COMMUNICATION DURING INTERPERSONAL ARGUING: IMPLICATIONS FOR STRESS SYMPTOMS

Rachel M. Reznik, Michael E. Roloff, and Courtney Waite Miller

Research suggests that arguing can be stressful. We report two studies that explore the relationships between distributive, integrative, and avoidant communication reported to have occurred during an argument and individuals' post-episodic stress symptoms and health problems. Self-reported distributive and avoidance actions were positively related to post-episodic hyperarousal and hyperarousal mediated the positive relationship between both actions and health problems. Unexpectedly, self-reported integrative actions were positively related to post-episodic intrusive thoughts and hyperarousal, although only hyperarousal mediated the relationship between integrative actions and health problems. 

Key Words: interpersonal arguing, arguing tactics, hyperarousal, stress, well-being

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Arguing is a common phenomenon in interpersonal relationships (Argyle & Furnham, 1983) and verbal disagreements are more likely to occur in intimate than in nonintimate relationships (Roloff & Soule, 2002). In addition to arguments being commonplace, many individuals characterize their disagreements as negative experiences (e.g., McCorkle & Mills, 1992). Indeed, ongoing arguments can be viewed as chronic stressors (Malis & Roloff, 2006b). Segerstrom and Miller (2004) argue that duration, frequency, and resolvability are three defining features of chronic stressors and similar features of ongoing arguments are linked to stress. For example, argument frequency is positively related to individuals experiencing hyperarousal, interference with their daily life activities due to emotional problems, and physical pain (Roloff & Reznik, 2008). Believing that an ongoing argument will be resolved is negatively related to stress, hyperarousal, intrusive thoughts, and trying to avoid thinking about the episodes (Malis & Roloff, 2006a). We think that other components of arguments such as the type of communication enacted during argumentative episodes contribute to arguing being a stressor. To investigate the role that communication during arguments plays on stress and subsequent health problems, we conducted a study that tests the relation between three general conflict acts (distributive communication, avoidant communication, and integrative communication), stress, and well-being. We begin by noting the relationship between stress and health and then hypothesize how communication during arguments might stimulate stress and health problems.
Stress and Health Problems

As a result of experiencing a traumatic event, individuals often become stressed. Although the stress diminishes in intensity over time, individuals may experience stress long after the initiating event occurred (Sundin & Horowitz, 2002). Feeling stressed can manifest in three psychological symptoms (Weiss & Marmor, 1997). Stress can be manifested in avoidance during which individuals try to avoid thinking or talking about the event as well as trying to avoid residual feelings from the event. Thought suppression has been shown to have measurable effects on individuals’ immune systems (Petrie, Booth, & Pennebaker, 1998) and can result in intrusive thoughts (Lane & Wegner, 1995). Intrusive thoughts involve recurring memories, visions, feelings, and dreams about a traumatic event (Weiss & Marmor). Finally, individuals might feel hyperarousal that is characterized by irritability, hyper-vigilance to physical states, outbursts of anger, and trouble concentrating (Weiss & Marmor). Stress prompts a variety of physiological reactions that can lead to serious illness (Vanlantie, 2002). Indeed, there is evidence that stress symptoms mediate the relationship between experiencing trauma and health problems with hyperarousal being the strongest mediator (Kimerling, Clum, & Wolfe, 2000). Although stress reactions are most serious in violent situations (Sundin & Horowitz), they also are reported after episodes of serial arguing (Malis & Roloff, 2006a; 2006b) and are positively correlated with experiencing sleep problems, physical health problems, and pain (Roloff & Reznik, 2008). Furthermore, stress is associated with physical illness (Lawler et al., 2003). Stressors have a negative impact on individuals’ immune systems (Segerstrom & Miller, 2004). Interpersonal stress is also linked with higher blood pressure and increased heart rate (Powch & Houston, 1996).

Arguing, Stress, and Health Problems

Our framework for understanding the relationships among reoccurring arguments, stress, and health is an extension of an analysis provided by Vuchinich and Teachman (1993). Working from a utility theory frame, they argue that conflict engagement is a function of the benefits and costs associated with conflict. The benefits arise from the projected outcomes of resolving the dispute in one’s favor, whereas the costs arise from the process of engaging in conflict. As an argument continues, the costs increase as individuals sacrifice or redirect resources, but the perceived benefits from the outcomes remain stable. Hence, conflict will continue as long as participants can afford to expend resources in pursuit of projected benefits.

In an interpersonal disagreement, individuals expend resources during their encounters. They often try to express their positions in a clear and convincing manner while responding to the positions presented by their partners. They sometimes must deal with their partner’s challenges to their positions and themselves. And of course, they try to develop solutions to resolve the issues. All of this resource expenditure may tax both cognitive and affective resources. Hence, disagreements can be exhausting and stressful. And when engaged in ongoing arguing, the loss of resources and the level of stress can grow. Vuchinich and Teachman (1993) found that family conflicts, relative to strikes or wars, end quickly because individuals have more difficulty sustaining the personal loss of resources. Thus, the stress levels resulting from sustained interpersonal arguing might be considerable as resources become depleted. When deciding whether to continue an ongoing argument, individuals might take into consideration the health costs associated with continuing the argument and
compare them with the benefits arising from eventually resolving the dispute. In some cases, individuals could conclude that the personal costs of continued arguing are so high that disengagement or capitulation is preferable even if there is no resolution.

As noted earlier, features of reoccurring arguments are correlated with stress symptoms and health problems. However, we also believe that these problems will be related to the actions that individuals perform during an argumentative episode. We will focus on three commonly occurring categories of conflict actions: distributive acts, avoidance acts, and integrative acts (Sillars, Pike, Jones, & Redmon, 1983). Distributive acts are competitive and often involve verbal attacks, hostility, and pressure (Sillars et al.). Avoidance acts minimize the level of disagreement by being indirect or passive (Sillars et al.). Finally, integrative acts are disclosive and reflect problem-solving skills (Sillars et al.).

