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Goals Do Not Buy Well-Being, but They Help: Qualitative Illustrations of Goals Prioritization and Stabilization When Facing Age-Related Challenges

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ABSTRACT

Although personal goals give meaning to life and contribute to well-being, achieving goals can become difficult in older adults faced with age-related challenges. A group of 49 older adults aged 65 to 92 years completed a semi-structured interview on personal goals, obstacles to goal achievement, and contributors to well-being. Using thematic analysis, we identified several types of goals contributing to well-being and general aspects of well-being. Results revealed that, although older people might say that they no longer have major goals in their lives, they end up mentioning many activities that theoretically are goals. Many of these activities are geared toward maintaining or increasing their general well-being. Of importance, they report few complaints regarding goal achievement, which they explained by (1) reducing the number and breadth of their goals, (2) adjusting and reevaluating these goals, and (3) overcoming difficulties and stabilizing current functioning, thereby maintaining a sense of continuity and satisfactory levels of well-being. This study illustrates the interactions between resources and stressors from the viewpoint of older adults. Taken together, the results advocate for the usefulness of the functional quality of life model and proactive approaches to successful aging, and they provide directions for individualized interventions in the elderly

Reaching goals that match one's inner motives and needs provides meaning to life and is of critical importance for well-being and life satisfaction (Emmons, 1996; Sheldon & Elliot, 1999). Indeed, setting and achieving goals takes a tremendous place in our daily lives, as goals shape most of our actions.

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Following Elliot and Fryer's definition (2008, p. 244), we consider that "a goal is a cognitive representation of a future object that the organism is committed to approach or avoid." This object can be an event, an experience, or a characteristic that is central to the goal. It includes both concrete, physical, and observable goals as well as abstract, psychological, or unobservable ones. Goals differ from "needs" and "motivations" in the sense that individuals consciously and intentionally pursue goals to approach or avoid a given end state.

Goal selection, pursuit, and achievement entail the complex coordination of various cognitive, affective, and motivational processes (Brown & Pluck, 2000). Critically, several of these cognitive processes decrease with age and can have a direct impact on the autonomy and ability of older adults to achieve personal relevant goals (Glisky, 2007). In addition, aging usually comes with a decline in physical, health-related, or social resources that also contribute to efficient goal pursuit. Although a decline in these resources may hinder goal achievement, older people generally function well in daily life. In line with this claim, Strawbridge et al. (2002) showed that, while health-related problems and resource limitations are often obstacles to goal achievement, they do not constitute an inflexible exclusion criterion for successful aging. Changes in emotion-regulation strategies as well as motivational and goal selection processes may explain the limited impact of age-related diminished resources on the daily lives of older adults.

Indeed, compared with younger adults, older adults allocate their efforts more selectively and more rarely engage in demanding activities that are not particularly self-relevant (Hess, 2014). They also favor goals inducing positive emotions because of reduced time perspective in late life (Carstensen et al., 2003). Hence, older adults preferentially pursue meaningful goals supporting affective regulation - particularly social goals - thereby maintaining a high level of subjective well-being and life satisfaction. The interplay between life satisfaction, well-being, and personal and environmental resources is central to the concept of successful aging (Freund et al., 2012).

According to the lifespan approach, key dimensions to successful aging are (1) active engagement in life, (2) maintenance of a mastery/growth mindset, and (3) implementation of positive adaptation strategies to effectively deal with increased losses and decreased gains in late-life stages (Baltes & Baltes, 1990; Baltes & Carstensen, 1996; Freund et al., 2012). Baltes and Baltes proposed three such goal management strategies: selection, optimization, and compensation (SOC theory). As resources lessen with age, selection processes help to reduce the number of goals worth pursuing and to foster investment of efforts into these goals. Within the remaining pursued goals, optimization processes aim at maximizing internal and external resources (goal-relevant means) to increase functioning efficiency in these goal domains. Finally, compensation processes aim at minimizing or counteracting the impact of difficulties that limit functional outcomes. In older adults, the use of these three metaprocesses relates to increased subjective and psychological well-being and quality of life, especially in individuals with limited resources (Carpentieri et al., 2017; Jopp & Smith, 2006).

Most models of successful aging encompass a normative judgment about what "success" means in aging (Freund et al., 2012; Rowe & Kahn, 1997). Yet, it is unclear whether any criteria or functional outcomes should be used to assess success in older adults' daily lives and, if so, which ones. In a

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literature review on well-being in older adults, Stanley and Cheek (2003) concluded that, despite the amount of theoretical models and empirical research conducted on successful aging, studies on the perception of older adults of their own well-being were still missing at the time. These authors strongly recommended the use of qualitative studies to gain insight into lay perceptions of well-being and successful aging in older adults and to understand what it means to age well from the elderly's perspective. These recommendations will "[...] allow determination of predictors truly relevant to persons who are aging" (Phelan & Larson, 2002, p. 1308). Accordingly, von Faber et al. (2001) showed that older participants view successful aging as an adaptation process to existing challenges. Indeed, despite physical and/or cognitive impairments, older adults can perceive themselves as successful agers as long as they experience a high level of social functioning and subjective well-being. Similarly, a focus-group study revealed that (1) adopting a positive attitude toward life, (2) having good environmental, material, and social conditions that provide a sense of security and stability, and (3) staying engaged in life and maintaining stimulating activities are just as important as health for the well-being of older adults (Reichstadt et al.,2007). Follow-up semi-structured interviews further indicated that successful aging comes from a subtle balance of self-acceptance/contentment and engagement with life/self-growth (Reichstadt et al., 2010). This latter result echoes psychological approaches to well-being and lifespan approaches to successful aging (Baltes & Carstensen, 1996; Ryff & Singer, 2008).

