Abstract

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

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

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

Conclusions: These findings suggest that connectedness as assessed through communal mastery serves as an important shield against the effects of traumatic stress for Black and Latina women. Future research would benefit by exploring interventions that aim to increase communal mastery.
in order to help highly trauma-exposed racial and ethnic minority women in low-resource environments.

Keywords: communal mastery, minority women, trauma, posttraumatic stress disorder, depression, women’s mental health
Public Significance Statement: Communal coping is often overlooked in research focused on coping processes, particularly for racial and ethnic minority women from low-resource urban areas. This study demonstrated that communal mastery, a collectivist style of coping that values being closely interconnected with others in order to face challenges and achieve goals, was uniquely associated with less severe posttraumatic stress disorder (PTSD) symptoms in a sample of Black and Latina women, even when accounting for other known predictors of PTSD. This highlights how coping via close interconnection with others could be considered as an avenue to increase resilience and protect against psychopathology symptoms among low-resource communities.
Communal Mastery and Associations with Depressive and PTSD Symptomatology among Urban Trauma-Exposed Women

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

How women cope with trauma exposure is an important factor affecting psychopathology risk and recovery (Banyard & Williams, 2007; Perrin et al., 2014). However, research historically has focused on individualistic coping behaviors while more communal or collectivist coping styles have seldom been explored. The purpose of this study was to explore one type of communal coping, communal mastery, and its associations with psychopathology symptoms in a sample of racial and ethnic minority women from low-resource urban areas with significant exposure to traumatic events. We were especially interested in exploring how communal mastery relates to psychopathology while considering other individualistic coping skills and perceived
social support, in an effort to better explain the potential influence of these related yet distinct coping resources.

**Communal Mastery**

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

**Communal Mastery vs. Social Support**

Social support is the utilization of instrumental support (e.g. such as money or assistance with tasks) and emotional support (e.g. receiving love and sympathy; Carver, Scheier, & Weintraub, 1989) from specific family members, friends, and acquaintances or formal networks of health care professionals that one perceives as available (Heaney & Israel, 2002). Social support often represents a one-way provision/receipt of help, guidance, or resources, with type and degree of social support varying by person and situation. Although closely related to social support, communal mastery is distinguishable from social support in that it constitutes a sense of
efficacy or perceived control over one’s behavior specifically using interpersonal attachments toward goal attainment. Hence, whereas social support pertains to the attachment to the social group (which may or may not entail a sense of efficacy in engaging the social group in order to cope), communal mastery implies that one’s sense of efficacy is specifically based on that involvement. In light of this, we approached the central research question examining the relationship between communal coping and psychopathology among trauma-exposed individuals taking into account both individualistic coping processes, social support, and the added component of sense of efficacy in engaging social attachments for the purposes of overcoming challenges, i.e., communal mastery.

Coping in Traumatized Populations

A collectivist coping style such as communal mastery may be particularly important to examine in trauma-exposed racial and ethnic minority women from low-resource urban areas. Women are more likely to develop PTSD after a traumatic event than men (Christiansen & Hansen, 2015; Olff, 2017). Whereas robust evidence exists for the protective effects of social support on the development and recovery from post-trauma psychopathology, (Brewin, Andrews, & Valentine, 2000; Evans, Steel, & DiLillo, 2013; Hyman, Gold & Cott, 2003; Ozer, Best, Lipsey, & Weiss, 2003; Schumm, Briggs-Phillips, & Hobfoll, 2006; Shand, Cowlishaw, Brooker, Burney, & Ricciardelli, 2015; Wright, Kelsall, Sim, Clarke, & Creamer, 2013), little is known about the extent to which communal mastery is related to psychopathology among trauma-exposed individuals, particularly when examining co-occurring existing social support. A sense of efficacy in overcoming challenges may be an additional coping process and of particular relevance for women who may cope specifically through engaging their social attachments, but this aspect of coping is not often considered.
There are cultural differences in reliance on individualistic vs. collectivistic coping processes (Engelbrecht & Jobson, 2015), with less focus on collectivistic coping in traumatic stress research. Although cultural identity factors were not an explicit focus of the current study, ethnic and racial minority women may benefit from greater efficacy-through-social attachments and exploring this avenue of coping offers a dimensionality to understanding coping processes of populations often underrepresented in research. Thus, it may be particularly important to examine communal mastery in communities that are more likely to utilize collectivist styles of coping, although it has yet to be examined alongside individualistic coping strategies to determine associations with mental health outcomes among trauma-exposed individuals.

