

Review

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Posted Date: 12 December 2025

doi: 10.20944/preprints202512.1077.v1

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Review

The Economic Crisis and Its Impact on Mental Health: A Scoping Review

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Abstract

Economic crises characterized by financial instability, rising unemployment, and austerity measures are known to have profound social and public health consequences. While their economic impacts are widely studied, their effects on mental health across diverse populations and geographic regions remain fragmented and require synthesis. This scoping review aims to consolidate existing evidence on the relationship between economic crises and a broad range of mental health outcomes, including suicide, depression, anxiety, psychological distress, and health service utilization. Multiple databases (PubMed, EMBASE, Web of Science, Scopus, PsycINFO, EconLit) were explored for reports published between January 2000 and December 2025, following PRISMA-ScR guidelines. Totally, 122 studies met the inclusion criteria. Economic crises are consistently associated with adverse mental health outcomes. Key findings include increased suicide mortality, particularly among working-age men, with pronounced spikes during and after major crises such as the 2008 global financial crisis and the 1997 Asian financial crisis. Non-fatal suicidal behaviors (ideation, attempts, self-harm), depression, anxiety, and psychological distress also rise significantly, driven by unemployment, income loss, debt, and housing insecurity. Vulnerable groups, including the unemployed, low-income populations, youth, and those with pre-existing mental health conditions are disproportionately affected. The evidence also indicates mixed patterns in mental health service utilization, often constrained by austerity and access barriers. Social protection systems and supportive policies appear to mitigate negative mental health impacts. Economic crises exert a significant and multifaceted toll on population mental health, exacerbating inequalities and increasing the burden of mental disorders and suicidal behavior. The findings underscore the need for integrated policy responses that strengthen social safety nets, ensure accessible mental healthcare,

and address the psychosocial and economic determinants of health during periods of financial instability. Research gaps remain, particularly in low- and middle-income countries and regarding long-term mental health trajectories post-crisis.

Keywords: austerity; economic recession; public health; psychiatric disorders; psychological distress; health policy

1. Introduction

Economic crises, defined as periods of substantial financial instability characterized by declining gross domestic product (GDP), rising unemployment, collapsing credit systems, and widespread fiscal austerity, are recurring phenomena with profound social and public health consequences (Karanikolos et al., 2013; Stuckler et al., 2009). While the immediate focus during such downturns is often on economic indicators, the ripple effects extend far beyond financial markets. Individuals, households, and communities experience elevated stress, reduced access to essential goods and services, and heightened vulnerability to disease. The relationship between macroeconomic instability and public health outcomes has been increasingly documented, with evidence showing that recessions and financial collapses can adversely affect mental health, exacerbate inequalities, and disrupt healthcare provision (Catalano et al., 2011; Reeves et al., 2013).

Economic crises are not a recent phenomenon. The 19th century witnessed numerous financial contractions, including the Long Depression (1873–1896) following the collapse of European banks and declining commodity prices, which led to mass unemployment and impoverishment in affected regions (Khramov and Lee, 2013; Morgan, 2013). The early 20th century saw the Great Depression (1929–1939), which profoundly altered global economic and social landscapes. Unemployment skyrocketed, banks failed, and widespread poverty contributed to malnutrition and the spread of infectious diseases in many countries (Langthorne and Bambra, 2020; Tapia Granados and Diez Roux, 2009). Following World War II, the global economic order stabilized somewhat, but crises continued to emerge, often triggered by speculative asset bubbles, mismanaged fiscal policies, or exogenous shocks such as oil price spikes (Berend, 2012; Hamilton, 2013).

More recent examples illustrate the globalized nature of economic vulnerability. The Asian financial crisis of 1997–1998 caused severe economic contraction in several East Asian countries, resulting in job losses, decreased household income, and a documented rise in communicable diseases such as tuberculosis (Arinaminpathy and Dye, 2010; Choi et al., 2019; Suhrcke et al., 2011).

The bursting of the dot-com bubble in 2000 and subsequent lending excesses culminated in the 2007–2008 global financial crisis, widely regarded as the most severe economic shock since the Great Depression. This crisis resulted in widespread corporate bankruptcies, massive job losses, a collapse in private sector lending, surging public debt, and a sharp drop in global trade (Falagas et al., 2009; Fountoulakis et al., 2013, 2012; Liaropoulos, 2012; Parmar et al., 2016; Suhrcke et al., 2011; Van Hal, 2015; Wade, 2009).

More recently, economic shocks driven by pandemics, migration, armed conflicts, and climate change have further strained public health systems, particularly in low- and middle-income countries (Clech et al., 2022; Foroughi et al., 2025; Goodell, 2020). Rising unemployment, currency devaluation, and inflation reduce household purchasing power and limit access to essential services, amplifying the negative health consequences of these crises.

Economic crises affect health through multiple direct and indirect pathways. One primary pathway is psychosocial stress, driven by unemployment, income insecurity, and uncertainty about the future. Elevated stress levels are strongly associated with depression, anxiety, substance use, and suicidal behavior (Frasquilho et al., 2015; Guerra and Eboime, 2021; Gunnell et al., 2004; Haw et al., 2015). Evidence indicates that populations experiencing high unemployment rates during recessions show increased prevalence of mental health disorders, and suicide rates often rise in parallel, particularly among working-age men and young adults (Milner et al., 2014; Virgolino et al., 2022).

A second pathway is healthcare access and service provision. Fiscal austerity and declining public revenues often lead to cuts in health budgets, reduced availability of preventive and primary care, and increased out-of-pocket expenditures for patients (Broadbent et al., 2023; Stuckler et al., 2009). During the 2008 global financial crisis, several European countries implemented austerity policies that reduced funding for hospitals, mental health services, and public health programs, disproportionately affecting vulnerable populations (Kentikelenis and Papanicolas, 2012; Maresso et al., 2015; Van Gool and Pearson, 2014).

In low-income countries, reductions in donor support and local health budgets can impair vaccination campaigns, infectious disease surveillance, and treatment programs, leading to increased morbidity and mortality (Clech et al., 2022; Foroughi et al., 2025; Suhrcke et al., 2011).

Third, changes in health-related behaviors during economic crises can exacerbate health risks. Financial stress may drive individuals toward cheaper, nutrient-poor diets, increased tobacco or alcohol consumption, and reduced physical activity.

Behavioral shifts, combined with weakened health services, can lead to higher prevalence of chronic diseases, obesity, and non-communicable disease-related mortality (De Goeij et al., 2015; European Centre for Disease Prevention and Control. Stockholm: ECDC, 2013; Frاسquilho et al., 2015; Suhrcke et al., 2011).

The socioeconomic gradient in health becomes particularly pronounced during economic downturns. Poorer populations are disproportionately affected due to limited resources, pre-existing health disparities, and lower resilience to shocks. Rural populations, marginalized urban communities, and informal workers often bear the brunt of adverse health outcomes during crises, including increased malnutrition, injury, infectious disease exposure, and preventable mortality (Heggebø et al., 2019; Maynou and Saez, 2016; Regidor et al., 2016).

