

Communal Mastery and Associations With Depressive and PTSD Symptomatology Among Urban Trauma-Exposed Women

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1 Abstract

2 **Objectives:** Racial and ethnic minority women from low-resource urban communities
3 experience disproportionately high rates of trauma exposure. Higher rates of lifetime trauma
4 exposure are strongly associated with subsequent psychological sequela, specifically depression
5 and posttraumatic stress disorder (PTSD). *Communal mastery* is the ability to cope with
6 challenges and achieve goals by being closely interconnected with friends, family, and
7 significant others. Yet, it is unknown if communal mastery is protective specifically against
8 PTSD and depressive symptoms.

9 **Methods:** Participants ($N = 131$) were Black and Latina women (88.5% Black, mean monthly
10 income: $< \$750$) recruited from an urban outpatient obstetric-gynecological clinic at an academic
11 medical center. Participants completed an online questionnaire that assessed trauma history,
12 PTSD and depressive symptoms, types of individualistic coping, social support, and communal
13 mastery.

14 **Results:** Hierarchical multiple regression models demonstrated that communal mastery is
15 uniquely associated with fewer PTSD symptoms ($\beta = -.23, p = .003$). More severe trauma history,
16 more use of passive coping skills, and poorer social support were also significantly associated
17 with PTSD symptoms, explaining over half of the variance in PTSD symptoms. Although
18 significantly correlated, communal mastery was not uniquely associated with fewer depressive
19 symptoms ($\beta = -.13, p = .201$).

20 **Conclusions:** These findings suggest that connectedness as assessed through communal mastery
21 serves as an important shield against the effects of traumatic stress for Black and Latina women.
22 Future research would benefit by exploring interventions that aim to increase communal mastery

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23 in order to help highly trauma-exposed racial and ethnic minority women in low-resource
24 environments.

25 *Keywords: communal mastery, minority women, trauma, posttraumatic stress disorder,*
26 *depression, women's mental health*

27 **Public Significance Statement:** Communal coping is often overlooked in research focused on
28 coping processes, particularly for racial and ethnic minority women from low-resource urban
29 areas. This study demonstrated that *communal mastery*, a collectivist style of coping that values
30 being closely interconnected with others in order to face challenges and achieve goals, was
31 uniquely associated with less severe posttraumatic stress disorder (PTSD) symptoms in a sample
32 of Black and Latina women, even when accounting for other known predictors of PTSD. This
33 highlights how coping via close interconnection with others could be considered as an avenue to
34 increase resilience and protect against psychopathology symptoms among low-resource
35 communities.

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50 **Communal Mastery and Associations with Depressive and PTSD Symptomatology**
51 **among Urban Trauma-Exposed Women**

52 Women from low-resource urban communities experience disproportionately high rates
53 of exposure to trauma compared to women living in affluent communities, creating disparities in
54 psychopathology among trauma-exposed individuals (Kennedy, Bybee, & Greeson, 2014;
55 Nurius, Uehara, & Zatzick, 2013). Low-resource urban communities are defined as those with
56 less access to affordable housing, greater food insecurity, greater disease burden, and lower life
57 expectancy, which are disparities that disproportionately affect communities composed of
58 primarily racial and ethnic minorities (Rush CHNA/CHIP, 2020). Women in low-resource urban
59 communities often experience rates of trauma exposure and posttraumatic stress disorder that are
60 significantly higher than national average (PTSD; Cubbin, Hadden, & Winkleby, 2001; Deaton &
61 Lubotsky, 2003; Seng, Kohn-Wood, McPherson, & Sperlich, 2011; Walker, Keane, & Burke,
62 2010). Lifetime trauma exposure tends to accumulate, with trauma exposure early in one's life
63 associated with increased risk of additional exposure (Cloitre et al., 2009; Kessler, 2000).

