

## RESEARCH ARTICLE

# Healthy and successful: Health-behavior goal striving in daily work life

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**Abstract**

Health behaviors (physical activity and healthy eating) can be an essential part of everyday work life and are relevant for employees' affective states. Many worksite interventions, including goal-striving approaches, have been developed to promote health behavior at work. However, these approaches often neglect that making progress with respect to health-behavior goals necessarily takes place during workday episodes, so that work tasks are accomplished simultaneously. In our study, we aim to advance the understanding of how health-behavior goal progress is facilitated and how reflecting on it evokes affective states—taking into account simultaneous pursuit of work-task progress. We collected daily diary data from 205 employees on 1399 days. Analyses showed that goal importance positively predicted health-behavior goal progress, which in turn positively predicted pride and negatively predicted shame at the end of the workday. The negative relation between health-behavior goal progress and shame was stronger on days with low work-task progress, implying compensatory effects. Work-task progress did not moderate the relation between health-behavior goal progress and pride. We discuss the theoretical and practical relevance of integrating research on multiple goal striving when promoting health behavior in daily work life by means of goal-striving techniques.

**KEYWORDS**

daily diary study, goal importance, health behavior, multiple goal striving, self-conscious emotions, work tasks

## 1 | INTRODUCTION

Health behaviors such as physical activity and healthy eating are essential in everyday work life (Postema et al., 2021; Sonnentag et al., 2017). For example, both physical activity during the workday (Calderwood et al., 2021) and healthy eating (Conner et al., 2017) are associated with relevant outcomes at work such as enhanced

well-being. Still, employees often cannot realize sufficient levels of health behavior (Parry & Straker, 2013), so that worksite interventions have been developed to promote health behavior (Abraham & Graham-Rowe, 2009; Maes et al., 2012). Often, these worksite interventions include goal striving as an essential behavior-change technique (Malik et al., 2014). However, interventions focusing on health-behavior goal striving during the workday tend to

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overlook that striving for health-behavior goals necessarily takes place while work tasks need to be accomplished simultaneously. Considering the resulting temporal overlap of various goal-striving processes during the workday, there is a need for a better understanding of successful health-behavior goal striving when concurrently aiming for successful progress in work tasks.

Successful goal striving in health-behavior goals and work tasks is reflected in making progress across the day. Although previous research has examined predictors and outcomes of experiencing progress (e.g., Diener et al., 1999; Sheldon & Elliot, 1999), it is yet unclear how progress occurs in the context of health-behavior goal striving (i.e., health-behavior goal progress) during the workday. For example, employees may strive for goals such as “performing 10,000 steps” (to increase physical activity) or “eating more fruits” (to increase healthy eating) when being at work. To gain insights into successful health behavior promotion at work, it is important to understand how health-behavior goal progress most likely results in beneficial consequences. In this study, we focus on affective states that follow from health-behavior goal progress at work and also consider the moderating role of work-task progress (i.e., perceiving progress in daily work-related duties). Thus, we not only aim to answer the question how successful health-behavior goal progress is facilitated and beneficial for employees, but also how simultaneous striving towards work-task progress might interfere when it comes to affective states following health-behavior goal progress.

We build our research on the self-concordance theory (Sheldon & Elliot, 1999) and suggest that evaluating one's health-behavior goal as important predicts successful health-behavior goal progress during the workday. Successful health-behavior goal progress, in turn, should predict favorable affective states (i.e., high pride, low shame) at the end of the workday (cf. Weiss & Cropanzano, 1996). Building on multiple-goals research (e.g., Hirschi et al., 2019; Vancouver et al., 2010), we further argue that health-behavior goal striving should not be seen in isolation when employees are at work, as work tasks largely influence employees' workday. In this context, we exploratively investigate whether and how work-task progress moderates the relation between health-behavior goal progress and affective states. Figure 1 summarizes our research model.

Our study offers contributions to the literature on the interface of health behavior and work life. First, we address multiple goal striving with respect to the additional demand of making work-task

progress when striving for progress in health-behavior goals during the workday. Previous research often focused on reasons why employees cannot maintain sufficient levels of health behavior in work life (e.g., Mazzola et al., 2016; Parry & Straker, 2013) and accordingly targeted health-behavior promotion (e.g., by developing interventions; Abraham & Graham-Rowe, 2009; Maes et al., 2012). However, this approach neglects crucial insights from multiple-goals research (e.g., Hirschi et al., 2019; Vancouver et al., 2010). Specifically, employees' main purpose at work is to make progress with respect to their work tasks, so that affective states may result from an interplay of health-behavior goal progress and work-task progress. Our perspective on health-behavior goal striving while work tasks need to be accomplished helps advance the understanding of simultaneous goal striving in health and work domains. Practically, it shows how health-behavior goal striving interventions might be affected by work tasks when being implemented in daily work life.

Second, we take a closer look at health-behavior goal progress by investigating what facilitates and follows from health-behavior goal progress. Importantly, we argue that health-behavior goal progress has implications beyond increasing health behavior per se, specifically for affective states when leaving the workplace. In addition, it is important to understand how health-behavior goal progress can be promoted in order to develop health-behavior interventions that are successful despite barriers within work life (e.g., workload; Mazzola et al., 2016). Our specific focus on goal importance thereby addresses the relevance of personal attachment to health-behavior goals (cf. Sheldon & Elliot, 1999). This knowledge is critical to gain a more holistic understanding of health-behavior goal striving in daily work life.

Third, our study offers starting points for practical interventions that promote health behavior at work. Specifically, practitioners can learn from our study when instructing day-specific goal-striving interventions (i.e., referring to personally important goals) so that favorable affective states at the end of the workday are promoted. In addition, we emphasize that practitioners should not only consider health behavior when evaluating the interventions, but also consider employees' affective states that follow from integrating health behavior into their daily work life. Because affective states are relevant in daily work life (Seo et al., 2004), both physical (i.e., health behavior) as well as psychological aspects (i.e., affective states following goal striving) of health-behavior promotion should be considered.

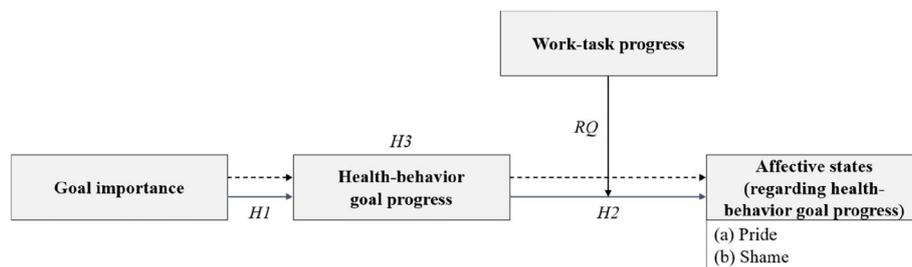


FIGURE 1 Conceptual model at the day level. *H*, Hypothesis; *RQ*, Research Question. Solid lines refer to direct effects, dashed lines refer to indirect effects.