Despite growing interest, evidence on the health impacts of economic crises remains fragmented. Many studies focus on specific countries, population subgroups, or outcomes, and few integrate infectious and non-communicable diseases, mental health, and healthcare system disruptions in a single analysis.

The World Health Organization (WHO) describes mental health as encompassing a wide range of activities that directly or indirectly relate to mental well-being, aligning with its overall definition of health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease.” This approach is also in line with the perspective of the American Psychiatric Association (APA), which defines psychological disorders as patterns of symptoms or behaviors that impair an individual’s well-being and interfere with normal daily functioning (Llosa et al., 2018).

This scoping review aims to fill this gap by evaluating the impact of economic crises including recessions, financial collapses, and austerity measures on a wide spectrum of mental health outcomes. By integrating data across multiple countries, income levels, and health outcomes, this review aims to provide a holistic understanding of how economic instability shapes population mental health resilience. Recognizing these linkages is crucial for designing interventions that protect mental health in times of financial hardship and reduce inequities exacerbated by economic crises.

2. Methodology

2.1. Search Strategy

This study was conducted in accordance with the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) checklist (Tricco et al., 2018) (Figure 1). A comprehensive search was conducted in electronic databases including PubMed, EMBASE, Web of Science, Scopus, Psychological Information Database (PsycINFO), and Economics Literature (EconLit). Additional searches were performed in WHO, the Organization for Economic Co-operation and Development (OECD), and relevant government health department websites as well as the reference lists of relevant studies, reviews, and meta-analyses. All studies published between January 2000 and December 2025, with no time restriction, were considered eligible.

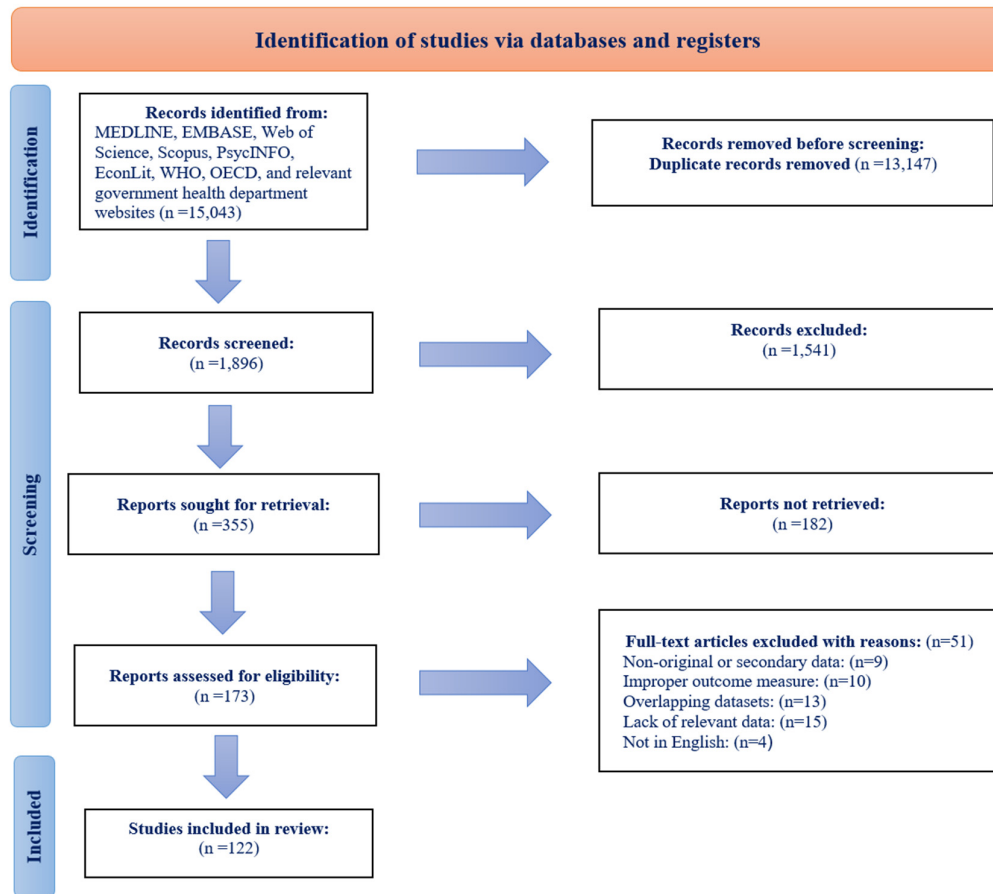


Figure 1. PRISMA flow diagram of the study design process.

The search terms were outlined as: “austerity”, “economic crisis”, “fiscal crisis”, “financial crisis”, “economic recession”, “economic depression”, “economic insecurity”, “economic recession”, “banking crisis”, “unemployment”, “personnel downsizing”, “job loss”, “mental health”, “mental disorder”, “mental illness”, “depression”, “anxiety”, “suicide”, “psychological distress”, “depressive disorder”, “mood disorder”, “psychiatric disorder”, “psychological wellbeing”, and “emotional distress” employing “OR” and/or “AND” Boolean operators.

2.2. Study Selection Process

Following the removal of duplicates, two reviewers independently screened all titles and abstracts against the predetermined eligibility criteria. Studies that clearly did not meet the inclusion criteria were excluded at this stage.

The full texts of potentially relevant articles were then obtained and independently assessed by the same two reviewers for eligibility. Any disagreements between reviewers were resolved through discussion, and when consensus could not be reached, a third reviewer was consulted for final decision-making.

2.3. Eligibility Criteria

2.3.1. Inclusion Criteria

1) Primary empirical studies of any design (quantitative, qualitative, or mixed-methods) examining the association between an economic crisis and mental health outcomes; 2) Studies focusing on either the general population or specific vulnerable groups (e.g., unemployed

individuals, migrants, healthcare workers); 3) Studies that clearly define or describe exposure to an economic crisis event, published between January 2000 and December 2025; 4) Studies reporting mental health outcomes measured using validated instruments, including depression, anxiety, psychological distress, or composite mental health indicators; and 5) Peer-reviewed original research articles published in English.

2.3.2. Exclusion Criteria

1) Non-primary study designs, including case reports, case series, review articles (systematic, scoping, narrative), meta-analyses, letters, editorials, commentaries, conference abstracts without full text, and publications containing non-original or secondary data; 2) Studies reporting only health behaviors (e.g., smoking, alcohol consumption) without mental health outcomes, and studies using non validated mental health measures; and 3) Studies for which relevant data could not be extracted or where outcomes did not align with the review objectives.

2.4. Software and Data Analysis

All references were imported into Mendeley software for de-duplication. Data from the included studies were charted using Microsoft Excel following the Joanna Briggs Institute (JBI) guidelines for scoping reviews.

3. Results

3.1. Study Selection

The systematic search of electronic databases and relevant sources identified a total of 15,043 records. After removing 13,147 duplicate entries, 1,896 records remained for title and abstract screening. During this initial screening phase, 1,541 records were excluded as irrelevant to the review's scope, leaving 355 records for full-text retrieval. Of these, 182 reports could not be retrieved, resulting in 173 articles assessed for eligibility through full-text review.