**Distributive Acts**

Distributive communication can be detrimental to one's health and stress level. Distributive communication requires a great deal of resource expenditure due to the attack-and-defend cycles that often are enacted. Indeed, having a dominating, or competing conflict style is positively related to stress because of its tendency to stimulate relational conflict (Friedman, Tidd, Currall, & Tsai, 2000). Moreover, the negative effects of distributive communication might result from the expression of negative affect that often accompanies it. The intensity of negative affect expressed during conflict is related to individuals' experiencing increased blood pressure and decreased immune functioning (Kiecolt-Glaser et al., 1993). Not surprisingly, research has shown that mutual hostile communication during arguments is positively related to stress symptoms and stress-related health problems (Roloff & Reznik, 2008). Specifically, the more individuals engaged in mutual negative communication in the form of yelling, threatening, name calling, swearing, or verbally attacking each other during their argumentative episodes, the more likely they were to report that they experience a hyperaroused state, increased stress levels, problems sleeping, high anxiety, physical health problems, and physical pain. They also reported trying to avoid thoughts about the encounter and cutting down on daily activities due to emotional problems (Roloff & Reznik).

The aforementioned implies that individuals who engage in distributive actions might experience stress symptoms after an episode and could become ill. Because of the negativity involved in these exchanges, we anticipate that individuals who have used distributive communication will suffer from intrusive thoughts about what was said and will attempt to avoid recalling the actions and feelings that occurred during the episode. In effect, they will replay hurtful statements that they experienced as unpleasant and consequently they will try to avoid doing so. In addition, the high degree of arousal they felt during the argument could carry over into residual arousal and they will report being hyperaroused. Based on prior research, these three stress reactions should increase the likelihood of experiencing health problems. Hence, we predict the following:

**H1:** Self-reported use of distributive actions will be positively related to experiencing post-episodic intrusive thoughts, avoidance, and hyperarousal and these three stress symptoms will mediate the relationship between distributive actions and reported health problems.
Avoidance Acts

Some individuals try to avoid engaging in an argument and this can lead to negative outcomes such as relational dissatisfaction (Caughlin & Afifi, 2004). When trying to avoid an argument, individuals might withhold complaints, be nonresponsive to a partner's complaints, or try to minimize the disagreement. Although possibly successful at preventing a prolonged argument or escalation, avoidance strategies can require considerable resources to enact and might be stressful. For example, Gelles and Straus (1988) observed that abused wives often engaged in avoidance, which produced stress and exhaustion as they anticipated dangerous topics, shifted the focus, and generally tried to keep things calm. Furthermore, individuals with an avoidant style often reported greater levels of stress resulting from the greater incidence of task and relational disagreements they experience (Friedman et al., 2000). Avoidance could lead to health problems. Individuals who take an avoider role during disagreements with their spouses often have increased systolic blood pressure reactivity, which is associated with heart disease (Denton, Burleson, Hobbs, Von Stein, & Rodriguez, 2001).

The goal of avoidance seems to be preventing an argument from continuing or escalating (Roloff & Ifert, 2000). The avoidant individual might be nonresponsive and try to avoid thinking about what is being said. Hence, avoidance during the episode should be positively related to trying to avoid replaying the episode later. Because avoiders might try to prevent an argument episode from reoccurring, they might experience ongoing physiological arousal and hence, avoidance should be positively related to hyperarousal. These symptoms could increase their susceptibility to health problems. We predict the following:

H2: Self-reported use of avoidance actions will be positively related to experiencing post-episodic avoidance and hyperarousal and these two stress symptoms will mediate the relationship between avoidance actions and health problems.

Integrative Acts

Research suggests that using integrative behaviors during an argument might actually result in health gains. When being integrative, individuals share information and seek alternative solutions to their problems. They act like problem solvers rather than adversaries or escape artists. Although effortful to enact, integrative acts can create positive responses and movement toward resolution that reduces the expenditure of resources. Distributive and avoidant acts might misdirect attention away from finding a solution to the problem and might simply extend the argument and resource expenditures. Integrative actions focus attention on solutions and can provide a more efficient path to solving the issues at hand. As a result, integrative actions might reduce stress by yielding progress toward resolution. Indeed, having an integrative argument style is negatively related to self-reported stress largely because an integrative style reduces the likelihood of both task and relational conflict (Friedman et al., 2000). Also, having a social problem-solving orientation is negatively related to experiencing stress after a problem has been solved (D'Zurilla & Sheedy, 1991). Moreover, successful social problem-solving lessens the negative effects of stress (Nezu, 2004). Finally, Roloff and Reznik (2008) found that mutually constructive communication was negatively related to stress symptoms but only when individuals expressed low levels of mutual hostility.

Overall, we believe this pattern suggests that acting in an integrative style can attenuate and perhaps counter the effects of stress. Some research suggests that an integrative approach
might facilitate resolving a conflict (e.g., Sillars, 1980) and produce a solution with which both sides are satisfied (e.g., Pruitt, 1981). Consequently, integrative actions should reduce the likelihood of post-episodic stress symptoms. Integrative individuals have few negative statements to recall and hence, they are not likely to engage in post-episodic avoidance. Moreover, their integrative actions might move them closer to resolution, which could reduce residual arousal. Hence, we predict the following:

H3: Self-reported use of integrative actions will be negatively related to experiencing intrusive thoughts, avoidance, and hyperarousal and these three stress symptoms will mediate the relationship between using integrative actions and reported health problems.

STUDY 1

Method

Participants. Undergraduate students at a private, Midwestern university received course credit for participating in the study (N = 117). Participants were asked to report on either a current dating relationship (n = 77, 62%) or one that had terminated (n = 44, 38%). Twenty-eight percent of the participants were men (n = 33) and 72% of the participants were women (n = 84). The participants’ mean age was 19.71 years (SD = 1.15).1

Procedure. Upon arrival at the lab, the participants signed IRB-approved informed consent forms, completed questionnaires, and were debriefed by the researchers. In general, the study took the participants less than an hour to complete.

