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RESEARCH ARTICLE

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Social sharing and expressive suppression in major depressive disorder and borderline personality disorder: An experience sampling study

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Abstract

Major depressive disorder (MDD) and borderline personality disorder (BPD) are characterized by disturbed patterns of emotional and interpersonal functioning, which might imply altered use of emotion regulation in interpersonal contexts. In the current study, we examined how individuals with MDD and/or BPD differ from healthy controls in (1) their overall daily life use of expressive suppression and social sharing and (2) their tendency to adjust the use of these strategies to the emotional context (i.e., preceding negative and positive affect). Thirty-four individuals with MDD, 20 individuals with BPD, 19 individuals with comorbid MDD and BPD, and 40 healthy controls participated in a week of experience sampling during which they reported their use of expressive suppression, social sharing, and experienced negative and positive affect. The results indicated that all clinical groups reported more expressive suppression and social sharing in their daily lives than healthy controls. Group differences remained when controlling for differences in mean experienced affect, except for increased suppression for MDD and increased sharing for BPD and comorbid MDD and BPD, which seemed related to these participants' overall higher levels of negative affect. Additionally, associations between within-person fluctuations in negative or positive affect and subsequent strategy use were equally strong for clinical and control participants, indicating that clinical groups did not differentially adjust the use of suppression and sharing to the emotional context. In conclusion, individuals with MDD and/or BPD showed increased use of suppression and sharing in daily life, which might contribute to, or follow from their emotional and interpersonal difficulties.

KEYWORDS

borderline personality disorder, daily life, emotion regulation, experience sampling methodology, expressive suppression, major depressive disorder, social sharing

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1 | INTRODUCTION

Major depressive disorder (MDD) and borderline personality disorder (BPD) are characterized by disturbed emotional and interpersonal functioning (American Pyschiatric Association, 2013). Given these emotional and interpersonal difficulties, enhancing our understanding of how people regulate their emotions in interpersonal contexts seems key to gain further insight into how these psychopathologies are maintained and can be intervened upon. In this study, we used experience sampling methodology (ESM) to examine how individuals with MDD and BPD differ from healthy controls in their use of two emotion regulation strategies that occur in interpersonal contexts: expressive suppression and social sharing. Specifically, we examined differences in (1) the extent of their usage of expressive suppression and social sharing in daily life and (2) the associations between fluctuations in emotional context (preceding negative and positive affect intensity) and use of suppression and sharing.

1.1 | Expressive suppression and social sharing

Expressive suppression and social sharing are commonly used to regulate emotions in daily life (Heiy & Cheavens, 2014). Expressive suppression refers to inhibiting the outward expression of experienced emotions (Gross & John, 2003). Social sharing refers to sharing emotions with others (Rimé, 2009). Suppression and sharing are distinct emotion regulation strategies, i.e., they show weak to moderate correlations and differentially relate to intra- and interpersonal outcomes (Cameron & Overall, 2018). The use of expressive suppression is usually considered maladaptive in terms of affective and interpersonal outcomes, for example, relating to increased negative feelings and lower relationship satisfaction (see Cameron & Overall, 2018). Social sharing does not seem inherently adaptive or maladaptive, i.e., it has been related to positive (e.g., increased positive affect and decreased negative affect) as well as negative (e.g., increased negative affect) outcomes (see Brans et al., 2013; Choi & Toma, 2014; Rauers & Riediger, 2023).

Given the emotional and interpersonal difficulties of individuals with MDD and BPD, they might use these emotion regulation strategies differently than healthy controls. Research examining such differences mainly assessed suppression and social sharing using trait questionnaires. Such studies indicate that MDD and BPD patients use more expressive suppression than healthy controls (see Beblo et al., 2012; Carvalho Fernando et al., 2014). With regard to social sharing, it has been found that depressed individuals shared less than nondepressed individuals (Rude & McCarthy, 2003), but there were no differences in venting (negatively expressing emotions) (Gutiérrez-Zotes et al., 2015). Research on social sharing comparing clinical patients to healthy controls is sparse, but studies looking at a symptom level also found that depressive symptoms were negatively related to social sharing (Horn et al., 2017), but unrelated to venting (Dixon-Gordon et al., 2018). Additionally, BPD symptoms were found to be positively related to venting (Gratz et al., 2020) and online social sharing (Deutz et al., 2022).

