common and linked to greater severity, poorer response to monotherapy, higher chronicity, and increased risk of suicidal behaviour. Comorbid physical illness (cardiovascular disease, diabetes) is frequent and contributes to complexity in management (31).

Management Approaches Evidence and Delivery Models

Prevention and Population Approaches

Primary prevention strategies that address social determinants (poverty reduction, education, employment programs) and early-life interventions (parenting programs, school social-emotional learning) can reduce incidence at the population level. Community-level strategies promoting social connectedness and reducing stigma are also important; evidence for large-scale preventive impact is growing but heterogeneous (32).

Health-system Integration and Task-Sharing

Scaling up care in low-resource settings has been successfully pursued with task-sharing: training non-specialist health workers to deliver structured psychological interventions or to provide basic pharmacological management with specialist supervision. WHO's Mental Health Gap Action Programme (mhGAP) and its Intervention Guide provide pragmatic algorithms for non-specialist management of priority conditions and form the backbone of many scale-up efforts. Implementation studies show improved coverage and clinical outcomes when task-sharing is combined with supervision, referral pathways, and health-system strengthening (33.)

Psychological Therapies

Psychological treatments—particularly cognitive-behavioural therapy (CBT) and related modalities—have a strong evidence base for both depression and anxiety disorders. Meta-analyses indicate moderate to large effect sizes vs waiting list/placebo and durable benefits for many patients; effect sizes vary by disorder, delivery format (individual vs group vs guided self-help), and study quality. Digital and low-intensity psychological interventions (internet CBT, guided self-help, brief behavioural activation) expand reach and can be effective when properly adapted and supervised (34)

Pharmacotherapy

Antidepressants (SSRIs, SNRIs, tricyclics and others) are effective for many adults with moderate to severe major depressive disorder and for several anxiety disorders. Large network meta-analyses show that most commonly used antidepressants are superior to placebo in the acute treatment of major depression, though effect sizes and acceptability profiles differ across drugs. Pharmacotherapy is often combined with psychotherapy for greater benefit in more severe or chronic cases. Careful attention to side-effects, monitoring, and patient preference is essential (35)

Combined and Stepped Care Models

Guidelines increasingly endorse stepped-care approaches: begin with low-intensity, low-cost interventions (psychoeducation, guided self-help, brief psychotherapies) for mild cases and step up to specialist psychotherapy, combined therapy, or pharmacotherapy as needed. Stepped care conserves specialist resources while ensuring access to effective treatments (36) .

Evidence Synthesis: What Works and for Whom

CBT and Related Psychotherapies

Robust evidence across multiple disorders; scalable in adapted formats; effectiveness depends on fidelity and supervision (37)

Antidepressants

Substantial RCT evidence of superiority to placebo for acute response in major depression; differences among agents are modest and choice often guided by side-effect profile, comorbidity, cost, and availability (38).

Task-sharing/ mhGAP Implementations

Effective for expanding access in low- and middle-income countries when combined with supervision, referral, and health-system supports (39).

Barriers to Effective Care and Implementation Challenges

Treatment Gap and Workforce Shortages

In many countries, the majority of people with mental disorders do not receive any treatment. Resource and workforce constraints, especially in low- and middle-income countries, are major bottlenecks (40).

Stigma and Cultural Factors

Stigma reduces help-seeking. **C**ulturally tailored interventions and anti-stigma campaigns are needed (41).

Financing and Political Priority

Mental health often receives a small fraction of health budgets; sustainable financing mechanisms are required to scale services (42).

Quality and Fidelity

Rapid scale-up risks dilution of treatment quality unless supervision, training, and monitoring systems are embedded (43).

Measurement and Data Gaps

Routine monitoring, standardized outcome measurement, and health-information system integration are uneven globally (44) .

Emerging Directions and Research Priorities

Digital Mental Health

Online CBT, mobile apps, and telemedicine show promise to increase access; evaluation of long-term effectiveness, equitable access, and safety is a priority (45).

