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The Effect of Depression and Social Support on Ruminative Thinking in Patients Diagnosed with Depression

Depresyon Tanılı Hastalarda Depresyon ve Sosyal Desteğin Ruminatif Düşünceye Etkisi

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Abstract

Introduction: Depression is a psychiatric disorder with a significant public health impact. Rumination is known to play a key role in both the onset and the chronicity of depression. Social support is a powerful factor that helps protect an individual's health. This study is descriptive and aims to explore the relationship between rumination and social support in patients with depression.

Methods: This study was carried out with patients diagnosed with depression in the outpatient and psychiatry inpatient clinics of two state hospitals. As a data collection tool in the study; "Sociodemographic Data Form", "Beck Depression Inventory (BDI)", Multidimensional Scale of Perceived Social Support (MSPSS), "Ruminative Reasponses Scale (RRS)" were used.

Results: The mean BDI score of the depressive patients who took part in the study was 29.35±11.29, the mean RRS score was 59.98±15.05, and the mean MSPSS score was 37.23±12.04. BDI and RRS are strongly and positively correlated. BDI and MSPSS are strongly and negatively correlated ($p<0.05$). There was a strong negative link between RRS and MSPSS ($p<0.05$). It has been determined that depression and social support are two very effective factors in influencing ruminative thinking.

Discussion and Conclusion: When the level of ruminative thinking increases in patients, the severity of depressive symptoms increases and the perceived social support level decreases. In addition, when there is a decrease in the level of depressive symptoms in patients, the level of ruminative thinking also decreases and the perceived social support level increases. It is recommended to plan and implement interventions to reduce ruminative thinking and depressive symptoms that negatively affect patients' lives and to support effective use of social support.

Keywords: Depression; Psychiatric nursing; Ruminative thinking; Social support

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Depression is one of the most common psychiatric disorders. This disorder manifests itself with symptoms such as depressed mood, appetite disturbance, reluctance, sleep problems, loss of energy, feeling of worthlessness, attention/concentration problems, and suicidal thoughts.[1–3] Pathogenesis shows that it is affected by biological, psychological, and social factors, and the cognitive vulnerability–stress model emphasizes that negative cognitive style is one of the essential risk factors leading to depressive disorder. Ruminative thought, as a maladaptive cognitive style, is implicated in the relationship between biased cognitive processing and mood dysregulation, which is a typical feature of mental disorders; therefore, rumination is regarded as a central mechanism triggering depressive disorders.[4] Rumination is defined as a thinking process in which the same thought, feeling or memory is thought of as if ruminating.[5] Rumination is known to play a significiant role in both developing and maintaining of depression.[6] Social support refers to psychosocial resource that is accessible in the context of interpersonal relationships within one's social network. Numerous epidemiological studies have explored the protective factors and social support was a robust protective factor against depression.[7] In addition, the idea that those who constantly behave in a ruminative manner cannot engage in relationship-supporting behavior in their social relationships has been supported by many studies.[8]

It is thought that ruminative thinking increases depressive symptoms, while social support plays a protective role in depression and reduces depressive symptoms and ruminative thinking. Therefore, the aim of this study was to evaluate the effects of depression and social support on ruminative thinking in patients diagnosed with depression.

Materials and Methods

Type of Research

This study is of descriptive nature and in a relationship-seeking type. It was conducted patients diagnosed with depressive disorder according to the DSM-5 diagnostic criteria, who applied to inpatient and outpatient Psychiatry clinics in two state hospitals between January 27 and March 11, 2020.

Population and Sample of The Research

Patients who applied for inpatient and outpatient psychiatry clinics during the research period were included in the study. The sample size calculation was based on studies using the "Ruminative Reactions Scale" were taken as basis, while the minimum sample size in the G-Power programme was α=0.05, and the power of the test (1-β) was 0.95. The required number of samples was determined as 130. 130 patients from the current population who met the inclusion criteria formed the sample of the study.

Criteria for Inclusion

Applied outpatient or inpatient clinics with a diagnosis of depressive disorder, Volunteer to participate in the study, 18–65 age group, did not receive an additional psychiatric diagnosis other than depressive disorder.