However, *trait* questionnaires such as used in the studies cited above aim to assess individual differences in habitual, global strategy use, but do not necessarily capture momentary, *state* strategy use in daily life. Specifically, global and momentary measures of emotion regulation strategy use have been found to correlate weakly to moderately, potentially because global reports are subject to retrospective biases or do not specifically capture the *use* of strategies, but rather broader aspects of emotion regulation (e.g., antecedents or consequences of emotion regulation strategy use; Koval et al., 2023). Research assessing individuals in their daily lives can circumvent these issues, however, few studies to date examined the association between MDD and BPD (symptoms) and the use of suppression and sharing in daily life. In a community sample, Houben et al. (2023) found that higher MDD symptoms and BPD symptoms were both associated with more expressive suppression, but were unrelated to social sharing. Similarly, Zetsche et al. (2023) found that patients with MDD or BPD used more suppression than healthy controls. There were no differences in social sharing, except when group differences in overall strategy use were controlled for: then MDD and BPD patients were found to share less than healthy controls. As patients overall used more regulation strategies, this suggests that they did not use less social sharing per se, but did use relatively less social sharing than healthy controls when patients' overall increased strategy use was taken into account. Findings concerning momentary social sharing in daily life thus seem to differ from those in trait research and replication of daily life findings in clinical samples is needed. Moreover, to enhance our understanding of what may drive altered emotion regulation in MDD and BPD, further extension of this research is needed. Clinical groups may differ from healthy controls in overall use of suppression and sharing, possibly related to differences in overall experienced emotion, but may also differ in how they adjust emotion regulation to changes in the emotional context (Bonanno & Burton, 2013).

1.2 | The role of emotional context

Healthy emotion regulation should vary with the emotional context (Matthews et al., 2021; Sheppes, 2020), meaning that individuals adapt their emotion regulation strategy use to their emotional experiences. Indeed, in community samples, negative affect intensity has been found to positively predict subsequent expressive suppression, whereas negative or no associations were found between positive affect intensity and suppression (see Brans et al., 2013). Moreover, research suggests that increased positive and negative emotions are associated with heightened social sharing (see Ruan et al., 2020).

Whether (and if so how) associations between emotional context and suppression and sharing are different for individuals with MDD and BPD compared to healthy controls has not been examined to date. Individuals with psychopathologies characterized by emotional dysregulation have been proposed to less flexibly adapt their strategy

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use to the context (or to adapt their strategy in a way that does not fit the situation; Bonanno & Burton, 2013; Kalokerinos & Koval, 2024). Therefore, delineating whether individuals with MDD and BPD, compared to healthy controls, show differential reactivity of emotion regulation use in response to fluctuations in their experienced emotions seems an important step toward a better understanding of these disorders. On the one hand, attenuated adaptation could be predicted, in line with the proposition that they less flexibly adapt their emotion regulation strategy use to the context (Fitzpatrick et al., 2023; Millgram et al., 2019). Indeed, prior research in community samples found that depressive symptoms moderated the effect of negative affect intensity on sharing: this effect was attenuated for individuals with more depressive symptoms indicating that individuals with more depressive symptoms avoid sharing highly negative emotions with others (Garrison & Kahn, 2010; Garrison et al., 2012). On the other hand, they may adapt their strategies to the context but not adaptively so, and for example more strongly suppress high intense negative and positive emotions (Kahn & Garrison, 2009; Vanderlind et al., 2020).

1.3 | Current study

We used ESM to study how people with MDD and BPD differ from control participants concerning (1) the extent of their usage of suppression and sharing in daily life and (2) the association between the emotional context (i.e., fluctuations in preceding positive and negative affect) and use of suppression and sharing. We compared three different clinical groups to healthy controls: individuals with only MDD, only BPD, and comorbid MDD and BPD. MDD and BPD are both characterized by disturbed emotional functioning, but differently so (see Houben et al., 2021). Additionally, MDD and BPD often co-occur (Lieb et al., 2004), and including these three groups allowed us to focus on the unique effects of MDD and BPD, as well as explore the effects of comorbid MDD and BPD, which might relate to the most severe problems (e.g., depression severity was found to be higher in individuals with comorbid BPD and depressive disorders than in individuals with BPD or depression only; Köhling et al., 2015). We focused on the differences between these three groups and healthy controls in our main analyses, but also explored differences between clinical groups in additional analyses.

