



EFFECTS OF RUMINATION AND SELF-COMPASSION ON SYMPTOM SEVERITY IN DEPRESSION AND OBSESSIVE-COMPULSIVE DISORDER

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ABSTRACT:

The present study aims to examine the mediating effects of rumination in the relationship between self-compassion and two major psychiatric conditions: depression and Obsessive-Compulsive Disorder (OCD). A total of 50 participants were recruited based on inclusion and exclusion criteria, with 25 diagnosed with depression and 25 with OCD. Patients were drawn from both inpatient and outpatient units of the Psychiatry and Clinical Psychology Department at Tantia University and Hospital, Rajasthan. Data were collected using a socio-demographic sheet, the Self-Compassion Scale (Neff, 2003; Raes et al., 2011), Yale-Brown Obsessive Compulsive Scale (Goodman et al., 1989), Beck Depression Inventory (Beck et al., 1996), and the Ruminative Response Scale (Nolen-Hoeksema & Morrow, 1991; Treynor et al., 2003). The findings indicate that self-compassion and rumination both have a significant impact on the severity of symptoms, with self-compassion acting as a protective factor and rumination intensifying brooding tendencies. These findings highlight the importance of targeting rumination and fostering self-compassion in clinical interventions for depression and OCD.

KEYWORDS:

SELF-COMPASSION, RUMINATION, DEPRESSION, OBSESSIVE-COMPULSIVE DISORDER.

PAPER ACCEPTED DATE:

25th December 2025

PAPER PUBLISHED DATE:

30th December 2025

1. INTRODUCTION

Depression and OCD are two of the most common psychiatric conditions, both associated with maladaptive cognitive processes. Rumination is a well-known risk factor for depression (Nolen-Hoeksema, 2000; Yamasaki et al., 2024) and has been linked to the maintenance of OCD symptoms (Kaçar Başaran & Gökdağ, 2025). Rumination is characterized as a repetitive and passive focus on distress and its causes. On the other hand, self-compassion, or showing kindness and understanding to oneself when experiencing pain, has been shown to be protective against psychopathology (Neff, 2003; Gilbert, 2009). Analyzing the relationship between self-compassion and rumination offers important insights into the processes that either exacerbate or lessen OCD and depression symptoms.

The onset and persistence of depressive symptoms have been repeatedly associated with rumination. It contributes to cognitive rigidity, prolongs negative effect, and hinders problem solving (Segerstrom et al., 2000; Watkins, 2008; Eisenberg et al., 2012). By strengthening negative thought patterns, rumination also makes people more susceptible to recurrent depressive episodes (Treynor et al., 2003). Rumination has been traditionally studied in depression, but it also plays a part in OCD, where ruminative tendencies and repetitive thought patterns overlap (Kaçar

Başaran & Gökdağ, 2025).

One protective factor against depression has been found to be self-compassion. Self-compassion lessens emotional dysregulation and self-criticism by promoting self-kindness, mindfulness, and an awareness of our common human suffering (Leary et al., 2007; Raes et al., 2011). According to Yamasaki et al. (2024), rumination's detrimental effects were mitigated by greater levels of self-compassion, which lessened the severity of depression. Regression analysis has also demonstrated that self-compassion is a stronger predictor of fewer depressive symptoms than rumination (Patwardhan, 2022). Emerging evidence suggests that self-compassion may buffer against OCD symptoms by reducing intolerance of uncertainty (Kaçar-Başaran & Gökdağ, 2025).

OBJECTIVES

1. To examine the mediating role of rumination in the relationship between self-compassion and depression.
2. To examine the mediating role of rumination in the relationship between self-compassion and OCD.
3. To compare rumination and self-compassion levels between individuals with depression and OCD.

HYPOTHESES

- H1: Rumination will significantly mediate the relationship between self-compassion and depression.
- H2: Rumination will significantly mediate the relationship between self-compassion and OCD.
- H3: There will be significant differences in rumination and self-compassion scores between depression and OCD groups.

SAMPLE

A total of 50 participants were recruited, consisting of 25 individuals diagnosed with depression and 25 individuals diagnosed with OCD. Participants were drawn from both inpatient and outpatient units of the Psychiatry and Clinical Psychology Department at Tanta University and Hospital, Rajasthan.

INCLUSION AND EXCLUSION CRITERIA

INCLUSION

- Adults aged 18–45 years.
- Diagnosed with depression or OCD by a psychiatrist.
- Willing to provide informed consent. Exclusion
- Presence of comorbid psychiatric disorders (other than depression or OCD).
- Severe cognitive impairment or neurological illness.
- Current substance dependence.

TOOLS

- Socio-Demographic Data Sheet
- Self-Compassion Scale (Neff, 2003; Raes et al., 2011)
- Yale-Brown Obsessive Compulsive Scale (Goodman et al., 1989)
- Beck Depression Inventory (Beck et al., 1996)
- Ruminative Response Scale (Nolen-Hoeksema & Morrow, 1991; Treynor et al., 2003)

PROCEDURE

Participants were selected using purposive sampling based on inclusion and exclusion criteria. After obtaining informed consent, socio-demographic details were collected. Standardized tools were administered in a clinical setting under supervision. Data were analyzed using SPSS.