Criteria for Exclusion

Has a physical or cognitive disability that prevents communication, having received an additional psychiatric diagnosis other than depressive disorder, under 18 and over 65 years old.

Data Collection Tools

Personal Information Form: It consists of 22 questions aiming to establish the sociodemographic characteristics of the patients and knowledge about their depressive disorder.

Beck Depression Inventory (BDI): It consists of 21 items improvement by Beck and used to measure the symptoms of depression in somatic, sensory, cognitive and motivational areas and the severity of these symptoms. Each item on the scale receives a score between 0 and 3. The lowest score that can be obtained is 0 and the highest score is 63. A high score indicates that the level or severity of depression is high. Two independent studies were carried out on its adaptation into Turkish.[9] The Cronbach's alpha value of the scale was 0.90 in this study.

Ruminative Responses Scale (RRS): Ruminative Responses Scale is a subscale of the 71-item Responses Styles Inventory developed by Nolen-Hoeksema and Morrow,[10] which aims to measure responses to depressive moods. Items specific to depression were removed from the Responses Styles Inventory and this subscale consisting of 22 items was created. This 22-item scale measures people's tendency to think ruminatively about negative events. Ruminative Responses Scale consists of two different subscales: "thinking in depth" (items 7, 11, 12, 20, 21) and "thinking like rumination" (items 5, 10, 13, 15, 16). is formed. Each item in the scale is scored on a scale of 4 (1: almost never, 4: almost always). The adaptation of the scale into Turkish was carried out by Neziroğlu.[10] In the Turkish version, the Cronbach alpha value was 0.89. The Cronbach alpha value of the scale was 0.97 in this study.

Multidimensional Scale of Perceived Social Support (MSPSS): The scale, which subjectively assesses the adequacy of social support received from three different sources, consists of 12 short items. It can be completed quickly, is easy to administer, and is simple to apply. These; Family Support (items 3, 4, 8 and 11), Friend Support (items 6, 7, 9 and 12), Special Human Support (items 1, 2, 5 and 10). Each item in the scale is scored on a scale of 4 (1: almost never, 4: almost always). The Turkish validity and reliability study of the scale was made by Eker et al.[11] In the Turkish version, the Cronbach alpha value was between 0.80 and 0.95. The Cronbach alpha value of the scale was 0.93 in this study.

Data Analysis

The data obtained in the study were analyzed using the Statistical Package for the Social Sciences (IBM SPSS 23.0, Chicago, USA), and a p-value of <0.05 was considered statistically significant. Cronbach's alpha coefficients were calculated to assess reliability. Descriptive statistics are presented as mean±standard deviation for numerical variables, and frequency (number) and percentage (%) values are provided for categorical variables. The normality of the data was tested using the Shapiro-Wilk test. The student's t-test was applied to compare normally distributed variables between two independent groups, while the Mann-Whitney U test was used for non-normally distributed variables. When comparing numerical data across more than two independent groups, a one-way analysis of variance (ANOVA) with multiple comparison tests was used for normally distributed variables, and the Kruskal-Wallis test with multiple comparisons was applied for non-normally distributed variables. Relationships between numerical variables were assessed using the Spearman correlation coefficient. Additionally, the effects of depression and social support on ruminative thinking were evaluated using regression analysis.

Ethical Approval

The neccessary permission was obtained prior to the study to ensure compliance with the ethical requirements of clinical research. Ethical approval was granted from Gaziantep University Clinical Research Ethics Committee (Reference No: 2019/429/04.12.2019) and Dr. Ersin Arslan Provincial Health Directorate. Detailed information about the purpose of the study and what participation would involve was given on the first page of the questionnaire. Participants were informed that they could withdraw at any time, without giving a reason, and that all information and responses would remain confidential and anonymous. The participants gave verbal and written consent after being informed about the study. The research was conducted in accordance with the principles of the Declaration of Helsinki. Artificial intelligence-based technologies were not used in this study. Permission to use the scales used in this study was obtained.

