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Yoga for Depression and Anxiety: A Narrative Review of Mechanisms and Clinical Efficacy

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ABSTRACT

Introduction: Depressive and anxiety disorders are highly prevalent and frequently co-occurring mental health conditions, contributing significantly to global disease burden. Limitations of standard treatments highlight the need for complementary therapeutic approaches.

Aim: To evaluate the efficacy of yoga as an adjunctive intervention for depressive and anxiety disorders and related symptoms, and to summarize its underlying neurobiological and psychological mechanisms.

Methods: A narrative review of the literature published between 2006 and 2026 was conducted using databases such as PubMed, Scopus, and Google Scholar. Studies assessing yoga interventions in adult populations with depression and/or anxiety were included.

Results: Yoga demonstrated small-to-moderate reductions in depressive and anxiety symptoms, particularly when compared with passive controls. It appears effective as an adjunct to psychotherapy, with additional benefits linked to neurobiological mechanisms (e.g., HPA axis regulation, increased GABA and BDNF) and improved emotional regulation. However, its efficacy is less consistent when compared as a standalone intervention against active controls such as CBT.

Conclusions: Yoga is a safe and beneficial complementary intervention for depression and anxiety, especially when combined with standard treatments. It should not replace first-line therapies but may enhance overall outcomes and well-being.

Keywords:

yoga, depression, anxiety, complementary therapy, neurobiology, psychotherapy

1. Introduction

1.1. Epidemiology of depressive and anxiety disorders

Depressive and anxiety disorders are among the most common mental disorders worldwide [1]. They often co-occur; approximately 67% of individuals with a depressive disorder also have a current anxiety disorder, while 63% of those with an anxiety disorder concurrently experience depression [2]. Although anxiety disorders are presumably more frequent than depressive disorders, both are associated with high rates of comorbidity and morbidity [3].

These conditions remain among the leading contributors to the global burden of disease, ranked 13th for depressive disorders and 24th for anxiety disorders in terms of disability-adjusted life-years (DALYs). Notably, the burden of these disorders is greater in females than in males [1].

1.2. Current treatment

Standard treatment for depressive and anxiety disorders includes both pharmacotherapy and psychotherapy. Given that these disorders frequently co-occur and share common pathophysiological mechanisms, their treatments largely overlap [4].

Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) and serotonin–norepinephrine reuptake inhibitors (SNRIs), are first-line pharmacological treatments for both conditions. Medications such as sertraline, fluoxetine, and venlafaxine have demonstrated efficacy in alleviating both depressive and anxiety symptoms [5].

However, pharmacological treatments are associated with a range of adverse effects. Gastrointestinal complaints are the most common, with nausea and vomiting being the leading causes of treatment discontinuation in clinical trials [6].

Other frequent adverse effects include sexual dysfunction (e.g., decreased libido, erectile dysfunction, anorgasmia), weight gain, insomnia or somnolence, headache, and increased sweating [7]. Additionally, **treatment-resistant depression affects approximately 30% of patients with major depressive disorder [8].**

Regarding psychotherapy, cognitive-behavioral therapy (CBT) is the most extensively evidence-based intervention for both disorders. Combined treatment (pharmacotherapy plus psychotherapy) has been shown to provide superior outcomes [9].

Considering potential treatment resistance, accessibility barriers, and patient preferences for complementary approaches, alternative or adjunctive interventions may prove beneficial for optimizing mental health outcomes.

1.3. Yoga as a therapeutic intervention

There is an indissoluble relationship between mental and physical health. Engagement in exercise has been shown to significantly improve symptoms of depression, anxiety, and psychological distress across diverse adult populations [10]. Group-based and supervised exercise settings appear to enhance antidepressant effects, while shorter-duration, lower-intensity exercise is particularly effective for anxiety reduction [11].

The biological mechanisms underlying these benefits include enhanced neuroplasticity, anti-inflammatory effects, and regulation of the endocrine system [12], [13].

Meditation is another effective, low-resource intervention, including second-generation mindfulness-based interventions (SG-MBIs), which integrate ethical, spiritual, and wisdom-based components. These approaches have been shown to significantly reduce depressive and anxiety symptoms in clinical populations and may enhance

self-compassion [14]. Notably, mindfulness can also be experienced outside formal meditation contexts, as it is conceptualized as a present-moment state of nonjudgmental awareness, whereas meditation is a structured practice used to cultivate this state [15], [16].