Predictors. Participants completed measures about communication during argumentative episodes and their physical and mental well-being as part of a larger study on resolvability in arguments. Participants were randomly assigned to think of an argument that was either difficult or easy to resolve in their current dating relationship or one that had occurred in a past relationship. All were able to do so. In order to control for known predictors of stress, we also asked individuals how many times they had argued about the issue. The remainder of the questionnaire included questions regarding the communication strategies they used during argumentative episodes. Participants also reported on the aftermath of their most recent argumentative episode. Measures of stress as well as health problems were included as dependent measures. These measures will be described below. The measures are discussed in the order in which they were presented. In order to ease the interpretation of multi-item scales we summed the scores of all items and divided the sum by the total number of items.

Level of resolvability. Participants were randomly assigned to think of an argument that was difficult to resolve (n = 62, 53%) or easy to resolve (n = 55, 47%). Participants were instructed that “difficult to resolve” was defined as, “you don’t think you and your partner will ever agree about this issue.” Arguments that were “easy to resolve” were defined as, “you think you and your partner will agree about this issue.”

Frequency of episodes. Respondents were asked to estimate how many argumentative episodes had occurred. Respondents reported an average of 11.68 arguments (SD = 27.80).

Communication during conflict. We used items from Johnson (1998), who adapted the measures from Witteman (1988). Three items were used to assess avoidance (e.g., When the problem was brought up, I tried to change the topic of the discussion. M = 2.48, SD = 1.35);

1 We used the Levene’s Test for Equality of Variances to ensure that men and women did not significantly differ from one another on any of the independent or mediating variables.
four items measured *distributive communication* (e.g., I demanded that my partner change his/her behavior or attitudes. \( M = 2.28, SD = 1.24 \)); and five items assessed *integrative communication* (e.g., I shared with my partner how the problem might be mutually resolved. \( M = 5.05, SD = 1.19 \)). The reliabilities for these scales were adequate (\( \alpha = .65, \alpha = .71, \alpha = .80 \)) for avoidance, distributive communication, and integrative communication, respectively. We also conducted a confirmatory factor analysis, which verified that the three factor measurement model fit the data well, \( \chi^2 (43, N = 117) = 55.73, p = .09, CFI = .97, RMSEA = .05. \)

**Mediators: Stress symptoms.** We used the Revised Impact of Event scale to assess the aftermath of the most recent argumentative episode (Weiss & Marmar, 1997). Participants indicated on five-point response formats (0 = not at all, 4 = extremely) the degree to which they experienced the following symptoms after the most recent episode. Hyperarousal was measured with six items (e.g., I was jumpy and easily startled. \( M = 1.79, SD = .71 \)). The degree to which participants tried to avoid/suppress thoughts and feelings about the episode was measured with eight items (e.g., I tried not to think about it. \( M = 2.32, SD = .80 \)). Intrusive thoughts, feelings, and images related to the episode were assessed using eight items (e.g., I thought about it when I didn’t mean to. \( M = 2.29, SD = .83 \)). The reliabilities for these scales were good (\( \alpha = .82, \alpha = .80, \alpha = .88 \)) for hyperarousal, avoidance, and intrusive thoughts, respectively. A confirmatory factor analysis showed that the three factors model fit the data moderately well, \( \chi^2 (190, N = 117) = 261.78, p < .01, CFI = .94, RMSEA = .06. \)

**Dependent Variable: Health problems.** Physical problems were included because they can be caused by stress (e.g., Cohen & Hoberman, 1983; Spector & Jex, 1998). We assessed a myriad of participants’ health problems (e.g., back pain, headache) right after their most recent argumentative episode using 33 items from the Cohen-Hoberman Physical Symptoms Checklist (CHIPS, Cohen & Hoberman, 1983) as well as six items from the Physical Symptoms Inventory (Spector & Jex, 1998) that were not included in the CHIPS (\( M = 1.34, SD = .47 \)). The reliability for this scale was very good (\( \alpha = .94 \)). Participants were instructed to indicate how much each problem had bothered or distressed them after their last argument. Items were answered on a 0 (not been bothered by the problem) to 4 (the problem has been an extreme bother) response scale.

**Results**

**Preliminary Analysis.** We conducted several exploratory analyses. First, we conducted a power analysis to determine whether our sample size was large enough to detect a medium effect size (.80) for relationships at \( p < .05 \). Roloff and Reznik (2008) conducted an analysis similar to our own that related communication patterns to intrusive thoughts, hyperarousal, avoidance, and pain problems that reportedly occurred after a recent episode of a serial argument. Their analysis found that after controlling for selection biases, communication patterns accounted for 7% of the variance in intrusive thoughts, 11% in hyperarousal, 10% in avoidance, and 12% in pain problems. Using those effect sizes, the statistical power associated with our communication patterns was .71 for intrusive thoughts, .91 for hyperarousal, and .89 for avoidance. Although we used a different measure of health symptoms, if we use the effect size associated with pain problems, the statistical power is .96. Hence, our sample size is generally sufficient to detect significant relationships among our variables.

Second, we also noted that there was an unequal gender distribution in the sample that mirrors the percentage of males and females in the subject pool from which our sample was
drawn. To assess a possible gender bias, we examined whether our three independent and four dependent variables differed with regard to gender. None of the dependent variables or distributive acts significantly differed for women or men. However, women reported that they engaged in significantly, $t(115) = 2.18$, $r^2 = .04$, $p = .03$, more ($M = 5.20$, $SD = 1.13$) integrative communication than did men ($M = 4.67$, $SD = 1.27$) and men reported using significantly, $t(115) = 2.69$, $r^2 = .07$, $p < .01$, more ($M = 3.00$, $SD = 1.47$) avoidant actions than did women ($M = 2.27$, $SD = 1.26$). To assess a possible gender bias, we conducted a moderated regression analysis to see if any relationship between integrative communication and avoidant acts and our dependent variables are affected after controlling for gender and whether any relationship was moderated by gender. We found that controlling for gender did not significantly change the results associated with testing our hypotheses and gender did not significantly ($p < .05$) moderate the relationships between the communication acts and hyperarousal, intrusiveness, avoidance, and health problems.