64 How women cope with trauma exposure is an important factor affecting psychopathology
65 risk and recovery (Banyard & Williams, 2007; Perrin et al., 2014). However, research
66 historically has focused on individualistic coping behaviors while more communal or collectivist
67 coping styles have seldom been explored. The purpose of this study was to explore one type of
68 communal coping, *communal mastery*, and its associations with psychopathology symptoms in a
69 sample of racial and ethnic minority women from low-resource urban areas with significant
70 exposure to traumatic events. We were especially interested in exploring how communal mastery
71 relates to psychopathology while considering other individualistic coping skills and perceived

72 social support, in an effort to better explain the potential influence of these related yet distinct
73 coping resources.

74 **Communal Mastery**

75 Communal mastery describes a coping process whereby “individuals see themselves as
76 able to be effective in achieving their goals and coping with life challenges by virtue of their
77 being attached to significant others” (Hobfoll, Schröder, Wells, & Malek, 2002a, p. 363). As a
78 collectivistic coping process (versus an individualistic coping process), communal mastery
79 emphasizes forming coalitions with significant others, including family, friends, and neighbors.
80 In contrast, self-efficacy, stems from concepts of “rugged individualism,” and the idea that
81 coping is based on personal strength of the individual (Dunahoo, Hobfoll, Monnier, Hulsizer, &
82 Johnson, 1998; Monnier, Hobfoll, Dunahoo, Hulsizer, & Johnson, 1998). Hobfoll and colleagues
83 (2002a) evaluated communal mastery in samples of undergraduates, community adults, and
84 urban women and found increased communal mastery to be associated with acquiring more
85 social support and greater interdependence among group members. Importantly, communal
86 mastery was associated with lower psychological distress (Hobfoll et al., 2002a).

87 **Communal Mastery vs. Social Support**

88 Social support is the utilization of instrumental support (e.g. such as money or assistance
89 with tasks) and emotional support (e.g. receiving love and sympathy; Carver, Scheier, &
90 Weintraub, 1989) from specific family members, friends, and acquaintances or formal networks
91 of health care professionals that one perceives as available (Heaney & Israel, 2002). Social
92 support often represents a one-way provision/receipt of help, guidance, or resources, with type
93 and degree of social support varying by person and situation. Although closely related to social
94 support, communal mastery is distinguishable from social support in that it constitutes a sense of

95 efficacy or perceived control over one's behavior specifically using interpersonal attachments
96 toward goal attainment. Hence, whereas social support pertains to the attachment to the social
97 group (which may or may not entail a sense of efficacy in engaging the social group in order to
98 cope), communal mastery implies that one's sense of efficacy is specifically based on that
99 involvement. In light of this, we approached the central research question examining the
100 relationship between communal coping and psychopathology among trauma-exposed individuals
101 taking into account both individualistic coping processes, social support, and the added
102 component of sense of efficacy in engaging social attachments for the purposes of overcoming
103 challenges, i.e., communal mastery.

104 **Coping in Traumatized Populations**

105 A collectivist coping style such as communal mastery may be particularly important to
106 examine in trauma-exposed racial and ethnic minority women from low-resource urban areas.
107 Women are more likely to develop PTSD after a traumatic event than men (Christiansen &
108 Hansen, 2015; Olf, 2017). Whereas robust evidence exists for the protective effects of social
109 support on the development and recovery from post-trauma psychopathology, (Brewin,
110 Andrews, & Valentine, 2000; Evans, Steel, & DiLillo, 2013; Hyman, Gold & Cott, 2003; Ozer,
111 Best, Lipsey, & Weiss, 2003; Schumm, Briggs-Phillips, & Hobfoll, 2006; Shand, Cowlshaw,
112 Brooker, Burney, & Ricciardelli, 2015; Wright, Kelsall, Sim, Clarke, & Creamer, 2013), little is
113 known about the extent to which communal mastery is related to psychopathology among
114 trauma-exposed individuals, particularly when examining co-occurring existing social support.
115 A sense of efficacy in overcoming challenges may be an additional coping process and of
116 particular relevance for women who may cope specifically through engaging their social
117 attachments, but this aspect of coping is not often considered.