By combining physical activity and meditation, yoga emerges as a potentially valuable therapeutic intervention. It may serve as an adjunct to pharmacotherapy or psychotherapy in the treatment of mental disorders.

Yoga originates from traditional Indian philosophy, where it is described as an eight-stage process combining ethical practices, physical preparation, and meditation, ultimately leading to spiritual liberation [17].

In Western contexts, yoga is often reframed as a form of physical exercise combined with mindfulness techniques, frequently with reduced emphasis on its spiritual aspects [18].

Traditional styles such as Hatha yoga and Ashtanga yoga integrate physical postures (asanas), breathing techniques (pranayama), and meditation within a single session. More exercise-oriented styles, such as Vinyasa yoga and Power yoga, also incorporate meditation but typically place greater emphasis on physical activity and less on meditative components [19], [20].

However, in the study by Mandlik et al., all 968 surveyed yoga teachers reported incorporating multiple components of yoga practice regardless of their primary teaching style, reflecting the inherently holistic nature of yoga [19].

Given that distinctions between different yoga styles often blur in practice, we chose to include all yoga types in our review while also highlighting potential differences among them.

2. Methods

2.1. Study design

This study was conducted as a narrative review aimed at synthesizing current evidence on the effects of yoga on depressive and anxiety disorders and related symptoms. Given the heterogeneity of yoga interventions, study populations, control conditions, and outcome measures, a flexible approach was adopted to provide an overview of both clinical and mechanistic findings.

2.2. Literature search

A non-systematic literature search was conducted to identify relevant publications. Electronic databases including PubMed, Scopus, and Google Scholar were searched for studies published between January 1, 2006, and February 28, 2026.

Search terms included combinations of keywords such as “yoga,” “depression,” “depressive disorder,” “anxiety,” and “anxiety disorders”. Boolean operators (AND/OR) were used to refine the search.

In addition, reference lists of relevant articles were manually screened to identify further studies. Seminal publications published prior to 2006 were included selectively to provide important theoretical context.

2.3. Eligibility criteria

2.3.1. Inclusion criteria

Studies were included if they:

(a) investigated yoga as an intervention or exposure;

(b) examined outcomes related to: depressive symptoms, anxiety symptoms, or closely related constructs (e.g., psychological distress, stress);

(c) included adult populations (≥18 years), either: clinically diagnosed (DSM/ICD), or assessed using validated questionnaires (e.g., PHQ-9, GAD-7);

(d) reported measurable psychological, clinical, or biological outcomes;

(e) were published in English.

To provide a broader understanding of underlying mechanisms, **mechanistic studies examining the biological effects of yoga or related mind–body interventions (e.g., neurobiological, endocrine, or physiological research) were also included, even when conducted in non-clinical populations.**

2.3.2. Exclusion criteria

Studies were excluded if they:

(a) did not assess yoga or yoga-based interventions;

(b) did not report outcomes relevant to mental health;

(c) focused exclusively on pediatric populations.

2.4. Quality appraisal

Given the narrative nature of this review, a formal risk-of-bias assessment was not performed. Instead, studies were evaluated qualitatively based on their methodological rigor, including study design, sample size, use of validated outcome measures, and consistency of findings with the broader literature.

Greater emphasis was placed on higher levels of evidence, such as meta-analyses, systematic reviews, and randomized controlled trials. However, observational and mechanistic studies were included where they provided important contextual or explanatory insights.

2.5. Data synthesis

Due to substantial heterogeneity in study design, findings were synthesized qualitatively and organized into thematic domains, including neurobiological mechanisms, psychological mechanisms, clinical efficacy for depression, clinical efficacy for anxiety and stress, safety and adverse effects. Additionally, effect sizes were reported as presented in the original studies and were not converted to a common metric due to heterogeneous study designs.

3. Narrative synthesis

3.1. Potential mechanism of action

3.1.1. HPA axis

From a neurobiological perspective, yoga practice is associated with improved regulation of both the sympathetic nervous system and the HPA axis, as evidenced by reduced cortisol levels (both waking and evening), decreased blood pressure, and improved heart rate variability [21], [22].

