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## On multiple goals and continuous conflict

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Generally spoken, we know all too well what we should be doing for our health. We should eat less, move more but make sure that we do not get sports injuries, and we should not smoke, drink alcohol or take drugs. However, we should drink one or two glasses of red wine a day but not everyday of the week. In addition, we need to use condoms consistently for at least six months into a new relationship and get ourselves tested for STI regularly. We have to stay out of the sun but make sure that we do get enough of it to produce enough Vitamin D, eat lots of fruits and vegetables, but refrain from eating chocolate or candy or cake, or anything else fattening or salty. We have to avoid “stress”, use bicycle helmets, not drink and drive, brush our teeth twice a day for at least two minutes at a time and floss them, and so on and so forth.

The list could be almost endless, and if we add to it other non-health related activities that we are required to do, it truly becomes never-ending. For example, on a typical day of a working father he may also have to ensure that he is on time for work, that he looks representative, that his work can meet with his own and his boss’ standards, that he is at home on time and does the groceries on his way, that he helps his children with their homework, that he takes the dog out for a walk, and so on. It is the fact that we hold multiple goals at given moment, that may cause us not to pursue a certain health behavioral goal or to not to sustain it over time.

In other words, a health goal:

- ▶ may not be regarded as (most) salient or is not actively represented in the working memory; or
- ▶ may not be (continued to being) pursued over time because it has to continuously compete with other goals for limited resources including time, money and energy.

Consequently, for continued efforts in the attainment of health goals, it is crucial that they are prioritized and shielded from alternative goals during all phases of goal pursuit.



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### Goal prioritization during goal adoption

People are at times disinclined to accept a certain health behavior as a personally held goal. That is, pressured as they may feel by all the different tasks they have to fulfill, they may tend to refuse to adopt yet another new goal that again requires time and effort. For instance, a person may reason in a following manner: “There are so many things that I must do, one cannot do everything that “is good”, and this is just the one thing I will not change! It is me, it is my choice, it is the way I am, and this behavior belongs to me”. This particular person may not want to take up exercise or quit smoking, because: “I am not the sporty type and I am certainly not one of these lunatics who run around all Sunday in their jogging suits. I am the more sensible person who spends the Sunday morning reading the newspaper in peace, which is my preferred choice for stress reduction. And smoking is the only other pleasure I allow myself; I will not have anyone taking that away from me. At least I do not drink or do drugs”. As can be derived from this example, the desired health behavioral goal (such as “taking up exercise”) is embedded in a configuration of related and conflicting goals (such as “relaxing”). What is ▶

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## original article

**On multiple goals and continuous conflict (cont'd)**

most important, i.e. what is the most “desired” or most “unwanted” end-state, varies enormously between individuals, *and* across situations (Förster, Liberman & Friedman, 2007).

At other times, people may accept the health goal and conceive its attainment as truly desirable, but they may find themselves in situations where they have other pressing issues to attend to. The health goal is merely one of the tasks on the “to-do” list, and whether a goal is being pursued is, therefore, dependent on the relative salience of the health goal. This, in turn, is influenced by the level of potential goal conflict between the health behavioral goal and other valued goals, and – conversely – by the extent to which the goal may facilitate other goals (e.g., Gebhardt, 2007; Riediger & Freund, 2004). When one does not have to attend to a conflict between goals, less effort and attention is required. Similarly, when goals coincide, for example, when joining a health club is accompanied by meeting new people in the place one has moved to, the goal is more protected from being overruled by other valued aims. Thus, the extent to which a health goal is mentally represented as a goal that serves other life aspirations and does not conflict with them is likely to influence goal adoption. Indeed, the rather scarce empirical research in this area applied to health behavior clearly indicates that goal conflict and goal facilitation both influence the initiation of health behavior change (see for a review Gebhardt, 2006; 2007).