118 There are cultural differences in reliance on individualistic vs. collectivistic coping
119 processes (Engelbrecht & Jobson, 2015), with less focus on collectivistic coping in traumatic
120 stress research. Although cultural identity factors were not an explicit focus of the current study,
121 ethnic and racial minority women may benefit from greater efficacy-through-social attachments
122 and exploring this avenue of coping offers a dimensionality to understanding coping processes of
123 populations often underrepresented in research. Thus, it may be particularly important to
124 examine communal mastery in communities that are more likely to utilize collectivist styles of
125 coping, although it has yet to be examined alongside individualistic coping strategies to
126 determine associations with mental health outcomes among trauma-exposed individuals.

127 **Individualistic Coping**

128 Individualistic coping is conceptualized as the cognitive and behavioral actions that a
129 person may use in response to a stressor, often used to solve a problem or to regulate their
130 emotions (Lawler, Ouimette, & Dahlstedt, 2005; Moos, 2004). Lazarus and Folkman (1984)
131 defined two of the most common coping styles, specifically: *problem-focused coping*, which
132 involves actively approaching specific problems to reduce stress (e.g. planning), and *emotion-*
133 *focused coping*, which attempts to minimize the emotional distress associated with the stressor
134 (e.g. humor). *Passive coping* is another common coping style that utilizes maladaptive
135 behavioral responses (e.g. substance use, avoidance, denial) and tends to be associated with
136 poorer mental health outcomes, such as increased depressive symptoms, PTSD symptoms, and
137 self-blame (Ullman, Peter-Hagene, & Relyea, 2014; Violanti et al., 2018). Given the associations
138 between types of coping and mental health outcomes (Kraaij, Arensman, Garnefski, & Kremers,
139 2007), including in traumatized populations (Matheson, Skomorovsky, Fiocco, & Anisman,

140 2007), it is necessary to better understand how coping types may influence psychopathology in
141 women from low-resource communities.

142 **The Current Study**

143 Women in low-resource urban communities are much more likely to live in
144 neighborhoods where poverty, childhood trauma, and multiple lifetime trauma exposures rates
145 significantly exceed national averages, with over 50% of women endorsing physical and/or
146 sexual interpersonal violence exposure (National Institutes of Health (US), 2014; Schumm,
147 Stines, Hobfoll, & Jackson, 2005; Schumm, Briggs-Phillips, & Hobfoll, 2006; USDHHS, 2014).
148 Examining the relationship between communal mastery and psychopathology among trauma-
149 exposed individuals may be a missing step toward understanding and addressing how
150 populations living in low-resource areas overcome higher levels of lifetime trauma exposure.
151 Thus, elucidating the communal mastery-traumatic stress linkage stands to make a significant
152 contribution to reducing health disparities. We explored communal mastery in a sample of Black
153 and Latina women from low-resource urban communities with high levels of lifetime trauma
154 exposure in order to better understand the relationship between communal coping and other
155 types of individualistic coping to determine associations among mental health outcomes. The
156 primary hypothesis: increased communal mastery will be positively correlated with social
157 support and aspects of individualistic coping, and negatively correlated with PTSD, depressive
158 symptoms, and individualistic coping. The secondary hypothesis: lower communal mastery will
159 be associated with increased severity of PTSD and depressive symptoms, even after accounting
160 for social support and other types of individualistic coping.

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Method

Participants and Procedures

Participants ($N=131$) were Black and Latina female patients recruited from an outpatient obstetric-gynecological clinic at an academic medical center in a large Midwestern city (see Table 1). Participants were recruited from the outpatient obstetric-gynecological clinic as it exclusively serves low-income, primarily ethnic and racial minority women who have Medicaid or Medicaid-equivalent insurance and high levels of traumatic stress. Participants were primarily Black (88.5%) and on average 29 years of age ($SD = 7.9$). Most participants did not have a partner (64.9%) and about a third had a high school education or less (38.9%). The average monthly income was \$742 ($SD = \$1,185$) and more than half were unemployed or on disability (57.2%). Most of the sample had experienced at least one traumatic event in their lifetime (96.2%). In relation to specific types of lifetime trauma, a majority of participants (56.5%) endorsed experiencing at least one crime-related event while nearly every participant (90.8%) endorsed general and disaster trauma (e.g. accidents, witnessing dead bodies, learning of sudden deaths, and combat). Many participants endorsed experiencing physical assault (43.6%) or sexual violence (51.9%) in their lifetime, with 25.9% endorsing experiencing both physical and sexual violence. Of all participants, 19.1% and 12.2% met criteria for probable diagnoses of depression and PTSD, respectively, comparable to earlier studies composed of similar non-perinatal racial and ethnic minority populations (Black et al., 2010; Galea et al., 2007; Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995; Schumm, Stines, Hobfoll, & Jackson, 2005; Schumm, Briggs-Phillips, & Hobfoll, 2006).

