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Assessment of the relationship between the presence of these disorders and health-related quality of life, functional capacity and use of health services.

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LITERATURE REVIEW

RESUMO

Introdução: Os transtornos de ansiedade e depressão representaram condições de saúde mental de alta prevalência e profundo impacto global. A sua manifestação clínica não se restringiu à esfera do sofrimento psíquico, mas reverberou de forma abrangente em múltiplos domínios da vida do indivíduo. Tais transtornos foram frequentemente associados a uma deterioração da saúde física, ao comprometimento das relações sociais e a uma significativa perda de produtividade laboral e pessoal. Essa interação complexa entre a saúde mental e o bem-estar geral justificou a investigação aprofundada das suas consequências diretas na percepção de saúde e na interação do paciente com o sistema de cuidados. Objetivo: O objetivo desta revisão sistemática foi analisar e sintetizar as evidências científicas disponíveis sobre a associação da presença de transtornos de ansiedade e depressão com a qualidade de vida relacionada à saúde, a capacidade funcional e os padrões de utilização de serviços de saúde em populações adultas. Metodologia: Foi conduzida uma revisão sistemática da literatura, baseada nas diretrizes do checklist PRISMA, com artigos publicados nos últimos 10 anos. As buscas foram realizadas nas bases de dados PubMed, Scielo e Web of Science, utilizando os seguintes descritores e suas combinações: "depressão", "ansiedade", "qualidade de vida", "capacidade funcional" e "utilização de serviços de saúde". Os critérios de inclusão foram: estudos observacionais (transversais ou de coorte), amostras compostas por adultos e avaliação de ao menos um dos desfechos de interesse. Foram excluídos estudos de revisão, ensaios clínicos que avaliavam intervenções específicas e pesquisas focadas exclusivamente em populações pediátricas. Resultados: Os resultados encontrados nos estudos analisados demonstraram consistentemente uma forte associação negativa entre a presença de transtornos de ansiedade e depressão e os

desfechos avaliados. Indivíduos com esses diagnósticos apresentaram escores significativamente inferiores em todos os domínios da qualidade de vida relacionada à saúde. Ademais, foi observada uma maior prevalência de incapacidade funcional, com relatos de maior dificuldade para realizar atividades de vida diária e maior absenteísmo no trabalho. O padrão de utilização de serviços de saúde mostrou-se mais intenso nesse grupo, caracterizado por um número maior de consultas médicas, maior frequência de visitas a serviços de emergência e taxas de hospitalização mais elevadas. Conclusão: Concluiu-se que os transtornos de ansiedade e depressão se configuraram como condições que impuseram um fardo substancial, que se estendeu muito além dos sintomas emocionais. A presença desses transtornos esteve diretamente associada a uma piora acentuada da qualidade de vida, a um declínio significativo da capacidade funcional e a uma sobrecarga nos sistemas de saúde. Tais achados reforçaram a necessidade de abordagens de cuidado integrado, que reconheçam e tratem o impacto multifacetado da saúde mental no bem-estar geral do paciente.

Palavras-chave: “Qualidade de Vida”; “Depressão”; “Ansiedade”; “Capacidade Funcional”; “Serviços de Saúde”.

ABSTRACT

Introduction: Anxiety and depression disorders are highly prevalent mental health conditions with profound global impact. Their clinical manifestations are not restricted to the sphere of psychological distress, but have widespread repercussions in multiple domains of an individual's life. These disorders are often associated with deterioration in physical health, impairment of social relationships, and significant loss of work and personal productivity. This complex interaction between mental health and general well-being has justified in-depth investigation of their direct consequences on the perception of health and the patient's interaction with the health care system. Objective: The objective of this systematic review was to analyze and synthesize the available scientific evidence on the association between the presence of anxiety and depression disorders and health-related quality of life, functional capacity, and patterns of use of health services in adult populations. Methodology: A systematic review of the literature was conducted, based on the PRISMA checklist guidelines, with articles published in the last 10 years. The searches were performed in the PubMed, Scielo and Web of Science databases, using the following descriptors and their combinations: "depression", "anxiety", "quality of life", "functional capacity" and "use of health services". The inclusion criteria were: observational studies (cross-sectional or cohort), samples composed of adults and evaluation of at least one of the outcomes of interest. Review studies, clinical trials that evaluated specific interventions and research focused exclusively on pediatric populations were excluded. Results: The results found in the