## 1.1 | Making health-behavior goal progress

Engagement in health behavior is motivated by personal goals serving as a standard for specific behaviors (cf. Austin & Vancouver, 1996; Locke & Latham, 2002). Goals describe internal, mental, and future-oriented representations of subjectively valued states (Austin & Vancouver, 1996; Lee et al., 1989). They arise from a felt discrepancy between a certain current and a more attractive desired state (Johnson et al., 2013). Tension associated with this discrepancy stimulates action (Locke & Latham, 1990), such that individuals advance towards their desired state. This advancement manifests itself as goal progress (Harris et al., 2003). Goal progress is made by effort exertion in goal-relevant behaviors (Lord & Hanges, 1987). In more detail, we differentiate between progress being made and progress being reflected. In line with Beal et al. (2005), we define progress being made as a process occurring across several episodes whereas the momentary reflection and evaluation of one's progress constitutes a specific event. Thereby, progress occurs continuously over time (i.e., within episodes) and the realization of a specific, not necessarily final state occurs in a single moment (i.e., as an event). Adopting these concepts also emphasizes our focus on goal progress instead of goal attainment, as we are explicitly interested in the process of goal striving across episodes rather than single moments of goal attainment. We thus define health-behavior goal progress as the advancement towards a self-set health-behavior goal (e.g., “performing 10,000 steps at work” for a physical activity goal or “eating more fruits” for an eating goal) across workday episodes. As important workday episodes, we consider the morning and the afternoon as two episodes naturally separated by a lunch break.

Importantly, motivational aspects are relevant for goal progress because they intensify engagement and effort exertion (Sheldon & Elliot, 1999). In this regard, self-concordance theory (Sheldon & Elliot, 1999) states that individual differences in the source of goals (e.g., personal interests) matter for goal progress (Koestner et al., 2002). That is, goal striving is successful when a goal is self-concordant, meaning when it refers to personal interests and values of the person striving for it (Sheldon & Elliot, 1999). On a day level, goal self-concordance might appear in terms of day-specific goal importance—describing the extent to which an employee attaches personal relevance to moving towards a goal on a specific day (cf. Orbell et al., 2001). There is already some research acknowledging the day-specific variance of goal importance from daily diary studies (e.g., Harris et al., 2003; Robinson & Irvin, 2022). In addition, goal importance has also been conceptualized as varying with respect to different goals (Steinmann et al., 2018), implying that setting different goals everyday might also result in a daily variation in goal importance. Accordingly, the importance that employees attach to their goals might not be high on every day because health-behavior goals might interfere with other aspects of their work life on some days. That is, health-behavior goals as well as their importance for employees may vary between days. Yet, on days employees attach high personal importance to their specific health-behavior goal, they may be more motivated and more willing to engage in goal-directed

behaviors (i.e., increase physical activity and healthy eating). Thus, we suggest that daily goal importance positively predicts daily health-behavior goal progress.

Previous research is in line with this assumption by showing that goal importance is crucial for goal progress (Austin & Vancouver, 1996; Harris et al., 2003). Specifically, goal importance has been revealed as a predictor of goal progress (Beattie et al., 2015). While this research has neglected specific goal-striving domains or exclusively focused on work goals (e.g., Harris et al., 2003), we assume that this relation exists similarly for health-behavior goal striving while being at work. Especially in daily work life, many other demands may be present, so that attaching personal importance to health-behavior goals is essential for health-behavior goal progress. Hence, we propose daily goal importance as a predictor of daily health-behavior goal progress.

**Hypothesis 1** Daily goal importance positively predicts daily health-behavior goal progress.

Going further, health-behavior goal progress has implications for subsequent affective states (Klug & Maier, 2015; Wiese, 2017), which are of major relevance in everyday work life (Seo et al., 2004). More precisely, affective states may arise from affective events (Weiss & Cropanzano, 1996) such as recognizing goal progress. Taking up the differentiation between episodes and events (cf. Beal et al., 2005), the moment of reflecting on progress after episodes in which progress was made constitutes a specific event that triggers affective states. Within this event, affective states refer to health-behavior goal progress made across the workday episodes (i.e., across the morning and across the afternoon). Because of their event specificity, these affective states can be seen as emotions (Bindl & Parker, 2010; Brief & Weiss, 2002). Thus, employees may experience more positive and less negative emotions when recognizing and reflecting on successful health-behavior goal progress (Diener et al., 1999). Within our study, this reflection is specifically stimulated by instructions that allow for progress evaluations and the associated emotions: “Please think about your progress today with respect to the goal you set for yourself this morning on your snacking behavior (physical activity). Having that in mind, how do you feel right now?”. Accordingly, recognizing and reflecting on health-behavior goal progress should promote favorable and reduce unfavorable emotions at the end of the workday.

In our study, we focus on self-conscious emotions arising from health-behavior goal progress. Self-conscious emotions as a specific type of affective states are driven by individuals' reflection and evaluations—like evaluations occurring during the event of health-behavior goal progress. The resulting affective states are relevant outcomes in daily work life as they regulate thoughts, feelings, and behaviors (Campos, 1995; Fischer & Tangney, 1995). Specifically, we examine pride and shame induced by recognizing and reflecting on health-behavior goal progress. Pride describes a self-confident state resulting from performance or achievement (Takahashi et al., 2007) for which people feel responsible (Leary, 2007). Shame describes a negative state (Burney & Irwin, 2000; Tangney, 1995), which is experienced when not living up to own expectations in personally

relevant situations (Silberstein et al., 1987). In more detail, pride and shame may arise when employees experience a positive, self-confident state because of high health-behavior goal progress or a negative state because they feel not having progressed enough. For example, an employee who has set the health-behavior goal to perform 10,000 steps during the day and has already performed 8000 steps until the moment of reflecting on progress, may experience higher positive self-confidence captured in pride as well as lower shame with respect to the health-behavior goal.

Empirical evidence in this relation is scarce, but there is some research points to self-conscious emotions as reactions to goal striving (e.g., Parks-Stamm et al., 2010; Wolf et al., 2018). For example, pride and shame were shown as responses to academic examinations (Fang et al., 2023) as a situation naturally associated with goal striving. Again, we assume that these relations can be transferred to the context of health-behavior goal striving at work because making health-behavior goal progress may similarly increase experiences of pride and reduce experiences of shame. Thus, we propose health-behavior goal progress as a predictor of affective states.

**Hypothesis 2** Daily health-behavior goal progress during the workday (a) positively predicts pride and (b) negatively predicts shame at the end of the workday.

Taking up our previous hypotheses, we propose that goal importance indirectly relates to affective states via health-behavior goal progress. Relying on self-concordance theory (Sheldon & Elliot, 1999), employees will not only make more sustained goal progress following personally important goals but, as an indirect consequence, also experience more pride and less shame. Indeed, goal importance has been referred to as a key element when studying goal progress and affective states (Harris et al., 2003), because it reflects a motivational aspect which can predict subjective reactions (Lazarus & Folkman, 1984). Further extending this theoretical view, we argue that goal importance indirectly relates to the event of progress reflection. Because goal importance should be present already prior to and during goal striving episodes, it should serve as an indirect motivational driver of affective states following the event of progress reflection. In detail, goal importance motivates for goal striving during workday episodes, and can only thereby (i.e., indirectly) relate to the event following these episodes, namely the progress reflection that results in a specific affective state. Thus, goal importance should indirectly evoke beneficial affective states.