Results

30.8% of the patients participating in the research are between the ages of 46–55, 89.2% are women, 73.8% are married, 90.8% live with their family, 46.9% are primary school graduates, 80.0% are housewives. 3.1% drank alcohol, 30% smoked, 2.3% used substances, 2.3% did not experience a significant separation/immigration/relocation as a child, 66.7% of those who experienced any of these situations experienced a separation as a child, 1.5% of them said that they were separated from their mother/father, 100% of those who were separated that they were separated from their father, 66.2% believed that they received family support in difficult times, 93.8% thought about an event, person or memory that upset them very often, 60.0% of them can easily share their happiness, success, mistakes and sadness with their relatives, 26.2% had another illness, 26.2% used medication regularly, and 12.3% of those who used medication regularly used antihypertensive medication. 68.5% of the patients had previously received treatment for depression, 17.7% had previously been hospitalized due to a psychiatric disorder, 100% of those hospitalized were due to depression, and 56.2% had someone in their family with a psychiatric disorder, 56.9% of them often needed the help of others when making important decisions about their lives. It was determined that the average duration of current treatment of the patients was 19.33±5.13 months and the average time of hospitalization due to a psychiatric disease was 6.18±7.86 months (Table 1).

The mean RRS scores of patients who often need the help of others when making important decisions about their lives, who believe that they receive family support in difficult times, who state that they do not think about an event, person or memory that upsets them very often, who state that they can easily share their happiness, successes, mistakes and sorrows, who have comorbidities, who were not hospitalized due to a psychiatric disease were statistically significant (p<0.05) (Table 2).

The mean BDI score of the patients was 29.35±11.29, the mean RRS score was 59.98±15.05, and the mean MSPSS score was 37.23±12.04 (Table 3).

Table 1. Descriptive data of patients

	n	%		n	%
Gender			Working status		
Male	14	10.8	Not working	9	6.9
Female	116	89.2	Self employment	12	9.3
			Student	5	3.8
			Housewife	104	80.0
Age group			Believing have family support during difficult times		
18–25	10	7.7	Believe	86	66.2
26–35	18	13.8	Not believe	44	33.8
36–45	36	27.7			
46–55	40	30.8			
>55	26	20.0			
Marital Status			To share their happiness, success, mistakes and sadness easily		
Single	12	9.2	Yes	78	60.0
Married	96	73.8	No	52	40.0
Divorced	14	10.8			
Widow	8	6.2			
People living together			Known comorbidity		
Nuclear family	118	90.8	Yes	34	26.2
Only with mother	3	2.3	No	96	73.8
Only with siblings	2	1.5			
Only with child	2	1.5			
Living alone	5	3.9			
Educational background			To think very frequently about an event, person or memory that upsets		
Illiterate	28	21.5	Yes	122	93.8
Primary school graduate	61	46.9	No	8	6.2
Middle school graduate	17	13.1			
High school graduate	16	12.3			
University graduate	8	6.2			
Alcohol use			Smoking		
Yes	4	3.1	Yes	39	30.0
No	126	96.9	No	91	70.0
Substance use			A significant separation/immigration/relocation as a child		
Yes	3	2.3	Yes	127	97.7
No	127	97.7	No	3	2.3
Being separated from parents as a child			Regular medication use		
Yes	2	1.5	No	96	73.8
No	128	98.5	Yes	34	26.2
			Antidiabetic	2	5.8
			Antidiabetic and antihypertensive	2	5.8

SD: Standard deviation; Min: Minimum; Max: Maximum.

Table 1 (cont). Descriptive data of patients

	n	%		n	%
			Antihypertensive	17	50.0
			Antihistamine	1	2.9
			Antineoplastic	1	2.9
			Cortisone	11	33.6
Presence of another person with psychiatric illness in the family			Previous treatment for depression		
Yes	73	56.2	Yes	89	68.5
No	57	43.8	No	41	31.5
Frequently needing help from others when making important life decisions			Hospitalization due to a psychiatric illness		
Yes	74	56.9	No	107	82.3
No	56	43.1	Yes	23	17.7
			Depression	23	100

	Mean±SD	Min–Max
Current duration of treatment (in months)	19.33±5.13	6–72
Previous hospitalization due to a psychiatric illness (how many months ago)	6.18±7.86	0.5–36
Age at the time of a significant separation/immigration/relocation as a child	7.33±2.31	6–10
Age when separated from parents as a child	8.00±2.31	6–10
If a smoker, frequency of use (pieces/day)	21.13±11.44	4–60
If there is alcohol use, using times in a month	1.25±0.50	1–2

SD: Standard deviation; Min: Minimum; Max: Maximum.

