Patient Preference and Adherence Dovepress

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Enhancing Adherence to Health Behaviors Research: Reflections on Current Methods and Future Directions [Letter]

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Dear editor

We were fortunate to read the article by Li et al in your journal, Mediating Effect of Perceived Health Competence on the Association Between Mindfulness and Adherence to Health Behaviors in Patients with Acute Coronary Syndrome: A Cross-Sectional Study.[1] This study provides insight into how mindfulness affects health behaviour adherence in ACS patients through perceived health competence and is an important contribution to the field of mental health and chronic disease management. However, we have questions about some of the author's points and would like to have them taken seriously.

Firstly, this study initially used Spearman's rank correlation analysis to explore the correlation between mindfulness, perceived health competence and health behaviour adherence (Table 2). However, this method failed to provide precise adjustment in the presence of multiple potential influences.[2] This is because differences in educational level may lead to differences in health awareness and information acquisition, while gender differences may affect individuals' acceptance and implementation of health advice. Therefore, the use of multiple regression analysis would be a more appropriate method to minimize the effects of confounding factors, resulting in more accurate and reliable results.

Second, the authors conducted a mediation analysis using perceived health competence as a mediating variable. However, Baron and Kenny in 1986 made it clear that the three variables involved must meet four conditions before performing mediation analyses.[3] The fourth of these conditions requires verifying whether the effect of the independent variable (positive thoughts) on the dependent variable (health behaviour adherence) is attenuated after controlling for the mediating variable (perceived health competence). This step is key evidence to confirm the role of the mediating variable, but the article does not appear to report this analysis in detail. This lack of data may affect the transparency of the study and the interpretability of the results.

Finally, we found that subgroups such as age and gender were not analysed in the study, and these analyses are critical to understanding how variables are affected in different populations. Individuals in different age groups may differ in their reception of health information, processing capacity and motivation for behaviour change.[4] In addition, lifestyle habits, in which women may prefer a healthier diet and men may face greater challenges in controlling tobacco and alcohol, are strongly associated with health behaviour adherence.[5] We believe that the relationship between mindfulness and health behavior adherence in different subgroups can be better understood with the help of subgroup analysis.

As psychologists, our goal is to improve treatment outcomes and optimise the overall health of our patients. Lee et al's study provides a new perspective on improving health behavior adherence by enhancing mental health. These findings prompt us to value psychological and behavioural interventions as a complement to traditional medical interventions. In the future, I would like to see more studies of this kind that delve deeper into the impact of mindfulness and perceived health competence in different populations in order to develop more personalised interventions.

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Disclosure

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this communication.

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