Concerning research question (1), based on reported literature we predicted that patients with either MDD, BPD, or comorbid MDD and BPD would use more suppression than healthy controls. We expected no differences in overall social sharing between clinical groups and healthy controls. Concerning (2), we made no directional hypotheses for the effects of MDD or BPD on the associations between negative and positive affect intensity and expressive suppression given the lack of previous research. Regarding social sharing, we expected that negative and positive affect would positively predict social sharing. We expected that the effect for negative affect would be attenuated for MDD compared to healthy controls as individuals higher on depression tend to share more intense negative affect less (Garrison et al., 2012). Concerning positive affect, an attenuated effect on social sharing for MDD may be tentatively expected, because social sharing of positive emotions tends to upregulate positive affect (see Choi & Toma, 2014) and depressed individuals are inclined to upregulate positive affect less (Vanderlind et al., 2020). Due to absent prior research concerning associations between affect intensity and sharing in BPD, we made no specific predictions regarding these effects, neither for the BPD group nor for the comorbid BPD and MDD group. This study's hypotheses, methods, and analysis plan were preregistered at https://osf.io/4q3sf, after data collection, but before analyses were conducted.

2 | METHODS

2.1 | Participants

The final sample consisted of 113 participants: 34 participants with current MDD, 20 with BPD, 19 with comorbid MDD and BPD, and 40 healthy controls. For the clinical groups, the inclusion criterion was a diagnosis of current MDD, BPD, or both, and exclusion criteria were psychotic disorders, a primary diagnosis of substance use, being in an acute psychotic or manic phase, or lacking the ability to use a smartphone. Exclusion criteria for control participants were current or past psychiatric diagnoses or using psychotropic medication. Table 1 reports demographics per group. Supporting Information S1: Table S1 reports (co)morbidities. Initially, 139 participants were enrolled. Of these, three dropped out during baseline assessment, eight were excluded because they had <50% ESM compliance, two were excluded due to malfunctioning ESM equipment, and 13 were excluded based on diagnosis (e.g., patients who were diagnosed with a current depressive episode and had experienced past (hypo)manic

TABLE 1 Descriptives per group.

	MDD	BPD	MDD + BPD	HC
N	34	20	19	40
Age (*M* (SD))	41.26 (13.37)[a]	29.95 (11.53)[b]	33.21 (11.07)[ab]	35.23 (11.54)[ab]
Gender female (*n* (%))	17 (50%)[a]	19 (95%)[b]	16 (84%)[bc]	23 (58%)[ac]

Note: Values with different superscript letters in a row differ significantly ($p < 0.05$).
Abbreviations: BPD, borderline personality disorder; HC, healthy control; MDD, major depressive disorder; SD, standard deviation.

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episodes, controls who met Structured Clinical Interview for DSM [SCID] criteria for a psychiatric disorder).

2.2 | Procedure

Clinical participants were recruited from two collaborating psychiatric centers. Healthy participants were recruited via advertisements, social media, and the KU Leuven recruitment system. All participants provided written informed consent. The full study procedure comprised: (1) test session in the lab or clinic, (2) 1 week of ESM, (3) second test session, and (4) online follow-up questionnaires. Only data from the test sessions (i.e., diagnostic status) and ESM week were used. For the latter, participants were provided a research-dedicated smartphone on which they received beeps prompting them to complete 10 surveys per day between 9 a.m. and 9 p.m. for seven consecutive days. The ESM software was MobileQ (Meers et al., 2020). Days were divided into 10 equal time intervals and beeps were sent at random times within each interval. Average compliance to the ESM protocol was 87% (SD = 11). Ethical approval was obtained from the Ethical Committee Research UZ/KU Leuven (S58526). Participants received a monetary compensation of a maximum of 40 euros (depending on their response compliance).

2.3 | Measures

2.3.1 | Diagnostic status

Diagnostic status was assessed with the SCID-IV Axis 1 Disorders (Van Groenestijn et al., 1999) and the SCID-IV Axis II Personality Disorders borderline subscale (Weertman et al., 2000). Interviews were conducted by two trained psychologists. Interrater reliability calculated on a random subsample of seven interviews was excellent ($\kappa = 0.93$ for diagnoses and $\kappa = 0.92$ for symptoms).

2.3.2 | Expressive suppression and social sharing

At each ESM beep, participants rated their use of expressive suppression ("Since the last beep, to what degree did you try to suppress the expression of your emotions?") and their use of social sharing ("Since the last beep, to what degree did you talk with others about your emotions?") on a sliding scale ranging from 0 ("not at all") to 100 ("a lot").