Participants were recruited into a larger study of traumatic stress and biomarkers of immune function. Details of recruitment procedures are described elsewhere (Redacted

186 references, 2013a and 2013b). Female patients presenting for their routine gynecologic and well-
187 woman visits were recruited via posters and brochures, and consistent staff invitations.
188 Gynecologic providers were also notified about the study and encouraged to invite their patients
189 to participate. Interested patients completed a telephone eligibility screening. Criteria for
190 inclusion: age 18- 45 years; free of major illnesses or acute infections for the previous two
191 weeks; not given birth in the previous two months, not currently pregnant, and not currently
192 breastfeeding. In previous studies, more than 70% of women attending the center's obstetric-
193 gynecological clinics have been primarily racial and ethnic minority women from low-resource
194 urban areas with high rates of trauma exposure (e.g. > 30% of prenatal patients endorsed positive
195 screens for PTSD; Redacted for references, 2019). A total of 153 women expressed interest in
196 the study but 14 women did not meet inclusion criteria as described above. To focus solely on
197 Black and Latina women, the small number of White women ($n = 8$) were excluded, resulting in
198 a final sample size of 131.

199 After screening, participants who were eligible met in person with a research assistant to
200 complete the informed consent process and then complete study measures during their visit.
201 Measures were administered online via *SurveyMonkey.com*. The research assistant remained
202 present while participants completed measures to answer any questions about the website, to
203 clarify what the question was asking, and to address any technical issues. Participants received
204 \$50 upon completion of the survey. All study procedures were approved by the university's
205 Institutional Review Board. Authors have complied with APA ethical standards in the treatment
206 of all participants.

207 **Measures**

208 *Participant Characteristics*

209 Participants' sociodemographic data were obtained by completion of questionnaires
210 during their visit. These included age, educational level, employment status and occupation,
211 monthly earnings, relationship status, children under the age of 18, race and ethnicity, number of
212 rooms in the home, and number of individuals in the household.

213 *History of Trauma Exposure*

214 The Trauma History Questionnaire (THQ; Green, 1996) is a well-validated 24-item
215 measure used to assess history of exposure to a variety of potentially traumatic events across the
216 lifespan. The THQ has been utilized in over 60 published studies with study populations that
217 have included intimate partner violence survivors (Humphreys, Lee, Neylan, & Marmar, 1999)
218 and childhood trauma survivors (Heilemann, Kury, & Lee, 2005). The THQ has demonstrated
219 good concurrent validity with other trauma history measure such as the Stressful Life Events
220 Screening Questionnaire ($r = .77, p < .001$; Nijenhuis, Van der Hart, & Kruger, 2002; Goodman,
221 Corcoran, Turner, Yuan, & Green, 1998) as well as predictive validity for PTSD symptoms when
222 measured by validated instruments (median symptom intraclass correlation (ICC) of .96 between
223 THQ and Clinician Administered PTSD Scale [CAPS; Weathers, Keane, & Davidson, 2001];
224 Mueser et al., 2001). The THQ is composed of three subscales, *Crime-Related Events*, *General*
225 *Disaster and Trauma*, and *Physical and Sexual Experiences*. To compute the total trauma
226 exposure score, the number of trauma exposures endorsed for each scale was summed; higher
227 scores reflect more trauma exposure. There were 13 participants that had missing data in at least
228 one of the subscales; only the number of items endorsed was used for calculating the total scale
229 and percentages of events experienced. As the measure assesses discrete traumatic events,
230 internal consistency statistics were not calculated (Hooper, Stockton, Krupnick, & Green, 2011).