However, the effects on cortisol may vary depending on yoga style and timing. For instance, meditative yoga (Hatha style) significantly decreases salivary cortisol levels immediately post-session, whereas power yoga (Vinyasa style) does not produce significant cortisol changes [23]. Furthermore, yoga stretching may produce more sustained effects on the hormone system. In a crossover study, salivary cortisol levels significantly decreased 120 minutes after yoga stretching, while the testosterone-to-cortisol ratio increased, indicating a shift toward a more anabolic hormonal state [24]. These differential effects may relate to the intensity: dynamic yoga may initially activate the stress response, whereas slower, meditative practices more directly engage parasympathetic activation and HPA axis downregulation.

HPA axis dysregulation is one of the most consistent biological findings in major depressive disorder, particularly in melancholic depression [25]. Moreover, the incidence of cortisol rhythm disruption is significantly higher in depression with comorbid anxiety compared with depression without anxiety [26]. However, the relationship between symptom severity and

cortisol is not linear. Research using the tripartite model dimensions (general distress, anhedonic depression, and anxious arousal) found inverted U-shaped associations with the cortisol awakening response, with both high and low symptom severity associated with lower responses compared with intermediate severity levels [27].
In this regard, HPA axis alterations may occur only in a subset of patients, indicating that treatments targeting HPA axis components, such as yoga, may be most pronounced in individuals with baseline dysregulation.

3.1.2. GABAergic system

The main function of GABAergic neurotransmission is to provide inhibitory control of neuronal excitability, maintaining the balance between excitation and inhibition in the central nervous system [28]. GABAergic medications, such as benzodiazepines, primarily target symptoms including anxiety, insomnia, agitation, and epilepsy. In turn, gabapentinoids (gabapentin and pregabalin) are used for conditions such as epilepsy, neuropathic pain, and anxiety [29].
Yoga may be associated with enhanced GABAergic neurotransmission [30]. For instance, exploratory imaging studies demonstrate that yoga increases thalamic GABA levels, which are implicated in pathophysiology of psychological distress [31]. However, this evidence is based on small-scale studies and requires replication in larger samples.
A proposed hypothesis involves vagal nerve stimulation during yoga practices, which may correct parasympathetic nervous system underactivity and increase GABA system activity [30]. This suggests that yoga may modulate similar pathways to GABAergic and related neuroinhibitory medications, without their side effects such as sedation, dizziness, weakness, and unsteadiness [32]. Overall, these findings provide preliminary support for a role of GABAergic modulation in the anxiolytic effects of yoga.

3.1.3. Monoamines

Monoamine dysregulation may also play a role in depression and anxiety; however, its historical formulation, suggesting that deficiencies in serotonin, norepinephrine, and/or dopamine directly cause these disorders, is now considered inadequate [33]. Current evidence suggests a more complex model in which monoamine dysregulation represents one component within broader neurobiological cascades involving neuroplasticity, inflammation, and circuit dysfunction [25], [34].

However, there is more consistent evidence supporting a potential role for dopaminergic dysfunction in depression, particularly in relation to anhedonia [35]. Neuroimaging studies have shown reduced striatal dopamine transporter (DAT) binding in major depressive disorder, interpreted by some authors as compensatory downregulation in response to decreased dopamine transmission. Additionally, dopamine depletion studies demonstrate rapid increases in depressive symptoms in remitted patients, providing more direct evidence for dopamine's role [36].

In this context, considerably limited neuroimaging evidence suggests that yoga practice may increase endogenous dopamine release within the ventral striatum [37]. The ventral striatum functions as a target region receiving dopaminergic projections from midbrain structures, where dopamine modulates reward processing, motivation, and learning [38].

However, this evidence is preliminary, based on small samples, and has not been directly linked to clinical outcomes. Consequently, while yoga may plausibly influence reward-related neural processes, current data are insufficient to establish a causal effect on mental health.

3.1.4. BDNF

BDNF is a critical regulator of neuroplasticity, involved in neuronal growth, synaptic transmission, and structural brain changes [39]. It plays a key role in achieving clinically meaningful improvement in depression and anxiety, with studies showing that treatment responders and remitters exhibit increased BDNF levels, whereas non-responders do not [40], [41].

Exercise is one of the most potent and well-established interventions for enhancing BDNF levels, with high-intensity exercise producing the greatest effects; approximately 4–5-fold greater increases compared with prolonged low-intensity exercise [42]. A meta-analysis of exercise interventions in patients with depression found that yoga is among the most effective modalities for elevating BDNF levels, ranking third after combined aerobic–resistance exercise and resistance exercise alone [43]. Accordingly, more dynamic forms of yoga may be especially beneficial; however, there is a notable gap in the literature examining their effects on BDNF.