2.3.3 | Positive and negative affect

At each beep, participants also rated the extent to which they currently experienced three positive ("How happy/euphoric/relaxed do you feel at the moment?") and four negative emotions ("How stressed/depressed/anxious/angry do you feel at the moment?") on a scale ranging from 0 ("not at all") to 100 ("very"). These items were chosen to cover the affect grid, capturing positive and negative emotions with different arousal levels (Russell & Barrett, 1999). Positive emotions were averaged per beep for momentary positive affect, and negative emotions for momentary negative affect, with acceptable to excellent reliability estimates for positive ($\omega_{within} = 0.72$, $\omega_{between} = 0.87$) and negative affect ($\omega_{within} = 0.74$, $\omega_{between} = 0.94$).

2.4 | Analyses

Multilevel regression analyses were conducted with either expressive suppression or social sharing as criterion using the nlme package in R (R version 4.1.2, Pinheiro et al., 2021). All momentary predictors (level 1) were person-mean centered. Lagged predictors were specified as missing for the first beep of the day to account for overnight breaks. As clinical groups differed in gender ratio, we controlled for gender (male/female) by adding a dummy in all analyses.

We first examined how clinical groups differed from healthy controls in their overall use of suppression and sharing. As example, we describe the equations for expressive suppression. Suppression at time t was predicted by a random intercept and random slope of suppression at $t-1$ (to account for serial dependence between the previous and current timepoint). This random intercept and slope were related to three dummy variables representing the presence of only MDD, only BPD, and comorbid MDD and BPD, to model group differences in strategy use and account for any group differences in serial dependence, respectively. The corresponding equations are as follows.

Level 1:

$$\text{Suppression}_{it} = \gamma_{0i} + \gamma_{1i}\text{Suppression}_{it-1} + \varepsilon_{it}.$$

Level 2:

$$\gamma_{0i} = \beta_{00} + \beta_{01}\text{MDD}_i + \beta_{02}\text{BPD}_i + \beta_{03}\text{MDD\&BPD}_i + \beta_{04}\text{Gender} + v_{0i},$$

$$\gamma_{1i} = \beta_{10} + \beta_{11}\text{MDD}_i + \beta_{12}\text{BPD}_i + \beta_{13}\text{MDD\&BPD}_i + \beta_{14}\text{Gender} + v_{1i}.$$

i = individual i; t = timepoint t.

To assess whether any group differences in strategy use were related to differences in overall experienced emotion, we ran two additional models per strategy, controlling for grand-mean centered person-mean negative affect or positive affect.

We then studied how either preceding negative or positive affect relate to suppression and sharing in clinical groups compared to healthy controls. As an example, we describe the analyses with negative affect as predictor and suppression as criterion. Suppression at time t was predicted by a random intercept and the random slopes of suppression (to account for serial dependence) and negative affect, both at $t-1$. Again, the random effects were regressed on the three dummies representing group membership. The corresponding equations are as follows.

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Level 1:

$$\text{Suppression}_{it} = \gamma_{0i} + \gamma_{1i}\text{Suppression}_{it-1} + \gamma_{2i}\text{Negative Affect}_{it-1} + \varepsilon_{it}.$$

Level 2:

$$\gamma_{0i} = \beta_{00} + \beta_{01}\text{MDD}_i + \beta_{02}\text{BPD}_i + \beta_{03}\text{MDD\&BPD}_i + \beta_{04}\text{Gender} + v_{0i},$$

$$\gamma_{1i} = \beta_{10} + \beta_{11}\text{MDD}_i + \beta_{12}\text{BPD}_i + \beta_{13}\text{MDD\&BPD}_i + \beta_{14}\text{Gender} + v_{1i},$$

$$\gamma_{2i} = \beta_{20} + \beta_{21}\text{MDD}_i + \beta_{22}\text{BPD}_i + \beta_{23}\text{MDD\&BPD}_i + \beta_{24}\text{Gender} + v_{2i}.$$

i = individual i; t = timepoint t.

2.4.1 | Sensitivity and exploratory analyses

To test the robustness of results across different negative and positive affect operationalizations, we ran a leave-one-out multiverse analysis (Steegen et al., 2016). To this aim, we computed a series of affect indices where one emotion item was left out and ran models across the multiverse of indices. Moreover, whereas in the main analyses the healthy control group served as reference group, we reran the models with different reference groups to explore differences between the different clinical groups. Upon reviewer's suggestion, we also ran a leave-one-out multiverse analysis for the analyses with the different reference groups to test the robustness of findings across different affect operationalizations. Finally, to explore whether intensity of particular emotions related differentially to suppression and sharing based on clinical group, we ran the second set of models with single emotion items.

3 | RESULTS

3.1 | Descriptive statistics

Table 2 shows descriptives and within-and between-person correlations of the key variables. Testing differences in mean affect, we found that all clinical groups experienced more negative and less positive affect than healthy controls (see Supporting Information S1: Table S2).