**Goal prioritization during goal enactment and continued goal pursuit**

Having a great number of different goals requires control systems that determine continuously which goal is going to be given priority above other goals at any given moment. The outwardly perceived easy choice of selecting and continuing to pursue those goals which produce the most profit in the long run, is frequently compromised by cues in the environment that change the accessibility and the value of these goals. For example, people often indicate that it is not so much that they did not want to perform a certain behavior, but that they “just did not get round to it” (e.g., Abraham & Sheeran, 2003). More recent or more urgent goals may have overridden the prior goal, even if the latter is considered (more) important (e.g., Weinstein, 1988). Thus, attendance to a goal can at times be more a function of what stands out the most in the field of attention than of what is most important per se, and reminder systems (i.e., cues to action) are necessary to

have the original goal returned to our attention. It, thus, appears important that alternative goals are forgotten in the process of goal pursuit and that the goal is shielded from them (Shah, Friedman & Kruglanski, 2002).

When then, will people remain committed to their longer-term goal, which health-goals so often are? Empirical evidence seems to support the notion, that the more people are satisfied with their advancement towards the goal, the more they are inclined to continue their efforts (e.g., Carver, 2004). The nearer you are to your goal, the more you long to actually attain it. If, however, you are disappointed with the outcomes of your endeavours, you are likely to adopt other behavioural strategies to adjust your goals or to disengage from the goal all together (e.g., Wrosch, Scheier, Miller, Schulz & Carver, 2003).

Fishbach and Dhar (2005), however, found support for the exact opposite hypothesis, i.e., that progress towards one goal increases the chance of disengagement and the pursuit of other conflicting goals. For example, female dieters who were made to believe that they had made good progress towards their goal of “losing weight” were more likely to choose a chocolate bar over an apple as a parting gift, than those had been informed that they had hardly progressed. The authors conclude that expected or actual progress towards a goal leads to distancing oneself from it. Similarly, Fishbach and colleagues (2006) observed in another study that those who were informed that they exercised more than others were less willing to maintain a healthy diet and exercise than those who were led to believe that they exercised less than others. However, this pattern was reversed when the goal of “keeping in shape” was primed. Thus, the negative effect of goal progress on subsequent behaviour seems to be fully mediated by the level of commitment to - and accessibility of the higher order (long term health) goal, such as “losing weight” or “increasing fitness levels”. Interestingly, Ramanathan and Menon (2006) conducted a series of studies to investigate the dynamic process over time when people are exposed to tasty food primes (sweets). It appeared through moment-to-moment tracking of desires, that those who are impulsively oriented override their self-control after being primed (with sweets) and continue to do so. This was indicated by an increased desire over time for the temptation (cookies) and eventually by a corresponding increase of the behavioural tendency (i.e., eating more and more of them). In ►

## original article

**On multiple goals and continuous conflict (cont'd)**

contrast, those who were more prudent, also showed an increase in desire after being primed and demonstrated impulsive behaviour (ate cookies) initially, but their desire decreased and a compensatory reaction of avoidance occurred shortly thereafter (restraining from eating cookies). Successful self-regulators thus, may have the goal of "willpower" activated in reaction to temptations. Impulsive behaviours, on the other hand, may be primarily a function of the degree to which hedonic goals are chronically accessible. Similarly, in a recent study among dieters by Palfai and Macdonald (2007) it was found that temptation cues (such as the words "cake", "chocolate", "cookies" or "ice cream") reduced the valence of the goal of "controlling weight". At the same time these primes increased the value attached to words referring to the conflicting goal of "affect enhancement".

In short, recent research indicates that a goal may lose its salience when one is successfully progressing towards it. For example, if one already has lost six pounds of weight, it may seem less necessary to lose two extra pounds in order to reach the target one has set for oneself. The alternative goals (e.g., the goal of "experiencing pleasure"), particularly if they are chronically accessible, will then increase their influence on behaviour. If however, the superordinate goal (e.g., the goal of "looking attractive" or of "self-control") remains to be activated during the process, this "rebound-effect" will be far less likely to occur.

**Implications of the multiple goal perspective for health behaviour research**

Thus, people strive for various goals simultaneously at any one time, leading continuously to situations in which conflicts between goals arise. As a result, a certain health goal may not be considered or be deserted, even if it is conceived of as a strongly desired end-state.