If one possible definition of successful aging is the ability to maintain and pursue new goals and to experience a high quality of life and positive affect, we must gain an in-depth understanding of how older adults maintain goals despite reduction in resources and how this relates to well-being. In that regard, Knight and Ricciardelli (2003) conducted interviews to explore community-dwelling older adults'perception of successful aging and adaptation to age-related losses. When asked about their goals, more than half of the participants reported no longer having goals. However, if goals provide meaning in life and goal achievement contributes to well-being and successful aging, this last result appears contradictory for participants who consider themselves successful agers. This apparent disagreement calls for further studies to explore how participants maintain and adapt personally relevant goals.

Accordingly, this study aimed to conduct in-depth semi-structured interviews with older adults and to apply a qualitative methodology to explore how participants manage their goals to maintain well-being. More specifically, the present study seeks to assess (1) community-dwelling older adults' perceived self-relevant goals, (2) how these various goals contribute to perceived well-being, and (3) older adults' goal management strategies. Following Elliot and Fryer's (2008) broad definition, we consider both general long-term and abstract as well as specific short-term and concrete goals. Hence, a qualitative approach is particularly suitable to account for the vast heterogeneity in goals present in older adults and for the idiosyncratic nature of goal pursuit. We interpret the results in light of predominant models of well-being, successful aging, and quality of life.

Materials and Methods

PARTICIPANTS AND DATA COLLECTION

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We conducted semi-structured interviews with 49 French-speaking, cognitively healthy retired adults recruited via advertisement within elderly clubs and by word of mouth in the local community. Inclusion criteria were age 65+ years and living independently at home in the Greater Geneva Area (Switzerland and nearby France). Exclusion criteria were a diagnosis of dementia, neurological antecedents, severe motor or sensory disability, and known psychiatric disorders. The Ethical Committee of the Faculty of Psychology and Educational Sciences of the University of Geneva approved the protocol. All participants gave their informed consent to participate and earned 50 Swiss Francs for their participation.

The sample (see Table 1) comprised individuals between 65 and 92 years of age, presenting a wide range of highest education degrees (from minimum compulsory school to Ph.D.). Despite self-rating their health as good or rather good - only seven participants (14.29%) rated their health as "average" or below - 30 (61%) participants had at least one chronic health condition (heart disease, mobility and joints issues, chronic pain, cancers, etc.). Twenty-one participants (43% of the total sample and 70% of those reporting at least one chronic health condition) reported a small impact of these health-related difficulties on their daily functioning, while 8 (16% of the total sample, 26% of those with chronic health issues) reported a substantial impact of these difficulties.

SEMI-STRUCTURED INTERVIEW

We followed Galletta's guidelines (2013) in constructing the semi-structured interview around three main segments: (1) activities and personal goals, (2) personal and environmental aids, barriers to goals achievement, and (3) well-being and its relations with goal-achievement. For each segment, we provided visual material support to elicit concrete content generation. The first author (EJB) conducted all interviews (in French) at the participants' homes, following a structured list of questions, and then included personalized follow-up probes to elicit meaningful responses. She invited participants to a relaxed yet structured discussion concerning their goals, encouraging them to give as much context and details as they needed to illustrate their narratives. The interview structure and associated visual material support can be found in Appendix A of the Supplementary Material by Joly-Burra, Van der Linden, and Ghisletta (2020). The interviews lasted between 45 minutes and 2 hours and were fully audio-taped. EJB and EG manually transcribed each interview, double-checking to ensure transcript accuracy. The final corpus comprised 600 A4 pages of single-spaced text (type size 12).

DATA ANALYSIS

EJB and EG conducted an in-depth qualitative analysis of participants' personally relevant goals and their relations to well-being, as well as their goal-management strategies (see Figure 1). They adopted a thematic analysis approach using a mixture of deductive and inductive coding strategies in line with the pragmatic perspective (see Fereday & Muir-Cochrane, 2006).

Table 1. Sample characteristics

Variable	N (%) or M (SD)
Sex	

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Female	31 (63.27%)
Male	18 (36.73%)
Living situation	
With spouse/partner	32 (65.31%)
Alone	17 (34.69%)
Age	73.90 (5.95)
Years of education	13.73 (3.37)
Global self-rated health	4.06 (0.80)
Very poor	1 (2.04%)
Poor	1 (2.04%)
Average	5 (10.20%)
Good	29 (59.18%)
Very good	13 (26.53%)

DEFINITION OF THE INITIAL CODING SCHEME

Based on research questions and theoretical frameworks, EJB and EG conjointly developed an initial a priori deductive coding scheme (e.g., being autonomous, positive relationships with others, health status). They then read the corpus multiple times and, when necessary, included additional inductive codes (e.g., simple pleasures in life).