It was determined that there was a strong, statistically significant and positive relationship between the BDI and RRS scale of the patients (r=0.792, p<0.001). It was determined that there was a strong, statistically significant and positive relationship between the subscales of the RRS scale, between the deep thinking subscale of the RRS and the BDI (r=0.708, p<0.001), and between the ruminative thinking subscale of the RRS and the BDI (r=0.753, p<0.001). It was determined that there was a statistically significant, negative and strong relationship between MSPSS and RRS (r=-0.833, p<0.001). A strong, statistically significant and negative relationship was found between the deep-thinking subscale of the RRS and the MSPSS (r=-0.714, p<0.001), and between the ruminative thinking subscale of the RRS and the MSPSS (r=-0.810, p<0.001).

There is a statistically significant and strong negative correlation between the family support subscale of MSPSS and RRS (r=-0.742, p<0.001) and between the friend support subscale subscale of the MSPSS and RRS (r=-0.721, p<0.001). A statistically significant, negative and moderate relationship was found between RRS (r=-0.570, p<0.001). A strong negative relationship was found between the family support subscale of the MSPSS, and the deep-thinking subscale of the RRS, (r=-0.649, p<0.001), and between the family support subscale of the MSPSS and the ruminative thinking subscale of the RRS (r=-0.722, p<0.001).

There was a statistically significant negative difference between the friend support subscale of the MSPSS, and deep thinking subscale of the RRS, at a moderate relationship (r=-0.599, p<0.001), and a statistically strong negative relationship between the friend support subscale of the MSPSS and the ruminative thinking subscale of the RRS (r=-0.708, p<0.001). There is a statistically significant and moderate negative difference between the special someone support subscale of the MSPSS and the deep thinking subscale of the RRS (r=-0.506, p=0.001), and between the special someone support subscale of the MSPSS and the ruminative thinking subscale of the RRS (r=-0.526, p<0.001). A statistically significant, negative and strong relationship was detected between BDI and MSPSS (r=-0.757, p<0.001) (Table 3).

The increase in depression level has a highly significant positive effect on ruminative thinking rates (r=0.79,

Table 2. Comparison of patients' disease-related characteristics and RRS total score

Characteristic	Deep thinking RRS	Ruminative thinking RRS	Total RRS
Frequently needing help from others when making important life decisions			
Yes	12.16±3.42	13.77±3.47	57.45±14.72
No	13.39±3.47	15.11±3.57	63.34±14.95
p	**0.04**	**0.023**	**0.026**
Believing have family support during difficult times			
Believe	11.49±3.14	12.95±3.06	54.33±13.48
Not believe	15.05±2.89	17.07±2.86	71.05±11.45
p	**0.001**	**0.001**	**0.001**
To think very frequently about an event, person or memory that upsets			
Yes	13.04 ±3.22	14.73±3.22	61.63±13.69
No	7.38 ±3.16	8.50±3.55	34.88±12.97
p	**0.001**	**0.001**	**0.001**
To share their happiness, success, mistakes and sadness easily			
Yes	11.73±3.45	13.36±3.51	55.27±14.70
No	14.13±3.03	15.83±3.12	67.06±12.71
p	**0.001**	**0.001**	**0.001**
Known comorbidity			
Yes	11.50±3.18	13.32±3.60	55.26±14.29
No	13.11±3.50	14.71±3.50	61.66±15.03
p	**0.002**	0.091	**0.033**
Previous treatment for depression			
Yes	12.85±3.76	14.70±3.74	61.36±16.07
No	12.34±2.80	13.59±3.04	57.00±12.19
p	0.438	0.099	0.125
Hospitalization due to a psychiatric illness			
No	14.91±3.44	16.57±2.68	70.52±13.01
Yes	12.21±3.32	13.87±3.56	57.72±14.53
p	**0.001**	**0.001**	**0.001**

RRS: Ruminative Responses Scale.