3.2 | Group differences in overall strategy use

Results on group differences in overall strategy use are presented in Table 3. Positive effects of MDD, BPD, and comorbid MDD and BPD on the use of suppression indicated that all clinical groups reported more suppression than healthy controls. Controlling for mean negative affect (see Supporting Information S1: Table S3), the effect of MDD became nonsignificant, suggesting that the higher use of suppression in MDD patients was related to their overall increased experience of negative affect. Effects of BPD and comorbid MDD and BPD remained significant, suggesting that these groups suppressed their emotions more, independent of group differences in overall negative affect. All group differences in suppression remained significant when controlling for mean positive affect (see Supporting Information S1: Table S4).

Concerning social sharing, we found that all clinical groups shared their emotions more than healthy controls. Controlling for mean negative affect, the effect of MDD remained significant suggesting that MDD used more social sharing, over and above them experiencing more negative affect. Effects of BPD and comorbid MDD and BPD became nonsignificant, suggesting that these participants' increased sharing was related to them experiencing more negative affect overall. Controlling for mean positive affect, all group effects on social sharing remained significant.

TABLE 2 Descriptives and within-and between-person correlations.

	1	2	3	4
1. Expressive suppression		0.47***	0.87***	−0.45***
2. Social sharing	0.03*		0.50***	0.07
3. Negative affect	0.34***	0.05***		−0.51***
4. Positive affect	−0.23***	0.08***	−0.51***	
5. Lagged negative affect	0.19***	0.07***	0.41***	−0.25***
6. Lagged positive affect	−0.16***	0.01***	−0.28***	0.41***
M	30.75	20.75	28.27	34.56
SD	21.83	12.54	19.74	14.30

Note. Means reflect average person means. Correlations were calculated using the psych package in R (Revelle, 2021). Between-person correlations are presented above the diagonal. Within-person correlations are presented below the diagonal.
Abbreviation: SD, standard deviation.
*$p < 0.05$; ***$p < 0.001$.

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TABLE 3 Group differences in overall use of expressive suppression and social sharing.

	Expressive suppression			Social sharing		
	B (SE)	95% CI	*t*	*B* (SE)	95% CI	*t*
Intercept (HC)	10.28 (2.61)	[5.18, 15.39]	3.95***	12.26 (2.03)	[8.28, 16.24]	6.04***
MDD	31.97 (3.34)	[25.35, 38.59]	9.57***	16.48 (2.60)	[11.32, 21.64]	6.33***
BPD	20.31 (4.08)	[12.22, 28.41]	4.97***	7.78 (3.19)	[1.46, 14.09]	2.44*
MDD + BPD	44.64 (4.07)	[36.58, 52.70]	10.98***	12.64 (3.17)	[6.36, 18.93]	3.99***
Gender	−0.59 (3.06)	[−6.66, 5.49]	−0.19	−1.42 (2.39)	[−6.16, 3.31]	−0.60
Strategy at *t* − 1 (HC)	0.20 (0.04)	[0.12, 0.28]	4.96***	0.20 (0.04)	[0.12, 0.27]	4.99***
MDD	0.04 (0.05)	[−0.05, 0.14]	0.87	0.11 (0.05)	[0.01, 0.21]	2.12*
BPD	0.09 (0.05)	[−0.01, 0.20]	1.73	0.13 (0.06)	[0.01, 0.24]	2.20*
MDD + BPD	0.05 (0.05)	[−0.06, 0.16]	0.94	0.07 (0.06)	[−0.05, 0.18]	1.14
Gender	−0.02 (0.04)	[−0.10, 0.07]	−0.38	−0.07 (0.05)	[−0.16, 0.02]	−1.45

Abbreviations: BPD, borderline personality disorder; CI, confidence interval; HC, healthy control; MDD, major depressive disorder; SE, standard error.
*$p < 0.05$; ***$p < 0.001$.

TABLE 4 Group differences in effect of preceding negative affect on the use of expressive suppression and social sharing.