After detailed evaluation, 51 full-text articles were excluded for the following reasons: non-original or secondary data (n=9), improper outcome measures (n=10), overlapping datasets (n=13), lack of relevant data (n=15), and not published in English (n=4). Ultimately, 122 studies met all inclusion criteria and were included in the final scoping review.

3.2. Characteristics of the Included Studies

3.2.1. Study Designs

The methodological approaches of the 122 included studies were diverse, reflecting the multifaceted research on economic crises and mental health. The most common design was the ecological study (n=34, 27.9%), which analyzed population-level data to correlate economic indicators (e.g., unemployment rates) with mental health outcomes.

Longitudinal designs, including cohort and panel studies (n=32, 26.2%), constituted the next largest group, following individuals or groups over time. Repeated cross-sectional surveys (n=29, 23.8%) were also prevalent, capturing trends at multiple time points before, during, and after economic downturns. The remaining studies employed standard cross-sectional designs (n=18, 14.8%), case-control methods (n=2, 1.6%), interrupted time-series analyses (n=4, 3.3%), and other designs (n=3, 2.5%).

The research encompassed a wide geographical scope, with studies from Europe, North America, Asia, and Oceania, and spanned from 2001 to 2024, with a particular concentration around the 2008 global financial crisis (Table 1).

Table 1. Characteristics of the included studies.

No	Study	Country/Region	Study Design	Mental Disorder Type	Key Findings/Associations
1	Ostamo & Lönnqvist (2001)	Finland	Repeated cross-sectional	Suicide	Male attempted suicide rates decreased significantly during severe recession
2	Solantaus et al. (2004)	Finland	Cohort	Child Mental Health	Family economic stress creates risk for child mental health through family processes
3	Munne (2005)	Argentina	Cross-sectional	Substance Use	Economic crisis led to drinking more at home, shifting to cheaper alcohol
4	Lindstrom (2005)	Sweden	Cross-sectional	Psychological Distress	Unemployed: OR=5.81 (6.43-7.79) for psychological distress
5	Savarovalci et al. (2005)	Brazil	Cross-sectional	Depression/Anxiety	Strong association between unemployment and depression/anxiety in men
6	Reinhardt Pedersen et al. (2005)	Denmark/Sweden	Cross-sectional	Child Psychosomatic	Children with unemployed parents: OR=1.52-3.20 for psychosomatic symptoms
7	Sleskova et al. (2006)	Slovakia	Cross-sectional	Adolescent Health	Parental unemployment negatively associated with adolescent health
8	Newman & Bland (2007)	Canada	Case-control	Suicide	Association between unemployment and parasuicide: OR=12.0 (6.0-23.9)
9	Thomas et al. (2007)	UK	Cohort	Psychological Distress	Job loss increased risk of distress: OR men=3.15 (2.50-3.98)
10	Taylor et al. (2007)	UK	Cohort	Psychological Distress	Housing payment problems and debts have detrimental effects on mental wellbeing
11	Meltzer et al. (2007)	UK	Cross-sectional	Suicide	Those in debt twice as likely to think about suicide
12	Kondo et al. (2008)	Japan	Repeated cross-sectional	Self-Rated Health	OR for poor self-rated health increased from 1.02 to 1.14 after crisis
13	Charles & Decicca (2008)	USA	Repeated cross-sectional	Psychological Distress	1% unemployment → 3.4% point increase in sadness
14	Stuckler et al. (2009)	26 EU countries	Ecological	Suicide	1% unemployment increase → 0.79% increase in suicide <65 years
15	Carter et al. (2009)	New Zealand	Cohort	Psychological Distress	Lowest wealth quintile: RR=3.06 (2.63-3.50) for psychological distress
16	Molarius et al. (2009)	Sweden	Cross-sectional	Depression/Anxiety	Unemployment (OR=2.9) and financial strain strongly related to anxiety/depression
17	Chang et al. (2009)	Japan; Kong; Korea	Time-trend Honganalysis South(Japan; Kong; South Korea)	HongSuicide South	Suicide rate in men: RR=1.387 (1.358-1.417) after Asian crisis Suicide rate in men: RR=1.443 (1.263-1.649) Suicide rate in men: RR=1.446 (1.387-1.507)

18	Wang et al. (2010)	Canada	Cross-sectional	Depression		12-month MDD prevalence increased from 5.1% to 7.6% post-crisis
19	Lee et al. (2010)	Hong Kong	Repeated cross-sectional	Depression		MDE prevalence increased from 8.5% (2007) to 17.25% (2009)
20	Ford et al. (2010)	England	Cross-sectional	Common Disorders	Mental	Risk of common mental disorders greater in unemployed individuals
21	Meltzer et al. (2010)	UK	Cross-sectional	Depression		Job insecurity (OR=1.58) and debt (OR=2.17) associated with depression
22	Borges et al. (2010)	21 countries	Cross-sectional	Suicide		Unemployment strong risk factor for suicidal ideation and attempts
23	Stuckler et al. (2011)	Multiple countries	EU Ecological time-series	Suicide		Suicide increased ~7% in old EU countries after 2008 recession
24	Madianos et al. (2011)	Greece	Repeated cross-sectional	Depression		Major depression prevalence: 6.8% (2008) vs 3.3% (2009)
25	Davalos & French (2011)	USA	Cohort	General Mental Health		State unemployment worsens individuals' mental HRQoL
26	Strandh et al. (2011)	Sweden	Cohort	Psychological Distress		Negative effects of unemployment rate on mental health of unemployed
27	Economou et al. (2011)	Greece	Repeated cross-sectional	Suicide		High economic distress associated with suicide attempts (p<0.001)
28	Hong et al. (2011)	South Korea	Repeated cross-sectional	Suicide		Income gradient-related suicide behavior increased post-recession
29	Karjalainen et al. (2011)	Finland	Case-control	Substance Use		Unemployment strong predictor of driving under influence of drugs
30	Jefferis et al. (2011)	EU countries /Chile	Cohort	Depression		Job loss → RR=1.58 (0.76-3.27) for depression
31	Freyer-Adam et al. (2011)	Germany	Cross-sectional	Substance Use		84.8% of long-term unemployed young men were smokers
32	Sareen et al. (2011)	USA	Cohort	Mood/Anxiety/Substance		Income decrease → RR=1.30 (1.06-1.60) for mood/anxiety/substance disorders
33	Sargent-Cox et al. (2011)	Australia	Cohort	Depression/Anxiety		Economic distress linked to depression/anxiety in older adults
34	Borges et al. (2011)	Portugal	Cross-sectional	Adolescent Health		Parental unemployment negatively impacts adolescent health perceptions
35	Barr et al. (2012)	England	Time-trend analysis	Suicide		Excess suicides in men: RR~1.036 (1.02-1.052)
36	Katikireddi et al. (2012)	England	Repeat cross-sectional	Psychological Distress		GHQ caseness in men: OR=1.53 (1.26-1.86) in 2009 vs 2008
37	Gill et al. (2012)	Spain	Repeated cross-sectional	Depression		Major depression increased by 194% from pre-crisis period