Third, we conducted an exploratory analysis to uncover factors that might be correlated with the communication enacted during arguments and could create artifactual relationships. Table 1 contains a correlation matrix among independent and dependent variables as well as variables that have been commonly used as covariates in prior research (e.g., Roloff & Reznik, 2008). Because more than a third of the sample reported on failed relationships, we determined whether those in intact versus terminated relationships might use different communication strategies. To some degree they did. Respondents whose relationships had terminated were significantly more likely, $t(115) = 2.63$, $r^2 = .06$, $p = .01$, to report that they used distributive communication during episodes ($M = 2.66$, $SD = 1.33$) than were those in existing relationships ($M = 2.05$, $SD = 1.14$). Also, participants whose relationships had ended were significantly more likely, $t(68) = 4.59$, $r^2 = .17$, $p < .001$, to report that they used avoidant communication during episodes ($M = 3.21$, $SD = 1.50$) than were those whose relationships were still intact ($M = 2.03$, $SD = 1.04$). However, the use of integrative communication was not significantly different for individuals in terminated versus intact relationships, $t(115) = -1.35$, $r^2 = .02$, $p = .180$.

We also found that the level of resolvability was significantly different for one independent variable. Participants who reported on an argument that was difficult to resolve were significantly more likely, $t(110) = 2.85$, $r^2 = .06$, $p = .005$, to report that they used avoidant communication during episodes ($M = 2.80$, $SD = 1.50$) than were those who reported on arguments that were easy to resolve ($M = 2.12$, $SD = 1.07$). However, level of resolvability
was not significantly different for the use of distributive communication, $t(115) = 1.26$, $r^2 = .01$, $p = .212$, or integrative communication, $t(115) = -.29$, $r^2 = .001$, $p = .772$.

The number of episodes in which respondents had argued was not significantly related to any of the variables in the study.

Of the three measures of communication, only self-reported avoidance and integrative actions were significantly correlated, $r = -.35$, $p < .001$. The three self-reported stress symptoms were significantly inter-correlated: hyperarousal with intrusive thoughts, $r = .76$, $p < .001$, and avoidance, $r = .45$, $p < .001$; intrusive thoughts and avoidance, $r = .56$, $p < .001$. As expected, self-reported health symptoms were positively related to hyperarousal, $r = .67$, $p < .001$; intrusive thoughts, $r = .49$, $p < .001$; and avoidance, $r = .33$, $p < .001$.

**Analytic Scheme.** We used a three-step approach when statistically analyzing each hypothesis. First, we looked at the relationships among the self-reported assessments of communication, stress symptoms, and health problems. We first examined bivariate correlations, and because we felt it was prudent to rule out interactions among the three forms of communication, we also used moderated regression (see Aiken & West, 1991). Moderated regression allows researchers to identify whether a variable moderates the relationship between two variables. It tests whether the interaction of two variables can account for an increment of variance beyond that accounted for by each variable separately. On the first step, we entered three control variables commonly used in earlier research to control for selection biases: relational status (0 = broken up, 1 = still together), level of resolvability (0 = difficult, 1 = easy), and number of argumentative episodes. On the second step, we entered the three assessments of communication actions: integrative, distributive, and avoidance. On the third step, we entered all two-way interactions among the communication actions. Finally, on the fourth step, we entered the three-way interaction among the communication actions. Because none of the two-way or three-way interactions accounted for a significant increment of variance, those results will not be reported. Table 2 contains the results of the regressions. All hypothesized associations were tested with one-tailed significance tests.

The second portion of our statistical analysis tested for mediation. Because we proposed that the relationship between each of our communication forms and health symptoms would be mediated by several stress symptoms, we chose a test that examines multiple mediators (Preacher & Hayes, 2008). This test examined the indirect paths from a given communication form through each of the three stress symptoms to health problems while controlling for three covariates and the other two communication forms. For example, we examined whether the relationship between integrative actions and health symptoms was mediated by hyperarousal, intrusive thoughts, and avoidance while controlling for the number of prior argumentative episodes, relational status, resolution difficulty, avoidant acts, and distributive acts. By using a bootstrapping method, one can create a sample-based estimate of the indirect effect and biased-corrected, accelerated confidence intervals. In our case, we created 5,000 possible samples. If the 95% confidence interval for a given indirect path does not contain 0, there is evidence of mediation. Furthermore, by using confidence intervals, we determined

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To address the potential problem of memory bias, we also tested to see if time since the most recent argument was correlated with our independent variables. Time since the last episode was not significantly correlated with distributive communication, $r = .05$, $p = .60$, but was significantly correlated with integrative communication, $r = -.21$, $p = .04$, and avoidant communication, $r = .35$, $p < .001$. When entered as a control variable in the regression analysis, the results did not significantly change. However, we chose not to include time since the most recent episode as a variable in the final analysis due to the loss of participants. Eighteen participants did not provide an adequate answer for this item.
TABLE 2.
SUMMARY OF REGRESSION ANALYSIS OF STRESS-RELATED PROBLEMS ON CONTROL VARIABLES AND COMMUNICATION DURING ARGUMENTS

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Note. †$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$

whether the magnitude of a given indirect path differed from that of other two paths. Finally, we tested the adequacy of the entire model using path analysis.

Hypothesis 1. Hypothesis 1 predicts that the self-reported use of distributive actions will be positively related to experiencing post-episodic intrusive thoughts, avoidance, and hyperarousal and these three stress symptoms will mediate the relationship between distributive actions and reported health problems. The bivariate correlations confirm that distributive acts were positively related to experiencing intrusive thoughts, $r = .19$, $p = .022$, avoidance, $r = .24$, $p = .005$, and hyperarousal, $r = .28$, $p = .002$. The moderated regression analysis indicates that distributiveness was positively related to avoidance, $\beta = .15$, $p = .040$, and hyperarousal, $\beta = .20$, $p = .014$, but not significantly related to intrusive thoughts, $\beta = .08$, $p = .196$. We also found that distributive acts were positively related to self-reported health problems, $r = .18$, $p = .024$, which was replicated in the regression analysis, $\beta = .15$, $p = .060$.