$p<0.05$). The increase in depression level can explain 61% of ruminative thinking rates ($R^2=0.61$). It was observed that one unit increase in depression would increase the rate of ruminative thoughts by 1.04 (b=1.04) (Table 4). The increase in the level of social support has a highly significant negative effect on the rates of ruminative thinking (r=0.84, $p<0.05$). The increase in the level of social support can explain 71% of the ruminative thinking rates ($R^2=0.71$). It was observed that one unit increase in the level of social support would cause 1.05 unit decrease in the rate of ruminative thinking (b=-1.05) (Table 4).

Discussion

It is well-established that rumination plays a significant role in both devoloping and becoming chronicled by depressive disorder.[12] People who tend to ruminate in stressful situations are more likely to experience long-term depressive symptoms and major depressive episodes compared to people who do not.[6] It was determined that the patients in this study had high depressive symptoms and ruminative thinking, and their perceived level of social support was low. Additionally, the analyses determined

Table 3. Relationship between BDI, RRS, MSPSS total score and subscale score (n=130)

Scale Mean±SD (min–max)		Total BDI 29.35±11.29 (8–60)	Total MSPSS 37.23±12.04 (12–84)	Family support 16.38±5.03 (4–24)	Friend Support 11.21±5.56 (4–26)	Special someone supprot 9.64±3.84 (4–22)
Total RRS	r	0.792	-0.844	-0.742	-0.721	-0.570
59.98±15.05 (22–88)	p	0.000	0.000	0.000	0.000	0.000
Deep thinking RRS	r	0.708	-0.714	-0.649	-0.599	-0.506
12.69±3.48 (5–20)		0.000	0.000	0.000	0.000	0.000
Ruminative thinking RRS	r	0.753	-0.810	-0.722	-0.708	-0.526
14.35±3.56 (5–20)	p	0.000	0.000	0.000	0.000	0.000
Toplam MSPSS	r	-0.757	1.000	0.817	0.871	0.751
37.23±12.04 (12–84)	p	0.000	–	0.000	0.000	0.000

SD: Standard deviation; Min: Minimum; Max: Maximum; BDI: Beck Depression Inventory; MSPSS: Multidimensional Scale of Perceived Social Support; RRS: Ruminative Responses Scale.

Table 4. The effect of depression and social support on ruminative thinking

Scale	Mean±SD	F*/p	r**	R^2	B	Beta
BDI	59.98±15.05	F=206.94 / p=**0.01**	0.79	**0.61**	1.04	0.78
MSPSS	37.23±12.04	F=308.08 / p=**0.01**	0.84	**0.71**	-1.05	-0.84

BDI: Beck Depression Inventory; MSPSS: Multidimensional Scale of Perceived Social Support; SD: Standard deviation; *: Analysis of variance; **: Pearson correlation coefficient.

that rumination had a positive relationship with depression and that depression affected ruminative thinking by 61%.

Social support functions as a coping resource against stressors and protects mental health. Lack of social support has been identified as an important determinant of depression along with feelings of loneliness, while individuals with strong social ties are reported to experience fewer depressive symptoms.[13,14] According to the study conducted by Şahin and Karataş in 2015 with 386 secondary school students to determine the relationship between perceived social support, depression and life satisfaction, when there is an increase in the level of social support, there is a decrease in the level of depressive symptoms.[15] In the study conducted by Doğan[16] in 2008 with 254 university students to determine the relationship between social support and psychological symptoms, it was reported that there was a decrease in the level of depressive symptoms as the perceived social support increased. The results of this study support the literature. It was observed that the perceived social support of the participants diagnosed with depression was quite low. Additionally, a strong negative relationship was determined between social support and ruminative thinking. In further analysis, it was determined that social support explained 71% of ruminative thinking.