38	Reeves et al. (2012)	USA	Ecological	Suicide	1% unemployment rise → 0.59% increase in suicide rate
39	Berchick et al. (2012)	USA	Cohort	Depression	Job loss linked with depressive symptoms: coeff=0.333 (SE=0.108)
40	Butterworth et al. (2012)	Australia	Cohort	General Mental Health	19.1% with poor mental health experienced subsequent unemployment
41	Bellis et al. (2012)	UK	Cross-sectional	Life Satisfaction	Most deprived: 17.1% low life satisfaction vs 8.9% most affluent
42	McLaughlin et al. (2012)	USA	Cohort	Depression	Foreclosure → IDR=2.4 (1.6-3.6) for major depression
43	Redonnet et al. (2012)	France	Cohort	Substance Use	Low SES linked with higher rates of tobacco (OR=2.11) and cannabis use
44	Sirvio et al. (2012)	Finland	Cohort	Psychological Distress	Precarious workers have more distress symptoms vs permanent workers
45	Chang et al. (2013)	54 countries	Time-trend analysis	Suicide	Suicide rate in men: RR=1.033 (1.027-1.039) after 2008 crisis
46	Garcy & Vägerö (2013)	Sweden	Longitudinal Cohort	Suicide	Suicide mortality in men post-recession: HR=1.43 (1.31-1.56)
47	Vanderoost et al. (2013)	Belgium	Cross-sectional survey	Suicide	Employment loss → OR=8.8 (2-39.3) for suicidal thoughts
48	Bartoll et al. (2013)	Spain	Repeated cross-sectional	General Mental Health	Poor mental health in men: PR=1.15 (1.04-1.26) during crisis
49	De Vogli et al. (2013)	Italy	Ecological time-series	Mental Mortality	Disorder 1% unemployment increase → RR=1.074 (1.032-1.117) for mental disorder mortality
50	Modrek (2013)	USA	Longitudinal Industrial Cohort	Hypertension	High-layoff plant work → OR=1.6 (1.04-2.48) for hypertension
51	Zavras et al. (2013)	Greece	Repeated cross-sectional	Self-Rated Health	Self-reported good health deteriorated from 71% (2006) to 68.8% (2011)
52	Vandoros et al. (2013)	Greece/Poland	Repeated cross-sectional	General Health	Greece: OR=1.16 (1.04-1.29) for poor health vs control population
53	Hauksdottir et al. (2013)	Iceland	Cohort	Stress	High stress levels increased only among women during crisis
54	Gili et al. (2013)	Spain	Repeated cross-sectional	Depression	Risk of depression during crisis almost 3× higher than before
55	Bor et al. (2013)	USA	Cohort	Substance Use	Binge drinking increased from 4.8% (2006-07) to 5.1% (2008-09)
56	Lopez Bernal et al. (2013)	Spain	Ecological	Suicide	8.0% increase in suicide rate above trend since financial crisis
57	Flint et al. (2013)	UK	Cohort	Psychological Distress	Mental distress among unemployed 2.20× (1.98-2.40) higher than employed
58	Eichhorn (2013)	40 European societies	Ecological	Life Satisfaction	Unemployment lowers life satisfaction by 0.5-0.785 points

59	Evans-Lacko et al. (2013)	Europe (27 countries)	Repeated cross-sectional	General Mental Health	People with mental health problems more vulnerable to job loss: OR=1.12 (1.03-1.34)
60	Fountoulakis et al. (2013)	Greece	Ecological	Suicide	No correlation found between suicide rates and unemployment
61	Sauma et al. (2013)	England	Ecological	Suicide	Unemployment-suicide association significant at regional level only
62	Shin & Choi (2013)	South Korea	Ecological	Substance Use	20× higher alcohol-attributable deaths in unemployed
63	Olesen et al. (2013)	Australia	Cohort	General Mental Health	Negative correlation ($r=-0.16$) between unemployment and mental health
64	Kan (2013)	Japan	Cohort	General Mental Health	Job loss decreases mental health by 12.0 points (MHI-5)
65	Pinto-Meza et al. (2013)	EU countries	Cross-sectional	Depression/Anxiety	Unemployed showed highest prevalence of mood/anxiety disorders
66	Snoradottir et al. (2013)	Iceland	Cross-sectional	Psychological Distress	Downsizing associated with increased psychological distress
67	Murphy et al. (2013)	USA	Cross-sectional	Substance Use	Housing instability associated with alcohol dependence symptoms
68	Fone et al. (2013)	Wales, UK	Cross-sectional	General Mental Health	Income inequality at regional level associated with poorer mental health
69	Saurina et al. (2013)	England	Longitudinal	Suicide	Unemployment increase → coeff=0.384 for male suicide in South West
70	Economou et al. (2013)	Greece; Greece	Repeated cross-sectional (Greece)	Depression/Suicide	Major depression odds greater in 2011 vs 2008: OR=10.0 (1.97-3.43) Suicidal ideation increased from 5.2% (2009) to 6.7% (2011)
71	Minelli et al. (2014)	Italy	Longitudinal Panel	General Health	First-job seekers vs permanent workers: OR=0.65 for worse health
72	Iglesias García et al. (2014)	Spain	Ecological Time-Series	Mental Health Care Use	Unemployment rate negatively correlated with mental health care demand
73	Antonakakis & Collins (2014)	Greece	Time-Series	Suicide	1% decrease in govt expenditure → semi-elasticity=-0.0043 for male suicide
74	Drydakos (2014)	Greece	Longitudinal panel	General Mental Health	Unemployment (2008-2013) → $\beta=0.0318$ for worse mental health
75	Korhonen et al. (2014)	Finland	Time Series Analysis	Suicide	Economic hardship → coeff=4.12 for suicide rate (1970-2010)
76	Ásgeirsdóttir et al. (2014)	Iceland	Population-based cohort	Suicide	Economic collapse → RR=0.85 (0.76-0.96) for male suicide attempts
77	Bartoll et al. (2014)	Spain	Repeated cross-sectional	General Mental Health	Poor mental health among men: PR=1.15 (1.04-1.26) during crisis
78	Blomqvist et al. (2014)	Sweden	Repeated cross-sectional	Psychological Distress	Mental distress increased among women, especially unemployed