Nevertheless, a 3-month Isha yoga retreat (slow to moderate pace) increased plasma BDNF levels, with the magnitude of increase inversely correlated with anxiety scores both before and after the intervention [44]. Similarly, in patients with major depressive disorder, a 12-week yoga- and meditation-based lifestyle intervention resulted in an increase in plasma BDNF compared with controls, alongside reduced depression severity [45]. Collectively, these

findings suggest that yoga may contribute to neuroplastic changes associated with symptom improvement.

3.1.5. Psychological effects

Beyond neurobiological pathways, yoga appears to exert its benefits through several interrelated psychological mechanisms. A central process is interoceptive awareness, the capacity to perceive internal bodily sensations, which plays a key role in improving mental health. Yoga strengthens skills such as noticing, attention regulation, self-regulation, and body listening [46].

Evidence from a meta-analysis of 29 randomized controlled trials (RCTs) indicates that gains in self-reported interoception are associated with reductions in psychological distress [47]. These findings support a cascade model in which enhanced body awareness leads to improved emotion regulation, ultimately contributing to reduced distress [48].

Through yoga practice, individuals develop the ability to observe bodily sensations without judgment, enhancing a more adaptive relationship with physical symptoms. As a result, emerging sensations are experienced as less threatening or distressing. The present-focused nature of yoga may counteract the future-oriented tendencies of anxiety and the past-oriented rumination characteristic of depression [49].

Such practices can also be understood as a form of grounding techniques, constituting therapeutic interventions designed to help individuals manage dissociation, emotional dysregulation, and anxiety. Examples include controlled breathing exercises and the capacity to observe thoughts and feelings from a distance [50].

Importantly, all these mechanisms are unlikely to operate independently. Instead, yoga may exert synergistic effects across neuroendocrine, neurotransmitter, and psychological domains, contributing to its overall therapeutic potential.

A summary of the key neurobiological and psychological mechanisms associated with yoga is provided in Table 1.

Table 1. Potential mechanisms of action of yoga

Mechanism	Key Effect of Yoga	Clinical Relevance	Limitations
HPA axis	↓ Cortisol, ↑ parasympathetic activity	Improves stress regulation in depression/anxiety	Effects vary by yoga style/intensity; not all

			patients show HPA dysregulation
GABAergic system	↑ GABA activity (via vagal stimulation)	Reduces anxiety and promotes relaxation	Evidence based on small studies; limited replication
Monoamines (dopamine)	Possible ↑ dopamine release	May improve anhedonia	Preliminary evidence; no clear clinical linkage
BDNF	↑ BDNF and neuroplasticity	Supports recovery and symptom improvement	Limited data on yoga type/intensity effects; indirect evidence
Psychological mechanisms	↑ Interoception, ↓ rumination, improved emotion regulation	Enhances coping and reduces distress	Mostly self-reported outcomes; mechanistic pathways not fully established

Source: Author's synthesis based on the studies cited in the text [21-50].

3.2. Efficacy for depressive symptoms

Yoga is one of several effective exercise-based interventions for major depressive disorder (MDD), alongside walking/jogging and strength training, according to a network meta-analysis. Importantly, treatment effects are proportional to exercise intensity, and both yoga and strength training demonstrated the highest levels of acceptability and adherence among all exercise modalities [51].

Additional meta-analytic evidence further suggests a dose-response relationship, with greater reductions in depressive symptoms observed at higher frequencies of weekly yoga practice [52]. Across trials, yoga interventions vary in both duration and style, with most studies employing programs lasting 4–12 weeks and incorporating diverse approaches, including Hatha, Iyengar, and mindfulness-based yoga [53].

A recent 2024 meta-analysis of 24 RCTs found that yoga interventions produced a statistically significant small-to-moderate reduction in depressive symptom severity compared with passive control conditions (e.g., waitlist or treatment as usual), with a standardized mean difference (SMD) of –0.43. However, these effects were not observed when yoga was compared with active control conditions, such as attention control, aerobic exercise, or medication-only approaches [53].

In contrast, the earlier network meta-analysis reported moderate reductions in depressive symptoms associated with yoga even when compared with active controls, including usual care, placebo tablets, stretching, educational interventions, and social support (Hedges' g = –0.62) [51]. These discrepancies may reflect inconsistencies in the classification of control conditions

between studies, as interventions such as usual care or placebo tablets may function as passive rather than active comparators.

