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From crisis to well-being: the role of goal adjustment strategies in the face of health threats. A longitudinal perspective

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Abstract

Background. Research has shown that goal adjustment strategies (disengaging from unattainable goals and re-engaging them) are related to lower stress, fewer depressive symptoms and greater well-being. However, most studies have looked at young, healthy individuals. The aim of this study was to examine the moderation role of goal adjustment strategies longitudinally in overcoming action crises in achieving goals in the context of health threats.

Material and methods. In a longitudinal design, 633 people completed a questionnaire regarding health-impacted goals based on the Action Crisis Scale, Goal Adjustment Scale and Index WHO-5. The respondents had to suffer from a chronic illness or have a health status which had significantly deteriorated in the last 4 months.

Results. Health-related goal obstacles cumulating in action crisis can negatively impact the long-term well-being of a person. However, this relationship does not appear to be moderated by goal disengagement or re-engagement strategies in the context or timeframe examined in this study.

Conclusions. The results are unusual in light of previous research related to the topic. The current results emphasize the psychological cost of goal-related conflict while also highlighting the limits of the buffering role in goal adjustment strategies. This challenges assumptions in prominent motivational theories.

Keywords: goal-related obstacles, goal disengagement, health threat, crisis, well-being

Introduction

Goal pursuit and goal obstacles present an influential line in psychological research [1,2]. Moreover, knowledge about achieving goals can also be useful in looking at health-related goals in particular. It has been found that the sudden onset of disease or the chronification of health problems are an important source of obstacles and crisis in achieving a goal [3]. In 2011, Wrosch et al. [4] recommended that in the case of health-related problems and goals, the use of options for dealing with action crises and obstacles needed to be further explored. Despite these preliminary findings and recommendations, research focusing on overcoming obstacles in achieving health-related goals has been rare.

Health-related goals

The achievement of health-related goals is important, with people generally recognizing their responsibility for behaviors that impact their physical and mental well-being [5]. The health belief model [6] explains how people make decisions about their health and achieve health-related goals. The first key concept is how individuals subjectively assess the severity and consequences of a current health problem. If they perceive a disease or health condition as serious and threatening, they are more likely to take action to prevent or treat it. If they perceive the threat to be high, this may motivate them to make decisions and take measures that will reduce this risk [6]. The second concept is the perception of one's own vulnerability. If an individual feels vulnerable or perceives themselves to be at higher risk, they are more likely to take steps to protect their health. The last important aspect is the perception of the advantages and disadvantages of taking certain health actions. If a person perceives more advantages than disadvantages in performing a particular health goal-related behavior, they are more likely to start doing it.

Many health goals are aimed at achieving a positive state (approach goals e.g.: "I will add one piece of fruit to my lunch") or can be the result of a person's efforts towards avoiding a negative state (avoidance goals e.g.: "I will stop eating junk food to avoid weight gain") [7]. While both types of goals have the same intention, the consequences are quite different [7]. Approach goals induce positive emotions and thoughts and are associated with healthy self-esteem and greater psychological well-being [8]. Avoidance goals do not have a clearly defined desired successful result because they are related to constantly moving away from an undesirable state. As a result of having an unclear end point, avoidance goals can often cause anxiety in an individual [7].

Regardless of the type of goal an individual is striving for, the process of achieving a goal is not always ideal. In the action phase of pursuing a goal, individuals often experience obstacles and difficulties. Milyavskaya et al. [9] have defined goal obstacles as certain interfering forces that can inhibit a person in achieving a goal. Obstacles influence the direct and originally intended way of achieving the goal. According to Kreibich et al. [10], the experience of obstacles is essential, although it is often associated with not achieving the desired goal. Health-related goals can be particularly prone to obstacles as they require long-term effort, sacrifice and constant self-discipline [10]. On the other hand, a natural source of obstacles can also include a deterioration in health or the chronicity of health problems. Health threats can make previously realistic personal goals unattainable [11].