EXTRACTION OF IDEA UNITS

Instead of adopting a line-by-line coding strategy, EJB and EG applied the coding scheme to idea units extracted from the interviews' transcripts (Miche et al., 2014). Based on transcripts and using the QSR NVivo 11 for Windows International software, they extracted an idea unit each time they identified a segment of text referring to a goal or an aspect of well-being. Following Elliot and Fryer's (2008) definition, the coders considered as goals the purpose of activities participants deemed important and reported investing (or planning to invest) time and energy into. In turn, the coders considered well-being to be instances of text where participants mentioned aspects of their daily lives that elicited both long-lasting positive and negative affects. Examples of idea units for goals and well-being (both positive and negative affects) are "Going to the gym to maintain strength," "Being proud when some of his writings or comments are published in local newspapers," and "Having difficulties with self-acceptance because of age-related disabilities." To ensure intercoder reliability, EJB and EG compared the idea units they separately extracted from 10 interviews. Intercoder agreement was high (74%); any disagreements were discussed until full consensus was reached. The remaining 39 interviews were

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randomly assigned to either EJB or EG. In total, the coders extracted 1,285 idea units across the 49 interviews (555 for goals, 730 for well-being; average of 26.22 idea units per participant).

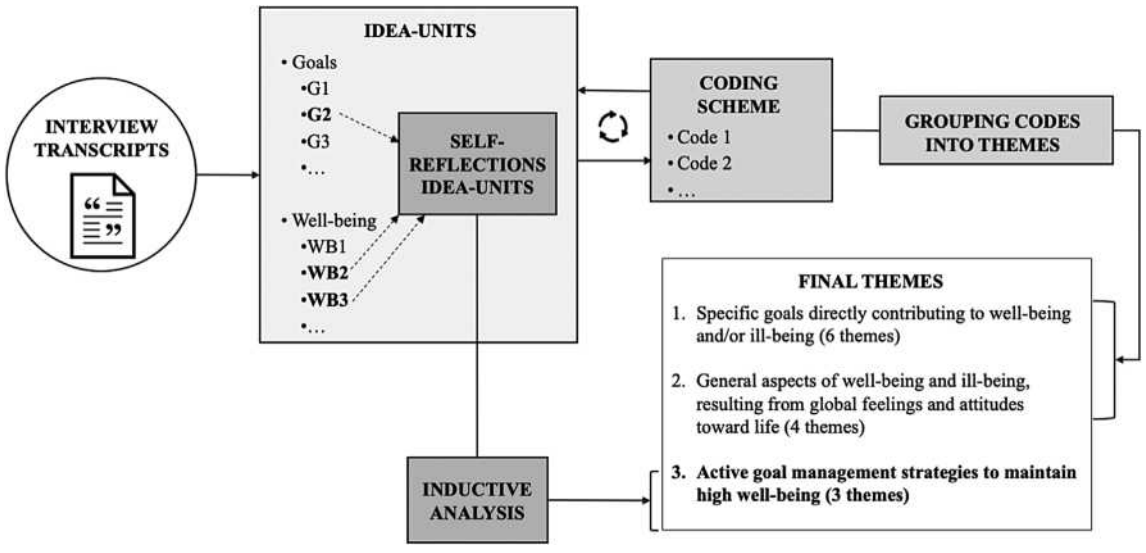

Figure 1. *Data analysis strategy. This figure synthetizes the various steps taken to analyze the data from interview transcript to selection of final themes. The three circular arrows indicate an iterative process.*

CODING OF IDEA UNITS

The coders applied the initial coding scheme to idea units. Codes were not mutually exclusive. EJB and EG revised the coding scheme regularly, by dropping irrelevant existing codes and by inductively adding new codes. They had regular coding meetings (generally once a week over 14 months) to compare codes and discuss discrepancies, until reaching full consensus.

The final coding scheme contained 21 codes, which the coders clustered into 10 themes after examining meaning overlap and co-occurrence frequencies between codes. Six of the 10 themes described specific goals directly contributed to well-being (e.g., caring for one's health and maintaining autonomy), whereas the remaining four described general aspects of well-being, resulting

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from global feelings and attitudes toward life (i.e., not directly related to a specific goal, e.g., satisfaction with one's life and self-acceptance).

THE EMERGENCE OF SELF-REFLECTIONS IDEA UNITS AND SUBSEQUENT BROAD THEMES

Most central to this paper, it emerged from the coding process that some idea units not only reflected goals or well-being, but also more generally addressed participants'goal-management strategies (e.g., prioritization of goals in life or consideration about one's metacognitive functioning). We labeled these idea units "self-reflections" (e.g., "Self-acceptance is a process that includes having to accept that we won't achieve all of our life-goals [e.g., volunteering abroad, playing curling]. Such a process of resignation and humility keeps depression at bay"). 388 of the 1.285 idea units (30.19%) were self-reflections. We then separately analyzed these idea units with a purely inductive approach (i.e., independent from the coding scheme) to investigate how participants actively engage in specific goals contributing to well-being. It resulted from the inductive analysis that self-reflections could be clustered into three broad themes: reducing the number of goals, adjusting and reevaluating goals, and overcoming difficulties and stabilizing current functioning to provide a sense of continuity.