Task-sharing Optimization

Research into the optimal mix of non-specialist tasks, supervision models, and incentives for retention is needed.

Precision Approaches and Biomarkers

Biological markers and personalized treatment algorithms remain largely investigational; translation into scalable practice is premature (46).

Addressing Social Determinants

Rigorous trials of upstream interventions (income support, housing, employment programs) with mental-health outcomes are required to guide multisectoral policy.

Implementation Science

Comparative effectiveness of delivery models across contexts, and methods to embed mental-health care sustainably into primary health systems, are critical knowledge gaps.

Policy and Practice Implications

Integrate mental health into primary care using mhGAP-informed task-sharing and stepped-care models (47).

Invest in workforce development (training, supervision) and digital platforms to extend reach.

Prioritize evidence-based psychological therapies and make antidepressants available where clinically indicated, while respecting patient preference (48).

Address upstream social determinants through multisectoral policies to reduce population risk.

Strengthen monitoring, financing, and anti-stigma programs to increase uptake and retention.

Conclusion

Depressive and anxiety disorders represent a major and enduring challenge for global health. They are highly prevalent across all regions, disproportionately affect women and younger populations, and account for a substantial share of years lived with disability worldwide. Unlike many conditions that dominate global health agendas, their burden is driven primarily by long-term impairment rather than mortality, resulting in profound consequences for individuals, families, communities, and economies. Yet, despite their scale and impact, depression and anxiety remain underprioritized in many health systems, and large treatment gaps persist across income settings.

Crucially, these disorders are treatable. Over several decades, a strong scientific evidence base has emerged demonstrating the effectiveness of both psychological and pharmacological interventions. Meta-analyses consistently show that structured psychological therapies—particularly cognitive-behavioural therapy and related approaches—are effective in reducing symptoms and improving functioning across a range of depressive and anxiety disorders (49). Pharmacological treatments, especially antidepressant medications, have demonstrated superiority to placebo in moderate to severe depression and efficacy in several anxiety disorders, with acceptable tolerability profiles when appropriately prescribed and monitored. Combined treatment approaches often yield superior outcomes for individuals with severe, chronic, or recurrent illness (50). From a purely clinical perspective, therefore, the tools required to reduce individual suffering are well established.

Beyond individual-level treatments, pragmatic delivery models have been developed to address the realities of constrained health-system capacity. Approaches such as stepped care, collaborative care, and task-sharing have shown that effective mental-health care can be delivered outside specialist settings and integrated into primary care . The WHO Mental Health Gap Action Programme (mhGAP) provides a globally relevant framework for scaling evidence-based interventions through non-specialist providers, particularly in low- and middle-income countries where specialist resources are scarce. Implementation research demonstrates that, when supported by adequate training, supervision, and referral systems, task-sharing can meaningfully reduce symptoms of depression and anxiety and improve access to care for underserved populations (51).

Despite these advances, the central challenge in reducing the global burden of depressive and anxiety disorders is not a lack of effective interventions, but rather the difficulty of scaling them equitably, sustainably, and with sufficient quality. In many countries, mental health remains marginal within health budgets, receiving a disproportionately small share of funding relative to its disease burden (52). Workforce shortages are widespread, supervision systems are underdeveloped, and mental-health services are often concentrated in urban tertiary facilities, leaving rural and marginalized populations with limited access. Even where services exist, stigma, discrimination, and low mental-health literacy continue to deter help-seeking and adherence to care (53).

The COVID-19 pandemic starkly illustrated these vulnerabilities. The rapid rise in depressive and anxiety disorders during the pandemic occurred in the context of already limited-service capacity, highlighting the fragility of mental-health systems and their sensitivity to social and economic disruption. Importantly, the pandemic also reinforced the role of social determinants in shaping mental-health outcomes. Economic insecurity, unemployment, housing instability, social isolation, and bereavement emerged as powerful drivers of population-level distress, particularly among those already experiencing disadvantage. These observations underscore a critical lesson: even the most effective clinical interventions will have limited impact on population burden if upstream social determinants remain unaddressed.