Rumination is defined as an important factor that plays a role in the etiology and chronicity of depression.[6] In the study conducted by Nolen-Hoeksema and Harel[17] with 1789 people, it was determined that when the tendency to rumination increases, the occurrence of depressive symptoms also increases. According to another study conducted by Nolen-Hoeksema et al.[18] with 496 female adolescents, rumination was held responsible for many psychopathologies, especially depression. According to Yılmaz's study[19] with 328 university students, there is a positive relationship between rumination and depression. In the study made by Kelly et al.[20] with 56 dysthymia patients who received sertraline treatment and were followed for 12 weeks, results were obtained indicating that rumination decreased as a result of treating depression with medication. In this study; It was found that as the patients' depressive symptoms increased, their ruminative thoughts increased, and as their ruminative thoughts decreased, their depressive symptoms decreased.

It is known that as perceived social support decreases, the tendency to rumination increases.[21] The study made by Flynn et al.[22] with 122 undergraduate students; It has been determined that individuals who are dissatisfied with the social support they receive have an increased tendency to rumination. These data support the research finding. Social support provides benefits such as providing the individual with the opportunity to understand and express his/her own

feelings, providing a realistic and harmonious evaluation of the current situation by receiving feedback from other individuals, obtaining information about problem solving through interpersonal communication, and being less harmed by stress, and helps the individual both. It protects against the tendency to ruminative thinking and many psychopathologies, especially depression.[23] In this study, it was found that as the level of social support perceived by the patients decreased, their ruminative thinking increased.

It is known that increasing perceived social support reduces depressive symptoms.[14,16] In the study performed by Yavuzer et al.,[23] it was found that there was a negative relationship between social support and depression. In Elmacı's study with 203 individuals between the ages of 15–18, the level of depressive symptoms decreases as social support increases.[24] According to the study conducted by Mersin and Arslan[25] with 100 patients, it was determined that there was a negative relationship between social support and depression. In this study, it was determined that there was a strong negative relationship between depressive symptoms and perceived social support level.

Deep thinking is the dimension of rumination that increases problem-solving skills and facilitates adaptation. According to the study conducted by Robinson and Alloy[12] with 148 undergraduate students to determine the relationship between depressive symptom severity and self-focus and depressive rumination, it was determined that there was no significant difference between age and rumination level. It was found that there was no significant difference between the average scores of the RRS subscales, such as rumination, and the RRS total score, according to age. However, it was determined that patients in the 26–35 age group used deep thinking rather than ruminative reactions. This situation can be explained by the fact that individuals in the 26–35 age group are in a period of stagnation against productivity according to Erikson's Psychosocial Development Theory, and in this period individuals are in the peak years of the life cycle when they have characteristics such as being productive, efficient and creative.[26]

Other people around the individual also constitute the individual's social support resources, the most important of which is the family.[27] Family support, which can be described as the primary source of social support, is very important for the course of diseases. Social support reduces depressive symptoms by creating a therapeutic effect on depressive symptoms.[28] According to Response Style Theory, frequent use of rumination causes loss of social support, which in turn leads to exacerbation of depression.[29] In this study; It was determined that the levels of depressive symptoms and ruminative thinking of patients who stated that they did not receive family support during difficult times were higher than other patients. This situation supports the existing data.

The events occurring in the thought content of depression patients cover a serious area, and there is repeated negative mental action regarding the events occurring.[7] Instead of solving their problems, ruminative individuals passively think over and over again about questions that make them more anxious and pessimistic. It is also known that frequent use of rumination causes loss of social support.[30] It has been determined that the level of perceived social support is lower, and the level of depressive symptoms and ruminative thinking is higher in patients who think about a distressing event, person or memory very frequently, compared to other patients. Also in this study; another finding showing the importance of social support is that patients who cannot easily share their happiness, success, mistakes and sadness with their relatives have high levels of depressive symptoms and ruminative thinking.

It was determined that those who did not have any other comorbidities had high levels of deep thinking and ruminative thinking. It is thought that patients with an additional disease learn effective coping methods with the disease and therefore exhibit less ruminative thinking. Also in the study; it was determined that patients with an additional disease had high levels of social support perceived from family and people they identified as special people. The fact that these patients are more likely to receive family support suggests that it may be related to their levels of deep thinking and ruminative thinking.