These aforementioned relationships indicate that it is meaningful to test whether stress symptoms mediate the correlation between distributive acts and health problems. Contrary
to our hypothesis, only hyperarousal proved to be a mediator, (C.L. .008 to .148). Furthermore, the indirect path from distributive acts through hyperarousal was larger than that between distributive acts and intrusive thoughts, (C.L. -1.74 to -.007), and between distributive acts and avoidance, (C.L. -1.36 to -.004).

Thus, distributive communication is positively related to hyperarousal and only hyperarousal mediates the positive relationship between distributive acts and health problems.

**Hypothesis 2.** Hypothesis 2 predicts that the self-reported use of avoidance actions will be positively related to experiencing post-episodic avoidance and hyperarousal and these two stress symptoms will mediate the relationship between avoidance actions and health problems. The bivariate correlations show that avoidant acts were positively related to post-episodic avoidance, \( r = .36, p < .001 \), and hyperarousal, \( r = .20, p = .014 \). Although not hypothesized, avoidant acts were also positively correlated with intrusive thoughts, \( r = .18, p = .051 \), two-tailed. The regression analysis indicates that avoidant actions were significantly related to avoidance, \( \beta = .30, p = .002 \), and to hyperarousal, \( \beta = .20, p = .028 \), but nonsignificantly related to intrusive thoughts, \( \beta = .16, p = .115 \), two-tailed. The correlation between avoidant actions and health problems was not statistically significant, \( r = .05, p = .299 \), and it only approached statistical significance in the regression analysis, \( \beta = .11, p = .155 \).

Although the association between avoidant acts and health problems was weak, we undertook a mediation analysis so as to complete the test of the hypothesis. The analysis indicated that hyperarousal was the only mediator, (C.L. .005 to .132). It was a stronger path than that of avoidant acts through intrusive thoughts, (C.L. -1.70 to -.006). It was no stronger than the one from avoidant acts through avoidance, (C.L. -1.21 to .004).

Thus, engaging in avoidant communication was positively related to post-episodic avoidance and hyperarousal. However, avoidant actions were only weakly related to experiencing health problems. The relationship between avoidant actions and health problems was mediated through hyperarousal.

**Hypothesis 3.** The third hypothesis predicts that the self-reported use of integrative actions will be negatively related to experiencing intrusive thoughts, avoidance, and hyperarousal and these three stress symptoms will mediate the relationship between integrative actions and reported health problems. Contrary to the hypothesis, engaging in integrative actions was positively related to intrusive thoughts, \( r = .24, p = .005 \), and to hyperarousal, \( r = .16, p = .043 \), but not significantly related to avoidance, \( r = .05, p = .313 \). The multiple regression analysis also indicates that engaging in integrative actions were positively related to intrusive thoughts, \( \beta = .30, p = .001 \), avoidance, \( \beta = .17, p = .031 \), and hyperarousal, \( \beta = .20, p = .019 \). Also, contrary to the hypothesis, integrative actions were positively correlated with health problems, \( r = .19, p = .021 \), and were a positive predictor of health problems in the regression analysis, \( \beta = .22, p = .018 \).

Our mediation analysis indicated that only hyperarousal mediated the relationship between integrative actions and health problems, (C.L. .005 to .132). This was of greater magnitude than the indirect effect of integrative communication through intrusive thoughts, (C.L. -1.70 to -.006), and between integrativeness and avoidance, (C.L. -1.21 to -.004).

Our third hypothesis received no support. Indeed, we found relationships that were significant and opposite of what we predicted. Engaging in integrative actions was positively related to intrusive thoughts, avoidance, and hyperarousal. Hyperarousal was the primary mediator of the positive relationship between integrative communication and health problems.
Path Analysis. We conducted a path analysis using AMOS 7.0 (Arbuckle, 2006) to test the adequacy of the entire mediation model. Because the current version of AMOS does not test the individual indirect paths from a predictor to outcome variable, we used Mplus (Muthen & Muthen, 2007) to do so. These indirect effects are described in the text below but are not included in the figures.

Our initial model examined the direct relationship between each of the three forms of communication acts and health symptoms as well as the indirect paths from each of the three forms of communication to health symptoms running through intrusive thoughts, avoidance, and hyperarousal.

To evaluate the fit of the model, we used conventional standards, nonsignificant chi square, CFI > .95; and RMSEA < .06 (Byrne, 2001). By these standards, the model was clearly inadequate, χ² (3, N = 117) = 122.70, p < .01, CFI = .54, and RMSEA = .59.

We then looked for possible specification errors (see Schumacker & Lomax, 2004). We first examined the standardized residuals to determine if some paths were mis-specified. None of the residuals were greater than 1.96 which indicates that the paths were not mis-specified. We then examined the modification indices to determine whether new paths should be drawn between variables initially assumed to be unrelated. We found that the fit of the model might be improved by adding two paths among the mediators. Specifically, paths should be added from hyperarousal to intrusive thoughts and from intrusive thoughts to avoidance. Both of these paths are consistent with theorizing about post-traumatic stress in which hyperarousal is thought to stimulate intrusive thoughts, which in turn prompts avoidance (Blanchard & Hickling, 1997).