One may, therefore, expect that when individuals are encouraged to reorganize their goal system in a way that the health behavior is positively linked to other valued goals, they will be more likely to pursue it and to remain doing so over time (Karoly et al., 2005). It should be noted here that Zhang, Fishbach and Kruglanski (2007) concluded from their study that linking a behavior such as exercising to more than one goal (e.g., "losing weight" and "increasing one's fitness level"), reduces the chance that people will perceive the behavior as being effective. They argue that a certain behavior will be more likely to be prioritized when only one corresponding goal – as opposed to more – is

activated. Thus, it is not so much that the number of links between a health goal and other goals should be strengthened, but rather that one strong connection between the behavior and one desired outcome should be established.

One possibility for enabling such a connection may be through linking the behavior to (un)desired self-conceptions (e.g. "I wish to be a young attractive looking person", see Markus & Nurius, 1986). For example, activation of goal salience in terms of how it may facilitate certain desired self-conceptions should increase the openness of the individual to recognize goal-related opportunities. Failing to act in accordance with one's long-term goals will then be seen as a violation of one's central values and core self-conceptions. In our recent study among 124 smokers (Gebhardt, van Ek & Dijkstra, in prep.), however, we found no direct support for this notion. Participants who were asked to reduce their smoking during one week, were randomly assigned to a condition in which they generated (1) a main advantage of quitting smoking (benefit condition), (2) a main positive association with being a future (i.e., in 10 years time) non-smoker (ideal-self condition), or (3) a main negative association with being a future smoker (feared-self condition). Subsequently, all participants formed an implementation plan specifying that whenever they would crave for a cigarette in the following week, they would think of the self-generated attribute and would not smoke. Overall the participants reduced the self-reported number of cigarettes smoked during the week substantially, but no main effect of condition on the reduction of number of daily smoked cigarettes was found. Looking at self-reported smoking patterns, it appeared that in the benefit condition 1/5 quit smoking in the week following the intervention versus 1/10 in feared-self and none in ideal-self condition. However, although they did not abstain from smoking, those in the ideal-self condition remained far more stable over time in their smoking reduction, while those in the benefit or feared-self condition were more likely to return to previous smoking levels during the course of the week. Apparently, different goal setting strategies yield different behavioural patterns, indicating that they may direct to other resolutions of goal conflict during the process of goal pursuit.

In line with the work by Ramathan and Menon (2006) mentioned above, another possibility for having the health behavioural goal "shielded" ►





## original article

## On multiple goals and continuous conflict (cont'd)

during goal pursuit may well be through the activation of the overall goals of “exerting will-power” and “persistence”. For instance, Alberts and colleagues (2007) showed that induction through priming of “perseverance” as a goal led to exerted self-control on a subsequent strenuous task, involving the squeezing of a handgrip. All participants in their study completed a difficult cognitive task (e.g., performing calculations while being exposed to distracting auditory cues). It was found that those who had been primed with persistence through a scrambled word task performed much better on the hand-grip squeezing task than those who had not.

Next to increasing goal-salience, and having the intrinsic value of the health goal readily accessible during goal pursuit, the intra-goal conflict—as it occurs—needs to be efficiently managed. Strategies related to coping with distractions in the form of alternative goals, therefore, appear essential. For example, Koestner, Lekes, Powers and Chicoine (2002) asked participants to prepare strategies for handling possible distractions that could occur during the pursuit of their self-generated goal for the weekend. This procedure positively affected subsequent goal progress. Similarly, Sheldon, Kasser, Smith and Share (2002) successfully instructed participants to regard the distress and discomfort during the pursuit of their (mostly academic) semester goals as indicators of the necessity to apply coping strategies rather than as feelings that should be avoided.

### Conclusion

In sum, researchers and professionals in the field of health promotion should take into account the other valued aims of the individual. Health behavioral goals should be considered as part of the conglomerate of personal goals the person is pursuing or striving for, and their exact position within this structure should be known. In other words, personal goals are in continuous interaction with one another, and attempts made to attain one aspired goal are likely to influence the chances of achieving any one other goal. We need to know how the health behavior relates to other goals, including the extent to which it hampers or facilitates their achievement. Investigating the content of the individual's other goals, how they are organized and how they interact is, therefore, essential to optimize our efforts in predicting or influencing health behaviors. Finally, more insight into how difficulties during the process of goal pursuit due to alternative goals may be overcome, is urgently needed ■

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