	Expressive suppression			Social sharing		
	B (SE)	95% CI	*t*	*B* (SE)	95% CI	*t*
Intercept (HC)	10.30 (2.61)	[5.19, 15.41]	3.95***	12.27 (2.03)	[8.29, 16.25]	6.04***
MDD	31.96 (3.34)	[25.33, 38.58]	9.57***	16.49 (2.61)	[11.32, 21.65]	6.33***
BPD	20.36 (4.08)	[12.27, 28.46]	4.99***	7.83 (3.19)	[1.51, 14.14]	2.45*
MDD + BPD	44.63 (4.07)	[36.57, 52.69]	10.98***	12.65 (3.17)	[6.36, 18.94]	3.99***
Gender	−0.60 (3.06)	[−6.68, 5.47]	−0.20	−1.44 (2.39)	[−6.17, 3.30]	−0.60
Strategy at *t* − 1 (HC)	0.14 (0.04)	[0.06, 0.23]	3.42***	0.18 (0.04)	[0.10, 0.25]	4.48***
MDD	0.05 (0.05)	[−0.05, 0.15]	1.05	0.11 (0.05)	[0.01, 0.21]	2.20*
BPD	0.07 (0.06)	[−0.04, 0.18]	1.28	0.13 (0.06)	[0.02, 0.24]	2.28*
MDD + BPD	0.08 (0.06)	[−0.03, 0.19]	1.39	0.07 (0.06)	[−0.04, 0.19]	1.25
Gender	−0.02 (0.05)	[−0.11, 0.07]	−0.43	−0.05 (0.05)	[−0.14, 0.04]	−1.11
NA at *t* − 1 (HC)	0.22 (0.08)	[0.07, 0.37]	2.82**	0.18 (0.08)	[0.03, 0.33]	2.40*
MDD	−0.02 (0.09)	[−0.19, 0.15]	−0.22	−0.08 (0.09)	[−0.25, 0.09]	−0.92
BPD	0.04 (0.10)	[−0.15, 0.23]	0.36	−0.01 (0.10)	[−0.20, 0.18]	−0.12
MDD + BPD	−0.13 (0.09)	[−0.32, 0.05]	−1.41	−0.10 (0.09)	[−0.28, 0.09]	−1.02
Gender	0.03 (0.07)	[−0.11, 0.18]	0.44	−0.08 (0.07)	[−0.22, 0.07]	−1.03

Abbreviations: BPD, borderline personality disorder; CI, confidence interval; HC, healthy control; MDD, major depressive disorder; NA, negative affect; SE, standard error.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

3.3 | Group differences in effect of emotional context on strategy use

Results on group differences in the effects of preceding negative and positive affect on strategy use are presented in Tables 4 and 5, respectively. Heightened negative affect predicted subsequent increased use of suppression and social sharing in healthy controls. This effect was not different for the clinical groups. Positive affect was negatively associated with subsequent expressive suppression and unrelated to social sharing in healthy controls, and these effects were not different for the clinical groups.

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TABLE 5 Group differences in effect of preceding positive affect on the use of expressive suppression and social sharing.

	Expressive suppression			Social sharing		
	B (SE)	95% CI	*t*	*B* (SE)	95% CI	*t*
Intercept (HC)	10.30 (2.61)	[5.19, 15.41]	3.95***	12.25 (2.03)	[8.27, 16.23]	6.03***
MDD	31.95 (3.34)	[25.32, 38.57]	9.56***	16.50 (2.6)	[11.33, 21.66]	6.33***
BPD	20.29 (4.08)	[12.20, 28.39]	4.97***	7.76 (3.19)	[1.44, 14.08]	2.43*
MDD + BPD	44.66 (4.07)	[36.60, 52.72]	10.98***	12.64 (3.17)	[6.36, 18.93]	3.99***
Gender	−0.59 (3.07)	[−6.67, 5.48]	−0.19	−1.41 (2.39)	[−6.15, 3.32]	−0.59
Strategy at *t* − 1 (HC)	0.17 (0.04)	[0.09, 0.25]	4.33***	0.19 (0.04)	[0.12, 0.27]	5.09***
MDD	0.04 (0.05)	[−0.05, 0.14]	0.84	0.11 (0.05)	[0.01, 0.20]	2.18*
BPD	0.08 (0.05)	[−0.03, 0.18]	1.45	0.12 (0.05)	[0.01, 0.23]	2.23*
MDD + BPD	0.05 (0.05)	[−0.05, 0.16]	1.01	0.06 (0.06)	[−0.05, 0.18]	1.11
Gender	−0.02 (0.04)	[−0.10, 0.06]	−0.47	−0.06 (0.05)	[−0.15, 0.03]	−1.28
PA at *t* − 1 (HC)	−0.11 (0.05)	[−0.20, −0.03]	−2.53*	−0.03 (0.05)	[−0.12, 0.06]	−0.57
MDD	−0.11 (0.06)	[−0.23, 0.01]	−1.75	−0.03 (0.06)	[−0.15, 0.10]	−0.44
BPD	−0.02 (0.06)	[−0.14, 0.10]	−0.33	−0.06 (0.06)	[−0.19, 0.07]	−0.94
MDD + BPD	−0.05 (0.07)	[−0.18, 0.08]	−0.74	0.03 (0.07)	[−0.11, 0.17]	0.39
Gender	0.03 (0.05)	[−0.08, 0.13]	0.53	0.00 (0.06)	[−0.11, 0.11]	−0.04

Abbreviations: BPD, borderline personality disorder; CI, confidence interval; HC, healthy control; MDD, major depressive disorder; PA, positive affect; SE, standard error.