Finally, we categorized all idea units according to whether they were oriented toward growth, maintenance, or loss management. When applicable, we categorized self-reflections idea units as selection, optimization, or compensation strategies (Baltes & Baltes, 1990).

Results

SPECIFIC GOALS THAT DIRECTLY CONTRIBUTE TO WELL-BEING

Six major types of goals contributing to well-being emerged from the coding process (see Table 2 for illustrating excerpts of participants' narratives corresponding to each theme). The most frequent goal reported was (1) maintaining meaningful social and familial relationships, which were a major source of positive as well as negative affect (in case of interpersonal conflicts or problems in their relatives' lives).

Table 2*. Themes, frequencies of occurrence, and examples of corresponding excerpts of participants' narratives*

	Theme present in N participants	Related to well-being (positive affect) in N participants	Related to well-being (negative affect) N participants	Excerpts of participants' narratives
Specific goals that directly contribute to well-being				
Social and familial relationships	47	45	29	"Having good relationships with our loved ones [talking about her children and grandchildren], that's really important, it's said to be the most important, almost the

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				goal!"
Caring for one's health and maintaining autonomy	46	34	23	"What really lowered my well-being in the long run was my vertebral fracture [...]. It enormously lowered my physical and mental - well, psychological - well-being. I suffered from not doing what I thought would be normal to do. We could say that I had my goals in mind, but that I was unable to attain them."
Leisure and cultural activities	37	31	4	"For me, the pleasure is all the rehearsal sessions during theyear! It's meeting up with friends and then singing together."
Volunteering and community life	34	17	5	"I feel that it's very, very important to share. [...] I was thinking that when you get to the last years of your life, you can ask yourself 'what I got, how can I give it back?'."
Personal growth and skills acquisition	31	28	2	[he wanted to see whether he was] "still capable of learning, so I had set myself the goal to pass my truck driving license. [...] and then, because my theory test was expired a long time ago, I had to redo it all over again, I had to redo the theoretical test.So, it was a challenge!"
Anticipating and planning for one's own or significant others' end-of-life	17	4	5	"My living will, I did it, I talked about it with my children. I even also prepared the envelopes that I would like to leave behind to people that are dear to me and that I have a relationship with. [..] And I really feel relieved that I did it."
General aspects of well-being				
Satisfaction with one's life and self-acceptance		42	17	"In self-acceptance, there is a negative side, that would be resignation, and then, there is a positive side, when you really have accepted. [3 seconds of silence]. But I think I'm halfway there. I mean, there are surely things that I... where I have accepted myself, and then others not. [...] Maybe aging well, without being depressed, without complaining about old age, maybe that's exactly being able to accept oneself, not too negatively."

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Feeling confident in one's abilities and useful/helpful to others		31	19	"When one of my grandchildren says to me 'Can you do this for me?' I'm glad to do, and at the same time it values me. I tell myself 'I'm still useful for something.' So, it's true, when we feel capable, we feel valued. To tell yourself 'You still have all those skills, I better not lose them'." "I'm sad because, in the end [pauses for 5 seconds], what am I still doing here? [...] I very often, in my current situation, have the feeling that I'm useless."
Enjoying simple pleasures of life and living day-to-day		31	0	"It is the small pleasures that make life, not the big things." "Now, it's on a day-to-day basis. [...] At our age, knowing that time goes by and there can be health problems and so on, personally, I'm happy with the day that just went by [...]I'm pleased with succeeding in what I've undertaken during that period of time."
Attitudes concerning end of life		9	15	"The folks I got to know around me [...] they are in retirement homes or at the graveyard. It's unfortunate, when you get to this age, you're almost alone!" "Dying that's part of life, but losing your dignity [...] So sadness for me is this. It's when the thought comes, when you ask yourself 'What's going to happen to you?'"

Then came goals related to (2) caring for one's health and maintaining autonomy, encompassing both proactive or reactive health-related behaviors (e.g., getting medical care, exercising to maintain one's shape and energy, or watching what one eats). While caring for one's health does not contribute to well-being per se, these behaviors are instrumental to the wider long-term goal of remaining autonomous and independent as long as possible. Participants also had goals related to (3) leisure and cultural activities (e.g., playing cards, reading, doing arts and crafts, playing an instrument, or singing). A large proportion of participants also (4) volunteered and/or engaged in community life to help others (e.g., serving in nonprofit associations, local libraries, senior clubs, political parties, or parish councils). Volunteering brought rich interpersonal relationships, a deep sense of belonging in the local community, and provided participants with activities in line with their personal values. Some participants continued learning new things and challenging themselves as they mentioned many goals related to (5) personal growth and skills acquisition (e.g., learning a new language, crafts skills, or an instrument, getting a driver's license for trucks). Curiosity and pleasure to learn new things motivated

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the pursuit and achievement of these goals, which led to a sense of intellectual and personal achievement. Finally, one last type of personally relevant goal in our sample was (6) anticipating and planning for one's or significant others' end-of-life (e.g., organizing their funerals, formulating a living will - including for medically assisted suicide - or sorting out their personal belongings). Several participants expressed engaging in these goals to facilitate matters for their children when they die. Participants who also have an ill or very old close relative often mentioned preparing themselves, both emotionally and administratively, for their passing.