231 *Communal Mastery*

232 The Communal Mastery Scale (CMS, Hobfoll, Schrodër, Wells, & Malek, 2002a) is a 10-
233 item scale that utilizes a four-point Likert scale ('strongly disagree' to 'strongly agree') to assess
234 community mastery. Items were summed to compute the final score. The measure was developed
235 from other validated measures of mastery (Pearlin, Lieberman, Menaghan, & Mullan, 1981) and
236 self-efficacy (Schwarzer, Bäßler, Kwiatek, Schröder, & Zhang, 1997), adapted to reflect more
237 collectivist-based statements. Examples of items included, "I can do just about anything I set my
238 mind to do because I have the support of those close to me", and "What happens to me in the
239 future mostly depends on my ability to work well with others". Higher scores indicate more
240 belief in informal social ties and use of the community to cope with challenges and help solve
241 problems. The measure was found to be reliable with a sample of 67 students over a two-week
242 period, with a test-retest reliability of .78 (Hobfoll et al., 2002a) as well as a sample of
243 reservation-living Native American women (Hobfoll et al., 2002b). Construct validity has been
244 demonstrated, indicated by moderate associations with related constructs of social support (r
245 =.42) and self-mastery (r =.46; Hobfoll et al., 2002b), indicating that although correlated, a
246 majority of the variance is independent of these other constructs. In the current sample, the
247 internal consistency reliability (Cronbach's coefficient alpha) was adequate (α =.74), similar to
248 other samples.

249 *Coping*

250 The Brief-COPE (Carver, 1997) is a 28-item measure used to assess types of coping
251 strategies used in the past year, derived from the original Coping Orientations to Problems
252 Experienced (COPE; Carver, Scheier & Weintraub, 1989). A 4-point Likert scale is utilized for
253 the 14 types of coping (1 = "I haven't been doing this at all" to 4 = "I've been doing this a lot").
254 While not part of the original Brief-COPE, researchers have found coping types to be

255 significantly clustered into three domains: (1) *emotion-focused coping*, which includes
256 acceptance, use of emotional support, humor, positive reframing, and religion; (2) *problem-*
257 *focused coping*, which includes active coping, use of instrumental support, and planning; (3)
258 *passive coping*, which includes behavioral disengagement, venting, denial, self-distraction, self-
259 blame, and substance use (Cooper, Katona, & Livingston, 2008; Wong et al., 2016). Items for
260 each sub cluster of coping were summed (2 items per sub cluster, 14 total sub clusters), with all
261 relevant sub clusters summed together to create the three subscale scores: emotion-focused,
262 problem-focused, and passive coping. Higher scores indicate more use of coping skills in each
263 domain. These sub clusters of coping strategies have been examined in various populations,
264 including adults with anxiety symptoms, caregivers of dementia patients, and intimate partner
265 violence survivors (Coolidge, Segal, Hook, & Stewart, 2000; Cooper et al., 2008; Wong et al.,
266 2016); similar characterization of passive coping has been utilized in predicting PTSD outcomes
267 among trauma survivors (Glass, Flory, Hankin, Kloos, & Turecki, 2009; Schnider, Elhai, &
268 Gray, 2007). Cronbach's coefficient alpha was sufficient across the three subscales (emotion-
269 focused coping $\alpha=.83$; problem-focused coping $\alpha= .85$; passive coping $\alpha=.78$).

270 ***Social Support***

271 The Social Support Provision Scale (SSPS; Cutrona & Russell, 1987) is a 10-item
272 measure used to assess perceived social support from friends and family. The SSPS assesses
273 various indicators of support, including if they feel that they have someone on who they can
274 depend, someone to confide in, and individuals who make them feel loved ('1 = no', '2 =
275 sometimes', '3 = yes', '4 = not sure'). Items were summed to compute the final score. Sample
276 items include, "Is there a person you could turn to for advice if you were having problems?" and
277 "Do you feel others do not respect your skills and abilities?". The measure is based on Weiss's

278 (1974) six domains of support conceptualization. Higher scores indicate more perceived social
279 support across domains. Cronbach's coefficient alpha for the current sample was adequate
280 ($\alpha=.79$).

