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AYURVEDIC PERSPECTIVE ON ANXIETY AND DEPRESSION A COMPREHENSIVE REVIEW

***[1]Dr. Nandani Upadhyay, [2]Dr. Ravi Sharma, [3]Dr. Indumati Sharma**

[1]MD Scholar, PG Department of Kaya-Chikitsa, Madan Mohan Malviya Government Ayurvedic College and Hospital, Udaipur (Raj.)

[2]Professor and Head of Department of Kaya-Chikitsa, Madan Mohan Malviya Government Ayurvedic College and Hospital, Udaipur (Raj.)

[3]Assistant Professor, Department of Kaya-Chikitsa, Madan Mohan Malviya Government Ayurvedic College and Hospital, Udaipur (Raj.)

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***Corresponding Author**

Dr. Nandani Upadhyay

MD Scholar, PG Department of Kaya-Chikitsa, Madan Mohan Malviya Government Ayurvedic College and Hospital, Udaipur (Raj.)

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ABSTRACT

Anxiety and depression are leading contributors to the global mental-health burden. Ayurveda addresses these conditions directly through the classical construct of *Manasika Vikara*, described across the *Brihatrayi* and allied Samhitas. To consolidate the primary classical Ayurvedic understanding of anxiety and depression, corroborated where relevant by secondary review literature. Primary source material comprised direct citations from *Charaka Samhita*, *Sushruta Samhita*, *Ashtanga Hridaya*, *Ashtanga Sangraha*, *Kashyapa Samhita*, and *Bhela Samhita*. Four peer-reviewed Ayurvedic review articles (2022–2025) served as secondary literature for cross-verification and modern correlation. The classics describe depression chiefly as *Vishada*/*Avasada*, a *Tamas*-dominant *Manasika Vikara*, and anxiety as a *Rajas*-dominant disturbance such as *Chittodvega*, both rooted in vitiated *Vata* and localised at *Hridaya*. Management follows the threefold classical model — *Daivavyapashraya*, *Yuktivyapashraya*, and *Satvavajaya Chikitsa* — supported by *Medhya Rasayana* herbs, *Panchakarma*, *Yoga*, and *Ahara-Vihara*. Secondary literature corroborates several of these interventions with plausible GABAergic, serotonergic, and HPA-axis mechanisms, though controlled trials remain scarce. The Samhitas provide an internally coherent, clinically

applicable model of mental illness; modern correlation strengthens but does not yet substitute for rigorous clinical validation.

KEYWORDS: Ayurveda; Depression; Anxiety; *Manasika Vikara*; *Vishada*; *Medhya Rasayana.*

INTRODUCTION

Health, per the classics, is the state of *Svastha* — equilibrium of *Dosha*, *Agni*, *Dhatu*, and *Mala* together with a cheerful *Manas* and *Indriya* (*Sushruta Samhita*, *Sutra Sthana*, Chapter 15, Verse 48).[1] This formulation anticipates the WHO's definition of health as physical, mental, and social well-being, underscoring that mental disturbance has never been peripheral to Ayurveda's understanding of disease.

Anxiety and depression today affect a substantial proportion of the global population, a burden corroborated by secondary Ayurvedic literature citing figures of roughly 280 million people living with depression and close to a billion affected by anxiety and depression combined.[24,25] The classics anticipate many of the same precipitating forces — *Asatmyendriyartha Samyoga*, improper conduct, and emotional excess — that secondary literature now attributes to urbanisation, occupational stress, and social-media exposure.[24]

Ayurveda's relevance lies in its integrated spiritual (*Daivavyapashraya*), pharmacological (*Yuktivyapashraya*), and psychological (*Satvavajaya*) model, articulated in the *Brihatrayi* long before the modern biopsychosocial model of mental illness. This review consolidates that classical understanding, using secondary peer-reviewed literature only to corroborate it against contemporary evidence.[23,24,25,26]

AIMS AND OBJECTIVES

Aim: To consolidate the primary classical Ayurvedic understanding of anxiety and depression as presented directly in the *Brihatrayi* and allied Samhitas, corroborated by secondary review literature.

- To outline *Nidana*, *Samprapti*, and doshic/*Triguna* involvement from primary classical sources.
- To present classical *Shodhana*, *Shamana*, *Satvavajaya*, *Daivavyapashraya*, and *Yoga*-based management.
- To correlate this classical model with modern pharmacological evidence.

MATERIALS AND METHODS

Study design: Narrative review prioritising primary classical Ayurvedic literature, supported by secondary peer-reviewed sources.