Compared with pharmacological research, RCTs of behavioral interventions such as yoga often involve greater heterogeneity in study design and control conditions. Moreover, studies directly comparing yoga and pharmacotherapy remain limited. One systematic review reported no significant short-term differences in depressive symptom severity between yoga and antidepressant medication, although conclusions were constrained by a small number of RCTs with low sample sizes (240 in total) [54].

There is modest evidence highlighting the potential of yoga as an adjunct to psychotherapy. In a pragmatic preference trial, the addition of yoga to CBT resulted in greater symptom improvement than CBT alone among individuals with comorbid depression and anxiety. This combined intervention was also associated with more rapid symptom reduction and sustained decreases in depressive symptoms over a 3-month follow-up period [55]. However, these findings should be interpreted with caution, as the sample size was small (59 in total) and patients' motivation, including increased engagement in various activities, may influence treatment outcomes.

Regarding remission of depression, yoga interventions have been associated with higher remission rates compared with both passive (OR = 3.20) and active control groups (OR = 2.04) in meta-analytic results. It is important to note that remission was variably defined across studies, including the use of cut-off scores for depression severity, diagnostic criteria, or a combination of both, with one study not reporting its definition [53]. These findings suggest that the benefits of yoga may extend beyond symptom reduction to clinically meaningful recovery; however, evidence is limited and heterogeneous.

3.3. Efficacy for anxiety symptoms and stress levels

Further evidence supports the beneficial effects of yoga on anxiety and stress. A recent meta-analysis (2026) including 30 studies found that yoga produced a moderate reduction in anxiety symptoms ($g = -0.52$) compared with all control groups (waitlist, active, and a standard control) [56].

Another meta-analysis of 8 RCTs, with a relatively small pooled sample (319 in total), reported small short-term effects of yoga on anxiety compared with no treatment (SMD = –0.43), and larger effects when compared with active interventions such as progressive muscle relaxation, social interaction, acupressure, and breathing techniques (SMD = –0.86). However, these

benefits were observed only in individuals with elevated anxiety levels or those diagnosed using non-DSM criteria, and not in patients with formally diagnosed DSM anxiety disorders [57]. This suggests that baseline symptom severity and diagnostic criteria play key roles in determining outcomes, with subclinical populations more likely to show improvement.

In terms of perceived stress, a meta-analysis of 13 RCTs found moderate short-term reductions in stress favoring yoga over passive control groups (SMD = –0.69). However, no significant differences were observed when yoga was compared with active interventions such as mindfulness training or progressive muscle relaxation. Furthermore, in the long term, these alternative interventions demonstrated superior outcomes for stress reduction over yoga practice (SMD = 0.23) [58].

It is important to distinguish between anxiety and stress despite their overlapping biological mechanisms, including interactions within the hypothalamic–pituitary–adrenal (HPA) axis and amygdala hyperactivation [59], [60]. Anxiety is typically defined as an emotional state characterized by anticipation of future threats, whereas stress refers to a physiological and psychological response to external demands or challenges [61]. Therefore, stress-related findings should be interpreted with caution in the context of anxiety disorders.

Regarding first-line treatments, evidence suggests that CBT is more effective than yoga. In a RCT of 226 adults with generalized anxiety disorder, Kundalini yoga was compared with CBT and stress education over 3 months. Response rates were 54.2% for yoga, 70.8% for CBT, and 33.0% for stress education. Although yoga significantly outperformed stress education (OR = 2.46), it did not meet noninferiority criteria compared with CBT, with a difference in response rates of 16.6%. Moreover, the effects of yoga were less robust, with benefits not consistently maintained at 6-month follow-up [62].

There is currently no reliable evidence directly comparing yoga to antidepressant treatment for anxiety. However, one relevant RCT involving 276 adults compared mindfulness-based stress reduction (MBSR) with escitalopram treatment over 8 weeks and demonstrated noninferiority of MBSR [63]. While MBSR incorporates some elements of yoga (e.g., stretching and breath awareness), it primarily emphasizes mindfulness-based cognitive processes; therefore, its findings cannot be generalized to yoga interventions.

An overview of the evidence on the efficacy of yoga for depression, anxiety, and stress is presented in Table 2.