**Individualistic Coping**

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

The Current Study

Women in low-resource urban communities are much more likely to live in neighborhoods where poverty, childhood trauma, and multiple lifetime trauma exposures rates significantly exceed national averages, with over 50% of women endorsing physical and/or sexual interpersonal violence exposure (National Institutes of Health (US), 2014; Schumm, Stines, Hobfoll, & Jackson, 2005; Schumm, Briggs-Phillips, & Hobfoll, 2006; USDHHS, 2014).

Examining the relationship between communal mastery and psychopathology among trauma-exposed individuals may be a missing step toward understanding and addressing how populations living in low-resource areas overcome higher levels of lifetime trauma exposure. Thus, elucidating the communal mastery-traumatic stress linkage stands to make a significant contribution to reducing health disparities. We explored communal mastery in a sample of Black and Latina women from low-resource urban communities with high levels of lifetime trauma exposure in order to better understand the relationship between communal coping and other types of individualistic coping to determine associations among mental health outcomes. The primary hypothesis: increased communal mastery will be positively correlated with social support and aspects of individualistic coping, and negatively correlated with PTSD, depressive symptoms, and individualistic coping. The secondary hypothesis: lower communal mastery will be associated with increased severity of PTSD and depressive symptoms, even after accounting for social support and other types of individualistic coping.
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...
references, 2013a and 2013b). Female patients presenting for their routine gynecologic and well-woman visits were recruited via posters and brochures, and consistent staff invitations. Gynecologic providers were also notified about the study and encouraged to invite their patients to participate. Interested patients completed a telephone eligibility screening. Criteria for inclusion: age 18-45 years; free of major illnesses or acute infections for the previous two weeks; not given birth in the previous two months, not currently pregnant, and not currently breastfeeding. In previous studies, more than 70% of women attending the center’s obstetric-gynecological clinics have been primarily racial and ethnic minority women from low-resource urban areas with high rates of trauma exposure (e.g. > 30% of prenatal patients endorsed positive screens for PTSD; Redacted for references, 2019). A total of 153 women expressed interest in the study but 14 women did not meet inclusion criteria as described above. To focus solely on Black and Latina women, the small number of White women (n = 8) were excluded, resulting in a final sample size of 131.

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

Measures

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

**History of Trauma Exposure**

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

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

Coping

The Brief-COPE (Carver, 1997) is a 28-item measure used to assess types of coping strategies used in the past year, derived from the original Coping Orientations to Problems Experienced (COPE; Carver, Scheier & Weintraub, 1989). A 4-point Likert scale is utilized for the 14 types of coping (1 = “I haven’t been doing this at all” to 4 = “I’ve been doing this a lot”). While not part of the original Brief-COPE, researchers have found coping types to be
significantly clustered into three domains: (1) emotion-focused coping, which includes acceptance, use of emotional support, humor, positive reframing, and religion; (2) problem-focused coping, which includes active coping, use of instrumental support, and planning; (3) passive coping, which includes behavioral disengagement, venting, denial, self-distraction, self-blame, and substance use (Cooper, Katona, & Livingston, 2008; Wong et al., 2016). Items for each sub cluster of coping were summed (2 items per sub cluster, 14 total sub clusters), with all relevant sub clusters summed together to create the three subscale scores: emotion-focused, problem-focused, and passive coping. Higher scores indicate more use of coping skills in each domain. These sub clusters of coping strategies have been examined in various populations, including adults with anxiety symptoms, caregivers of dementia patients, and intimate partner violence survivors (Coolidge, Segal, Hook, & Stewart, 2000; Cooper et al., 2008; Wong et al., 2016); similar characterization of passive coping has been utilized in predicting PTSD outcomes among trauma survivors (Glass, Flory, Hankin, Kloos, & Turecki, 2009; Schnider, Elhai, & Gray, 2007). Cronbach’s coefficient alpha was sufficient across the three subscales (emotion-focused coping $\alpha=.83$; problem-focused coping $\alpha=.85$; passive coping $\alpha=.78$).

**Social Support**

The Social Support Provision Scale (SSPS; Cutrona & Russell, 1987) is a 10-item measure used to assess perceived social support from friends and family. The SSPS assesses various indicators of support, including if they feel that they have someone on who they can depend, someone to confide in, and individuals who make them feel loved (‘1 = no’, ‘2 = sometimes’, ‘3 = yes’, ‘4 = not sure’). Items were summed to compute the final score. Sample items include, “Is there a person you could turn to for advice if you were having problems?” and “Do you feel others do not respect your skills and abilities?” The measure is based on Weiss’s
(1974) six domains of support conceptualization. Higher scores indicate more perceived social support across domains. Cronbach’s coefficient alpha for the current sample was adequate ($\alpha=.79$).