Addressing the social determinants of mental health must therefore be considered a core component of any strategy to reduce the burden of depression and anxiety. Evidence consistently links poverty, unemployment, low educational attainment, gender-based violence, and social exclusion to increased risk and poorer outcomes. Policies that reduce income insecurity, improve access to education and employment, strengthen social protection, and promote safe and inclusive communities are likely to yield mental-health benefits alongside broader social gains (54).

However, such multisectoral approaches require political commitment, cross-ministerial coordination, and robust evaluation frameworks—factors that are often lacking in current policy environments.

At the same time, health systems must be strengthened to deliver mental-health care as a routine component of universal health coverage. Integration of mental health into primary care is essential to reduce fragmentation and improve access, particularly for individuals with comorbid physical conditions. Investment in workforce development—including training, supervision, and career pathways for non-specialist providers—is critical to sustaining task-sharing and collaborative care models at scale. Financing mechanisms must support not only service delivery but also monitoring, quality assurance, and continuous improvement to prevent erosion of care quality during scale-up.

Digital mental-health interventions and low-intensity delivery models offer promising avenues to extend reach, especially in contexts with limited human resources. Internet-based cognitive-behavioural therapy, telepsychiatry, and mobile health applications have demonstrated effectiveness for mild to moderate symptoms and can complement face-to-face care. However, digital solutions are not panaceas. Their impact depends on thoughtful integration into health systems, appropriate human support, cultural adaptation, and attention to equity, privacy, and data security. Without these safeguards, digital innovations risk exacerbating existing disparities rather than alleviating them.

Reducing stigma remains another essential pillar of effective response. Stigma and discrimination undermine help-seeking, social participation, and recovery, and they influence policy priorities and funding decisions. Sustained, culturally appropriate anti-stigma interventions—combined with service user involvement and rights-based approaches—are necessary to create environments in which individuals feel able to seek and receive care without fear of exclusion or marginalization.

From a research perspective, future priorities should increasingly focus on implementation science and systems-level interventions. While the efficacy of many treatments is well established, less is known about how best to deliver them at scale across diverse cultural, economic, and health-system contexts. Comparative studies of delivery models, supervision structures, financing approaches, and digital–human hybrids are needed to inform policy decisions. Additionally, greater attention should be paid to evaluating the mental-health impacts of social and economic policies, thereby strengthening the evidence base for multisectoral action.

In summary, depressive and anxiety disorders are common, disabling, and—importantly—amenable to effective intervention. The scientific literature provides clear guidance on evidence-based psychological and pharmacological treatments and on pragmatic delivery models capable of expanding access. The persistence of high global burden reflects not a failure of science, but a failure of implementation, equity, and political prioritization. A concerted and coordinated response—combining health-system reform, sustainable investment, workforce development, anti-stigma efforts, digital innovation with human support, and policies addressing social determinants—offers the most credible path toward reducing the global burden of depression and anxiety. Embedding mental health within universal health coverage and broader development agendas is not only a moral imperative, but a necessary investment in human capital, social cohesion, and global well-being.

Abbreviations

ACE: Adverse Childhood Experiences, CBT: Cognitive Behavioural Therapy, DALY: Disability-Adjusted Life Year, GAD: Generalized Anxiety Disorder, GBD: Global Burden of Disease, HPA axis: Hypothalamic–Pituitary–Adrenal axis, iCBT: Internet-based Cognitive Behavioural Therapy, LMICs: Low- and Middle-Income Countries, MDD: Major Depressive Disorder, WHO: World Health Organization.

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Author Contributions

Reetika Kashyap: conceptualized the study, conducted the literature review, and drafted the manuscript.

Conflict of Interest

The author declares no conflicts of interest related to this work.

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