Adaptive goal adjustment strategies and action crises

An action crisis can occur when there is an accumulation of multiple obstacles or even the high intensity of one obstacle [2]. An action crisis is defined as a critical phase in goal pursuit when the goal appears difficult to reach or is unattainable due to goal obstacles [12]. An action crisis is accompanied by various negative emotions [13] such as stress and frustration during unsuccessful goal attainment. It can even decrease well-being in an individual. An action crisis has an impact on an individual's evaluation of goal progress [14]. Moreover, attempting to generate and test alternative goal attainment strategies can further complicate this process [13]. Wrosch et al. [15] have pointed out that dealing with the outcomes of an action crisis can be very difficult. However, in the case that an action crisis that does not last too long, it can serve adaptively and functionally. In the case of unachievable goals, an action crisis can be associated with immediate and even effective actions [15].

In the case of obstacles and action crises, an individual has more than one option. They could increase their effort and continue to pursue the goal (goal engagement strategy) or abandon it completely (goal disengagement strategy). There is also the possibility of changing the goal into a more realistic, achievable form by redefining it (goal re-engagement strategy) [15]. The goal re-engagement and goal disengagement strategies represent the process of goal revision, which are also commonly referred to as adaptive goal adjustment strategies and are often considered relatively stable self-regulatory strategies [16]. Wrosch et al. [4] have explained that the adaptive component of self-regulation is not only adapting to a goal but also the ability to respond differently. This is especially the case in dealing with an unrealistic, unattainable goal in the form of the individual disengaging from such a goal [16]. Goal re-engagement or goal disengagement strategies involve three processes. Firstly, the individual must renounce the energy they have already spent pursuing the goal and minimize the commitment to it. Subsequently, they need to formulate an alternative goal and redirect their effort and commitment before starting to pursue it. Wrosch et al. [15] found that students who gave up unrealistic goals more easily experienced less stress, had fewer intrusive thoughts and had a better quality of life. Wrosch and Scheier [17] found that a goal disengagement strategy also led to better physical health. In comparison, those respondents who only slightly re-engaged their goals had lower well-being compared to those who had completely given up on their goals and created new ones [4]. Kreibich et al. [18] provided evidence that an action crisis is a significant predictor of goal disengagement.

Aim of the work

The relationship between action crises, goal adjustment strategies and the subsequent health benefits of lower stress levels, fewer depressive symptoms and improved well-being has been well-researched in the literature [12,14]. However, the main weakness in these studies has been the focus on healthy, young participants who have never experienced a threat to their health. It was found that there had only been minimal research into this topic in connection with health. A study by Wrosch et al. [4] focused on caregivers taking care of relatives suffering from mental illness. They found that caregivers who effectively disengaged themselves from unattainable goals or re-engaged them were less likely to engage in self-blame and substance use (ineffective coping strategies). This helped them to cope better with stress and maintain subjective well-being. Wrosch and Scheier [17] explain that repeated obstacles in achieving a goal generates negative emotions such as sadness or frustration, naturally reducing subjective well-being. On the other hand, experiencing negative emotions such as sadness or depressive feelings is often associated with abandoning goals because these feelings often help individuals recognize when a certain goal is no longer achievable [17]. Subjective well-being connected to positive emotions can encourage individuals to start pursuing new goals after giving up on their previous goals [19]. In a cross-sectional study, Offerman et al. [20] examined re-engagement strategies in a sample of 20 men with head and neck cancer and their female partners. It was found that re-engagement in goal pursuit was negatively associated with depressive symptoms in the male patients. This study suggests that having an alternative goal may be an adaptive coping strategy for people with cancer. In spite of this study, research on the regulatory influence of action crisis in achieving goals disrupted by a serious health diagnosis are still rare.

In the present research, we build on the well-documented link between action crises and reduced levels of well-being [12,14,17] and identify potential moderators in this association. To this end, we posit that action crises can result in subsequent well-being in the context of health threats if the dispositional capacities to goal adjustment strategies are used. In order to address this, the current study aims to explore the moderation role of goal adjustment strategies longitudinally in the association between action crisis and subsequent well-being in the context of health threats.