Participants presented a wide range of goals contributing quite directly to well-being (positive affect). Negative affect most frequently arose from interpersonal conflicts and health-related obstacles to goal achievement and independent living. Nevertheless, some aspects of well-being are not directly tied to a specific kind of goal or activity, but rather stem from the global functioning of the individual or from his/her attitudes toward life and aging.

GENERAL ASPECTS OF WELL-BEING

Most participants agreed that (7) being satisfied with their life and/or accepting who they are is a key aspect of well-being. Yet, some participants emphasized the ambiguous nature of self-acceptance as they reported being satisfied with some aspects of their life but not with others, some-times simultaneously causing positive and negative affects. Participants also stressed the importance of (8) feeling confident in their abilities and being useful/helpful to others, which elicited positive affects such as joy, relief, or pride. Conversely, a lack of confidence in their abilities or a feeling of uselessness was a major source of negative affect. Further, participants explained they do not necessarily need to achieve big life goals to be happy, but that (9) enjoying the simple pleasures of life and living day-to-day were increasingly important to their well-being as they aged (e.g., being outdoors in nature, enjoying a beautiful sunset, or having a great meal). Finally, participants had various (10) attitudes concerning end of life, strongly influencing their general positive and negative affects. Several participants, especially amongst the oldest, highlighted feeling a sense of social withdrawal or social network shrinkage. Many participants were concerned not only with dying itself, but also with how they were going to age and spend the last years of their life, fearing cognitive and physical decline, synonymous with losing one's autonomy and dignity.

GOAL MANAGEMENT STRATEGIES TO MAINTAIN WELL-BEING

Almost all participants considered being able to reach goals as contributing to well-being, whereas failure to do so does not necessarily hinder well-being. However, encountering obstacles to achieving goals or having to surrender personally relevant goals - especially for health reasons – often caused negative affect. Given this contradiction, we analyzed self-reflective idea units to understand how participants manage their goals to maintain high levels of well-being (high positive affect and low negative affect).

More than half of self-reflective idea units (51.91%, controlling for the number of idea units per participant) contained a description of selection strategies, while 17.22% were about optimization, and 15.82% about compensation (see Joly-Burra et al., 2020, for further analysis of predictors of use of

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selection, optimization and compensation in this sample).

REDUCING THE NUMBER OF GOALS

Almost half of the participants reported not "having goals anymore": "I don't have any goals, I don't want to build a castle anymore, or to launch a start-up, as they say." They spontaneously mentioned reducing the number of their goals to focus their efforts on health and on maintaining positive relationships: "I think that, at this point in life, my goals are for my children and grandchildren. For me, it's rather about being alive. It's mostly about staying healthy and keeping in touch with friends as much as possible. And being autonomous - I don't want to depend on anybody." Interestingly, whereas only participants with chronic health-related issues presented an extreme reduction of goals, those in better health also expressed reduced motivation for new goals.

ADJUSTING AND REEVALUATING GOALS

Participants not only spontaneously expressed reducing the scope of their goals, but also actively adjusting and reevaluating them. First, participants quite frequently mentioned that, with increasing age, they feel freer to pursue hedonic goals for sheer pleasure: "That's what age lets us have – the choice to direct your life as you please!"

Second, participants expressed assessing the costs and benefits to decide whether to continue pursuing a current goal or to engage in a new one. If a goal is too taxing on resources to attain, elicits no positive affect, and there is no obligation to pursue it, they just give it up: "Together with a friend, we tried tennis lessons and we soon realized that it's not that easy to learn to play tennis at our age. [...] Oh boy, we quickly dropped that idea. There were too many complications for a mediocre result." They instead prefer allocating their resources to more personally relevant and meaningful activities.

Third, a major aspect of goal adjustment (44 participants) is learning how to adapt one's goals to one's capacities and resources, to prevent both abandoning the goal altogether and feeling the negative affects elicited by failure. Adapting goals encompasses both loss-based selection and compensation processes. For instance, one participant continued practicing winter sports, but had to adjust the intensity of the activity to her physical abilities by quitting backcountry skiing and practicing easier skiing or snowshoeing instead.

Finally, participants reported using affective regulation strategies such as putting difficulties in perspective with their age. They also focused their attention on what they can still do to reinforce the feeling of confidence in their abilities. In conclusion, these strategies of goal adjustment enable participants to select and continue pursuing meaningful goals in the long run, and to experience a sense of continuity despite the age-induced reduction in capacities and resources.