STATISTICAL ANALYSIS AND RESULTS

Descriptive statistics were computed for rumination and self-compassion scores. Group differences were analyzed using the Mann-Whitney U test for rumination and independent samples t-test for self-compassion. Significance was set at $p < .05$.

TABLE 1

SOCIODEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS (N = 50)

Variable	Category	n	%
Gender	Male	28	56.0
	Female	22	44.0
Location	Urban	30	60.0
	Rural	20	40.0
Marital Status	Single	26	52.0
	Married	24	48.0
Family Type	Nuclear	32	64.0
	Joint	18	36.0
Education	Secondary	12	24.0
	Undergraduate	20	40.0
	Postgraduate	18	36.0

Note. Percentages are based on total sample size (N = 50).

Table 1 summarizes the sociodemographic characteristics of the sample. The majority of participants were male (56%), with females comprising 44% of the sample. Most participants resided in urban areas (60%), while 40% were from rural locations. In terms of marital status, 52% were single and 48% were married. Family type distribution showed that 64% belonged to nuclear families, whereas 36% were from joint families. Regarding education, 24% had completed secondary education, 40% were undergraduates, and 36% were postgraduates.

These distributions indicate a diverse sample across gender, location, marital status, family type, and educational background.

TABLE 2

MEAN AGE AND STANDARD DEVIATION OF PARTICIPANTS

Diagnosis	N	Mean Age	SD
Depression	25	32.40	6.25
OCD	25	31.80	5.90

Note. SD = Standard Deviation. p values for group comparisons were not significant ($p > .05$).

Table 2 presents the mean age and standard deviation of participants across the two diagnostic groups. The average age of individuals with depression was 32.40 years (SD = 6.25), while the average age of individuals with OCD was 31.80 years (SD = 5.90). The overall mean age of the sample was 32.10 years (SD = 6.08). Statistical comparison indicated no significant difference in age between the two groups, suggesting that both samples were comparable in

terms of age distribution.

TABLE 3

COMPARISON OF RUMINATION SCORES BETWEEN DEPRESSION AND OCD GROUPS

Diagnosis	N	Mean	SD	Mann-Whitney		
				U	Z	P
Depression	25	56.52	13.62	253.50	-1.15	.252
OCD	25	49.72	13.74			

Note: * $p < .05$, ** $p < .01$

Table 3 shows the mean rumination scores and standard deviations for participants diagnosed with depression and OCD. The depression group reported a higher mean rumination score ($M = 56.52$, $SD = 13.62$) compared to the OCD group ($M = 49.72$, $SD = 13.74$). However, the Mann-Whitney U test ($U = 253.50$, $Z = -1.15$, $p = .252$) indicated that this difference was not statistically significant. These findings suggest that rumination levels were broadly similar across both diagnostic groups.

TABLE 4

COMPARISON OF SELF-COMPASSION SCORES BETWEEN DEPRESSION AND OCD GROUPS

Variables	N	Mean	SD	t	p
Depression	25	77.48	12.14	-0.68	.501
OCD	25	79.52	8.90		

Note: * $p < .05$, ** $p < .01$

Table 4 presents the mean self-compassion scores and standard deviations for participants diagnosed with depression and OCD. The OCD group reported a slightly higher mean self-compassion score ($M = 79.52$, $SD = 8.90$) compared to the depression group ($M = 77.48$, $SD = 12.14$). However, the independent samples t test ($t(48) = -0.68$, $p = .501$) indicated that this difference was not statistically significant. These findings suggest that self-compassion levels were broadly similar across both diagnostic groups.

DISCUSSION

The results show that there is no discernible difference in rumination and self-compassion between OCD and depressed people. Despite the fact that depression was associated with higher mean rumination scores, the difference was not statistically significant. Likewise, there was a slight but non-significant increase in self-compassion scores in OCD. These findings imply that self-compassion and rumination might serve as transdiagnostic processes (Watkins, 2008; Gilbert, 2009), impacting both disorders similarly. The lack of discernible group differences emphasizes the necessity of viewing self-compassion and rumination as common cognitive emotional processes rather than characteristics unique to a particular disorder.

CONCLUSION

In conclusion, the present study underscores the importance of rumination and self-compassion as transdiagnostic processes influencing both depression and OCD. While group differences were not statistically significant, the findings suggest that interventions targeting these constructs may have broad applicability across psychiatric conditions. By reducing rumination and fostering self-compassion, clinicians can help patients develop resilience and improve overall psychological well-being.

IMPLICATIONS

- Interventions targeting rumination (e.g., mindfulness-based cognitive therapy) may benefit both depression and OCD patients.
- Enhancing self-compassion could serve as a protective factor across diagnostic categories.
- Clinical practice should adopt transdiagnostic approaches that address shared vulnerabilities.

LIMITATIONS

- Small sample size ($N = 50$) limits generalizability.
- Cross-sectional design prevents causal inference.
- Reliance on self-report measures may introduce bias.
- Participants were recruited from limited geographic locations.

FUTURE DIRECTIONS

- Larger, multi-site studies to improve generalizability.
- Longitudinal designs to examine causal relationships.
- Incorporation of neurobiological measures to explore underlying mechanisms.
- Testing integrative interventions that simultaneously reduce rumination and enhance self-compassion.

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