79	Alameda-Palacios et al. (2014)	Spain	Ecological	Suicide	Suicide rates increased in young people (15-44) at 1.21% annually
80	Pompili et al. (2014)	Italy	Ecological	Suicide	Suicide rate for men in labor force increased 12% (2006-2010)
81	Coope et al. (2014)	England/Wales	Ecological	Suicide	Downward trend in male suicide rates stopped/reversed after 2008
82	Reeves et al. (2014)	EU countries /Canada/USA	Ecological	Suicide	Suicide rose: EU +6.5%, Canada +4.5%, USA +4.8%
83	Breuer (2014)	26 EU countries	Ecological	Suicide	1% unemployment increase → 0.79% increase in suicide <65 years
84	Toffolutti & Suhrcke (2014)	23 EU countries	Ecological	Suicide	1% unemployment increase → 34.1% increase in suicide rates
85	Baumbach & Gulis (2014)	8 EU countries	Ecological	Suicide	Suicide increases: Germany +5.3%, Poland +19.3% with unemployment rise
86	Moheenich-Enaghrou (2014)	USA	Ecological	Suicide	Positive correlation between unemployment and suicide in prime-age workers
87	Phillips & Nugent (2014)	USA	Ecological	Suicide	Strong positive association between unemployment and suicide rates
88	Cylus et al. (2014)	USA	Ecological	Suicide	1% unemployment → 0.16 more suicide deaths per 100,000
89	Chan et al. (2014)	South Korea	Ecological	Suicide	Unemployment rate positively associated with suicide rates
90	Madianos et al. (2014)	Greece	Ecological	Suicide	Suicide rates correlated with public debt/GDP and unemployment
91	Fountoulakis et al. (2014)	Hungary	Ecological	Suicide	Unemployment associated with suicidality after 3-5 year lag
92	Houle & Light (2014)	USA	Ecological	General Mental Health	Foreclosure rate contributed to increased suicides (b=0.04, p<0.1)
93	Mattei et al. (2014)	Italy	Ecological	General Mental Health	GDP decrease associated with male suicides due to financial problems
94	McKenzie et al. (2014)	New Zealand	Cohort	Psychological Wellbeing	Job loss decreased mental health by 1.34 points (SF-36)
95	Milner et al. (2014)	Australia	Cohort	Depression	Unemployed: -1.64 points mental health vs employed
96	Aslund et al. (2014)	Sweden	Cross-sectional	Substance Use	Unemployed: OR=2.11 (1.79-2.50) for poor psychological wellbeing
97	Riumallo-Herl et al. (2014)	EU countries /USA	Cohort	Suicide	Unemployment associated with 42% increase in depressive symptoms (USA)
98	Gfroerer et al. (2014)	USA	Repeated cross-sectional	Suicide	Unemployed show higher prevalence of substance use disorders
99	Miret et al. (2014)	Spain	Cross-sectional	Suicide	Unemployment associated with suicidal ideation in 18-49 year olds

100	Rhodes et al. (2014)	Canada	Cohort	Adolescent Health	Downward trend in adolescent suicidal behavior stopped after recession
101	Gassman-Pines et al. (2014)	USA	Repeated cross-sectional	Life Satisfaction	State job loss increased girls' suicidal ideation and plans
102	Pförtner et al. (2014)	31 countries	Cross-sectional	Depression	Ireland/Portugal: 9-17% rise in adolescent health complaints with unemployment
103	Klanšček et al. (2014)	Slovenia	Cross-sectional	Suicide	Low SES adolescents: 4× higher odds of low life satisfaction
104	Cagney et al. (2014)	USA	Cohort	Mental Health Care Use	Foreclosure → OR=1.75 (1.14-2.67) for depression in older adults
105	Córdoba-Doña et al. (2014)	Spain; Spain	Ecological time-series (Spain)	Suicide	1% unemployment increase → 1.08 increase in suicide attempt rate 8.6% more suicide attempts (2017 in men, 2972 in women) 2008-2012
106	Modrek et al. (2015)	USA	Longitudinal Panel	Suicide	Post-2009 trend: $\beta=0.0192$ (0.0115-0.0269) for outpatient MH visits
107	Reeves et al. (2015)	20 EU countries	Cross-national panel	Suicide	1% male unemployment increase → 0.94% increase in male suicide
108	Branas et al. (2015)	Greece	Interrupted Time Series	Suicide	Austerity measures → 35.7% increase in total suicides
109	Rachiotis et al. (2015)	Greece	Ecological Study	Stress/General Health	Mental Austerity period (2011-2012) → RR=1.34 for total suicide rate
110	Norstrom & Gronqvist (2015)	30 countries	Ecological	Mental Health Care Use	Unemployment detrimental to suicide, especially in less protected countries
111	Giorgi et al. (2015)	Italy	Cross-sectional	Suicide	Job stress mediates relationship between fear of crisis and mental health
112	Dunlap et al. (2016)	USA	Cross-sectional (NSDUH)	General Mental Health	County unemployment (Q4 vs Q1) → RR=0.58 (0.46-0.74) for MH service use
113	Ásgeirsdóttir et al. (2016)	Iceland	Population-based cohort	Mental Health Care Use	Economic collapse → RR=0.86 (0.79-0.92) for female suicide attempts
114	Nour et al. (2016)	Canada	Repeated cross-sectional	Depression	Austerity period → OR=1.26 (1.17-1.34) for poor mental health
115	Buffel et al. (2016)	Europe countries)	(27) Repeated cross-sectional	Depression	High unemployment → OR=1.031 for contacting GP for MH (employed men)
116	Sicras-Mainar & Navarro-Artieda (2016)	Spain	Retrospective observational	Mental Health Care Use	MDD prevalence increased 0.081 (0.074-0.088) during crisis
117	Lee et al. (2017)	Taiwan	Interrupted time series	Depression	Low-income men: 18% increase in depression hospitalizations post-2008

118	Petrou (2017)	Cyprus	Interrupted time-series	Suicide	Co-payment introduction non-significant effect on MH service visits
119	Forbes & Krueger (2019)	USA	Longitudinal cohort	Suicide	Financial hardship → OR=1.3 (1.23-1.42) for depression symptoms
120	Elbogen et al. (2020)	USA	Longitudinal Cohort	Depression	Cumulative financial strain → OR=1.53 (1.32-1.77) for suicide attempt
121	Meda et al. (2022)	175 countries	Ecological	Suicide	1% unemployment increase → RR=1.03 (1.02-1.03) for male suicide (30-59)
122	Bracone et al. (2024)	Italy	Prospective cohort	Child Mental Health	High economic hardship → OR=1.84 (1.26-2.7) for depression increase

3.2.2. Geographic Distribution of the Studies

Of the 122 studies included in the review, the geographical distribution was predominantly centered on Europe, with 70 studies (57.4%) conducted in European nations. A significant portion of these focused on countries deeply impacted by the 2008 financial crisis and subsequent austerity measures, including Greece, Spain, the United Kingdom, and Italy. North America was the second most represented region, contributing 23 studies (18.9%).

Research from Asia, Australasia, and South America was less common, with a combined total of 17 studies (13.9%). This distribution reveals a notable geographical gap, as no studies from Africa were identified, and only two studies originated in South America. Additionally, nine studies (7.4%) utilized cross-continent or multi-country population samples, analyzing data from groupings such as the European Union or global datasets (Table 1).

3.2.3. Population/Participants

The populations studied were heterogeneous, encompassing: 1) General adult populations: The majority of studies (n=85) analyzed data from national or regional adult populations, often stratifying by sex and age; 2) Specific workforce groups: Several studies (n=18) focused on employed individuals, those experiencing job loss, temporary workers, or employees in specific industrial sectors (e.g., manufacturing plants); 3) Clinical/Patient populations: A subset of studies (n=12) examined individuals with mental health conditions, those attempting suicide, or patients utilizing mental health services (inpatient, outpatient, primary care); and 4) Vulnerable subgroups: Research specifically addressed low-income groups (n=9), unemployed individuals (n=22), older adults (n=3), and adolescents (n=7, often in the context of parental unemployment).