281 *Psychopathology Symptoms*

282 The PTSD Symptom Scale–Self Reported (PSS-SR; Foa, Riggs, Dancu, Rothbaum,
283 1993) is a well-validated 17-item scale used to assess DSM-IV PTSD symptom severity scores
284 over the last week using a four-point Likert scale (0='not at all' to 3='almost always'). Higher
285 scores indicate more severe symptoms across three specific symptom clusters (intrusions;
286 persistent avoidance of trauma-related stimuli and numbing of general responsiveness; and
287 increased arousal). The sensitivity of the PSS-I has been reported to be 88% with a specificity
288 rate of 96% (Foa et al., 1993). A probable PTSD diagnosis was made when a participant
289 endorsed at least 1 reexperiencing, 3 avoidance and 2 arousal symptoms as a "1" or greater. The
290 Cronbach's coefficient alpha was excellent ($\alpha=.95$).

291 The Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a 10-
292 item scale that measured frequency and severity of depressive symptoms , as well as level of
293 impairment, over the last two weeks with a four-point Likert scale (0='not at all' to 3='nearly
294 every day'). The PHQ-9 is a well-validated screen for major depressive disorder (MDD; Manea,
295 Gilbody, & McMillan, 2015), created from a subset of questions from the Patient Health
296 Questionnaire (Spitzer, Kroenke, Williams, & Patient Health Questionnaire Primary Care Study
297 Group, 1999). A score of 10 or greater on the PHQ-9 is considered the threshold score for
298 meeting criteria for MDD across samples (Moriarty, Gilbody, McMillan, & Manea, 2015).
299 Cronbach's coefficient alpha for the first nine questions assessing symptom frequency and
300 severity was good ($\alpha=.88$). Items for each measure were summed to compute the final score.

301 **Data Analysis**

302 All statistical analyses were performed using SPSS Statistics 22 (IBM, Armonk, NY).
303 Missing data was minimal (0.7-7.9%, mean 2.5% across predictors and outcome scales). Mean
304 imputation was utilized by replacing the missing values with the mean score of all remaining
305 values of the same variable. Bivariate correlations and hierarchical multiple regression analyses
306 were utilized. Bivariate correlations were conducted between study variables to assess the zero-
307 order relationships between communal mastery, social support, types of coping skills (problem-
308 focused, emotion-focus, and passive coping), trauma history (including subscales of traumatic
309 events) and psychopathology. Associations among variables were examined to determine if
310 multicollinearity was present. For the subsequent hierarchical multiple regression models, total
311 trauma history was included in Step 1; social support and all three coping subscales were
312 included in Step 2; and communal mastery was included in Step 3. Outcome variables for each
313 regression model were PTSD and depressive symptom scores. To rule out overlap in social
314 support and individualistic coping, separate hierarchical regression analyses were conducted with
315 emotion-focused and problem-focused coping subscales that omitted social support specific
316 items (e.g. “use of emotional support” and “use of instrumental support”, respectively).
317 Hierarchical regression analyses revealed no differences in outcomes; emotion-focused and
318 problem-focused coping subscales were used as previously reported in the literature. Correlations
319 were statistically significant at alpha level $\alpha = .05$.

320 **Results**

321 All coping subscales, communal mastery, and social support variables were normally
322 distributed, with no variable exhibiting significant skew or kurtosis.

323 **Associations among Study Variables**

324 Communal mastery was significantly positively associated with levels of social support (r
325 = .48, $p < .001$) and adaptive forms of coping (problem-focused, $r = .24$, $p = .008$; emotion-
326 focused, $r = .28$, $p = .002$; all correlations in Table 2). Communal mastery was negatively
327 associated with PTSD symptoms ($r = -.37$, $p < .001$) and depressive symptoms ($r = -.33$, $p <$
328 $.001$), as well as maladaptive coping (passive coping, $r = -.21$, $p = .023$). Social support was
329 significantly negatively associated with PTSD ($r = -.48$, $p < .001$) and depressive symptoms ($r =$
330 $-.46$, $p < .001$). In relation to other forms of coping, only utilization of passive coping was
331 significantly positively related to psychopathology symptoms (PTSD, $r = .64$; depressive
332 symptoms, $r = .57$, $p < .001$).