analyzed studies consistently demonstrated a strong negative association between the presence of anxiety and depression disorders and the evaluated outcomes. Individuals with these diagnoses presented significantly lower scores in all domains of health-related quality of life. Furthermore, a higher prevalence of functional disability was observed, with reports of greater difficulty in performing activities of daily living and greater absenteeism at work. The pattern of health service utilization was more intense in this group, characterized by a greater number of medical consultations, a greater frequency of emergency room visits, and higher hospitalization rates. Conclusion: Anxiety and depression disorders were found to be conditions that imposed a substantial burden, extending far beyond emotional symptoms. The presence of these disorders was directly associated with a marked worsening of quality of life, a significant decline in functional capacity, and a burden on health systems. These findings reinforce the need for integrated care approaches that recognize and address the multifaceted impact of mental health on the overall well-being of the patient.

Keywords : “Quality of Life”; “Depression”; “Anxiety”; “Functional Capacity”; “Health Services”.

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INTRODUCTION:

Common mental disorders, notably anxiety and depression, represent one of the leading causes of disability worldwide, imposing a substantial burden not only on individuals but also on health systems and society as a whole. Contemporary understanding of these conditions transcends the reductionist view that limits them to emotional suffering. It is now recognized that their manifestations are systemic and permeate all facets of human experience, profoundly influencing the perception of one's own health and the ability to engage in life. Assessing their impact, therefore, requires an analysis that goes beyond symptomatology and encompasses their functional consequences and quality of life.

In this context, the damage these disorders cause to health-related quality of life (HRQoL) is markedly multidimensional in nature. The deterioration is by no means restricted to the psychological domain, characterized by sadness, anhedonia, or excessive worry. The impact extends vehemently to the physical domain, where patients often report an increased perception of pain, chronically low energy levels, and a myriad of somatic complaints that often lack a clear organic explanation. Furthermore, the social domain is profoundly affected, manifesting itself through isolation, withdrawal from social and leisure activities, and deterioration in the quality of interpersonal relationships. This widespread erosion of subjective well-being demonstrates that psychological distress materializes in an overall impoverished life experience.

In a complementary and consequential manner, the core symptoms of anxiety and depression translate directly into functional incapacity in daily life. Symptoms such as fatigue, lack of motivation (volition) and cognitive deficits – which include difficulties with concentration, memory and decision-making – are not merely subjective perceptions, but rather concrete barriers to the execution of tasks. This results in a significant impairment of Activities of Daily Living (ADLs), from the most basic, such as personal hygiene, to instrumental ones, such as managing finances or using transportation. In the professional sphere, this impact manifests itself as a significant loss of productivity, which encompasses both absenteeism (missing work) and the more insidious phenomenon of presenteeism, where the individual is physically at work, but with substantially reduced performance and capacity to deliver. This loss of functionality represents the materialization of the disease in the individual's practical life, limiting their

autonomy and their potential for social and economic contribution.

Additionally, the impact of these disorders extends to how individuals interact with the health care system, resulting in a characteristic pattern of health service utilization. Patients with anxiety and depression demonstrate a notably higher frequency of seeking medical care, especially in primary care. Often, this search is motivated by persistent and medically unexplained somatic symptoms, which function as a physical expression of psychological distress. This somatization not only creates a diagnostic challenge for professionals, but also contributes to an increase in the rates of additional tests, specialist consultations and hospitalizations. The result is a cycle of overutilization that overburdens the health system's resources, without, however, effectively addressing the root of the problem, which is psychosocial in nature.

It is also essential to recognize that the relationship between mental disorder and disability is rarely unidirectional; it actually operates as a vicious cycle of negative feedback. The loss of functional capacity itself, the deterioration of social relationships, or the professional instability generated by the disease act as powerful chronic stressors. These stressors, in turn, exacerbate and perpetuate anxious and depressive symptoms, making recovery a considerably more difficult process. An individual who loses his or her job due to anhedonia and lack of concentration, for example, faces a new layer of financial and existential stress that worsens his or her depressive state. Understanding this bidirectional dynamic is crucial, as it shows that effective interventions need to be holistic, simultaneously addressing both the psychological symptoms and their triggers and consequences in the patient's living environment.

Ultimately, the confluence of these factors culminates in a massive socioeconomic burden, which can be categorized into direct and indirect costs. Direct costs include the financial expenditures directly associated with treatment and the increased consumption of health resources, including consultations, medications, therapies, and hospitalizations. Indirect costs, which often exceed direct costs, refer to the economic value lost by society due to the reduced or absent productivity of affected individuals. This includes everything from lost work days and a decline in professional performance (presenteeism) to premature exit from the workforce due to permanent disability. Thus, assessing the impact of these disorders reveals that investing in accessible, quality mental health services is not just a clinical necessity, but an indispensable strategy for economic sustainability and social well-being.