Primary sources: Direct citations from *Charaka Samhita*, *Sushruta Samhita*, *Ashtanga Hridaya*, *Ashtanga Sangraha*, *Kashyapa Samhita*, and *Bhela Samhita*, located by Sthana, chapter, and verse wherever available, were treated as the authoritative basis for definitions, etiology, pathogenesis, and treatment.

Secondary sources: Four peer-reviewed Ayurvedic articles — PARIPEX (May 2022),[23] African Journal of Biomedical Research (October 2024),[24] AYUSHDHARA (March–April 2025),[25] and the Journal of Ayurveda and Integrated Medical Sciences (September 2023)[26] — were used only to cross-verify classical locants and to supply modern pharmacological and epidemiological correlation; they were not treated as primary evidence for classical content.

Inclusion criteria: Primary Samhita citations with identifiable Sthana, chapter, and verse; peer-reviewed secondary Ayurvedic literature (2022–2025) addressing *Manasika Vikara*.

Exclusion criteria: Non-peer-reviewed material and content unrelated to mental health.

Method of literature analysis: Classical citations were extracted first to structure each subsection; secondary literature was then consulted to verify and contextualise these against modern evidence, consistent with a hierarchy in which the Samhitas take precedence.

Ayurvedic Aspect

1. Ayurvedic View of Anxiety and Depression: Definition and Correlation

Ayurveda has no single lexical equivalent of "depression." Acharya Charaka states that *Vishada* is the foremost factor worsening disease (*Charaka Samhita*, *Sutra Sthana*, Chapter 25, Verse 40),[2] and includes it among the eighty *Vataja Nanatmaja Vikara* (*Charaka Samhita*, *Sutra Sthana*, Chapter 20, Verse 11).[3] Sushruta classifies *Vishada* as a *Manasa Roga* linked to *Tamasika Prakriti* (*Sushruta Samhita*, *Sutra Sthana*, Chapter 1, Verse 33),[4] a position Vagbhata extends by describing *Vishada* as a Garbha Bhava arising from Tamasa *guna* (*Ashtanga Hridaya*, *Sharira Sthana*, Chapter 3, Verse 8).[5] *Ashtanga Sangraha* (*Sutra Sthana*, Chapter 20, Verse 13)[6] and *Kashyapa Samhita* (*Sutra Sthana*, Chapter 28, Verse 29)[7] likewise enumerate it among the *Vataja Nanatmaja Vikara*. Anxiety is approached

through *Chittodvega* and *Bhaya*, *Rajas*-dominant disturbances of *Manas*, clinically distinguished from the *Tamas*-dominant inertia of depression — a distinction also drawn in secondary literature.[26]

2. *Nidana* (Etiological Factors)

Charaka identifies *Prajnaparadha* — intellect-driven wrongdoing — as a principal cause of disease, vitiating all three Doshas (*Charaka Samhita*, *Sharira Sthana*, Chapter 1, Verse 102),[8] alongside *Asatmyendriyartha Samyoga* and *Parinama* (*Charaka Samhita*, *Vimana Sthana*, Chapter 6, Verse 6).[9] Excessive *Krodha*, *Lobha*, *Moha*, *Irshya*, *Shoka*, *Chinta*, and *Udvega* are described as both cause and feature of *Manasika Vikara* (*Charaka Samhita*, *Sutra Sthana*, Chapter 7, Verse 51–52).[10] *Agantuja* causes, including *Dev Unmada* and *Bhoot Unmada*, are described in the *Nidana Sthana* (*Charaka Samhita*, *Nidana Sthana*, Chapter 7, Verse 4),[11] while individuals of *Hina Satva* are noted as constitutionally vulnerable (*Charaka Samhita*, *Vimana Sthana*, Chapter 8, Verse 119).[12]

3. *Samprapti* (Pathogenesis)

Charaka's *Tisraishaniya Adhyaya* situates the pathogenesis of *Manasika Vikara* in vitiated *Rajas* and *Tamas* superimposed on somatic *Vata*, *Pitta*, or *Kapha* disturbance (*Charaka Samhita*, *Sutra Sthana*, Chapter 11).[13] This localises at the *Hridaya*, the *Chetanasthana* or seat of *Manas* (*Charaka Samhita*),[14] producing disturbance of the *Manovaha Srotas* and resultant *Sharira*, *Indriya*, and *Sattva*-level features — *Anidra*, *Atichintana*, *Bhaya*, and *Pralapa* — that converge clinically as *Vishada*.[25]