333 **Communal Mastery and Psychopathology Outcomes**

334 *PTSD Symptoms*

335 In the context of hierarchical regression analyses, history of trauma ($\beta = .23$, $p = .002$) and
336 passive coping ($\beta = .49$, $p < .001$) were significantly positively associated with PTSD symptoms
337 while social support ($\beta = -.25$, $p = .002$) was negatively associated with PTSD symptoms in the
338 final model (see Table 3). Even after adjusting for trauma history, social support, and passive
339 coping, communal mastery was negatively associated with PTSD symptoms ($\beta = -.23$, $p = .003$),
340 explaining an additional 4% of the variance in the model ($R^2 \Delta = .039$). The total model explained
341 56% of the variance in PTSD symptoms (adjusted $R^2 = .53$).

342 *Depressive Symptoms*

343 In the context of hierarchical regression analyses, history of trauma ($\beta = .18$, $p = .031$) and
344 passive coping ($\beta = .43$, $p < .001$) were significantly positively associated with depressive
345 symptoms in the final model. After accounting for trauma history, social support, and coping

346 skills, communal mastery was not significantly related to depressive symptoms ($\beta = -.13, p =$
347 $.165$). The total model explained 41% of the variance in depressive symptoms (adjusted $R^2 = .38$).

348 **Discussion**

349
350 The findings from this study support communal mastery as an important and distinct type
351 of coping that has the potential to promote mental health outcomes for Black and Latina women
352 from low-resource urban communities affected by trauma. Most studies of trauma-exposed
353 women have examined the benefits of individualistic coping or the use of social support. To our
354 knowledge, this is the first study to compare communal mastery with other individual types of
355 coping, including the use of social support, to evaluate their associations with PTSD and
356 depressive symptoms in racial and ethnic minority women from low-resource urban areas. In our
357 sample, communal mastery was associated with the use of social support and lower levels of
358 PTSD symptoms, even after accounting for other types of individualistic coping. However,
359 contrary to our hypothesis, communal mastery was not significantly associated with lower levels
360 of depressive symptoms when covariates were included in the model. In sum, racial and ethnic
361 minority women from low-income urban areas who believe that their effectiveness depends on
362 support from close associates have less severe PTSD symptoms, even after accounting for other
363 coping and general social support.

364 Communal mastery may be important to consider in relation to populations from low-
365 resource communities, in both reducing negative mental health outcomes and increasing
366 resilience from trauma exposure (Sampson, 1997). Our findings demonstrate that communal
367 mastery is uniquely associated with PTSD symptoms, which adds to the limited existing
368 literature examining collectivist, communal forms of coping among trauma-exposed populations
369 from low-resource communities and associated mental and physical health outcomes, (Cohen,

370 Farley, & Mason, 2003; Cohen, Finch, Bower, & Sastry, 2006; Hobfoll, Jackson, Hobfoll,
371 Pierce, & Young, 2002b; Ursano et al., 2014). This study provided additional information about
372 the role of communal mastery and mental health outcomes in Black and Latina women.

373 One reason that communal mastery may be associated with lower levels of PTSD
374 symptoms is that individuals feel more comfortable reaching out for support when they have
375 close associates, such as friends, family, colleagues, and others that they would consider
376 confidants. According to the cognitive model theory of PTSD (Ehlers & Clark, 2000),
377 maladaptive appraisals of oneself, others, and the world can significantly affect the
378 development and maintenance of PTSD symptoms. Those close connections may help to
379 disprove the maladaptive appraisals often encountered in PTSD (e.g. “I’m broken, I’m alone”),
380 as well as buffer the traumatized individual from social isolation. A supportive environment that
381 rejects maladaptive appraisals is important; social environments characterized by indifference
382 or criticism are predictive of increased PTSD symptomatology (Ullman & Filipas, 2001;
383 Zoellner, Foa, & Bartholomew, 1999), with stronger effects among women compared to men
384 (Brewin & Holmes, 2003).