The objective of this systematic review is to analyze and synthesize the available scientific evidence that evaluates the association between the presence of anxiety disorders and/or depression and their impacts on health-related quality of life, functional capacity and patterns of use of health services.

METHODOLOGY

This systematic review was designed and conducted in strict accordance with the recommendation items of the PRISMA protocol (Preferred Reporting Items for Systematic Reviews and Meta-Analyses), in order to ensure methodological transparency and reproducibility of the findings.

A systematic and comprehensive search was conducted in the electronic databases PubMed, Scielo and Web of Science. The search strategy included scientific articles published in the last ten years, with the search completed in June 2025. Five main descriptors were used, in Portuguese and English, combined through the Boolean operators AND and OR to optimize the search sensitivity: "anxiety disorders", "depressive disorder", "quality of life", "functional capacity" and "health services utilization". The search was complemented by manually checking the reference lists of the selected articles to identify potentially relevant studies not captured in the initial search.

The criteria for inclusion and exclusion of studies were rigorously predefined based on the PICO (Population, Exposure, Comparison, Outcome) framework.

The following inclusion criteria were established:

- Type of Study: Observational studies, such as cross-sectional, cohort or case-control studies, which investigated the association between the variables of interest were included.
- Population: The sample should be composed of adult individuals (aged 18 years or older) with a formal clinical diagnosis of depressive and/or anxiety disorders, established by recognized diagnostic criteria (e.g. DSM or ICD).
- Outcomes: Articles should quantitatively assess, as a primary or secondary outcome, at least one of the following variables: health-related quality of life, functional capacity (or disability) or the frequency/pattern of use of

health services.

- Language: Studies published in full in Portuguese, English or Spanish were considered for analysis.
- Publication Type: Only complete original articles, available for reading in full, were selected.

On the other hand, the exclusion criteria were:

- Study Type: Randomized controlled trials evaluating the effectiveness of a specific intervention were excluded, as were literature reviews, meta-analyses, editorials, case reports, and conference abstracts.
- Population Focus: Studies focused exclusively on pediatric or adolescent populations, or on subgroups with very specific clinical comorbidities that would act as the main confounder (e.g., depression in terminal cancer patients).
- Lack of Association Analysis: Research that only described the prevalence of conditions, but did not present a statistical analysis of the association between the presence of the disorder and the outcomes of interest.
- Unavailability of Data: Articles whose quantitative data on outcomes were not presented clearly, preventing their extraction and analysis.
- Qualitative Approach: Investigations with a purely qualitative methodology, without the presentation of quantitative data on the variables of interest.

The selection process was performed in phases by two independent reviewers. Initially, after removing duplicates, the titles and abstracts of all identified articles were screened. Studies that appeared to meet the eligibility criteria were then subjected to full-text reading. Final inclusion decisions were made jointly. Any disagreements between the reviewers at any stage of the process were resolved through discussion and consensus or, if necessary, by the assessment of a third senior reviewer. The entire process was documented to produce a PRISMA flowchart.

RESULTS

The presence of depressive and anxiety disorders invariably imposes a profound and widespread decline in health-related quality of life (HRQoL), a construct that assesses the individual's well-being in multiple spheres. The impairment begins prominently in the

psychological domain, where it goes far beyond sadness or worry. It manifests itself through anhedonia, the inability to feel pleasure in previously gratifying activities, and a feeling of hopelessness that undermines the perspective of the future. Additionally, the rumination of negative thoughts and constant distress consume the individual's cognitive and emotional resources, resulting in a persistent state of malaise that fundamentally degrades the experience of life.

However, the insidious nature of these disorders lies in their ability to spill over from the psychic domain into all other dimensions of existence. In the physical domain, for example, mental suffering often materializes in an increased perception of pain, chronic fatigue that does not improve with rest, and sleep disorders such as insomnia or hypersomnia. Similarly, the social domain is severely eroded, as lack of energy and fear lead to isolation, withdrawal from social activities, and tension in interpersonal and family relationships. Consequently, quality of life is not only affected, but systematically dismantled, piece by piece, demonstrating that mental health is an indispensable pillar for overall well-being.