*$p < 0.05$; ***$p < 0.001$.

3.4 | Sensitivity and exploratory analyses

The multiverse analyses showed that findings were robust across different affect index operationalizations: no significant group differences were found in the associations between preceding affect and suppression or sharing for any of the computed affect indices (see Supporting Information S1: Figures S1 and S2).

The analyses with different groups as reference category suggested that the MDD group reported more suppression and sharing than the BPD group. Moreover, individuals with comorbid MDD and BPD seem to report more suppression than individuals with either MDD or BPD (Supporting Information S1: Tables S5 and S6). These analyses further suggested no differences between clinical groups in effects of preceding negative or positive affect on strategy use, except for one: individuals with comorbid MDD and BPD showed a less positive association between preceding negative affect and suppression compared to individuals with BPD only (see Supporting Information S1: Tables S7–S10). Note, however, that multiverse analyses indicated that this finding was not robust across different affect operationalizations (i.e., it became nonsignificant when either stressed or angry was left out).

Finally, using single emotion items we found that individuals with BPD used more suppression after they felt more stressed compared to healthy controls. Moreover, for comorbid MDD and BPD stronger euphoric feelings were more negatively associated with subsequent suppression than for healthy controls. None of the other single emotion items related differentially to suppression and sharing for individuals with MDD and/or BPD compared to healthy controls.

4 | DISCUSSION

This study examined differences in the use of expressive suppression and social sharing in daily life between individuals with MDD and/or BPD and healthy controls. We focused on (1) overall use of these strategies and (2) differential effects of preceding positive and negative affect. Results indicated that individuals with MDD and/or BPD overall reported using more expressive suppression and social sharing in daily life compared to healthy controls, but that they did not differentially adjust the use of these strategies to the emotional context.

The finding that individuals with MDD or BPD tend to suppress the expression of their emotions fits with previous research, both on a diagnostic group (Zetsche et al., 2023) and symptom level (Houben et al., 2023). Adding to previous literature on group differences in daily life emotion regulation that focused on noncomorbid MDD and BPD patients (Zetsche et al., 2023), our findings indicate that individuals with comorbid MDD and BPD also used more suppression than healthy controls. Given that expressive suppression has generally been related to negative outcomes (Cameron & Overall, 2018; Chervonsky & Hunt, 2017), it could be a relevant therapeutic target. Concerning social sharing, we predicted no group differences based on findings from two previous ESM studies looking at diagnostic groups with

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MDD and BPD only (Zetsche et al., 2023) or MDD and BPD symptoms (Houben et al., 2023). However, all clinical groups in our study indicated higher levels of social sharing than healthy controls. With regard to BPD, this finding does align with findings from trait research for BPD symptoms (Deutz et al., 2022; Gratz et al., 2020). However, for MDD it differs from trait-level findings that social sharing was lower for depressed versus nondepressed individuals (Rude & McCarthy, 2003) and for individuals higher in depressive symptoms (Horn et al., 2017). With regard to the comorbid group we are not aware of previous (trait) research on the use of social sharing. Speculatively, we may have captured co-rumination: extensively discussing problems with others, a strategy that has been found to be related to higher levels of internalizing problems (Spendelow et al., 2017). Note additionally, that general regulation research shows that clinical groups tend to report an increased use of emotion regulation strategies in daily life, potentially because they experience higher levels of negative affect (e.g., Lincoln et al., 2022).

We explicitly tested whether increased use of expressive suppression and social sharing in clinical groups was driven by different levels of overall experienced affect. Indeed, some group differences became nonsignificant when controlling for negative affect. Specifically, higher overall experienced negative affect seems to explain increased use of suppression for MDD and of sharing for BPD (either alone, or with comorbid MDD). These findings suggest that these groups use these strategies more in an attempt to regulate their higher levels of negative emotions. However, differences in mean negative (or positive) affect could not (fully) account for other group differences: BPD patients (with or without comorbid MDD) suppressed more and MDD patients shared more, independent of their mean experienced affect. These findings could suggest that for these patients the use of these strategies (partly) reflects a process not necessarily in service of regulating their emotions, but rather some kind of inflexible behavior that does not vary with fluctuations in the emotional context. However, this interpretation is not supported by our analyses investigating the role of emotional context.