We then tested a revised path model that included the two new paths among the mediators to the initial model. The model and standardized parameters are presented in Figure 1. The model fit was consistent with conventional standards, χ² (9, N = 117) = 0.15, p = .70, CFI = 1.00, and RMSEA = .01. The results are also consistent with those of the initial model. Hyperarousal was a significant mediator of the following relationships: distributive acts → health problems, β = .161, p = .026, (C.L. .019 to .302); avoidance acts → health problems, β = .187, p = .012, (C.L. .041 to .334), integrative acts → health problems, β = .158, p = .014, (C.L. .033 to .283). As before, none of the indirect paths involving intrusive thoughts was statistically significant: distributive communication → health problems, β = .004, p = .761, (C.L. -.023 to .031); avoidance acts → health problems, β = -.012, p = .544, (C.L. -.049 to .026); integrative acts → health problems, β = -.019, p = .479, (C.L. -.071 to .034), as was the case for avoidance: distributive acts → health problems: β = .015, p = .351, (C.L. -.016 to .045), avoidance acts → health problems: β = .028, p = .320, (C.L. -.027 to .083), or integrative acts → health problems: β = .001, p = .990, (C.L. -.020 to .020).

Consistent with earlier results, reporting health problems was not directly related to the self-reported use of distributive acts, β = .004, p = .999, (C.L. -.160 to .155), avoidance acts, β = -.068, p = .428, (C.L. -.217 to .103), or integrative communication, β = .071, p = .274, (C.L. -.054 to .200).

We also tested several variations of this model. In one, we tested whether the path between hyperarousal and intrusive thoughts was bidirectional. In other words, it seemed possible that hyperarousal prompts intrusive thinking that feeds back to stimulate more arousal. The results of that analysis indicated that the path from hyperarousal to intrusive thinking was statistically significant, but the path from intrusive thinking to hyperarousal was not. We also tested the possibility that a bidirectional path might exist between intrusive thinking and avoidance. It is possible that intrusive thinking stimulates someone to try to avoid thinking about the episode which, in turn, prompts more intrusive thinking. We found that the path from intrusive thinking to avoidance was significant but the path from avoidance to intrusive thinking was not. Hence, we chose to only report a model containing unidirectional paths.
Although not hypothesized, we also uncovered significant indirect paths leading from the three communication acts to avoidance. The first involved the following path, distributive acts→hyperarousal→intrusive thoughts→avoidance, $\beta = .080$, $p = .009$, (C.L. .011 to .149). The second involved avoidance acts, avoidance acts→hyperarousal→intrusive thoughts→avoidance, $\beta = .093$, $p = .005$, (C.L. .029 to .158). The last one involved integrative acts, integrative acts→hyperarousal→intrusive thoughts→avoidance, $\beta = .079$, $p = .009$, (C.L. .019 to .138).

Because the revised model was not parsimonious and contained numerous non-significant paths, we tested one last model that retained only the significant paths from the second model. The model and standardized parameters are presented in Figure 2. The model fit was consistent with conventional standards, $\chi^2 (9, N=117) = 7.58$, $p = .58$, RMSEA = .01 and CFI = 1.00 and the indirect effects discovered in the earlier version of the model remained significant. Hence, although some of the fit measures are slightly reduced, the model provides a more parsimonious description of the results.
Figure 2: Revised path-analytic model: Relationships of integrative, avoidance, and distributive communication with health problems mediated by thought avoidance, intrusiveness, and hyperarousal. All values are standardized parameter estimates except for those associated with error terms which are $R^2$. Broken lines indicate statistically significant relationships, $p < .05$. Chi-square ($9, N = 117$) = 7.58, $p = .58$, RMSEA = .01 and CFI = 1.00.

Discussion

The objective of this investigation was to determine whether communication enacted during an argumentative episode can lead to stress symptoms and health problems. We confirmed portions of our hypotheses and discovered some unanticipated patterns. As predicted, our path analysis found that self-reported distributive and avoidance actions were positively related to post-episodic hyperarousal, which mediated the positive relationship between distributive and avoidance actions and self-reported health problems. However, we also discovered some unanticipated results. We unexpectedly found that self-reported integrative acts were positively related to experiencing intrusive thoughts and hyperarousal and hyperarousal mediated the positive relationship between integrativeness and reported health problems. Rather than showing a negative relationship to stress and health problems, we found the exact opposite. As this result was the opposite of our hypothesis, the results of this investigation should be considered preliminary and be replicated with another sample.

Study 2

The second study seeks to replicate the final path model that we discovered in the first study. We used the same measures and procedures with one exception. In Study 1,
participants were instructed to report on either an argument that they found to be easy or difficult to resolve. Overall, participants reported that the argument had gone on for an average of 11 episodes. This implies the participants were engaging in serial arguing. Thus, in Study 2, we shifted our focus to look explicitly at a recent episode of a serial argument.

**Method**

**Participants.** Undergraduate students at a medium-sized, private, Midwestern university received course credit for participating in this study. In total, 167 participants completed the questionnaires. As with Study 1, participants were allowed to report on either a current dating relationship or one that had broken up (intact: n = 75, 45%; broken up: n = 88, 53%; 4 participants did not indicate the state of the relationship). Thirty-eight percent of the participants were men (n = 64) and 62% of the participants were women (n = 103). The participants’ mean age was 19.88 years (SD = 1.24).

**Procedure.** The recruitment and testing procedures for Study 2 were identical to those used for Study 1.

**Measures.** Participants completed measures assessing conflict tactics and physical and mental health. Participants were informed that they would be reporting on serial arguments that were occurring or had occurred in their dating relationships. The following definition was provided to help them identify such an incident: “A serial argument exists when individuals argue or engage in conflict about the same topic over time, during which they participate in several (at least two) arguments about the topic.” All participants indicated that they understood the concept. Then, participants were asked to think of a specific serial argument that was occurring in their current dating relationship or that had occurred in a past relationship. All participants could do this. The remainder of the questionnaire included the same questions regarding communication during the episodes and well-being that were assessed in Study 1 (see Table 3 for the correlations and descriptive statistics of the variables). Also, confirmatory factor analysis verified the fit of the three-factor model for the conflict management behaviors, $\chi^2 (40, N = 165) = 53.61, p = .07, CFI = .98, RMSEA = .05$, and Revised Impact of Events Scale, $\chi^2 (189, N = 166) = 300.31, p < .01, CFI = .94, RMSEA = .06$. As with Study 1, we added the scores of all items and divided the sum by the total number of items.
Results