4. Involvement of *Dosha, Dhatu, Srotas, Manas*, and the *Triguna*

Vata, described as dry, mobile, and subtle (*Ashtanga Hridaya*, *Sutra Sthana*, Chapter 1, Verse 11),[15] governs *Buddhiharana* and *Manodharana* and is implicated in the somatic core of depression; secondary literature attributes anhedonia and psychomotor retardation to *Kapha* and irritability to *Pitta*.[25] *Manas Prakriti* arises from the *Panchamahabhuta* and the *Triguna* (*Charaka Samhita*),[16] with *Rajas* and *Tamas* as the direct psychic substrate of disturbance and *Sattva* representing the natural, balanced mind. The *Manovaha Srotas*, originating at the heart and extending through the sense organs, is described as the principal channel of cognition and consciousness (*Charaka Samhita*, *Sharira Sthana*, Chapter 1, Verses 20–21).[17] Secondary literature correlates individual depressive symptoms with doshic predominance, summarised in Table 1.[25]

Table 1: Doshic correlation of depressive symptoms (secondary literature). [25]

Symptom of Depression	Predominant *Dosha*
Sadness of mood	*Vata*
Lack of pleasure (anhedonia)	*Kapha*
Sleep disturbance	*Vata*
Appetite changes	*Vata*
Easy fatigability	*Vata*
Psychomotor retardation	*Kapha*
Guilty feeling	*Vata*
Poor concentration	*Vata*
Suicidal ideation	*Vata*

5. Diagnostic Considerations

Diagnosis rests on *Nidana Parivarjana*, constitutional assessment of *Manas Prakriti*, and *Lakshana* across the *Sharira-Indriya-Sattva* triad. *Vataja Jwara* (*Charaka Samhita*, *Nidana Sthana*, Chapter 1, Verse 21)[18] and *Hina Satva Vyakti* (*Charaka Samhita*, *Vimana Sthana*, Chapter 8, Verse 119)[12] serve as classical markers of *Vishada*, while *Tamasa Prakriti* (*Sushruta Samhita*, *Sutra Sthana*, Chapter 1, Verse 33)[4] marks constitutional vulnerability; secondary literature recommends differentiating anxiety from depression along the activity–inactivity axis.[26]

6. Treatment Principles

Charaka describes three categories of Chikitsa — *Daivavyapashraya*, *Yuktivyapashraya*, and *Satvavajaya* (*Charaka Samhita*, *Sutra Sthana*, Chapter 11, Verse 54).[19]

6.1 *Shodhana Chikitsa* (*Panchakarma*)

Yuktivyapashraya includes *Shodhana* — *Vamana*, *Virechana*, *Nasya*, *Basti*, and *Raktamokshana* — to eliminate vitiated Doshas from the *Srotas*.[23] *Abhyanga* and *Shirodhara* pacify *Vata* and calm the nervous system, while *Karnapoorana* stimulates auricular pathways; these are indicated particularly for *Vata*-dominant presentations.[26]

6.2 *Shamana Chikitsa* (*Medhya Rasayana*)

Among *Medhya Rasayana*, *Shankhapushpi* (*Convolvulus pluricaulis*), *Guduchi* (*Tinospora cordifolia*), *Yashtimadhu* (*Glycyrrhiza glabra*), and *Mandukaparni* (*Centella asiatica*) are described with anxiolytic, antidepressant-like, and adaptogenic properties.[23] Secondary literature attributes complementary mechanisms to *Brahmi* (*Bacopa monnieri*), *Tagara* (*Valeriana wallichii*), *Jatamansi* (*Nardostachys jatamansi*), and *Ashwagandha* (*Withania*

somnifera), the last via HPA-axis stabilisation.[26] Classical formulations include *Brahmi Ghrita*, *Saraswatarishta*, *Ashwagandharishta*, and *Manasamitra Vataka*.[24,25,26]

6.3 *Satvavajaya Chikitsa* (Psychotherapy)

Satvavajaya — withdrawal of the mind from harmful objects (*Charaka Samhita*, *Sutra Sthana*, Chapter 11, Verse 54)[19] — comprises *Manonigraha*, *Santwana*, *Ashwasana Chikitsa*, *Chittaprasadana*, and *Atmavigyana*.[23] Secondary literature notes that stigma around counselling limits its practical uptake.[26]

6.4 *Daivavyapashraya Chikitsa*

Mantra, *Aushadha Dharana*, *Mani Dharana*, *Bali*, *Homa*, *Upavasa*, and *Tirthagamana* are indicated for *Agantuja* causation, individualised according to the patient's faith and culture (*Charaka Samhita*, *Chikitsa Sthana*, Chapter 9, Verses 93–94).[20]