Analyses were frequently disaggregated by sex/gender (male vs. female), revealing often distinct patterns in mental health outcomes.

3.3. Key Topics and Exposures

3.3.1. Suicide Mortality

The literature consistently shows that economic crises increase suicide rates, particularly among working-age men. A global time-trend study of 54 countries found that male suicide rates rose by 3.3% after the 2008 crisis (rate ratio 1.033, 95% CI: 1.027–1.039) (Chang et al., 2013), with larger increases in Europe (+4.2%) and the Americas (+6.4%). In England, Barr et al. reported roughly 846 excess male suicides and 155 excess female suicides during 2008–2010, and found that each 10% rise in unemployment corresponded to a 1.4% increase in male suicide (no significant change for women) (Barr et al., 2012).

The impact of austerity was especially pronounced in Greece reported a 35.7% increase in total suicides in June 2011 coinciding with austerity measures (Branas et al., 2015), and another research found suicide risk was 1.34 times higher during 2011–12 compared to the pre-austerity era (Rachiotis et al., 2015). Similar patterns were observed during the 1997–98 Asian financial crisis: Chang et al. reported male suicide rates rose 39% in Japan, 44% in Hong Kong, and 45% in South Korea (Chang et al., 2009).

Evidence from previous review (Frasquilho et al., 2015) further confirms that suicide rises following recessions are observed globally across multiple crises, including the early 1990s European recessions, the 1997 Asian financial crisis, and the 2008 global financial crisis. These studies consistently show stronger effects in men, middle-aged adults, and populations with weaker social safety nets. Contextual factors, such as timing of the crisis, social protection policies, and pre-existing mental health trends, modify the magnitude of the effect. For instance, Swedish data indicate a delayed increase in suicide among unemployed men post-recession (HR 1.43, 95% CI: 1.31–1.56) (Ásgeirsdóttir et al., 2017), whereas in Iceland, male suicide attempts decreased after the 2008 banking collapse (IRR 0.85, 95% CI: 0.76–0.96) (Garcy and Vågerö, 2013).

3.3.2. Suicidal Ideation, Attempts, and Self-Harm

Economic hardship is strongly linked to nonfatal suicidal behaviors. In Spain, Córdoba-Doña et al. (2014) estimated ~2,017 excess male suicide attempts during 2008–2012 (Córdoba-Doña et al., 2014). Individual-level analyses reinforce this: Belgian adults who lost employment in the past year had nearly nine times higher odds of suicidal thoughts (OR≈8.8, 95% CI: 2.0–39.3) (Vanderoost et al., 2013), and in the US, each additional recession-related hardship (e.g., debt, unemployment, housing loss) increased the odds of a suicide attempt by 53% (OR 1.53, 95% CI: 1.32–1.77) (Elbogen et al., 2020).

Hospitalization data also reflect this trend. In a longitudinal analysis from multi-centre study of Self-harm in England, Hawton and colleagues reported an increase in self-harm presentations following the 2008 recession: rates declined in men until 2008 but then rose steadily up through 2012 (Clements et al., 2019). Their ecological and patient-level study linked increased self-harm rates to areas with greater rises in unemployment (Hawton et al., 2016).

A broader review by Frasquilho et al. (Frasquilho et al., 2015) concluded that evidence from Europe, North America, and Asia consistently shows that economic recessions and associated stressors such as unemployment, income loss, and debt are associated with poorer mental health and increased suicidal behaviours (including attempts and self-harm).

However, the pattern does not always hold. For instance, a population-based study from Iceland found that after the 2008 economic collapse, rates of hospital attendances for suicide attempts and self-harm actually decreased among both men and women: first attendances post-collapse had an incidence rate ratio (IRR) of 0.85 (95% CI: 0.76–0.96) in men, and 0.86 (95% CI: 0.79–0.92) in women (Ásgeirsdóttir et al., 2017).

3.3.3. Depression, Psychological Distress, and Poor Mental Health

Financial strain and unemployment are strongly associated with depression and psychological distress. In Spain, individuals reporting mortgage-payment difficulties or other financial hardship during the crisis even after adjusting for unemployment had roughly double the odds of major depression (OR ≈ 2.11–2.12, $p < 0.001$), and combinations of unemployment and mortgage difficulties accounted for a large share of increased depression risk among primary-care attenders (Gili et al., 2013).

In Italy, being a first-job seeker or unemployed was associated with significantly worse self-reported health compared with permanently employed peers, and job insecurity or unemployment correlated with poorer mental health especially among young and male workers (Minelli et al., 2014).

In the Great Recession context in the United States, individuals who experienced one or more hardship events related to the recession, including job loss, financial strain, or housing problems had elevated risks of depressive symptoms, anxiety or other mental-health problems years after the recession ended (Forbes and Krueger, 2019). In Canada, a population-based analysis showed that

during the austerity period following the financial crisis, the odds of reporting “poor mental health” were 1.26 times higher (95% CI: 1.16–1.32) compared with pre-crisis periods (Nour et al., 2017).

Frasquilho et al. (2016) (Frasquilho et al., 2015) reviewed 101 studies and concluded that depression, anxiety, and psychological distress increased consistently during recessions, with unemployed, lower-income, and socially disadvantaged adults at greatest risk.

Gender differences were observed: men often experienced larger increases in psychological distress than women, likely reflecting male-dominated sectors and income losses.

3.3.4. Utilization of Mental Health Services and Medications

Economic crises appear to affect both mental-health needs and access to care. In the U.S., a previous study (Modrek et al., 2015), found that among employed, continuously insured workers there was an increase after 2009 in both outpatient and inpatient mental-health visits, and in the yearly supply of psychotropic medications. At the same time, a broader review of crises across countries (including the U.S.) observed mixed utilization patterns: while some studies showed increased general help-seeking or psychotropic drug use, others found no change or even declines in specialized mental health care use during and after recessions (Silva et al., 2020).

For example, one U.S. study referenced in the review reported that adults living in counties with higher unemployment rates had lower relative risk of using mental-health services compared to those in low-unemployment counties (ARR \approx 0.58–0.71 depending on the threshold) (Dunlap et al., 2016).

Thus, while economic downturns may increase mental-health burden and demand for care, access remains unequal, especially for disadvantaged populations or in high-unemployment regions (Frasquilho et al., 2015).

3.3.5. Other Mental and Behavioral Outcomes

Economic downturns are also associated with adverse behavioral and broader health outcomes. For instance, evidence from Impact of the 2008 global financial crisis on the health of Canadians: repeated cross-sectional analysis of the Canadian Community Health Survey, 2007-2013 shows that during the austerity period following the 2008 crisis, the odds of reporting poor self-perceived mental health rose by about 26% (OR = 1.26, 95% CI: 1.16–1.32), compared to pre-crisis baseline. Also in Canada, that same study found increased odds for heavy alcohol drinking (OR = 1.09 in the austerity period vs pre-crisis), indicating that substance use may rise in response to economic stressors (Nour et al., 2017).