Material and methods

Participants

Although 1,032 participants were included in the first phase of the study, 276 did not participate in all three phases of the research. A further 82 participants did not meet the criteria of stating the goal they were trying to achieve, as their goal was either too vague or they did not suffer from any health-related issues and perceive any obstacles at the time of the research. In addition, 41 participants had achieved their goal by the second phase of the study or were on the verge of it (stated achievement progress 95% and more). As such, these participants were eliminated from the study, which left 633 participants eligible for analysis.

The sample consisted mostly of women 62.4% (395) with the average age of 54.33 (SD=14.102). Over half the participants (51.5% (326)) were married, while 14.5% (92) were single, 13.9% (88) divorced, 12% (76) in a relationship and 7.9% (50) widowed. There was one participant going through a divorce.

The education level of the participants varied, with most of them having finished secondary education (44.9% (284)) or the first/second level of tertiary education (38.5% (244)). In terms of the remaining participants, 10.6% (67) of participants had finished lower secondary education, 4.7% (30) the third level of tertiary education, while 1.3% (8) had not finished primary education.

In terms of employment, 314 participants (49.6%) were employed, while 270 (42.7%) were retired. A further 28 participants (4.4%) were currently unemployed, 13 (2.1%) on maternity/paternity leave and 9 (1.4%) studying. There were 28 (4.4%) participants who reported combinations of their employment/study status – e.g. retired or studying but working, self-employed, etc.

More than half (68.9%=436) of the sample had been diagnosed with a serious illness/disease, with almost the same number of participants (67.8%=429) reporting a deterioration in health status during the last 4 months. Average duration of the disease/illness was 34.51 years (SD=63.167). The participants subjectively perceived their current health status mostly as average (M=3.91; SD=1.033).

Measures

Descriptive data

The basic descriptive and demographic data collected included age, gender, marital status (single – currently without a stable partner; single – in a relationship; married; divorced; widowed) and work/study status (working; studying; studying while working; unemployed; on maternity/parental leave, etc.). In order to assess the participants' health-impacted goals more objectively, the duration of the disease (in years), the deterioration of health status in the last 4 months (yes/no) and current subjective health status (from very poor to very good) were monitored.

Personal goals

The participants were asked about a personal goal they perceived as being problematic to achieve in relation to their actual health. The respondents were provided with a short definition of a goal to avoid them only writing about fantasies and plans: “A goal represents something we are trying to achieve – something we strive for. Think of one specific long-term goal that you will be working towards in the coming months and that you have already been pursuing for some time (at least a month). However, the pursuit of this goal is currently disrupted due to your serious illness or a sudden deterioration in your health”.

Action Crisis Scale

The Action Crisis Scale [21] has recently been adapted into Slovak [22]. The original scale uses six items and a five-point Likert scale (1 strongly disagree – 5 strongly agree) to capture the action crisis as a summary score. However, the five-point Likert scale was modified to a seven-point Likert scale (1 strongly disagree – 7 strongly agree) to align the instruments used in the current study. The Cronbach's alpha for the whole scale was 0.726.

Goal Adjustment Scale

The Goal Adjustment Scale (GAS) [4] is an instrument which consists of 10 items rated on a seven-point Likert scale (1 strongly disagree – 7 strongly agree). The Slovak version [23]

confirmed a two-factor structure – the goal disengagement and goal re-engagement factors. The scores are calculated for both factors separately. The first sub-scale of goal disengagement is made up of four items (items 1, 3, 6, 8 – with 3 and 6 needing to be re-coded). The second sub-scale of goal re-engagement consists of six items (2, 4, 5, 7, 9, 10). An internal consistency analysis of the Slovak version of the GAS showed acceptable Cronbach's alpha values (greater than 0.70) based on polychoric correlations.

World Health Organization Well-Being Index WHO-5

The World Health Organization Well-Being Index WHO-5 [24] is a self-report instrument which measures mental well-being. It consists of five statements relating to the past two weeks. Each statement is rated on a five-point scale, with higher scores indicating better mental well-being. The Cronbach's alpha for the whole scale was 0.826.