OVERCOMING DIFFICULTIES AND STABILIZING CURRENT FUNCTIONING TO PROVIDE A SENSE OF CONTINUITY

Ultimately, participants directed their efforts toward maintaining and stabilizing their current functioning in response to increasing losses with age: "A big goal in my life? ...Well, I'm going to tell

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you: to continue living as I do now." Accordingly, more than half of goals and well-being idea units were oriented toward maintaining already occurring activities (59.26% and 51.65%), one-quarter toward loss-management activities (24.57% and 18.68%), and fewer (15.83% and 9.71%) toward growth and self-development. In contrast, a vast majority of idea units related to loss management (63.26%, against only 3% for maintenance and none for growth).

Although participants emphasized staying in good physical health as a means to maintaining well-being and quality of life, there is no systematic relationship between health- related difficulties and low levels of well-being or high levels of ill-being across individuals. The central question thus appears to be how older adults maintain meaningful activities and goals when facing physical limitations.

A few participants with quite heavy objective health issues were still able to maintain meaningful goals and even engage in new ones. Indeed, objective health-related difficulties do not necessarily imply a reduction in goals and/or well-being. Instead, perception of one's resources as functional toward one's desired goals appears as more important. Below we contrast two participants (using fictional names) to illustrate this point: Jean, a 77-year-old male retired math teacher, living with his spouse, and Arlette, a 75-year-old-female retired schoolteacher, living with her husband. The two participants live in houses in the same geographical area; both have important heart problems (Jean also has osteoporosis), forcing them to give up cycling and hiking at an advanced level, which used to be their principal life-long hobby. The two participants do not know each other.

The two participants have quite similar objective health and environmental resources. However, they greatly differ in their perceived health status and subjective resources. Jean considers himself to still be in good physical shape, given his age: "So, I need to take some medicines, so I do it ... [but] me ... I'm not bothered by little health problems for now, because I'm still in a decent physical shape. And a decent mental condition, I didn't lose my head. So, as long as I'm in this situation, I have to live with it and that's it really... We have to ... we have to deal with it, that's what I personally think. [...] For now, hum, we don't have any money problems, we don't have too many health problems, and with my wife, we tell our- selves that we are blessed, so you know ... We're fine, as long as itlasts, as they say." Quite the opposite, Arlette has a less positive perception of her resources and sees her situation as a fatality: "I have more difficulties than before because I've had heart problems, health issues, since 2010. And since then, I'm pretty weak. [...] I always wanted to [go on hiking trips], we traveled or went on family outings, too. [...] I tell myself 'If I have ...I'm no longer able to do that ...'" [EJB asks: "So you feel like you're limited because of your health?"] "Yes, exactly. I think the desire is sort of gone ...No, it's not the desire - it's the fear of not being up to the job ... [5 seconds silence]." [EJB asks: "And this fear of not being up to it, does it lead you to give up some things?"] "Yes, the fear of feeling dizzy when organizing all that, that's it."

Jean reports having adapted his goals in response to his health issues - he quit cycling altogether and now hikes on easier trails - and underlines the importance of having multiple centers of interests (or goal domains), such that when he is no longer able to pursue a given goal, he still has other goals to which to turn. "Goals in life, I have had plenty, I tried to, to succeed, and now I've adapted. We need to know, during the course of our life, to adapt our goals to our means. That means that we need ...to have the attitude to say 'This, I can still do, so I'll do it; that I can't anymore, so you move on to

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something else,' and that's it, really. [...] That's the reason why it's good to have plenty of different things that you like: looking at flowers, reading, watching TV [...] when you have a lot of interests, if one disappears, you can still compensate with the others. [...] That's a harmonious whole. I like gardening, I like sports, I like cultural activities, I like reading and stuff. I mean, all the things I mentioned, it makes a whole that makes me feel good. If you were to take gardening away from me – one day I'll have to stop gardening anyway, I'm 77, I won't be gardening if I'll live five more years... The life expectancy is 78 [laughs]." In contrast, Arlette gave up cycling but also drastically reduced her hiking trips because she became worried she could have a fatal heart problem while hiking. Importantly, instead of turning to other goals, she disengaged from her other activities, such as volunteering, to focus her efforts entirely on taking care of her health and maintaining positive relationships with family and friends: "And in sports, too, I used to do a lot more before [10 seconds pause]. I also used to volunteer, and I was part of an association [name of her village] mutual aid. I stopped that. Having goals in life ... [speaks hesitantly], now I tell myself that my goals are especially for grandchildren, and children ... For me, except having a life ... Health, above all, is the priority and staying in contact with friends as much as possible. Being autonomous not to depend on anyone. [...]And otherwise, for the rest, I try to live like before."