385 However, our study did not examine communal mastery in relation to specific PTSD
386 symptoms, types of traumatic events, or mechanisms through which they may work and is an
387 area to further explore. Of note, while communal mastery was significantly associated with
388 PTSD, its contribution to the explained variance was modest. Results should be considered
389 preliminary and further research of communal mastery’s association with mental health
390 outcomes in low-resource populations is warranted.

391 The implications from this study provide information for future research. It is important
392 to understand how coping, especially communal coping, among racial and ethnic minority

393 women in low-resource communities may look differently when compared to more frequently
394 studied communities (i.e. White, affluent communities). Future interventions should examine
395 how to enhance communal mastery in informal interconnected networks (e.g. friend, family,
396 colleagues). It may be beneficial to explore interventions aimed at broader systems of
397 community support that are more central in low-resource areas (e.g. church, social activism
398 organizations) to improve communal mastery, although associations between community support
399 and communal mastery is speculative without more research. Moreover, future research may
400 benefit by examining the effectiveness of interventions aimed at increasing communal mastery as
401 well as individual coping as a helpful adjunct to more traditional psychotherapy in order to
402 improve mental health outcomes.

403 This study had several limitations. First, all data was cross-sectional and captured by
404 utilizing self-report measures. Future research would benefit from including observational
405 elements of how communal mastery is demonstrated in the community over time. Second,
406 individuals high in communal mastery may feel more support, yet they may also experience
407 vicarious trauma and stress contagion due to more exposure to others' stress (Afifi et al., 2018;
408 Hobfoll et al., 2002a). It is possible that there is a threshold for utilizing communal mastery
409 before other types of coping may be more beneficial and reduce burnout. Third, although we
410 posit here that communal mastery may be especially important for communities affected by high
411 rates of neighborhood violence and crime, we did not objectively assess community-level
412 violence or stress to which the women in our sample may have been exposed, both of which
413 would have provided important information about the sample. Previous studies utilizing a similar
414 sample and recruiting from the same clinic have found rates of PTSD greater than 30% and the
415 majority of women from low-resource areas (Stevens, Lillis, Wagner, Tirone, & Hobfoll, 2019).

416 However, an objective measurement of community-level violence, such as specific neighborhood
417 information, was not obtained and should be incorporated in future research. Fourth, our scales
418 had some limitations. Our PTSD measure assessed PTSD symptoms based on DSM-IV criteria,
419 rather than DSM-5, and social support and communal mastery measures were less well-validated
420 than other measures utilized, which could affect findings. Fifth, while a strength of our study
421 included targeting a population that is often omitted in the research, the homogeneity of our
422 sample raises questions on generalizability of the findings to other communities. It is unknown if
423 the same associations between communal mastery and PTSD symptoms would be replicated in
424 other populations, such as primarily Latina women or women in rural areas. Lastly, the low-
425 resource communities studied here are often and systematically marginalized by dominant social
426 structures. This study did not formally assess experiences of racism and discrimination, yet
427 future research that incorporates information on societal trauma could add more context to how
428 institutional discrimination may affect an individual's perception of communal mastery (Bryant-
429 Davis, Chung, Tillman, & Belcourt, 2009).

430 In conclusion, the current study provides important contribution to understanding the role
431 of communal mastery for mental health outcomes in racial and ethnic minority women from low-
432 resource urban areas. Communal mastery is associated with lower levels of PTSD (but not
433 depressive) symptoms after accounting for social support and other types of individualistic
434 coping. From both an intervention and public health perspective, the implications of the results
435 may be especially important for health disparities and community-based research. Future
436 interventions could target ways to increase connectiveness among informal networks, rather than
437 only targeting increasing individualistic coping skills. Given the negative and far-reaching
438 effects of trauma exposure and PTSD, promoting communal mastery through interventions that

439 improve the ability to cope and achieve goals by being closely interconnected with friends,
440 family, colleagues, and significant others may enhance treatment effectiveness and serve as
441 important tools for future researchers and public health officials to consider.

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