Statistical analysis and procedure

This study is observational and longitudinal, with a complex correlational design allowing for moderation path analysis. Goal disengagement and re-engagement were conceptualized as relatively stable self-regulatory strategies and were therefore examined as moderators rather than as outcomes of action crisis [15]. The demographic information and key variables were initially evaluated in SPSS. The core of this study is based on moderation analyses using 5,000 bootstrap samples (bias-corrected bootstrap), with confidence intervals (CI 95%). The moderation was analyzed using Model 1 of PROCESS macro (version 4.2) of IBM SPSS (version 25).

As the study was longitudinal, the data and questionnaires were collected three times (phase 1, phase 2, phase 3), with an interval of three months between each phase. This approach was selected to balance sensitivity to short-term changes in goal-related experience with participant retention, particularly given the health-related vulnerability of the sample. The participants were always reminded of the goal they had stated in the first-time data collection.

Results

A moderation analysis was conducted to examine whether goal disengagement and re-engagement (phase 2) moderated the relationship between action crisis at phase 1 and well-being at phase 3, controlling for baseline well-being (phase 1).

The overall model for disengagement was significant, $F(4, 628)=95.419, p<0.01$, with 37.8% of the variance in well-being at phase 3 being explained. The regression coefficients are presented in Table 1. The baseline well-being positively predicted subsequent well-being ($B=0.567, p<0.001$). However, action crisis did not significantly predict well-being ($B=-0.070, p=0.487$), and goal disengagement was also non-significant ($B=0.087, p=0.617$). Critically, the interaction between action crisis and goal disengagement was not significant ($B=-0.006, p=0.488$), indicating no moderating effect. The change in explained variance due to the interaction was found to be minimal ($\Delta R^2=0.000, F(1, 628)=0.481, p=0.488$).

Table 1. Regression coefficients for goal disengagement

Variables	Coefficient	SE	t	p	95% CI
Action crisis (X)	-0.070	0.101	-0.694	0.487	[-0.269, 0.128]
Goal disengagement (W)	0.087	0.174	0.500	0.617	[-0.255, 0.430]
Interaction (X x W)	-0.006	0.009	-0.693	0.488	[-0.026, 0.012]
Well-being (phase 1)	0.567	0.034	16.335	0.000	[0.499, 0.636]

The overall model for re-engagement was significant, $F(4, 628)=98.21, p<0.01$, and explained 38.4% of the variance in well-being at phase 3. The regression coefficients are presented in Table 2. Action crisis negatively predicted well-being ($B=-0.244, p=0.007$), and baseline well-being was also a strong positive predictor ($B=0.555, p<0.001$). Goal re-engagement was not found to be a significant predictor ($B=-0.031, p=0.965$) and the interaction between action crisis and goal reengagement was also not significant ($B=0.005, p=0.233$). The interaction term did not significantly increase the explained variance ($\Delta R^2=0.001, F(1, 628)=1.42, p=0.233$), indicating no moderation effect of goal re-engagement on the relationship between action crisis and later well-being.

Table 2. Regression coefficients for goal re-engagement

Variables	Coefficient	SE	t	p	95% CI
Action crisis (X)	-0.244	0.090	-2.684	0.007	[-0.422, -0.065]
Goal reengagement (W)	-0.031	0.079	-0.392	0.695	[-0.187, 0.124]
Interaction (X x W)	0.005	0.004	1.192	0.233	[-0.003, 0.014]
Well-being (phase 1)	0.555	0.034	15.962	0.000	[0.487, 0.624]

Discussion

The goal of this study was to examine whether goal adjustment strategies (goal disengagement and re-engagement) moderate the relationship between action crisis and subsequent well-being. In contrast to expectations, the results showed no evidence for a moderating role of either strategy in this relationship. In the model with goal disengagement as a moderator, the interaction between action crisis and disengagement was not statistically significant. Similarly, the interaction was also found to be statistically insignificant in the model with goal re-engagement. These findings suggest that neither disengaging from unattainable goals nor re-engaging in alternative pursuits buffered or amplified the effects of experiencing an action crisis on the subsequent well-being of individuals.