Specifically, in line with previous studies (see Brans et al., 2013; Medland et al., 2020), we found that preceding emotional context shapes the use of emotion regulation strategies in healthy controls: heightened negative affect predicted increased use of suppression and sharing, and heightened positive affect predicted decreased use of suppression. Importantly, these associations were not different for clinical groups, indicating that MDD and BPD patients adapt their use of suppression and sharing to their varying emotions to a similar extent as healthy controls.[1] These findings therefore suggest that increased overall use of suppression and sharing for MDD and BPD compared to healthy control participants cannot be explained by group differences in adjusting one's strategy use to the varying emotional context. Potentially, over time, using suppression and sharing have become a habit for these patients, resulting in them using these strategies already at lower levels than healthy controls. Alternatively, other group differences in overall contextual factors or adaptability of strategy use to those contextual factors may explain increased use of suppression and sharing. For example, emotion regulation motives (Millgram et al., 2020; Tamir, 2016) or social contextual factors (Paul et al., 2023; Ruan et al., 2020) can affect strategy use.

4.1 | Limitations and future directions

First, we did not directly ask participants which emotions they suppressed or shared. We therefore cannot be sure that our operationalization of emotional context actually captured which emotions individuals tried to regulate. Nevertheless, the associations between preceding emotional context and emotion regulation in the expected direction support the validity of the current operationalization. Additionally, we did not have information concerning whom participants were with when suppressing or sharing their emotions, and how many opportunities for sharing they actually had (as this strategy requires being in contact with others). Possibly, as clinical participants were in treatment, treatment sessions may have contributed to talking more about one's emotions on a day-to-day basis. Future research in clinical patients should consider collecting information on whom emotions were shared with to delineate potential effects of being in treatment. Relatedly, assessment of a wider range of contextual factors and emotion regulation strategies may be preferred for future studies to allow a more encompassing assessment of context-strategy fit, which has been proposed to be relevant for adaptive emotion regulation (Kalokerinos & Koval, 2024). Additionally, future studies may consider looking not only at whether but also at *how* individuals share their emotions as this may differ depending on psychopathology (Hofmann, 2014). Finally, our main analyses allowed to compare differences between healthy controls and the three clinical groups, but not between the different clinical groups. Comparing between clinical groups may be an interesting avenue for future research as this would allow to identify the potentially common versus distinct use of emotion regulation strategies in individuals with MDD, BPD or both. Our exploratory analyses comparing between the clinical groups suggested a few differences between clinical groups, however, these findings should be interpreted with caution as they required many comparisons. To reduce the number of comparisons made, future research may consider focusing on symptoms rather than comparing between clinical groups.

5 | CONCLUSION

We tested differences between clinical patients with MDD and/or BPD and healthy controls in their use of expressive suppression and social sharing in daily life. Findings indicated that individuals with MDD and/or BPD overall used more expressive suppression and social

[1]Exploratory analyses with single emotion items even suggested that for some clinical groups fluctuations in specific emotions more strongly related to their use of expressive suppression (i.e., associations between suppression and preceding stress and euphoria were stronger for individuals with BPD only and comorbid MDD and BPD, respectively). However, as such differences were only found for two single emotion items and two clinical groups, they should be interpreted with caution and need replication.

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sharing compared to healthy controls, but did not differentially adjust the use of these strategies to the emotional context. Moreover, increased suppression and sharing could only partially be explained by group differences in overall experienced negative affect. Patients' higher use of suppression and sharing in daily life might contribute to, or follow from their emotional and interpersonal difficulties.

AUTHOR CONTRIBUTION

Martine W. F. T. Verhees: Conceptualization; formal analysis; writing—original draft. **Eva Ceulemans**: Conceptualization; writing—review and Editing. **Laura Sels**: Conceptualization; writing—review and editing. **Peter Kuppens**: Conceptualization; writing—review and editing. **Egon Dejonckheere**: Data curation; methodology; project administration; writing—review and editing. **Marlies Houben**: Investigation; writing–review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

Ethical approval was obtained from the Ethical Committee Research UZ/KU Leuven (S58526). All participants provided written informed consent.

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PEER REVIEW

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