Still, the literature on alcohol use and economic crises is not uniform. A realist systematic review How economic crises affect alcohol consumption and alcohol-related health problems: a realist systematic review concluded that while psychological distress linked to unemployment and income reduction could increase harmful drinking, especially among men tighter budget constraints could reduce overall alcohol consumption. The net effect depends heavily on contextual factors (gender, social support, social norms, disposable income) (De Goeij et al., 2015).

Furthermore, long-term follow-up data from a recession in Finland (1990s) revealed significantly increased risk of psychiatric disorders and alcohol-related diseases among men who experienced recession-related hardships (HR \approx 2.20 and HR \approx 4.44, respectively) but not among women (Jarroch et al., 2022).

3.3.6. Moderating and Protective Factors

There is also evidence that social and policy context can mitigate the negative mental health effects of economic crises. The systematic review on mental-health outcomes in recessions notes that the overall impact varies considerably by country and is influenced by social protection systems, labor market policies, and welfare measures (Frasquilho et al., 2015). For example, some studies found that increased use of general practitioners (for mental health problems) rose in countries with growing unemployment, but use of specialized psychiatric care often did not increase suggesting that barriers to specialty care remain (Silva et al., 2020).

Likewise, in the U.S., although overall outpatient mental-health service use rose in the 2008–2015 period, much of the increase was driven by individuals with less serious or no psychological distress, rather than those with serious distress raising concerns about unmet need among the most vulnerable (Olfson et al., 2019).

Table 2 summarizes the key findings related to vulnerable population groups identified across the included studies.

Table 2. Summary of key findings related to vulnerable population groups identified across the included studies.

Group	Key Findings
Unemployed individuals	<i>Higher risk of depression, anxiety, distress, and suicide. Longer unemployment = worse mental health outcomes.</i>
Precarious/Insecure workers	<i>Job insecurity and temporary work linked to mental distress. Fear of crisis worsened mental health among workers.</i>
Individuals in debt / Financial hardship	<i>Debt and housing payment problems associated with depression and suicidal ideation. Low wealth linked to high psychological distress.</i>
Families and children	<i>Parental unemployment negatively affected children's mental health. Family economic stress mediated child psychological outcomes.</i>
Adolescents and young adults	<i>Recession linked to increased psychological complaints and suicidal behaviors in adolescents. Parental job loss affected adolescent well-being.</i>
Older adults	<i>Economic distress and foreclosure linked to depression in older adults. Financial insecurity worsened mental health in aging populations.</i>
People with pre-existing mental illness	<i>More vulnerable to job loss during recession. Faced increased discrimination and isolation.</i>

4. Discussion

This scoping review finds strong evidence that economic crises are associated with worsening mental health at the population level. The literature consistently shows that recessions and financial shocks coincide with higher rates of common mental disorders and substance use. In particular, many studies report that rising unemployment, wage cuts, and income loss act as powerful stressors that precipitate depression, anxiety, and related disorders (Mucci et al., 2016; Silva et al., 2016). For example, work by Gili et al. (Gili et al., 2013) and colleagues shows an epidemic of new-onset depression emerging alongside spikes in joblessness and financial insecurity during the 2008 Great Recession.

Unemployment and financial strain emerged repeatedly as strong correlates of depression. Most reviewed studies found that higher unemployment rates and individual job loss significantly increased depressive symptoms or diagnoses (Paul and Moser, 2009; Sterud et al., 2025). For instance, cross-national analyses documented that nations experiencing large rises in unemployment after 2008 saw proportionally more adults reporting major depression (Reeves et al., 2014). A systematic review and meta-analysis published in 2022 pooled evidence on unemployment and depression. It found that unemployment, overall, was associated with OR \approx 2.06 (95% CI: 1.85, 2.30) for depressive symptoms i.e. roughly double the odds compared to employed people. In the same review, the association with clinically diagnosed major depressive disorder (MDD) was also elevated: OR \approx 1.88 (95% CI: 1.57, 2.25) (Amiri, 2022a).

Anxiety disorders and psychological distress often rise with economic stress, but the population-level patterns can be nuanced: several reviews and population studies report only modest increases and in some national surveys anxiety prevalence remained stable during recessions (Guerra and Eboime, 2021). However, effects are concentrated in specific, vulnerable groups: people experiencing job loss, precarious employment, large debt burdens, or housing insecurity show substantially larger increases in anxiety symptoms (Forbes and Krueger, 2019). For example, studies using administrative and prescription data find increased use of anxiolytics and related psychotropic

medications among workers and populations exposed to downturns (Ferry et al., 2025). Mechanistically, job insecurity, debt, and housing worries appear to act as chronic psychosocial stressors that translate into heightened anxiety for those most exposed (Kopasker et al., 2018).

Economic downturns often drive increases in unhealthy coping behaviors. A large meta-analysis found that unemployed adults have significantly higher odds of heavy alcohol use (OR \approx 1.25) and smoking (OR \approx 1.43) compared with their employed peers (Amiri, 2022b). Similarly, a comprehensive review of over 130 studies concluded that risky alcohol consumption, illicit and prescription drug use, smoking, and substance-use disorders are more common among the unemployed (Henkel, 2011). For example, a U.S. national-survey study covering 2002–2010 reported that unemployed individuals had higher rates of past-month tobacco and illicit-drug use, heavy drinking, and past-year alcohol or drug abuse/dependence associations that persisted even during periods of major economic distress (Compton et al., 2014). In other words, as financial strain grows, many individuals may turn to tobacco, alcohol, or other substances as forms of stress relief compounding the public-health burden.

Evidence from the review by Sinyor et al. (Sinyor et al., 2024) underlines the strong impact of economic downturns, financial hardship, and unemployment on mental health, especially regarding suicide risk. It indicated that economic crises are unequivocally associated with heightened suicide rates across nations, regardless of income level or development status, underlining that the detriments of economic stressors on mental health are truly universal.

The relationship between economic crises and suicide is well documented, although the effects are not uniform across populations or contexts. For example, a time-series analysis covering 54 countries estimated about 4,900–5,124 “excess” suicides in 2009 compared with expected trends with significant increases concentrated among men in Europe (\approx 4.2%) and the Americas (\approx 6.4%). In some hard-hit regions, working-age men (especially those aged 45–64 in American countries) saw the largest increases (Chang et al., 2013). These findings suggest that sudden economic shocks, especially steep rises in unemployment may increase suicide risk among acutely vulnerable individuals.

However, the picture is more complex than a uniform rise in self-harm: a scoping review of subsequent research found that while most studies documented increased suicide mortality following recessions, several found little or no change in suicide attempts or self-harm hospitalizations in the post-recession period (Guerra and Eboime, 2021). This heterogeneity likely reflects the moderating influence of social supports: for example, in a study from Japan, increased local government spending during economic downturns was associated with reduced suicide rates among middle-aged adults (Matsubayashi et al., 2020). Moreover, economic stressors beyond unemployment such as housing insecurity also matter. One analysis found a significant positive association between state-level foreclosure rates and suicide among middle-aged adults (46–64 years) in the U.S., suggesting that home loss may compound financial and emotional stress in a way that can be fatal (Houle and Light, 2014).