It is known that the symptoms seen in the second and subsequent depressive attacks are more numerous and stronger than the symptoms seen in the first attack. There is a positive relationship between the severity of depressive symptoms and repeated hospitalizations in patients with depression.[30] The treatment of patients with depression who receive adequate social support is positively affected.[13] This study supports this information, and depressive symptom levels were found to be higher in patients who had previously been treated for depression. It was determined that patients who were previously admitted to a psychiatric clinic had more intense depressive symptom levels and ruminative thoughts. In addition, it was determined that the social support perceived by patients who were previously admitted to a psychiatric clinic was low.

Limitations

The fact that the research was conducted only with patients with depressive disorder who applied to psychiatry inpatient and outpatient clinics in two state hospitals constitutes the limitation of this study, and the findings can only be generalized to this group.

Conclusion

Patients diagnosed with depressive disorder have high levels of depressive symptoms and ruminative thinking, and low levels of perceived social support; It was observed that the level of ruminative thinking, such as rumination, was higher than the level of deep thinking, the social support they received from their family was higher than the social support they received from friends and someone special, and as the level of perceived social support decreased, the level of depressive symptoms and ruminative thinking levels increased. It has been determined that patients who have previously received treatment for depression have high levels of depressive symptoms and low levels of perceived social support. The patients who were expressing that they did not receive family support in difficult times, thinking very often about an event, memory or person that upsets them, cannot easily share their happiness, success, mistakes and sadness with their relatives; did not often need the help of others when making important decisions about their lives had high levels of depressive symptoms and ruminative thinking, and low levels of perceived social support. Additionally, it has been determined that depression and social support are two very effective factors in affecting ruminative thinking.

Interventions for depressed patients with rumination should be multifaceted, targeting both thought patterns and behavioural responses. Thought diary keeping, cognitive monitoring techniques and structured mindfulness studies can be applied to identify ruminative thoughts and develop awareness. It is recommended to improve the problem solving skills of the patients, to identify the ineffective coping methods used and to replace these methods with more effective coping strategies, to strengthen the social support systems of the patients since there is a strong relationship between rumination and social withdrawal, to improve communication skills and to address the reasons leading to social isolation in the therapeutic process, to direct individuals to activities that they enjoy and find meaningful, since reluctance and passivity due to depression may reinforce ruminative thought cycles.

Ethics Committee Approval: The Gaziantep University Clinical Research Ethics Committee granted approval for this study (date: 04.12.2019, number: 2019/429).

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References

1. Yalçın B, Öztürk O. The management of major depressive disorder in primary care. Turk J Fam Med Prim Care [Article in Turkish] 2016;10(4):250-8. [CrossRef]
2. Townsend, M. Depresif Bozukluklar In T. Özcan & N. Gürhan (Eds). Fundamentals of Mental Health and Psychiatric Nursing Evidence-Based Care Concepts. Akademisyen bookstore. 2016; p. 378-422.
3. Çelik F, Hocaoğlu Ç. Major depressive disorder' definition, etiology and epidemiology: a review. J Contemp Med 2016;6(1):51-66.
4. Li P, Mao L, Hu M, Lu Z, Yuan X, Zhang Y, Hu Z. Mindfulness on rumination in patients with depressive disorder: a systematic review and meta-analysis of randomized controlled trials. Int J Environ Res Public Health 2022;19(23):16101. [CrossRef]
5. Yılmaz A. The role of worry and rumination in the symptoms of anxiety and depression. Turk J Psychiatry 2014:1-8.
6. Nolen-Hoeksema S, Jackson B. Mediators of the gender difference in rumination. Psychol Women Q 2001;25:37-47. [CrossRef]
7. Li G, Li Y, Lam AIF, Tang W, Seedat S, Barbui C, et al. Understanding the protective effect of social support on depression symptomatology from a longitudinal network perspective. BMJ Ment Health 2023;26(1):e300802. [CrossRef]
8. Spasojevic J, Alloy L. Rumination as a common mechanism relating depressive risk factors to depression. Emotion 2001;1:25-37. [CrossRef]
9. Hisli N. Validity and reliability of beck depression inventory for university students. Psychol J 1989;7(23):3-13.
10. Neziroğlu G. Investigation of the relationships between rumination, experiential avoidance and problem solving skills and depressive symptoms [Master thesis]. Nursing Master's Program with Thesis; 2010.
11. Eker D, Arkar H, Yaldız H. Factor structure, validity and reliability of the revised form of the multidimensional perceived social support scale. Turk J Psychiatry 2001;12(1):17-25.
12. Robinson MS, Alloy MB. Negative cognitive styles and stress-reactive rumination interact to predict depression: a prospective study. Cognit Ther Res 2003;27(3):275-91.