To replicate the model, we conducted a multi-group path analysis that examined the degree to which the parameters of the model uncovered in Study 1 fit those in Study 2 (see Schumacker & Lomax, 2004). We began by fitting the same path model to each sample, but allowed the parameters to be different within each sample. The results indicated that the model fits both groups very well, $\chi^2 (18, N=283) = 14.28, p = .71, CFI = 1.00, and RMSEA = .01$. We then examined whether each of the nine unstandardized parameters in the model differed across the samples. Five of the parameters were statistically significant in each sample. Two parameters that were statistically significant with the Study 1 sample were not significant in the Study 2 sample. When directly compared with each other, they were significantly different in magnitude, avoidance acts $\rightarrow$ intrusive thoughts, $z = 2.25, p = .024$; and integrative acts $\rightarrow$ intrusive thoughts, $z = 2.12, p = .034$. Two additional parameters that were statistically significant in the Study 1 results were not significant in the analysis of the second sample, but their magnitude did not differ significantly across the two samples, avoidance acts $\rightarrow$ hyperarousal, $z = 0.15, p = .90$; integrative acts $\rightarrow$ hyperarousal, $z = 0.95, p = .34$. Finally, although the path from hyperarousal $\rightarrow$ health problems was statistically significant in both samples, the magnitude of the parameter was significantly different across samples, $z = 2.26, p = .023$.

We then refitted the model by constraining the six parameters whose magnitude did not differ significantly to be equal for both samples and allowing the three other parameters to vary with each sample. Again, the model fit both groups very well, $\chi^2 (24, N=283) = 21.43, p = .61, CFI = 1.00, and RMSEA = .01$. We also discovered that the refitted model fit as well as the original, $\chi^2 (6, N=283) = 7.15, p = .30$.

Figure 3 contains the standardized parameters for the newly-fitted model for the sample used in Study 1 and Figure 4 contains those for the Study 2 sample. In the Study 1 sample, hyperarousal was a significant mediator of the following relationships: distributive acts $\rightarrow$ health problems, $\beta = .148, p < .001, (C.L. .069 to .237)$; avoidance acts $\rightarrow$ health problems, $\beta = .121, p = .011, (C.L. .030 to .221)$, integrative acts $\rightarrow$ health problems, $\beta = .112, p = .014, (C.L. .022 to .209)$. The same mediation pattern was evident in the Study 2 sample: distributive acts $\rightarrow$ health problems, $\beta = .137, p = .026, (C.L. .062 to .215)$; avoidance acts $\rightarrow$ health problems, $\beta = .099, p = .011, (C.L. .025 to .175)$, integrative acts $\rightarrow$ health problems, $\beta = .098, p = .016, (C.L. .019 to .183)$.

We also replicated the indirect paths flowing from the three conflict actions to avoidance. For Sample 1, the path from distributive acts $\rightarrow$ hyperarousal $\rightarrow$ intrusive thoughts $\rightarrow$ avoidance was as follows, $\beta = .100, p < .001, (C.L. .046 to .161)$, and took the following form in Sample 2, $\beta = .095, p < .001, (C.L. .044 to .151)$. For the Study 1 sample, the path from avoidance acts $\rightarrow$ hyperarousal $\rightarrow$ intrusive thoughts $\rightarrow$ avoidance was $\beta = .082, p = .009, (C.L. .023 to.151)$, and for Study 2 sample was $\beta = .069, p = .010, (C.L. .019 to .125)$. Finally, for the Study 1 sample, the path from integrative acts, integrative acts $\rightarrow$ hyperarousal $\rightarrow$ intrusive thoughts $\rightarrow$ avoidance, $\beta = .076, p = .015, (C.L. .014 to .142)$ and in the Study 2 sample was $\beta = .069, p = .016, (C.L. .013 to .127)$. Only the path from integrative acts $\rightarrow$ intrusive thoughts failed to replicate.

Discussion

Our goal for Study 2 was to replicate the model from Study 1. The replication was generally successful as only one of the paths was not replicated with another sample. This
path analysis found that self-reported distributive, avoidance, and integrative acts were positively related to post-episodic hyperarousal, which mediated the positive relationship between these actions and self-reported health problems. Additionally, we also replicated the link between the three argument management tactics and avoidance mediated by hyperarousal. We now turn to a general discussion of our findings.

**GENERAL DISCUSSION**

The results of these two studies indicate that the three forms of arguing tactics are not beneficial for individuals' well-being. Unexpectedly, feeling hyperaroused mediated the relationship between integrative communication and health problems for the participants in the first study. This pattern was also found in Study 2. This finding seems contrary to prior research. However, a closer reading of the literature we cited in our review uncovers some possible explanations that reconcile this finding with earlier results. First, although having a social problem-solving orientation is negatively related to stress, the methods and measures used in social problem-solving research are different from those used in our study (D'Zurilla & Sheedy, 1991). The typical measure of problem solving assesses the degree to which individuals have an orientation in which they feel confident that they can address life's problems. As noted, this orientation is negatively related to stress regardless of the type of stressor they encounter. Our measure of integrativeness is focused on specific actions enacted
during an episode of an ongoing disagreement, which might provide a clue as to why our results are different. When specific problem-solving skills are assessed (e.g., defining the problem, generating alternative solutions), the relationship between problem solving and stress is inconsistent (Nezu, 2004). Hence, feeling confident about one’s ability to solve problems might reduce stress, but it is unclear that engaging in problem-solving behaviors has the same effect. Indeed, problem-solving behaviors can require a lot of effort. For example, Roloff and Jordan (1991) found that integrative bargaining is a high-energy endeavor requiring cognitive effort in planning and implementing negotiation tactics. It is possible that the energy expended in integrative actions depletes resources, which increases stress. Furthermore, there is evidence that arguments are unlike other stressors in that individuals take much longer to bounce back from the stress arising from arguments than from other everyday stressors (Bolger, DeLongis, Kessler, & Schilling, 1989).