Economic crises affect people of all ages, but empirical evidence is particularly limited for the very young and the elderly. Several studies show that children and adolescents whose families experience job loss, income reductions, or broader economic hardship report higher rates of depression, anxiety, self-harm, and suicidal thoughts (Feghali et al., 2025). Parental unemployment or declining household income, along with increased family stress or conflict during recessions, have been identified as key mediating factors (Golberstein et al., 2019). For older adults, the picture is more mixed. On one hand, a longitudinal analysis from the Great Recession (2007–2009) found that decreases in financial resources corresponded with increased “financial strain,” which in turn was strongly associated with worsening anxiety and depressive symptoms (Wilkinson, 2016). On the other hand, some older people may be buffered by fixed incomes or pensions though declines in wealth and job loss during recessions remain linked to adverse mental health and even elevated mortality risk among older workers who lost jobs (Cutler and Sportiche, 2022). Overall, existing research suggests that economic downturns tend to amplify social inequalities: individuals and households already disadvantaged, including low-income families, precarious workers, youth, and older adults with financial vulnerability suffer disproportionately (Frasquilho et al., 2015).

These observed outcome patterns point to several interrelated mechanisms. First, psychosocial stress constitutes a central pathway: conditions such as unemployment, debt, housing loss, and job insecurity tend to increase chronic stress and undermine mental well-being. Evidence for this comes from studies in which individuals reporting insecure employment or debt had significantly higher odds of depressive disorder (Meltzer et al., 2010). Psychological models and surveys consistently find that fear of job loss and the inability to meet basic needs precipitate feelings of hopelessness and despair. Second, behavioral pathways may amplify risk: economic hardship often leads to poorer nutrition, social isolation, increased substance use, and reduced physical activity all factors known to worsen mood and health (Frasquilho et al., 2015). Third, disruptions in healthcare and social systems play a role.

Many governments adopt austerity during recessions, cutting funding for mental-health and social services. In countries facing strict fiscal consolidation, reductions in preventive and community-based mental health services have been associated with increases in suicide and psychiatric admissions (Quaglio et al., 2013). Reduced access to counselling, medications, and community supports thus leaves vulnerable individuals with far fewer resources just when they need them most. Finally, the broader economic and social context significantly shapes outcomes. Research indicates that in nations with weaker social safety nets and lower pre-crisis employment protections, the impact of financial downturns on suicide rates and mental disorders tends to be more severe (Uutela, 2010).

Our findings are in line with prior literature. Several systematic reviews (Frasquilho et al., 2015; Gili et al., 2013) similarly conclude that economic downturns worsen population mental health. These reviews highlight consistent associations between financial stressors and depression/anxiety, as well as elevated substance use during high unemployment. We found that suicide trends during crises can differ by gender, age and country, and that the overall picture depends on intervention context. Importantly, we also note gaps echoing previous calls: much of the evidence comes from Western Europe and North America, with relatively few high-quality studies from low- and middle-income countries or outside the Organisation for Economic Co-operation and Development (OECD). Likewise, there is scant research on post-traumatic stress or on long-term recovery of mental health after a crisis subsides.

Recognizing these patterns is critical for policymakers. The strong links between economic shocks and mental illness underscore the need for robust social safety nets and accessible mental healthcare, especially during downturns. For example, unemployment benefits, housing protections, debt relief and job retraining can reduce the psychological stress of a recession. Community and clinical programs should screen for depression, anxiety and substance use during economic crises to catch problems early. At the population level, protecting health budgets and ensuring continuity of mental health services (rather than cutting them) may mitigate the typical recession-induced spike in disorders. Our review also suggests that enhancing resilience factors – such as social support, education and positive coping – can buffer individuals. Indeed, studies show that life satisfaction, optimism and close social ties consistently protect against depression even in bad economies. Thus, interventions that strengthen community bonds and provide economic stability (e.g. cash transfers, progressive taxation, living wage policies) could have important mental health benefits during financial crises.

5. Limitations

This scoping review has limitations common to the field. Most cited studies are observational and ecological, making causal inference difficult. Data are also highly heterogeneous: crisis severity, duration, and policy responses differ widely across studies, which limits generalizability. Publication bias may exist toward countries with stronger research capacity. Notably, important areas remain under-explored: for example, some types of mental disorders, long-term outcomes beyond the immediate recession, and the effects of combined crises (such as economic collapse plus pandemic) are seldom studied.

6. Conclusions

This scoping review synthesizes an extensive body of evidence that establishes a large and multi-dimensional impact of economic crises on population mental health. The findings consistently point out that financial crises marked by recession, austerity measures, and increased unemployment result in deteriorated mental health at an individual and population level. Indeed, the evidence is strongest for increases in suicide mortality, particularly among working-age men, with pronounced effects observed during major crises such as the 2008 global financial crisis and the 1997 Asian financial crisis. Clear increases have also been linked to economic stressors in respect of other non-fatal suicidal behaviors-ideation, attempts, and self-harm-and the prevalence of common mental disorders, especially major depression, anxiety, and psychological distress. Economic downturns are associated with adverse health-related behaviors, including increased risky alcohol use and smoking, often as maladaptive coping mechanisms. The pathways through which economic shock is linked to poor mental health are interrelated. Psychosocial stress from financial hardship and uncertainty acts as a primary mechanism, while behavioral changes-substance use and social withdrawal-and systemic disruption-particularly austerity-driven cuts to mental health services and social safety nets-increase vulnerability. The impact is not uniform; it is powerfully influenced by socioeconomic and demographic factors. It tends to widen the gap within inequalities, with the greatest burdens on the most vulnerable groups of people: the unemployed, poor, young from affected families, and those with previous vulnerabilities.

Importantly, the review also illustrates that such effects can be moderated by protective factors and policy contexts. In particular, countries with stronger social protection systems, maintained access to healthcare, community support, and proactive economic policies-including unemployment benefits and housing support-have witnessed less severe deterioration in mental health during crises. However, critical evidence gaps remain. There is a striking geographic bias of the literature toward high-income countries in Europe and North America, with almost no contribution from the low- and middle-income regions and Africa. Further, there is a necessity for longitudinal studies considering long-term trajectories of mental health post-crisis and those on under-researched outcomes such as trauma-related disorders.

Funding: This work received no financial support from any organization.

Ethics Statement: This study is based solely on literature reviews and reports. It did not involve human participants or animals; therefore, ethical approval was not required.

Data Availability Statement: All data used in this study are available from the corresponding author upon request.

Acknowledgments: We would like to express our appreciation to the Editor-in-Chief, Editors, and reviewers for their valuable feedback and insightful suggestions for improving this article.

Conflicts of Interest: The authors declare no conflicts of interest.

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