The study also showed that action crisis itself was only a significant predictor of later well-being in the model which included goal re-engagement. This aligns with previous research indicating that action crisis, which is accompanied by indecision, doubt and internal conflict about goal pursuit, can be psychologically taxing and negatively associated with mental health [25].

However, the absence of moderation effects in the study is somewhat surprising, particularly given the theoretical models emphasizing the role of adaptive self-regulation in mitigating the consequences of goal conflict [15]. There are many possible explanations for this. One of them might be connected to the timing and stage of goal pursuit. Goal adjustment strategies may be more likely to exert their regulatory influence primarily once individuals reach sufficient clarity or readiness to revise their goals, whereas action crisis reflects a more ambivalent phase [21]. During this period, individuals may not yet be in a motivational state in which disengagement or re-engagement strategies can be effectively applied, limiting their potential moderating role. This can particularly be the case when they are facing a health threat. Another explanation is that the effects of such strategies may unfold over longer time frames or interact with other contextual factors such as the importance of the goal or availability of alternatives [3]. Because goal adjustment strategies were measured after the initial assessment

of action crisis, the temporal ordering limits strong casual inferences, and it remains possible that goal adjustment partly reflects responses to ongoing-related difficulties.

The effectiveness of goal adjustment strategies might also depend on individual differences such as the resilience of an individual or how willing they are to adapt [26]. These strategies might not be consistently applied across all individuals or phases. Individuals characterized by different patterns of disengagement or re-engagement may show divergent well-being trajectories [27]. However, if these strategies are used inconsistently, or people are still dealing with emotional fallout from the crisis, the moderation effect can be undermined [3].

It is also possible that methodological factors could have played a role. The goal disengagement and re-engagement scales were assessed at phase 2, while action crisis was measured at phase 1. Although this decision was reasonable based on the prediction of goal achievement processes, it is possible that the assessment of goal adjustment at phase 2 may not have optimally captured the conditions under which these regulatory strategies function as moderators of the action crisis-well-being relationship. Moreover, although a three-month interval is sufficient to capture short-term changes in goal-related experience, longer follow-up periods might also be necessary to observe the full (slower or even cumulative) impact of goal adjustment strategies on well-being, and future studies should examine these processes over longer time spans.

Future research should consider more granular longitudinal designs which would capture these processes over multiple time points and include repeated measures of all the variables to understand the conditional associations better. While the current research tried to address this issue by having three time points, it seems that this approach did little more than scratch the surface of the issue.

Conclusions

Overall, the findings suggest that while action crises can negatively impact well-being over time, this relationship does not appear to be moderated by goal disengagement or re-engagement strategies, at least in the context and timeframe examined in this study. These results highlight the psychological cost of goal-related conflict, while also pointing out the limits in the buffering role of self-regulatory flexibility. This challenges assumptions in prominent motivational theories.

Implications

Theoretically, these results invite a more nuanced view of when and how goal adjustment strategies are effective, particularly in individuals dealing with a decline in health. Rather than acting as general-purpose buffers, disengagement and re-engagement may operate conditionally, depending on the phase of goal pursuit, perceived goal attainability or emotional readiness to let go. In practical terms, interventions aiming to enhance well-being through self-regulation training may need to consider the timing and motivational context. Encouraging goal disengagement too early, before individuals are ready, may not reduce distress and could even undermine motivation. Conversely, fostering awareness of action crisis and providing support for reflective decision-making might be a more effective first step in promoting long-term adjustment.

Disclosures and acknowledgements

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This study did not require approval from an institutional ethics committee as it did not involve any experimental intervention, manipulation or collection of personally identifiable or sensitive data. The research was conducted in accordance with the ethical principles of the Declaration of Helsinki and the APA Ethical Guidelines. All the participants were adults, informed about the nature of the study and provided their voluntary and anonymous consent. All the participants received a written informed consent form outlining the study's objectives, procedures and data confidentiality. The form also specified the participants' rights, including the voluntary nature and the right to withdraw from the study at any time without any negative consequences. The participants provided consent for the anonymous use and publication of their data.

Artificial intelligence (AI) was not used in the creation of the manuscript.

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