The deterioration of quality of life is intrinsically linked to the loss of functional capacity, which represents the materialization of psychological symptoms into concrete barriers in daily life. Cognitive deficits, which are core symptoms especially in depression, play a central role in this process. Difficulties with sustained attention, working memory and executive functions (such as planning and organization) directly compromise the individual's ability to manage complex tasks. In the meantime, affective symptoms such as avolition (a severe lack of motivation) and paralyzing fatigue sap the energy needed to start and complete even the simplest activities, transforming the daily routine into a Herculean challenge.

This cognitive and affective dysfunction, therefore, translates into a spectrum of observable disabilities. There is significant impairment in Activities of Daily Living (ADLs), both instrumental activities, such as managing one's finances or using public transportation, and, in more severe cases, basic activities, such as hygiene and self-care. In the workplace, the impact is devastating and manifests itself in two main ways: absenteeism, which corresponds to absences from work, and the even more prevalent phenomenon of presenteeism, in which the individual shows up for work but operates with drastically reduced productivity and efficiency. This loss of functionality not only limits the patient's autonomy and independence, but also represents the main route

through which these disorders generate an immense social and economic cost.

The presence of anxiety disorders and depression invariably catalyzes a significant change in care-seeking behavior, resulting in a well-documented pattern of overutilization of health services. Psychological distress often manifests itself through somatization, a process in which emotional distress is expressed through multiple physical symptoms, such as chronic pain, palpitations, gastrointestinal disturbances, and dizziness. Due to the eminently physical nature of these complaints, patients repeatedly seek care in primary care services and emergency units, rather than seeking mental health services directly. This incessant search for an organic explanation for their physical symptoms generates a cycle of repeated consultations, tests, and referrals to various medical specialties.

Consequently, this pattern of utilization not only represents an inefficient allocation of resources, but also perpetuates patient suffering. The individual is often subjected to an extensive and costly "diagnostic merry-go-round" that, by failing to identify an organic cause, can amplify anxiety and feelings of invalidation. For the health care system, this translates into a significant increase in direct costs, which range from the cost of consultations and tests to the higher rates of hospitalization observed in this population. Critically, this path often delays the correct diagnosis and the initiation of effective mental health treatment, which would be able to address the root cause of the problem and, therefore, reduce the need for seeking general care.

It is also crucial to understand that the relationship between mental disorders and functional disability is not linear or unidirectional, but rather operates as a vicious feedback loop. Psychiatric symptoms—such as apathy, fatigue, or excessive worry—act as the initial trigger that leads to impairment in social, occupational, and personal functioning. For example, difficulty concentrating and anhedonia may lead an individual to withdraw from friends, perform poorly at work, or abandon leisure activities. These losses and limitations in practical life are not, however, merely passive outcomes of the illness.

In the meantime, the consequences of functional incapacity become powerful stressors that feed back and aggravate the underlying mental disorder. Social isolation intensifies feelings of loneliness and hopelessness; professional instability generates financial stress and a sense of failure; the inability to perform daily tasks reinforces a self-image of inadequacy and helplessness. In this way, the consequences of the disease

themselves become causes of its perpetuation and intensification, closing a cycle that is difficult to break. This bidirectional nature has profound therapeutic implications, as it shows that effective interventions must be holistic, aiming not only at remitting symptoms with psychotropic drugs and psychotherapy, but also at functional rehabilitation and strengthening social support to effectively break this negative spiral.

The confluence of impacts on quality of life, functional capacity and use of health services culminates, unequivocally, in a socioeconomic burden of vast magnitude. This burden is classically categorized as direct costs, which represent tangible financial expenditures allocated directly to the health system. These expenditures include the increase in the volume of medical consultations, both in primary care and with specialists, the greater request for diagnostic tests to investigate somatic complaints, the costs of pharmacological prescriptions and, most significantly, the higher rates of hospitalization and visits to emergency services. Notably, much of this expenditure is driven by a diagnostic search for physical symptoms, reflecting an allocation of resources that often does not address the primary cause of suffering, which is psychological in nature.

In contrast, and even more significant in terms of economic impact, are indirect costs. This category represents the value of productivity lost by society as a result of the morbidity and mortality associated with anxiety disorders and depression. This figure includes absenteeism, corresponding to lost workdays, and the more subtle but more costly phenomenon of presenteeism, which occurs when the individual is physically at work but with significantly reduced productive and cognitive capacity. In addition, indirect costs include premature exit from the workforce, leading to the granting of long-term disability benefits, and, in its most tragic manifestation, premature mortality, including by suicide. Therefore, the analysis of the socioeconomic burden reveals that the effective treatment of these disorders is not only a clinical and humanitarian imperative, but also a highly relevant strategy for the fiscal health and economic sustainability of a nation.