13. Şireli Ö, Çolak M, Orak Y, Sakınç N. The relationship between perceived social support, depression and suicide probability in adolescents. J Child Adolesc Ment Health 2015;22(2):97-106.
14. Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review. BMC Psychiatry 2018;18:156. [CrossRef]
15. Şahin Baltacı H, Karataş Z. Perceived social support, depression and life satisfaction as the predictor of the resilience of secondary school students: the case of Burdur. Eurasian J Educ Res 2015;60:111-30. [CrossRef]
16. Doğan T. Social support and well-being as predictors of psychological symptoms. Turk Psychol Couns Guid J 2008;3(30):30-44.
17. Nolen-Hoeksema S, Harrell ZA. Rumination, depression and alcohol use: tests of gender differences. J Cogn Psychother 2002;16(4):391-403. [CrossRef]
18. Nolen-Hoeksema S, Stice E, Wade E, Bohon C. Reciprocal relations between rumination and bulimic, substance abuse, and depressive symptoms in female adolescents. J Abnorm Psychol 2007;116(1):198-207. [CrossRef]
19. Yılmaz E, Sungur M, Konkan R, Şenormancı Ö. Psychometric properties of the metacognition scales about rumination in clinical and non-clinical Turkish samples. Turk J Psychiatry 2014;25:1-11. [CrossRef]
20. Kelly O, Matheson K, Ravindran A, Merali B, Anisman H. Ruminative coping among patients with dysthymia before and after pharmacotherapy. Depress Anxiety 2007;24:233-43. [CrossRef]
21. Afifi T, Afifi W, Merrill A, Denes A, Davis S. "You need to stop talking about this!": verbal rumination and the costs of social support. Hum Commun Res 2013:1-27. [CrossRef]
22. Flynn M, Kecmanovic J, Alloy B. An examination of integrated cognitive-interpersonal vulnerability to depression: the role of rumination, perceived social support, and interpersonal stress generation. Cognit Ther Res 2010;34(5):456-66. [CrossRef]
23. Yavuzer Y, Albayrak G, Keldal G. Relationship between university students' perceived social support and depression levels: mediating effects of problem-solving skills. Hacettepe Univ J Educ 2018;33(1):242-55.
24. Elmacı F. The role of social support on depression and adjustment levels of adolescents having broken and unbroken families. Educ Sci Theory Pract 2006;6(2):421-31.
25. Mersin S, Arslan F. Social support perceptions of depressed patients. J Int Soc Res 2018;11(56):403-10. [CrossRef]
26. Gürses İ, Kılavuz A. The importance of intergenerational religious education and communication in terms of psychological developmental stages theory of Erikson. J Uludag Univ Fac Theol 2011;20(2):153-66.
27. Gariepy G, Honkaniemi H, Quesnel-Vallee A. Social support and protection from depression: systematic review of current findings in Western countries. Br J Psychiatry 2016;209(4):284-93. [CrossRef]
28. Aktaş A, Berk H. Psychometric properties of the provided social support scale. Stud Psychol 2012;32(2):71-84.
29. Nolen-Hoeksema S. The response styles theory. In: Papageorgiou C, Wells A, editors. Depressive rumination: nature, theory and treatment. Chichester: John Wiley & Sons; 2004. p. 107-19. [CrossRef]
30. Koçak C, İlhan M, Kuruoğlu A, Kaptan H. Evaluation of factors affecting the length of hospitalization for patients hospitalized in a university hospital psychiatric ward. Anatol J Psychiatry 2018;19(4):377-82.