Finally, they both differ greatly on their well-being level. Jean presents a high level of well-being and takes every available opportunity to enjoy life as much as possible: "You can't imagine the number of friends who tell me, 'But you must feel sad that you can't do that anymore,' and I tell them, 'Oh, not at all.' When I see the Tour de France cyclists fooling around, well, it reminds me of the turns ... And I tell Josie [his wife] 'Look, we went through there.' These are fond memories, and that's it. [...] I mean, with my wife, we take every little pleasure that we can find for ourselves because we figured that, for now, we are both here ... in full command of our capacities. Something could happen at any time, and so we have to live it up, you see. So, of course, we go on holidays, we take at least two 1-week holidays; we go walking with the walking group. And then we go on holidays as a couple, we took a cruise not so long ago. So, we try to seize all the opportunities we can find... [...] If we had a life like we did, I say that you have to say that we were lucky, we're fine." Arlette in turn rather expresses low levels of well-being and recurrent dissatisfaction with her current life situation. [EJB asks: "How long ago did you stop this, roughly?"]: "The long hikes, since 2010." [EJB asks: "So you stopped documenting your hikes and itineraries when you stopped doing these activities?"] "Yes, I had a little notebook, it was 'Mountains,' and here I have a drawer where I have all the books on mountains. When we used to go out with my husband, I was always the one choosing the site, preparing ... but now ...well, that's over. Here, that is a turning point that makes me a little bit [looks sad and pauses] ..." [EJB asks: "... that leaves a bitter taste?"]. "Yes ...yes. [...] I have a hard time accepting myself anyway. Accepting the little disabilities with regards to who/what we were before ... [embarrassed] That's all..."

These two participants thus differ drastically in their functional and well-being outcomes, even though they would appear to live a rather similar objective situation. It appears that key distinctions between them are their abilities to (a) identify (alternative) subjective resources that enable them to attain their goals, (b) perceive that they have control over their life (not seeing the situation as a fatality), and (c) accept giving-up unattainable goals, and, above all, (d) redirect efforts toward other meaningful goals.

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In the end, having a sense of control over one's life and trusting one's personal resources appears more important than health issues in determining whether goals need to be reduced to maintain well-being.

Discussion

A major result of this study is that, while older adults report not having broad long-term life goals anymore, they still largely hold onto immediate goals, such as maintaining meaningful social and familial relationships and autonomy, both of which contribute strongly to well-being (Knight & Ricciardelli, 2003; Rozario et al., 2011; von Faber et al., 2001). At the same time, unsatisfying relationships and hindered autonomy are major sources of negative affect. Other more specific and short-term goals contributing to well-being are engaging in leisure activities and volunteering, corroborating the idea that embracing an active lifestyle contributes to successful aging (Baltes & Carstensen, 1996; Hutchinson & Nimrod, 2012; Reichstadt et al., 2007).

Furthermore, in agreement with eudemonic approaches, staying autonomous, orienting goals toward personal growth, and learning are of paramount importance for well-being (Reichstadt et al., 2010; Ryff & Singer, 2008). Such goals strengthen confidence in one's abilities and help to find meaning in life (Doba et al., 2016). Our findings also tally with a recent phenomenological qualitative study by Russo-Netzer and Littman-Ovadia (2019) who investigated experiences, resources, and meaning in life in older adults from Israel. Similar to results in the present study, in their sample older adults feared losing control because of physical and mental limitations, which would limit their ability to enjoy life. In addition, connecting and belonging within the community enabled them to contribute to others and the world, which they saw as a strategy for coping with challenges in old age. They also stressed the role of being open to new experiences, savoring little joys of life, and adopting a positive attitude and moderation. Russo-Netzer and Littman-Ovadia's findings, therefore, clearly echo our themes of caring for one's health and maintaining autonomy, personal growth and skills acquisition, volunteering and community life, feeling confident in one's abilities and being useful/helpful to others, and enjoying simple pleasures of life and living day-to-day. Taken together, these results counter the view that aging largely entails disengaging from goals (Cumming & Henry, 1961). They further reinforce the claim that, despite increases in losses, there is still potential for gains in older age, even with fewer resources than before (Baltes & Carstensen, 1996).

Unsurprisingly, chronic health problems frequently precipitated goal disengagement. However, many participants with chronic health problems remain committed to their goals, thereby maintaining a high level of well-being. While objective health-related limitations undoubtedly make goal attainment more complex, slow, or even impossible, in our sample they do not necessarily hinder well-being (in agreement with Cosco et al., 2014; Hutchinson & Nimrod, 2012; Romo et al., 2013; Strawbridge et al., 2002; von Faber et al., 2001). We attribute this to the active selection and adaptation of goals, which minimize both the risks of failure and the likelihood of experiencing negative affect (Rozario et al., 2011). Indeed, older adults in our sample reduce the sheer quantity of their goals to concentrate their efforts on a few personally relevant goals and, second, to match these goals to their cognitive and physical resources (Carpentieri et al., 2017; Carstensen et al., 2003; Freund & Baltes, 1998, 2002; Hess,

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2014). We conclude that applying SOC strategies, adjusting goals, and identifying the functionality of one's resources concerning one's selected goals are essential to keeping goals, maintaining well-being, and considering oneself as aging successfully (Carpentieri et al., 2017).

Our qualitative results are therefore fully coherent with the functional quality of life (fQOL) model to understand how individuals can maintain goals and a high level of subjective well-being despite objectively diminished resources (Martin, Schneider, et al., 2012). This model stresses the critical role of perceiving one's resources as functional for performing activities aimed at maintaining subjective quality of life. Accordingly, subjective quality of life does not arise from optimal health or objective resources, but rather from performing various concrete activities that nourish personally relevant goal domains (e.g., interpersonal relations, autonomy, or leisure activities). If individuals make the best use of their resources and can identify achievable goals that contribute to broader life goal domains, a decrease in objective resources per se does not alter their subjective quality of life. This model posits that maintaining multiple ongoing activities and goal domains is key to stabilizing subjective quality of life, because, in case of forced cessation of one activity/goal, others remain available.
However, the fQOL model does not directly explain how to improve one's resources and reserves or the perceived functionality thereof. The preventive and corrective proactivity (PCP) model may provide additional insights along these lines.