We also noted in the literature review that having an integrative conflict management style is negatively related to general stress (Friedman et al., 2000). Unlike research on problem solving, this measure assesses the degree to which individuals prefer to manage their arguments. However, the measure of stress used by Friedman et al. was quite general and not focused on stress arising from arguing (i.e., the sample was composed of employees and the stress measure was focused on stress at work). It is possible that individuals who typically try to be integrative generally feel less stress but might feel considerable stress when engaged in a specific, ongoing disagreement.
Finally, we discussed in the literature review that Roloff and Reznik (2008) found that mutually constructive communication was negatively related to stress. We believe the difference between their results and our current results is due to the communication measure. Roloff and Reznik asked individuals about mutually constructive communication. In the current study, we only assessed what the respondents did and gathered no information about their partners' actions. Hence, it is possible that our measures included individuals who said they were integrative but who had partners who were distributive or avoidant. In such cases, they might have become very frustrated by their partners' recalcitrance or lack of engagement. In the Roloff and Reznik study, individuals who found that their partners did not reciprocate their integrative actions would have scored low in mutually constructive communication and, hence, would not have contributed to a positive correlation between constructive communication and stress.

Consequently, we believe that the positive relationships among integrative actions, stress symptoms, and health problems might indeed be valid. Having an integrative or problem-solving style might reduce general stress but could increase stress in specific instances arising from an ongoing disagreement.

The second unexpected finding resulted from our mediation analysis. Although we found that most of the communication actions were related to several stress symptoms, we found consistent evidence that only hyperarousal mediated the relationship between communication and health problems. The absence of a mediation role for post-episodic intrusive thoughts and avoidance does not reduce their importance. Although not hypothesized, we found potentially important paths involving intrusive thoughts and avoidance. Specifically, the three forms of communication actions were positively related to hyperarousal, which was positively related to intrusive thoughts and, subsequently, to avoidance. Although this path did not end with health symptoms, it is possible that it might be related to other important forms of well-being. For example, Foa, Riggs, and Gershung (1993) observed that post-traumatic intrusive thoughts and avoidance could reflect an inability to cope with a traumatic event and that could result in emotional numbing wherein individuals become isolated and withdrawn. If so, then the paths between the mediators might indicate that engaging in arguing will result in psychological and social problems.

We believe that our findings point to a new and different view of interpersonal arguing. Although prior research has investigated the relational consequences of arguing, we believe that this study reinforces the value of studying health-related consequences. Certainly, negative communication actions occurring during a disagreement have long been recognized as harmful to relationships, and our study contributes to the growing literature that indicates the personal consequences arising from actions. We also believe that our study might generally point to the problems associated with argument engagement. Not only did we find a positive association between self-reported distributive actions and stress-related health issues, but we also found a positive link between integrative behaviors and stress-related health issues. Scholars have generally viewed integrative actions as being a desirable way to manage disagreements, but our study suggests a potential disadvantage. Integrative conflict management techniques can require substantial energy expenditure that could increase stress and exhaustion. However, because our result was unanticipated, more research is required before we can be certain that integrativeness creates health problems.
Limitations

We acknowledge a number of limitations to our studies. Our samples comprised undergraduate daters and it is possible that their experiences do not generalize to other samples. We employed self-report measures and hence, we cannot independently assess whether the arguing behaviors, stress symptoms, and health problems are accurately reported. Only one person who participated in the argument was surveyed and, therefore, we cannot determine whether the participants' partners shared their assessments. We also note that we did not assess a wide variety of health-related problems, especially very serious ones. Consequently, our results might only generalize to relatively minor health issues. And, we employed a cross-sectional design that inherently cannot provide definitive information about causality.

Future Directions

With these limitations in mind, we believe that our findings have heuristic value. First, we think it is important that researchers investigate how the patterns we observed might change after the episode ends. The stress arising from a traumatic encounter dissipates over time (Sundin & Horowitz, 2002), and it could be of interest to determine whether the stress induced from the various forms of communication differ. For example, if argument avoidance tends to result in relatively brief argumentative episodes, it is possible that stress arising from avoidant behavior might be relatively short lived relative to the stress resulting from argument engagement.

Second, we believe that future research should investigate our unanticipated finding that integrative communication is related to hyperarousal. In particular, it is important that we better understand the features that account for this relationship. Klein and Lamm (1996) noted that constructive conflict communication includes listening, self-expression, and problem-solving. It is possible that these processes may differ with regard to their relationship to hyperarousal. Self-expression involves describing one's own point of view which, in some cases, could be emotionally cathartic. Merely getting the issue on the floor might allow an individual to feel some sense of closure and therefore lessen arousal. Although listening requires some expenditure of energy aimed at understanding the other person, it does not necessarily require an individual to create a solution or to be an active participant in the conversation. Certainly some individuals can be active listeners but when not accompanied by speaking, such listening may not be especially arousing. In contrast, problem-solving may be extremely taxing as individuals attempt to understand the problem, devise effective solutions, and convince each other that the solution will work. The amount of cognitive activity may be extremely high and individuals may become very aroused.

Third, it is essential that researchers explore the interplay between stress, health symptoms, and other consequences of arguing. Vuchinich and Teachman (1993) hypothesized that disagreements might end because one or both sides can no longer muster the resources to sustain arguments. It is possible that the stress and health problems we identify could impact an individual's desire to continue an argument. If episodes are personally costly to one's well-being, individuals might become motivated to resolve the problem or, in some cases, end the relationship.

Extant research indicates that ongoing arguing can be associated with reduced relational quality. The current study shows that different forms of argument behaviors also are positively related to post-episodic stress symptoms and health problems. Hence, this research suggests a challenge for both individuals and scholars. If relational arguments are
inevitable, how can individuals disagree with one another in ways that preserve both their individual and relational well-being?

REFERENCES