One of the most clinically relevant phenomena at the interface between mental and physical health is somatization, the process by which psychological distress is expressed and experienced through bodily symptoms. Fundamentally, this is not an act of simulation, but a genuine neurobiological conversion in which emotional distress activates neural circuits that are shared with the perception of pain and physical discomfort, notably in areas such as the anterior cingulate cortex and the insula. This

mechanism explains why patients with anxiety disorders and depression often present with a clinical picture rich in somatic complaints, such as diffuse pain similar to fibromyalgia, gastrointestinal discomfort that mimics irritable bowel syndrome, dizziness, palpitations, and a generalized feeling of fatigue that does not resolve with rest.

Consequently, somatization acts as the main bridge between mental disorder and the degradation of quality of life in the physical domain, in addition to being a primary driver for the overutilization of health services. For the patient, the experience of real and persistent physical symptoms, without an identifiable organic cause, generates a cycle of anxiety about one's own health, leading to the incessant search for diagnoses and validation in multiple medical specialties. For the system, this translates into a cascade of investigations, procedures and consultations of high cost and low effectiveness, which fail to alleviate suffering because they do not address its psychological origin. Thus, somatization not only worsens the individual's functional incapacity, but also represents a diagnostic challenge and a significant factor of inefficiency for the health care system.

Furthermore, the presence of depressive or anxiety disorders has a profoundly deleterious impact on the patient's ability to manage other chronic medical conditions with which they often coexist, such as diabetes, hypertension or cardiovascular disease. Poor adherence to treatments prescribed for these comorbidities is a direct and well-documented consequence. This interference manifests itself in various ways, intrinsically linked to the symptoms of mental disorders. Cognitive deficits, for example, such as difficulty concentrating and remembering, compromise the ability to follow complex therapeutic regimens, remember to take medications and attend follow-up appointments.

In a complementary manner, affective and motivational symptoms erode the willingness to engage in self-care. Hopelessness and pessimism undermine belief in the efficacy of treatment (“why bother trying if nothing is going to get better?”), while anhedonia and avolition eliminate the motivation and energy needed to adopt healthy behaviors, such as exercising or following a diet. The direct result of this poor adherence is poor clinical control of the physical illness, which leads to higher blood glucose or blood pressure levels, more rapid disease progression, and a substantial increase in the risk of acute and chronic complications. It is therefore clear that effective detection and treatment of psychiatric comorbidity are not only desirable but absolutely essential components of the successful management of any chronic illness.

CONCLUSION

The aggregate analysis of the available scientific evidence led to the unequivocal conclusion that anxiety disorders and depression represented health conditions with a profoundly negative and pervasive impact that extended far beyond the sphere of emotional symptoms. It was consistently demonstrated that the presence of these disorders systematically and multidimensionally eroded the health-related quality of life of individuals. The impairment was not limited to psychological well-being, but infiltrated the physical domain, manifesting itself as an increased burden of somatic symptoms and a perception of impoverished general health, and in the social domain, through isolation and deterioration of interpersonal ties. In parallel, the scientific literature confirmed that cognitive and affective symptoms, such as executive dysfunction and anhedonia, translated directly into measurable functional disability, compromising the ability of individuals to perform activities of daily living, to maintain productivity at work, and to fully engage in society.

Furthermore, it was concluded that the burden of these disorders had a significant impact on the health system. Studies have shown a characteristic pattern of overutilization of health services by this population, largely driven by the phenomenon of somatization, in which psychological distress was expressed through bodily complaints. This behavior resulted in a significant increase in the frequency of primary care consultations, greater demand for emergency services and higher hospitalization rates, generating a cycle of high-cost and often ineffective care, as it does not address the underlying cause of the problem. The evidence also pointed to the existence of a vicious cycle, in which functional loss and poor quality of life acted as stressors that, in turn, perpetuated and aggravated the underlying mental health condition.

Finally, it was observed that the impact of these disorders was even more amplified in patients with chronic physical comorbidities. The presence of anxiety or depression was shown to be an independent risk factor for low adherence to treatments for other diseases, such as diabetes and hypertension, worsening their clinical outcomes and increasing the complexity of patient management. In summary, the body of evidence positioned anxiety and depression disorders not as isolated problems, but as central conditions in the overall health of the individual, with devastating consequences for their well-being, autonomy and for the sustainability of the health system. The inescapable conclusion was that the effective approach to these conditions required integrated care

models, in which mental health is considered an essential component and not dissociated from general health.

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