The PCP model (Kahana et al., 2014) integrates decades of research on successful aging, quality of life, and well-being, and takes into account physical, functional, psychological, and social health. This model highlights proactive behavioral adaptations as a means of mobilizing resources and coping with personal or environmental stressors (e.g., chronic illness, age-related losses, or lack of person-environment fit). Proactive behavioral adaptations can either be preventive, to anticipate stressors appearance (e.g., taking care of one's health), or corrective, when stressors are already present (e.g., abandoning some activities in order to focus efforts on fewer central ones). In turn, these proactive behavioral adaptations interact with external (e.g., social) and internal resources (e.g., confidence in one's abilities or locus of control) to cope with stressors and ultimately result in quality of life outcomes (e.g., life satisfaction and self-acceptance, psychological well-being, and maintenance of valued activities). Physical functioning is not considered as a component of quality of life in itself, but rather as a stressor, whose impact on quality of life can be attenuated by proactive behavioral adaptations and personal resources. This assumption echoes both the fQOL and vulnerability models and agrees with our results. Thus, the PCP model offers concrete avenues to (a) under- standing how maintaining positive quality of life outcomes is possible despite multiple daily-life stressors and (b) identifying individuals who experience difficulties in adjusting to age-related stressors and goal disengagement.

Together, the fQOL and PCP models may provide concrete guidelines for individualized interventions aimed at maintaining goal engagement in older adults. The first step of such interventions would entail identifying (a) personally relevant goal domains (such as interpersonal relationships, maintaining autonomy, various leisure activities, or volunteering), (b) activities related to each of these goal domains, albeit within one's resources, (c) existing internal and external resources among those proposed by the PCP model, and (d) current or future obstacles and stressors. The second step

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would involve (e) setting up specific interventions to increase internal and external resources (e.g., fostering confidence in one's abilities or coping strategies) and (f) promoting proactive behavioral adaptations (e.g., proactively taking care of one's health, seeking support in the social environment, adapting the physical environment or the goal itself). A critical aspect of such interventions would be to raise participants' awareness of (g) how the selected activities are related to their personal goal domains and (h) how participants can identify their resources as functional with respect to these activities and goals.

LIMITATIONS AND PERSPECTIVES

Our study advocates the use of qualitative approaches to gain deeper insights into older adults' goals, goal- management strategies, and their contributions to well-being, yet it presents some limitations. First, qualitative exploration of cognitive complaints did not elicit very meaningful responses concerning goal achievement and may be limited by a lack of awareness of, or reluctance to report, one's weaknesses. It therefore remains unclear whether in our sample perceived cognitive impairments affect goal achievement. In that respect, comparing objective cognitive performance with self-reported goals in a mixed-method design (i.e., using both qualitative and quantitative data sources and analyses) could help to understand how maintaining or abandoning daily-life goals is related to cognitive status. For instance, following up on the present data and using objectively measured cognitive performance on the same participants, we showed that poorer self-reported health and cognitive performance significantly predicted higher use of compensation strategies as reported in the interviews (Joly-Burra et al., 2020). Mixed methods using interviews therefore appear to be a promising tool for future research to investigate participants' own perception of the buildup, maintenance, and activation of reserves across the lifespan, particularly in old age.

Furthermore, the present results do not determine which factors are specifically responsible for a substantial reduction in goals and well-being. We cannot infer causal relations from the present data, nor can we dissociate what is attributable to proactive adaptation to age-related losses (e.g., doing sports to prevent health and autonomy decline) from lifelong personality traits (e.g., lifelong tendency to be very active and to enjoy doing sports in addition to the health-related benefits). Stronger conclusions would at least require a longitudinal design, in which individuals of different ages and characteristics are repeatedly assessed over multiple years (Nesselroade & Baltes, 1979). Finally, short-term longitudinal designs, such as ecological momentary assessment studies, are valuable for investigating causal relations between variables such as the nature of a goal, the perceived functionality of individual resources for this specific goal, and the resulting affects when the goal is achieved or hindered (Brose & Ebner-Priemer, 2015). These methods are especially relevant because they limit the impact of retrospective memory biases in self-reports and provide large amounts of data suitable for analyses aimed at inferring causality.

Conclusion

Through detailed qualitative exploration of goals and well-

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being, this study further supports the claim that, in the eyes of older individuals, successful aging and well-being does not come from the absence of objective functional impairments, but rather from one's resilience and ability to adapt to age-related losses to maintain meaningful personal goals. At the end of the day, older adults report that well-being is not attained by reaching a given set of arbitrary outcome criteria, but by stabilizing their current functioning through proactive processes, to continue living their lives as long as possible (Martin, Jancke, et al., 2012).

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