Even though previous studies have accounted for the relevance of goal importance for goal progress and affective states (Emmons, 1996; Harris et al., 2003; Maier & Brunstein, 2001), goal importance has not been examined as an indirect predictor of affective states evoked by progress reflection. Instead, goal importance has rather been considered as a moderator, so that affective states are more likely to emerge from goal striving when goals are important (Harris et al., 2003). We do not contradict this view but see it as limited as it does not account for the sequence of goal striving episodes and progress-reflection events across the workday. Thereby,

we argue that goal importance as an important motivational driver is already critical earlier in the process, namely by impacting goal-striving episodes. To account for this impact, we suggest a model with goal importance predicting goal progress, and only indirectly relating to affective states arising within the event of progress recognition and reflection. Accordingly, we rely on our theoretical rationale and suggest that states of pride and shame arising during the event of progress reflection should indirectly originate from goal importance as a motivational aspect that drives progress towards health-behavior goals across workday episodes.

**Hypothesis 3** Daily goal importance indirectly predicts (a) higher pride and (b) lower shame at the end of the workday via increased health-behavior goal progress during the workday.

## 1.2 | The moderating role of work-task progress

Notably, the relation between goal progress and affective states is not always equally strong (Hoppmann & Klumb, 2012; Wiese, 2017). Accordingly, there is a need of a better understanding under which conditions goal progress most likely results in (un)favorable affective states (Klug & Maier, 2015). In our study focusing on health-behavior goal striving in daily work life, we therefore consider the demand of similar processes in the work domain that naturally take place at the same time—namely, making work-task progress. When being at work, employees strive for work-task progress because achievement at work is a crucial predictor of a successful life (Wiese & M Freund, 2005). Thus, making work-task progress should be a central purpose for employees when being at work.

Building on multiple-goals research (e.g., Hirschi et al., 2019; Vancouver et al., 2010), we suggest that work-task progress may interact with health-behavior goal progress in predicting affective states. Usually, people strive for multiple goals simultaneously (Neal et al., 2017; Vancouver et al., 2010). These goals must not be competitive (Hirschi et al., 2019). For example, “eating more fruits” as a health-behavior goal does not necessarily compete with progressing in work tasks. However, the work setting implies that affective states following health-behavior goal progress are shaped within this specific context. That is, when being at work, employees pursue certain work tasks, and thus may naturally aim to make work-task progress. Importantly, employees' work-task progress then occurs simultaneously to their health-behavior goal progress. Due to the specific self-set health-behavior goals, health-behavior goal progress should generally occur independently from work-task progress. However, affective states following health-behavior goal progress might indeed be affected by simultaneous goal striving in work tasks. Indeed, research suggests that emotional experiences can follow an attribution to the task or something other than the task (Beal et al., 2005). Applying this approach to our study implies that affective states following health-behavior goal progress can be driven by an interplay of health-behavior goal progress itself (i.e., the “task”) and also influenced by work-task progress (i.e., “other than the task”).

Given the setting at work and thus the high relevance of progressing in work tasks, we assume that low work-task progress is especially critical with respect to how health-behavior goal progress translates into affective states. That is, work-related goal striving is naturally present as employees commonly reflect their work by referring to underlying work goals (Roberson, 1990). Hence, lacking work-progress will be particularly critical, while high work-progress might be rather taken as “just fulfilling job requirements”. In turn, making health-behavior goal progress might only be a secondary goal at work. However, it could also protect from a too strong focus on the perceived failure in work-task progress. Thus, while lacking work-task progress should not impact health-behavior goal progress directly, it might indeed impact how health-behavior goal progress translates into affective states at the end of the workday (i.e., moderating role).

Following this reasoning, we suggest that, along with multiple goal striving at once, work-task progress moderates the relation between health-behavior goal progress and affective states. Even though the goals related to work and health behavior must not be competitive (Hirschi et al., 2019) and specific progress might be independent, goal striving occurs simultaneously within the same context (i.e., at work), emphasizing the relevance of considering the potential interplay. Drawing on multiple-goals research (e.g., Hirschi et al., 2019; Vancouver et al., 2010), there is, however, no clear basis guiding assumptions on how the interactions may look like. Thus, there may be different ways how health-behavior goal progress and work-task progress can interact in predicting pride and shame regarding health-behavior goal progress. In general, low work-task progress may strengthen versus attenuate the relation between health-behavior goal progress and affective states. Indeed, the moderation may, in case of a strengthening effect, be seen as compensation and, in case of an attenuating effect, be seen as spillover (cf. Edwards & Rothbard, 2000; In Zedeck, 1992). Briefly, compensation thereby implies to shift one's focus to health-behavior goal progress when work-task progress is low, and spillover implies that experiences from work-task progress translate to health-behavior goal progress. We illustrate these potential interaction patterns in Figure 2 and describe them in more detail in the following paragraphs.

On the one hand, strengthening effects correspond to compensation and imply that low work-task progress increases the relevance of health-behavior goal progress for subsequent affective states. These strengthening effects of low work-task progress are based on the assumption that health-behavior goal progress becomes more salient to employees, because employees try to compensate for low work-task progress. Thus, health-behavior goal progress is an especially strong driver of affective states when work-task progress is low. Specifically, employees may naturally aim to maintain a positive self-image (Korman, 1970) and therefore engage in strategies to protect their self-esteem (Di Paula & Campbell, 2002)—as looking for compensation. Indeed, low work-task progress might be threatening due to its high relevance at work. Thus, employees may try to ignore lack of progress in work tasks but rather focus on progress in health-

behavior goals, by which they can compensate for lacking work-task progress (cf. Zedeck, 1992). Following this reasoning, experiencing low work-task progress shifts the focus to health-behavior goal progress in which employees may perceive performance and achievement—as captured in pride (Takahashi et al., 2007). As an example, performing the targeted 10,000 steps may be a particularly strong predictor of pride on days when employees have not accomplished their most important work tasks. In other words, low work-task progress may, along with the principle of compensation, increase the salience of beneficial effects of high health-behavior goal progress, resulting in a stronger relation between health-behavior goal progress and pride (cf. Figure 2, Panel A).

Similarly, experiencing low work-task progress may strengthen the association between health-behavior goal progress and shame. Specifically, employees may realize not to have lived up to their own expectations in their work tasks and shift their focus to health-behavior goal progress instead. This switch in focus may stem from seeking positive experiences to compensate for a lack of work-task progress and thus may protect their self-esteem. Following this reasoning, experiencing low work-task progress leads to a stronger focus on health-behavior goal progress and increase employees' feeling of not having lived up to their own expectations in health-behavior goals—as captured in shame. Taking up the example, only performing 5000 of the targeted 10,000 steps may, along with the principle of compensation, is a particularly strong predictor of shame when employees have not accomplished their most important work tasks on that day. Hence, compensation is then unsuccessful, yielding especially critical effects. Thus, low work-task progress might also strengthen the relation between health-behavior goal progress and shame (cf. Figure 2, Panel C).

On the other hand, attenuating effects correspond to spillover and imply that low work-task progress decreases the relevance of health-behavior goal progress for affective states. These attenuating effects of low work-task progress are based on the assumption that work-task progress represents employees' major purpose when being at work and thus interferes with health-behavior goal progress when it comes to its affective consequences. Specifically, if employees realize that their work-task progress was low, this adverse experience might spill over to the evaluation of health-behavior goal striving. In turn, they will less likely benefit from health-behavior goal progress because the most important progress at work is lacking. Following this reasoning, experiencing high health-behavior goal progress less likely results in pride if performance and achievement with respect to the most relevant tasks during the workday are lacking. As an example, performing the targeted 10,000 steps may less likely result in pride if employees have not accomplished their most important work tasks on that day. In other words, low work-task progress may overshadow beneficial effects of high health-behavior goal progress. This process should result in a weaker relation with pride (cf. Figure 2, Panel B).