Table 2. Summary of evidence on the efficacy of yoga for depression, anxiety, and stress

Outcome	Result	Effect size	Comparator	Notes
Depression	Symptom reduction	SMD ≈ −0.43	vs passive controls	Not significant vs active controls in some analyses
Depression	Symptom reduction	g ≈ −0.62	vs active controls	May reflect differences in control definitions
Depression	Remission	OR ≈ 2.04–3.20	vs active and passive controls	Heterogeneous definitions of remission
Depression	Dose–response effect	—	—	Higher frequency → greater improvement
Depression	No statistically significant difference	—	vs antidepressants	Based on limited RCT data; small sample sizes
Depression	Greater symptom reduction in Yoga + CBT group	—	vs CBT alone	Faster improvement and sustained effects; small sample
Anxiety	Symptom reduction	g ≈ −0.52	vs all controls	Moderate effect
Anxiety	Short-term effect	SMD ≈ −0.43	vs no treatment	Stronger in elevated anxiety populations; small samples
Anxiety	Symptom reduction	SMD ≈ −0.86	vs active controls	Stronger in elevated anxiety populations; small samples
Anxiety	Inferior to CBT, difference in response rates ≈ 16.6%	—	vs CBT	Yoga did not meet noninferiority criteria; effects less sustained
Stress	Short-term reduction	SMD ≈ −0.69	vs passive controls	No advantage vs active interventions
Stress	Long-term effect	SMD ≈ 0.23	vs active controls	Other interventions may be superior to yoga

Source: Author's synthesis based on the studies cited in the text [51-62].
Note: Effect sizes (SMD, Hedges' g, OR) are reported as provided in the original studies and are not directly comparable.

3.4. Safety and adverse events

Yoga is generally considered a safe practice compared with many other physical activities. Although a considerable proportion of practitioners report injuries or adverse events, these are

typically mild, transient, and primarily musculoskeletal in nature, such as sprains, strains, or temporary increases in back pain. Importantly, the overall risk appears comparable to that of non-yoga practitioners [64].

However, population-level epidemiological data indicate that serious adverse events still occur in approximately 1.9% of yoga practitioners, underscoring the need for caution [64].

In clinical trials examining yoga as an intervention for depression and anxiety, yoga has not been associated with an increased risk of injury or worsening psychiatric symptoms during treatment [65], [57].

Individuals with serious acute or chronic health conditions should seek medical advice before beginning yoga. Additionally, yoga should be practiced under the guidance of a qualified instructor to minimize the risk of adverse events.

4. Limitations

This review has several limitations. As a narrative review, it is subject to selection bias, and the non-systematic search strategy may have resulted in the omission of relevant studies. Additionally, publication bias cannot be excluded, as studies with positive findings are more likely to be published.

No formal risk-of-bias assessment was conducted; studies were appraised qualitatively, and therefore the strength of the evidence should be interpreted with caution. The overall quality of included studies was variable, with limitations such as small sample sizes, short intervention durations, and limited follow-up.

A major limitation across the literature is substantial heterogeneity in yoga interventions, including differences in style, intensity, frequency, and intervention components. Furthermore, due to the behavioral nature of yoga interventions, double-blind designs are generally not feasible, which may increase the risk of performance bias.

Additional variability in study populations, outcome measures, and control group design further limits comparability and complicates interpretation of findings.

These limitations highlight the need for cautious interpretation and for more standardized research in this field.

5. Conclusions

Overall, yoga appears to be an effective adjunctive intervention for reducing symptoms of depression and anxiety. Unlike first-line treatments, yoga works by improving physical condition and influencing neurobiological pathways associated with exercise, which may significantly enhance overall well-being.

Research shows consistent benefits of yoga when compared with passive controls for both disorders, although its advantages are less consistent when compared with active treatments. Yoga seems particularly effective when combined with psychotherapeutic approaches such as CBT. However, when used as a standalone treatment, CBT remains more effective, especially for anxiety disorders. Emerging evidence also suggests that yoga may have a positive impact on remission rates. Additionally, higher frequency and intensity of practice are associated with greater therapeutic benefits.

Standard treatments, including antidepressants and psychotherapy, are supported by stronger evidence. This review does not support yoga as a first-line therapy. Instead, yoga may be especially beneficial for individuals with low levels of physical activity and as a tool for improving awareness of bodily sensations.

Future research should address existing gaps in the literature. This includes direct comparisons between different styles of yoga, as well as head-to-head trials against active treatments such as antidepressants and CBT. More studies examining yoga specifically as an adjunctive therapy are also needed. Importantly, greater standardization in study design and clearer control conditions will help reduce heterogeneity and allow for more reliable comparisons across trials.

Disclosure:

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