6.5 *Yoga*

Yoga calms *Vata* and *Tamas* while cultivating *Sattva* toward *Moksha* (*Sushruta Samhita*, *Unmada Pratishedha Adhyaya*).[21] *Pranayama*, including *Kumbhaka*, is correlated with calming cortical effects in secondary literature.[26]

6.6 *Ahara* and *Vihara*

Sadvritta (*Charaka Samhita*, *Sutra Sthana*, Chapter 8, Verses 17–29)[22] and *Achara Rasayana* underpin lifestyle management, alongside *Dinacharya*, *Ratricharya*, and a *Satvika* diet; secondary literature adds modern micronutrient recommendations.[25]

7. Corroboration from Secondary Literature

Secondary literature corroborates several classical mechanisms: *Shankhapushpi*'s GABAergic modulation, *Guduchi*'s multi-receptor antidepressant action, *Brahmi*'s cortisol-lowering effect, and *Ashwagandha*'s HPA-axis stabilisation.[23,26] Biomedical accounts of depression — monoamine deficits, HPA dysregulation, and hippocampal/prefrontal change — converge plausibly with these classical mechanisms, though most supporting studies remain preclinical.[25]

8. DSM-5 Diagnostic Correlation

To situate the classical picture against mainstream psychiatric nosology, the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), are summarised below alongside their nearest classical correlate.[27]

DSM-5 Major Depressive Disorder requires five or more of the following over the same two-week period, including depressed mood or anhedonia: depressed mood; anhedonia; weight/appetite change; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue; worthlessness or guilt; poor concentration; and recurrent thoughts of death or suicidal ideation, causing clinically significant distress or impairment.[27]

DSM-5 Generalized Anxiety Disorder requires excessive, difficult-to-control worry on most days for at least six months, with three or more of restlessness, fatigability, poor concentration, irritability, muscle tension, and sleep disturbance, causing clinically significant distress or impairment.[27]

Table 2: Correlation between DSM-5 diagnostic features and classical Ayurvedic constructs. **[27]**

DSM-5 Feature	**Nearest Classical Ayurvedic Correlate**
Depressed mood, anhedonia	*Vishada*, *Avasada* (*Tamas*-dominant *Manasika Vikara*)
Sleep, appetite, and energy disturbance	*Vata*-dominant somatic features
Worthlessness, excessive guilt	*Hina Satva* (diminished psychological resilience)
Diminished concentration, indecisiveness	*Buddhiharana*, impairment of *Prana Vata*
Recurrent thoughts of death, suicidal ideation	Advanced or severe *Vishada*
Excessive worry, restlessness (GAD)	*Chittodvega* (*Rajas*-dominant disturbance)
Muscle tension, irritability	*Vata-Pitta* involvement

This correlation is offered as a heuristic bridge rather than a validated diagnostic equivalence, since Ayurvedic categories do not map one-to-one onto DSM-5 criteria and were not formulated with categorical psychiatric diagnosis in mind.[25,27]

DISCUSSION

Primary classical literature situates depression and anxiety within *Manasika Vikara*, governed by *Rajas-Tamas* vitiation over somatic *Vata*, internally consistent across Charaka, Sushruta, and Vagbhata despite minor terminological variance — for instance, the occasional correlation of depression with *Kaphaja Unmada* alongside the more dominant *Tamas-Vishada* model.[25] Management is multimodal by classical design, anticipating the modern biopsychosocial approach long before its articulation in contemporary psychiatry.

Secondary literature corroborates this model but does not yet substantiate it with rigorous clinical trials: pharmacological evidence for *Medhya Rasayana* herbs remains largely preclinical, and *Panchakarma* procedures such as *Shirodhara* and *Nasya* lack outcome data specific to diagnosed anxiety or depressive disorder rather than generalised stress.[23,26] Its

principal strength lies in an individualised, multi-axis approach to causation and care; its principal limitation is the absence of large-scale controlled trials enabling direct comparison with standard pharmacotherapy. Future work should extend the preliminary DSM-5 correlation in Table 2[27] using validated psychometric instruments and controlled trial designs.

CONCLUSION

The Samhitas provide an internally coherent account of anxiety and depression as expressions of *Rajas-Tamas* vitiation over somatic *Vata*, managed through *Shodhana*, *Shamana*, *Satvavajaya*, *Daivavyapashraya*, and *Yoga* (*Charaka Samhita*, *Sutra Sthana*, Chapter 11, Verse 54).[19] Secondary literature corroborates several of these interventions with plausible neurochemical mechanisms, lending modern credibility to a primarily classical framework. Translating this framework into evidence-based practice still requires controlled trials correlating classical diagnosis with standardised psychiatric outcome measures.

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