Similarly, low health-behavior goal progress may less likely result in experiences of shame if work-task progress is low because the lack of work-task progress is especially salient within the work setting.

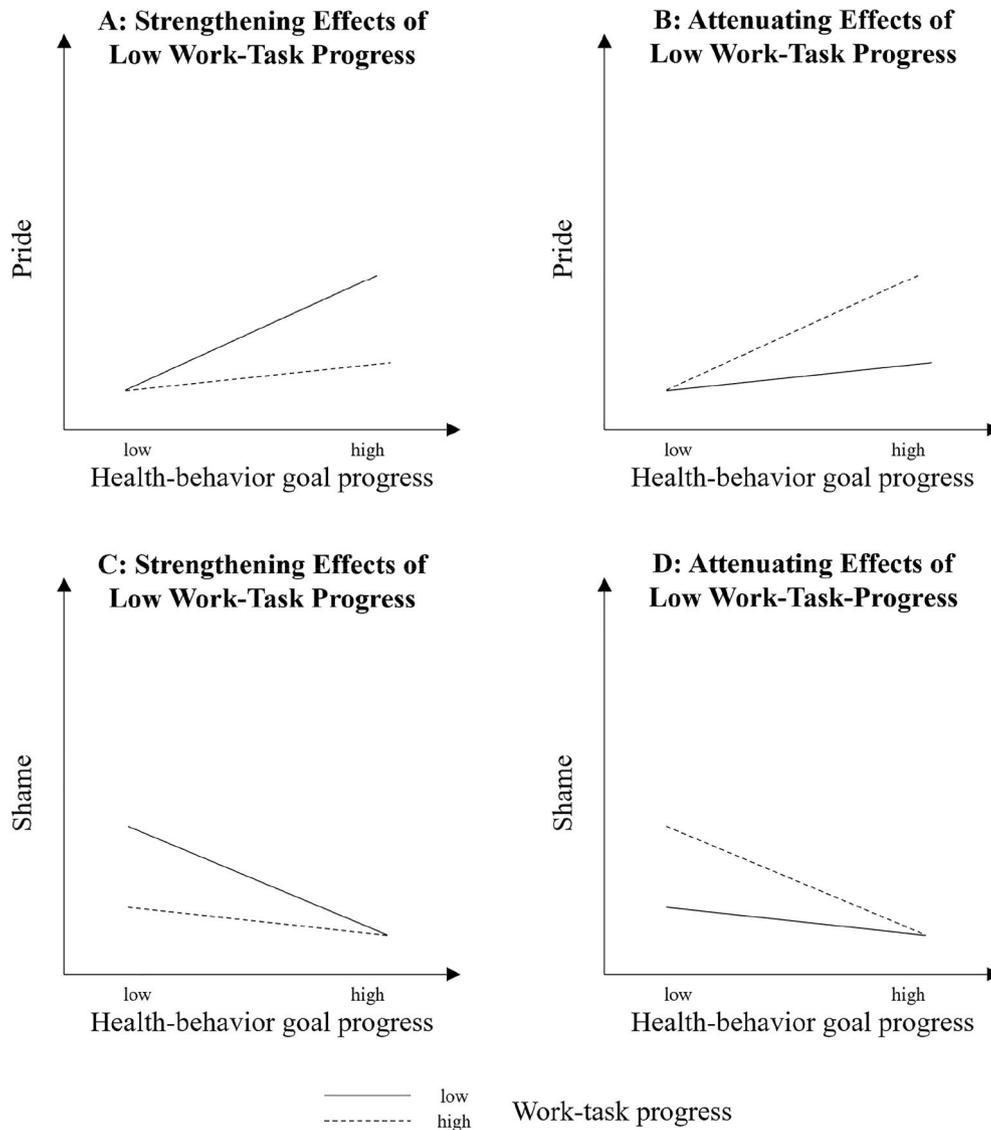


FIGURE 2 Potential interaction patterns at the day level.

Specifically, if employees realize to not have lived up to their expectations with respect to their work tasks, they may try to generally downplay the relevance of making progress, which might also spill over to the evaluation of health-behavior goal striving. In turn, their low health-behavior goal progress is less likely to translate into shame. Hence, lack of work-task progress overwrites experiences with respect to health-behavior goals. Taking up the example, only performing 5000 steps of the targeted 10,000 steps may less strongly predict shame when employees have not accomplished their most important work tasks on that day. Thus, low work-task progress might also attenuate the relation between health-behavior goal progress and shame (cf. Figure 2, Panel D).

Taken together, we argue that it is too short-sighted to only look at health-behavior goal progress predicting pride and shame when employees are at work. Instead, being at work implies that multiple goals are present, so that the perception of health-behavior goal progress cannot be seen isolated from the perception of work-task

progress, even though the goals do not necessarily compete (cf. Hirschi et al., 2019). Hence, we examine if work-task progress moderates the relation between health-behavior goal progress and affective states at the end of the workday.

Such moderator effects would correspond to compensation versus spillover patterns. So far, research explicitly contrasting potential compensation and spillover effects tends to be supportive for spillover effects (Banner, 1985; Staines, 1980). Accordingly, also recent empirical research at the interface of health behavior and work life rather followed spillover assumptions (e.g., Sonnentag et al., 2022). Yet, in other areas, there is some research empirically supporting compensation effects as well (Singh & Selvarajan, 2013). Also theoretically both spillover and compensation effects are reasonable and little research explicitly targets this phenomenon. Hence, given the paucity of research on the direction of the interaction effects, we perform an exploratory analysis in which we examine whether low work-task progress strengthens versus attenuates the relation between

health-behavior goal progress and affective states—corresponding to compensation versus spillover effects.

Research Question: Does low work-task progress during the workday strengthen or attenuate the relation between health-behavior goal progress during the workday and (a) pride as well as (b) shame at the end of the workday?

## 2 | METHOD

### 2.1 | Study design

We collected the data for this study within a larger research project on health behavior in daily work life between May 2020 and December 2021. The research project comprised a general questionnaire covering time-invariant constructs (e.g., demographics) and a daily diary phase over 10 workdays assessing our day-level variables. During the daily diary phase, we invited participants via e-mail to answer three surveys per day: a morning survey to be answered before work (available from 5 to 10 AM), a noon survey to be answered before the lunch break (available from 10 AM to 3 PM), and an afternoon survey to be answered right after work (available from 3 to 10 PM).

As part of the larger research project, participants were randomly assigned to two intervention groups and one control group so that about two thirds of the whole sample received an intervention targeting the promotion of health behavior in daily work life (i.e., increase of physical activity and decrease of unhealthy snacking behavior). The intervention was based on the concept of implementation intentions (Gollwitzer, 1999) and asked participants to set specific goals regarding their health behavior every day in the morning survey. In the present study, we focused on the goal-striving process and not on intervention effects, meaning that the daily intervention only served as a necessary research setting because our measures referred to the self-set daily health-behavior goals.

### 2.2 | Sample

We recruited participants mainly via social media networks and offered a lottery with three travel vouchers (€ 1200 value each). To be eligible for the research project, participants were required to work at least 30 h and at least 4 days per week. A total of 474 persons provided consent to participate in the study and answered the general survey. Before applying inclusion criteria for our specific study, we screened for careless responding in all daily surveys (cf. Goldammer et al., 2020). In detail, we excluded all daily surveys that were subject to response invariability (e.g., always choosing the same response option). Moreover, we checked for long interruptions during survey completion and thereby excluded daily surveys that were not finished within 120 minutes after starting. Because our study built on the intervention in which participants set daily goals, we only included participants who received intervention instructions, so that 322 employees remained in the sample. In addition, we only included

days on which participants' set a daily health-behavior goal (i.e., took part in the morning survey) and on which this health-behavior goal was rated as a meaningful goal in two independent ratings. In more detail, two persons coded every daily goal regarding its meaningfulness with 1 = *meaningful goal* or 0 = *unusable data* (e.g., when participants answered "none" or just typed random letters). Overall inter-rater agreement was 97.6% for daily eating goals and 96.3% for daily physical-activity goals. Excluding days coded as 0 (i.e., unusable data) or days on which the morning survey was not completed reduced the data set by 751 days. Beyond, because all of their morning surveys were unusable, 32 persons were excluded in this step, thereby keeping 1550 days from 290 employees in our preliminary data set. Finally, to ensure variance in the diary data, we only included participants who provided data for each daily survey on at least 2 days. This step led to our final sample of 205 participants, providing data on a total of 1399 days.

Participants in our final sample were mainly female (84.8%) and had a mean age of 39.3 ( $SD = 10.5$ ) years. The vast majority worked in occupations with sedentary activities (86.3%), mainly including administrative professions (46.2%), health, social, and educational professions (22.8%), and technical professions (13.2%). Dropout analysis showed that our final sample did not differ significantly from participants who answered the general survey, but were not included in the final sample with regard to age,  $t(416.53) = 1.03$ ,  $p = 0.302$ , or sedentary activities,  $\chi^2(1) = 0.01$ ,  $p = 0.914$ , but with regard to gender,  $\chi^2(1) = 3.90$ ,  $p = 0.048$  (i.e., less male employees were in the final sample).

### 2.3 | Measures

We used German Likert-scale measures (translated with the back-translation method; Brislin, 1970) with wording adjusted to day-specific experiences. We calculated Cronbach's alpha as reliability measure at between- and within-person levels (Geldhof et al., 2014).

#### 2.3.1 | Goal importance

We assessed goal importance regarding self-set health-behavior goals in the morning right after the intervention with three items adapted from Kyle et al. (2014). A sample item is "One of my highest priorities today is to achieve this goal". The response format ranged from 1 (not at all) to 5 (absolutely). Cronbach's alpha was 0.753 (within) and 0.964 (between).

#### 2.3.2 | Health-behavior goal progress

In line with our conceptualization of health-behavior goal progress occurring within episodes across the workday (cf. Beal et al., 2005) and in order to reduce hindsight bias, we measured health-behavior goal progress two times per day. Specifically, we measured health-

behavior goal progress at noon referring to progress made during the morning episode and after work referring to progress made during the afternoon episode. On each occasion, participants were shown their day-specific self-set health-behavior goal from the morning survey and then answered three items adapted from Hope et al. (2014) on a seven-point response format from 1 (*not at all*) to 7 (*absolutely*) to reflect on their progress. A sample item is “I made significant progress towards this goal this morning”. Cronbach's alpha was 0.953 (within) and 0.982 (between) for the noon measurement, and 0.966 (within) and 0.987 (between) for the afternoon measurement. Because our conceptual model refers to the progress during the whole workday (i.e., both episodes), we averaged data from the two occasions in our analysis model.

### 2.3.3 | Work-task progress

Similar to health-behavior goal progress, we measured work-task progress twice per day, at noon referring to progress during the morning episode and after work referring to progress during the afternoon episode. We adapted the same items from health-behavior goal progress to work-task progress (based on Hope et al., 2014), also using the same response format. A sample item is “I made significant progress towards my work goals this morning”. Cronbach's alpha was 0.940 (within) and 0.995 (between) for the noon measurement, and 0.950 (within) and 0.996 (between) for the afternoon measurement. Again, because our conceptual model refers to progress during the whole workday (i.e., both episodes), we averaged data from the two occasions for the measure to be included in our analysis.

### 2.3.4 | Affective states regarding health-behavior goal progress

We assessed pride and shame in the afternoon, using the State Shame and Guilt Scale (Marschall et al., 1994). In the instruction, we referred to participants' health-behavior goal progress and then used three items each for assessing pride and shame. Thereby, pride and shame were measured along with progress reflection as a specific event (cf. Beal et al., 2005). A sample item for pride is “I feel proud” and for shame “I feel worthless, powerless”. The response format ranged from 1 (*not at all*) to 5 (*absolutely*). Cronbach's alpha was 0.807 (within) and 0.920 (between) for pride, and 0.781 (within) and 0.910 (between) for shame.

### 2.3.5 | Control variables

To ensure that our assumed relations are not only based on “good versus bad day” effects (i.e., days characterized by good vs. bad mood), we controlled for pride and shame in the morning. We used the same items as for pride and shame referring to health-behavior goal progress (Marschall et al., 1994), but did not instruct a specific

context (i.e., used context-free measures). Cronbach's alpha was 0.731 (within) and 0.937 (between) for pride, and 0.638 (within) and 0.824 (between) for shame.

## 2.4 | Construct validity

We conducted multilevel confirmatory factor analyses within the R package “lavaan” (Rosseel, 2012) to test construct validity. We let items of all variables (goal importance, health-behavior goal progress in the morning and in the afternoon, work-task progress in the morning and in the afternoon, pride and shame regarding health-behavior goal progress) as well as our control variables (context-free pride and shame) load on the respective latent factors (Heck & Thomas, 2015). The factors of health-behavior goal progress in the morning and in the afternoon as well as the factors of work-task progress in the morning and in the afternoon were allowed to correlate. This overall measurement model fit our data reasonably well,  $\chi^2(576) = 1212.77$ ,  $p < 0.001$ , RMSEA = 0.031, CFI = 0.973, TLI = 0.967, SRMR<sub>within</sub> = 0.027, SRMR<sub>between</sub> = 0.066. In addition, we tested two alternative measurement models in which (1) health-behavior goal progress and work-task progress and (2) pride and shame loaded on one common factor per measurement occasion. Both alternative models, (1)  $\chi^2(606) = 6914.48$ ,  $p < 0.001$ , RMSEA = 0.096, CFI = 0.733, TLI = 0.691, SRMR<sub>within</sub> = 0.118, SRMR<sub>between</sub> = 0.136, (2)  $\chi^2(606) = 2987.93$ ,  $p < 0.001$ , RMSEA = 0.059, CFI = 0.899, TLI = 0.883, SRMR<sub>within</sub> = 0.060, SRMR<sub>between</sub> = 0.134, performed worse than our initial model, (1) Satorra-Bentler  $\Delta\chi^2 = 5701.70$ ,  $\Delta df = 30$ ,  $p < 0.001$ , (2) Satorra-Bentler  $\Delta\chi^2 = 1775.20$ ,  $\Delta df = 30$ ,  $p < 0.001$ . Overall, we conclude that all constructs represent distinct factors.

## 2.5 | Analytical strategy

Because of our nested data structure (i.e., days nested within persons), we made use of multilevel modelling (Hox et al., 2017) in Mplus 8.7 (Muthén & Muthén, 2017), using imputation for missing data as described below. Specifically, data on health-behavior goal progress during the morning (assessed in the noon survey) were missing on 162 out of the 1399 days (11.6% missingness), while data on health-behavior goal progress during the afternoon, pride, and shame (assessed in the afternoon survey) were missing on 148 out of the 1399 days (10.6% missingness). For goal importance as well as for our control variables pride and shame in the morning (assessed in the morning survey), there were no missing data because the morning survey was set as necessary as it included the goal setting instruction (cf. study design). Based on recommendations regarding the handling of missing data completely at random or at random<sup>1</sup> (Newman, 2014), we used multiple imputation in case of missing data at the day level (i.e., only on days on which at least the morning survey was available). Specifically, we imputed 50 data sets with our research model serving as imputation model (Lüdtke et al., 2017).<sup>2</sup>

For the main analyses, we specified two two-level path models (Preacher et al., 2010) with all paths at the within- and between-person level and with fixed within-person slopes<sup>3</sup> reflecting our conceptual model. As our hypotheses were at the within-person level, we focus on within-person findings when reporting the results. Affective states (i.e., context-free pride and shame as well as pride and shame regarding health-behavior goal progress) were allowed to correlate. The first model included the main effects only (cf. Hypotheses 1–3). In the second model, we additionally included the within-person interaction effects to address the research question. We calculated the within-person interaction terms by multiplying the person-mean centered variables (i.e., health-behavior goal progress  $\times$  work-task progress).

For examining indirect effects (cf. Hypotheses 3), we used the Monte Carlo Method by computing 95% confidence intervals with 20,000 iterations (Selig & Preacher, 2008). To test the within-person moderation effects, we computed simple slope tests based on high and low ( $\pm 1SD$ ) values of our moderator (cf. Preacher et al., 2016).

### 3 | RESULTS

#### 3.1 | Preliminary analyses

The descriptive statistics, intraclass correlations (ICC), and correlations of our variables are depicted in Table 1.

#### 3.2 | Test of hypotheses and examination of research question

Table 2 and Table 3 show the direct and indirect effects at the within-person level. We controlled for pride and shame in the morning when predicting all study variables.<sup>4</sup>

In line with Hypothesis 1, goal importance positively predicted health-behavior goal progress, estimate = 0.246,  $SE = 0.085$ ,  $p = 0.004$ . Supporting Hypothesis 2, health-behavior goal progress in turn (a) positively predicted pride, estimate = 0.159,  $SE = 0.015$ ,  $p < 0.001$ , and (b) negatively predicted shame, estimate =  $-0.066$ ,  $SE = 0.010$ ,  $p < 0.001$ . In Hypothesis 3, we proposed goal importance to indirectly predict affective states regarding health-behavior goal progress via health-behavior goal progress. Indeed, we found indirect relations between (a) goal importance and pride via health-behavior goal progress, estimate = 0.039,  $SE = 0.014$ , 95% CI  $[-0.0131, 0.0682]$ , as well as between (b) goal importance and shame via health-behavior goal progress, estimate =  $-0.016$ ,  $SE = 0.006$ , 95% CI  $[-0.030, -0.0050]$ .

When examining our Research Question on the strengthening (i.e., compensatory) versus attenuating (i.e., spillover) role of low work-task progress, we observed a moderating effect on the relation between health-behavior goal progress and shame (Research Question b), estimate = 0.022,  $SE = 0.010$ ,  $p = 0.033$ , but not on the relation between health-behavior goal progress and pride (Research Question a), estimate = 0.001,  $SE = 0.015$ ,  $p = 0.968$ . The significant moderation effect for shame is displayed in Figure 3. Simple slope analysis revealed that the interaction pattern supports the assumption of a strengthening effect of low work-task progress. Specifically, the negative relation between health-behavior goal progress and shame was stronger on days with low work-task progress ( $-1SD$ , simple slope =  $-0.087$ ,  $SE = 0.014$ ,  $p < 0.001$ ), although the relation was negative on days with high work-task progress as well ( $+1SD$ , simple slope =  $-0.043$ ,  $SE = 0.014$ ,  $p = 0.002$ ).

#### 3.3 | Additional analysis

Based on the interaction effect for shame as outcome, we analyzed conditional indirect effects. Health-behavior goal progress explained

TABLE 1 Descriptive statistics, intraclass correlations, and correlations of all variables.

Variable	M	SD	ICC	1	2	3	4	5	6	7
1 Pride (context-free) <sup>a</sup>	3.35	0.96	0.66		−0.18***	0.09**	0.01	0.07*	0.14***	−0.03
2 Shame (context-free) <sup>a</sup>	1.17	0.44	0.52	−0.47***		−0.01	−0.07*	−0.04	−0.08*	0.09**
3 Goal importance <sup>a</sup>	3.26	1.00	0.52	0.09	0.01		0.11***	0.06*	0.13***	−0.01
4 Health-behavior goal progress <sup>b</sup>	5.00	1.85	0.20	0.42***	−0.16	0.16 <sup>†</sup>		0.14***	0.41***	−0.27***
5 Work-task progress <sup>b</sup>	5.37	1.27	0.42	0.50***	−0.33***	0.21*	0.53***		0.13***	−0.10***
6 Pride (regarding health-behavior goal progress) <sup>a</sup>	3.35	1.02	0.58	0.92***	−0.41***	0.18*	0.47***	0.49***		−0.33***
7 Shame (regarding health-behavior goal progress) <sup>a</sup>	1.20	0.51	0.40	−0.38***	0.78***	0.07	−0.02	−0.22*	−0.37***	

Note: Correlations above the diagonal are day-level correlations ( $N_{\text{within}} = 1399$ ). Correlations below the diagonal are person-level correlations ( $N_{\text{between}} = 205$ ). ICC = Percentage of variance between persons (ICC = variance between persons/[variance between persons + variance within persons]). Pride and shame measured context-free served as control variables, while pride and shame regarding health-behavior goal progress served as outcome variables in our analyses.

<sup>a</sup>Response format = 1–5.

<sup>b</sup>Response format = 1–7.

<sup>†</sup> $p < 0.10$ ; \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ .

TABLE 2 Within-person direct effects.

	Point estimate	SE
Hypothesized main effects		
Goal importance → Health-behavior goal progress (H1)	0.246**	0.085
Health-behavior goal progress → Pride (regarding health-behavior goal progress) (H2a)	0.159***	0.015
Health-behavior goal progress → Shame (regarding health-behavior goal progress) (H2b)	-0.066***	0.010
Interaction effects (research question)		
Health-behavior goal progress x Work-task progress → Pride (regarding health-behavior goal progress)	0.001	0.015
Health-behavior goal progress x Work-task progress → Shame (regarding health-behavior goal progress)	0.022*	0.010
Effects of control variables and statistically included paths		
Pride (context-free) → Goal importance	0.096*	0.042
Pride (context-free) → Health-behavior goal progress	-0.036	0.092
Pride (context-free) → Work-task progress	0.103*	0.046
Pride (context-free) → Pride (regarding health-behavior goal progress)	0.150**	0.042
Shame (context-free) → Goal importance	0.027	0.068
Shame (context-free) → Health-behavior goal progress	-0.327	0.200
Shame (context-free) → Work-task progress	-0.243**	0.092
Shame (context-free) → Shame (context-free)	0.078	0.054
Goal importance → Pride (regarding health-behavior goal progress)	0.064*	0.027
Goal importance → Shame (regarding health-behavior goal progress)	0.015	0.019
Work-task progress → Pride (regarding health-behavior goal progress)	0.042*	0.019
Work-task progress → Shame (regarding health-behavior goal progress)	-0.028*	0.013

Note: SE = standard error. Unstandardized estimates were obtained from two-level path analysis in Mplus 8.7 (Muthén & Muthén, 2017). The paths from pride (context-free) and shame (context-free) were included as control variables in our model. \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ .

the negative relation between goal importance and shame regarding health-behavior goal progress on days with low work-task progress ( $-1SD$ , estimate of the indirect effect =  $-0.021$ ,  $SE = 0.008$ , 95% CI  $[-0.0393, -0.0066]$ ) as well as on days with high work-task progress ( $+1SD$ , estimate of the indirect effect =  $-0.011$ ,  $SE = 0.005$ , 95% CI  $[-0.0191, -0.0036]$ ). The difference between the two conditional indirect effects for days with low and high work-task progress was marginally significant only, estimate of the simple slope difference =  $-0.011$ ,  $SE = 0.006$ ,  $p = 0.081$ , but tended to be in line with the findings of the interaction pattern of Research Question b. Again, this finding supports the assumption of a strengthening effect of low work-task progress.

## 4 | DISCUSSION

Our daily diary study took a closer look at health-behavior goal striving in daily work life. We found that goal importance is related to health-behavior goal progress across workday episodes, which is beneficial for affective states (higher pride and lower

shame) when reflecting on the progress at the end of the workday. Moreover, the negative relation between health-behavior goal progress and shame was stronger on days with low work-task progress.

### 4.1 | Theoretical implications

Our study showed that day-specific goal importance matters for successful health-behavior goal striving. This finding is in line with self-concordance theory (Sheldon & Elliot, 1999), implying that employees may increase goal-directed behaviors when they attach personal relevance to their health-behavior goal. Importantly, we found that personal importance fluctuates on a daily basis and is critical for health-behavior goal progress on that specific day. While the day-level conceptualization of goal importance is in line with previous research (e.g., Harris et al., 2003), our study enriches the literature by translating this idea to health-behavior goal striving in daily work life and considering goal importance as a predictor of making health-behavior goal progress.

TABLE 3 Within-person (conditional) indirect effects.

	Point estimate	SE	95% Confidence interval
Indirect effects			
Goal importance → Health-behavior goal progress → Pride (regarding health-behavior goal progress) (H3a)	0.039	0.014	[0.0131, 0.0682]
Goal importance → Health-behavior goal progress → Shame (regarding health-behavior goal progress) (H3b)	-0.016	0.006	[-0.0300, -0.0050]
Conditional indirect effects (additional analysis)			
Goal importance → Health-behavior goal progress → Shame (regarding health-behavior goal progress) for low Work-task progress (-1SD)	-0.021	0.008	[-0.0393, -0.0066]
Goal importance → Health-behavior goal progress → Shame (regarding health-behavior goal progress) for high Work-task progress (+1SD)	-0.011	0.005	[-0.0191, -0.0036]

Note: Unstandardized estimates were obtained from two-level path analysis Mplus 8.7 (Muthén & Muthén, 2017). Confidence intervals were computed using the Monte Carlo Method with 20,000 iterations (Selig & Preacher, 2008).

Moreover, our findings emphasize that researchers should not only consider an actual increase of health behavior when implementing interventions but also affective states that follow health-behavior goal progress. While it is important to note that our assessments of pride and shame directly referred to reflecting health-behavior goal progress, our findings still imply that high health-behavior goal progress results in positive feelings at the end of the workday (i.e., high pride, low shame). Because affective states are important in daily work life (Seo et al., 2004), researchers should look beyond specific intervention effects (e.g., making goal progress) and consider affective outcomes arising from these interventions. In this regard, it might be important to account for actual goal attainment beyond goal progress. While we focused on goal progress during the time at work (i.e., workday episodes), the result pattern might differ when considering goal attainment or goal failure occurring later during the evening. Indeed, pride and shame may be particularly driven by ultimate goal attainment. We encourage future research to shed light on the role of goal attainment versus failure.

Finally, with respect to our research question, our analysis revealed that work-task progress moderates the relation between health-behavior goal progress and affective states. Specifically, low work-task progress strengthened the negative relation between health-behavior goal progress and shame, implying compensatory effects. This finding contributes to multiple-goals research (e.g., Hirsch et al., 2019; Vancouver et al., 2010) by showing that health-behavior goal striving should not be seen in isolation when employees are at work. Instead, making work-task progress is a relevant purpose during the workday and lack of work-task progress seems to be an additional driver of shame experiences. Specifically, this pattern suggests that a lack of health-behavior goal progress was especially detrimental with respect to shame when work-task progress was also low on that day. It might be that employees focus on their health-behavior goal progress on these days, because experiencing low work-task progress threatens the self-image because work-task progress is highly relevant at work. Thus, this focus on health-behavior goal progress might serve a compensatory function

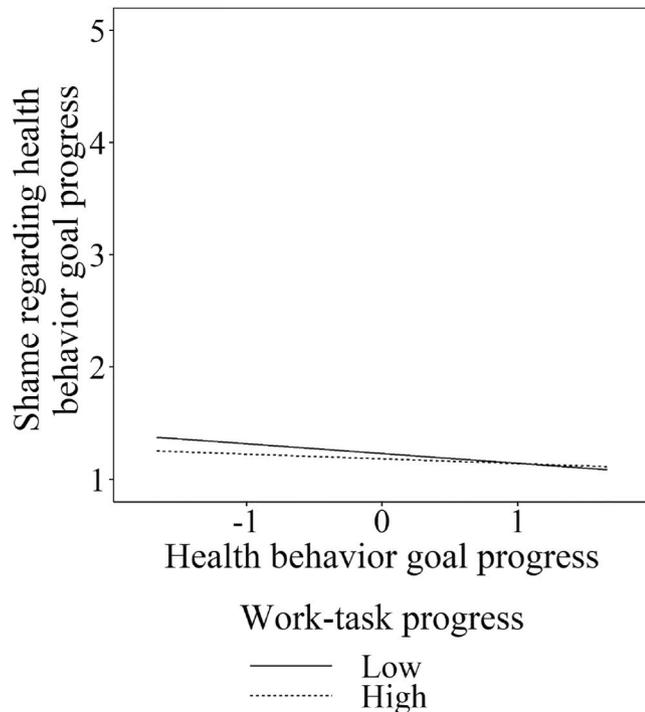
for low work-task progress. When compensation fails, however, shame following low health-behavior goal progress is especially strong on days with low work-task progress. Overall, our interaction finding underlines the need to consider simultaneous goal striving in health and work domains to understand how making progress predicts affective states.

Interestingly, while work-task progress moderated the relation between health-behavior goal progress and shame as a negative affective state, work-task progress did not moderate the relation with pride as a positive affective state. That is, the relation between health-behavior goal progress and pride remained unchanged—irrespective of low work-task progress. Similar to previous research (e.g., Patrick et al., 2009), our study thus emphasizes the distinct properties of the two emotions. Pride resulting from high health-behavior goal progress might be a more persistent emotion because positive states are naturally present as long as negative circumstances are absent (Grinde, 2016). In addition, pride may focus the attention more on the self along with the tendency to maintain ones' positive self-image (cf. Korman, 1970). Thus, pride might be less likely affected by adverse stimuli such as low work-task progress. More broadly, our differential pattern accentuates the relevance of considering both positive and negative emotions.

Integrating our results into the broader context of worksite health-behavior interventions, our findings emphasize that task-accomplishment processes interfere with consequences of such interventions. Hence, research on the interface of health behavior and work life should consider this challenge—regarding both predictors facilitating health-behavior goal progress as well as outcomes following health-behavior goal progress.

## 4.2 | Limitations and future directions

Our study comes with some limitations, thereby raising avenues for future research. First, our data only include self-report measures which implies the risk of common-method bias (Podsakoff et al., 2003). Using



**FIGURE 3** Plot of the within-person moderation effect of work-task progress on the relation between health-behavior goal progress and shame regarding health-behavior goal progress.

self-report measures may confound variance in the variables of interest with variance occurring from measurement properties. To reduce this potential issue, we assessed our variables on different measurement occasions (i.e., goal importance in the morning, affective states in the afternoon, health-behavior goal progress and work-task progress averaged from noon and afternoon measurements). Moreover, it is unlikely that the interaction effect only results from such methodological biases (Siemsen et al., 2010). Thus, our results should not be too heavily influenced by the self-report measures. We would like to encourage future research to employ other measures like objective ratings for health-behavior goal progress (e.g., activity trackers; Calderwood et al., 2021; photographic eating diaries; Wahl et al., 2017) or supervisor ratings for work-task progress.

Second, we included work-task progress by implicitly assuming that employees have certain daily work-task goals. However, we did not instruct them to set daily work-task goals, so that there may be large differences in how clear and present daily work-task goals were to employees. We chose this approach mainly to reduce participant burden (i.e., reducing questionnaire length) and because we wanted to avoid confounding of two interventions (i.e., simultaneously increasing health-behavior goal progress and work-task progress). In addition, goals at work come along with employees' job descriptions while not every employee has health-behavior goals. Nevertheless, future research may want to consider whether employees have daily work goals (i.e., by explicitly asking if they have a specific work goal they pursue in on that very day). This approach may also help reduce the risk of later mental realignment of work goals according to the progress made.

Third, we must acknowledge that our findings might not be fully generalizable. Our data stems from a predominantly female sample collected during the COVID-19 pandemic in Germany, including lockdown phases. For example, intentions to engage in physical activity may differ between countries (Shukri et al., 2015) and change during lockdown periods (Kua et al., 2022). Still, the sample met the most central criterion, namely employees in sedentary occupations. Furthermore, our analytical strategy (i.e., separation of variances) should prevent the within-person relations from being affected by stable between-person characteristics. Nevertheless, the characteristics of our data collection may limit conclusions on other samples, thereby calling for replications in other settings and during other time periods.

Beyond its limitations, our study provides starting points for future research. First, it might be interesting to look at longer-term and carry-over effects when investigating goal striving in work and health domains. For example, do beneficial affective states regarding health-behavior goal progress experienced at the end of the workday persist during after-work hours at home and thereby facilitate recovery processes? One could imagine that coming home from work with experiences of pride boosts energy during after-work hours. Uncovering such relations may advance our understanding of lagged effects that follow from health-behavior interventions at the workplace and emerge later at home.

Second, our findings may inspire research on interpersonal cross-over effects in health-behavior goal-striving. While we focused on individual health-behavior goal striving only, one could imagine that employees share their progress experiences with co-workers and support each other in maintaining health behavior. Indeed, research has accounted for the relevance of social support in health behavior (Uchino, 2004). It might be that employees who experience high health-behavior goal progress and accordingly high pride can motivate their colleagues by sharing these experiences. Uncovering such processes will help to shed light on the dynamics of health-behavior goal striving within workgroups.

### 4.3 | Practical implications

Many interventions have been developed in order to promote health behavior in daily work life (Abraham & Graham-Rowe, 2009; Maes et al., 2012). In this regard, goal-striving interventions may provide a good starting point but should be designed carefully to allow beneficial effects. Accordingly, practitioners can learn from our study in two main ways.

First, taking into account the theoretical rationale of self-concordance theory (Sheldon & Elliot, 1999) as well as our empirical findings, health-behavior goals should be personally important to employees on a daily basis. Practically, imposing goals only based on global recommendations (e.g., 30 minutes of physical activity per day; Waxman, 2004) might be insufficient, because employees may not care enough about such "goals" during a stressful workday because these goals might not be personally important. Indeed, lacking goal

importance—and low commitment as a consequence—might be a reason why employees largely do not keep up with such recommendations. Instead, employees should be encouraged to set personally meaningful health-behavior goals to increase health-behavior goal progress.

Second, when developing health-behavior interventions in daily work life, practitioners should take into account simultaneously occurring goal striving in work tasks. Specifically, practitioners should clearly instruct employees to set health-behavior goals in a way that they are realistic to be attained but not too ambitious to avoid adverse interferences with making progress in work tasks. If goals in both domains are very ambitious and hard to progress in, employees may neither experience health-behavior goal progress nor work-task progress—an especially detrimental combination with respect to shame. Educating employees on such consequences and supporting them to develop appropriate goals may benefit a successful integration of health behavior in daily work life.

## 5 | CONCLUSION

Our daily diary study provided insights on health-behavior goal striving in daily work life. Specifically, goal importance predicted health-behavior goal progress, which in turn predicted affective states. Importantly, the relation between health-behavior progress and shame was strengthened by low work-task progress, implying compensatory effects. Thus, we conclude that researchers and practitioners should consider multiple goal striving (i.e., health behavior goals and goals related to work tasks) to successfully implement health behavior in daily work life.

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## CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest in conducting or reporting the research and it is compliant with APA ethical standards. In addition, this research received ethics approval by the institutional review board.

## DATA AVAILABILITY STATEMENT

Data of this study are available from the first author upon reasonable request.

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## ENDNOTES

- <sup>1</sup> Because one might argue that employees do not want to report on health-behavior goal progress in case of little progress or other influences (i.e., low goal importance, unfavorable affective states), we tested whether our morning measures impacted on missingness in health-behavior goal progress. None of the variables (i.e., goal importance, pride, shame) significantly predicted missing values in health-behavior goal progress, supporting the assumption that missing data in health-behavior goal progress was unrelated to our study variables.
- <sup>2</sup> Although Newman (2014) suggests that multiple imputation and full information maximum likelihood can both be employed in cases of missing data at random or completely at random and should lead to essentially identical results, we empirically tested this assumption. Indeed, handling missing data with full information maximum likelihood estimation instead of multiple imputation did not change direction or significance of our results.
- <sup>3</sup> To ensure the accuracy of our fixed-slope model and avoid convergence issues when all slopes were random, we tested which slopes varied at the between-person level. Two slopes (goal importance → health-behavior goal progress and health-behavior goal progress → pride regarding health-behavior goal progress) showed significant variance at the between-person level. However, the result pattern of our path models remained unaffected when specifying these two slopes as random. Thus, for the purpose of parsimony, we kept our fixed-slope model.
- <sup>4</sup> The overall result pattern remained unchanged when not controlling for context-free affective states of pride and shame in the morning.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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