**Psychopathology Symptoms**

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

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

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

Results

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

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

**Communal Mastery and Psychopathology Outcomes**

**PTSD Symptoms**

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

**Depressive Symptoms**

In the context of hierarchical regression analyses, history of trauma ($\beta = .18, p = .031$) and passive coping ($\beta = .43, p < .001$) were significantly positively associated with depressive symptoms in the final model. After accounting for trauma history, social support, and coping
skills, communal mastery was not significantly related to depressive symptoms ($\beta = -0.13, p = 0.165$). The total model explained 41% of the variance in depressive symptoms (adjusted $R^2 = 0.38$).

**Discussion**

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

Communal mastery may be important to consider in relation to populations from low-resource communities, in both reducing negative mental health outcomes and increasing resilience from trauma exposure (Sampson, 1997). Our findings demonstrate that communal mastery is uniquely associated with PTSD symptoms, which adds to the limited existing literature examining collectivist, communal forms of coping among trauma-exposed populations from low-resource communities and associated mental and physical health outcomes, (Cohen,
Farley, & Mason, 2003; Cohen, Finch, Bower, & Sastry, 2006; Hobfoll, Jackson, Hobfoll, Pierce, & Young, 2002b; Ursano et al., 2014). This study provided additional information about the role of communal mastery and mental health outcomes in Black and Latina women.

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

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

The implications from this study provide information for future research. It is important to understand how coping, especially communal coping, among racial and ethnic minority
women in low-resource communities may look differently when compared to more frequently studied communities (i.e. White, affluent communities). Future interventions should examine how to enhance communal mastery in informal interconnected networks (e.g. friend, family, colleagues). It may be beneficial to explore interventions aimed at broader systems of community support that are more central in low-resource areas (e.g. church, social activism organizations) to improve communal mastery, although associations between community support and communal mastery is speculative without more research. Moreover, future research may benefit by examining the effectiveness of interventions aimed at increasing communal mastery as well as individual coping as a helpful adjunct to more traditional psychotherapy in order to improve mental health outcomes.

This study had several limitations. First, all data was cross-sectional and captured by utilizing self-report measures. Future research would benefit from including observational elements of how communal mastery is demonstrated in the community over time. Second, individuals high in communal mastery may feel more support, yet they may also experience vicarious trauma and stress contagion due to more exposure to others’ stress (Afifi et al., 2018; Hobfoll et al., 2002a). It is possible that there is a threshold for utilizing communal mastery before other types of coping may be more beneficial and reduce burnout. Third, although we posit here that communal mastery may be especially important for communities affected by high rates of neighborhood violence and crime, we did not objectively assess community-level violence or stress to which the women in our sample may have been exposed, both of which would have provided important information about the sample. Previous studies utilizing a similar sample and recruiting from the same clinic have found rates of PTSD greater than 30% and the majority of women from low-resource areas (Stevens, Lillis, Wagner, Tirone, & Hobfoll, 2019).
However, an objective measurement of community-level violence, such as specific neighborhood information, was not obtained and should be incorporated in future research. Fourth, our scales had some limitations. Our PTSD measure assessed PTSD symptoms based on DSM-IV criteria, rather than DSM-5, and social support and communal mastery measures were less well-validated than other measures utilized, which could affect findings. Fifth, while a strength of our study included targeting a population that is often omitted in the research, the homogeneity of our sample raises questions on generalizability of the findings to other communities. It is unknown if the same associations between communal mastery and PTSD symptoms would be replicated in other populations, such as primarily Latina women or women in rural areas. Lastly, the low-resource communities studied here are often and systematically marginalized by dominant social structures. This study did not formally assess experiences of racism and discrimination, yet future research that incorporates information on societal trauma could add more context to how institutional discrimination may affect an individual’s perception of communal mastery (Bryant-Davis, Chung, Tillman, & Belcourt, 2009).

In conclusion, the current study provides important contribution to understanding the role of communal mastery for mental health outcomes in racial and ethnic minority women from low-resource urban areas. Communal mastery is associated with lower levels of PTSD (but not depressive) symptoms after accounting for social support and other types of individualistic coping. From both an intervention and public health perspective, the implications of the results may be especially important for health disparities and community-based research. Future interventions could target ways to increase connectiveness among informal networks, rather than only targeting increasing individualistic coping skills. Given the negative and far-reaching effects of trauma exposure and PTSD, promoting communal mastery through interventions that
improve the ability to cope and achieve goals by being closely interconnected with friends, family, colleagues, and significant others may enhance treatment effectiveness and serve as important tools for future researchers and public health officials to consider.
References:


