

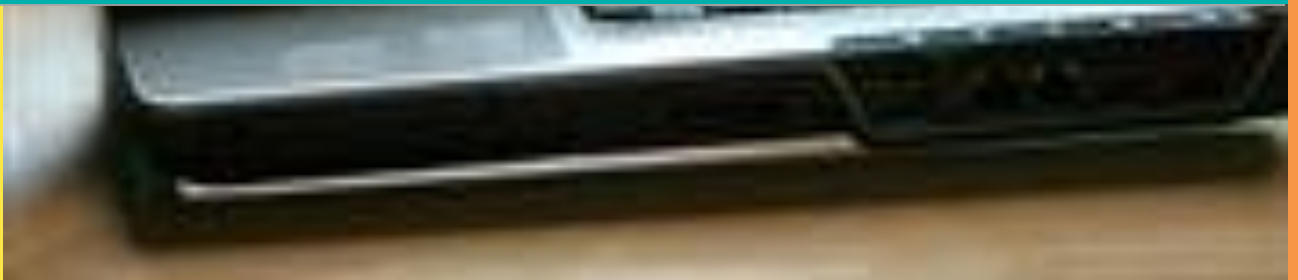
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TACTUS

## ANONYMOUS PARTICIPATION IN AN ONLINE-TREATMENT PROGRAM ALCOHOLDEBAAS.NL

HOW CAN PARTICIPANTS BE STIMULATED TO CHOOSE THE NON-ANONYMOUS OPTION?



Bachelor's thesis Psychology | Claudia Nowak

# Anonymous participation in an online-treatment program Alcoholdebaas.nl

How can participants be stimulated to choose the non-anonymous option?

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## Abstract

The website “Alcoholdebaas.nl” ([lookatyourdrinking.org](http://lookatyourdrinking.org)) has existed since March 2005. It was developed by Tactus, an addiction treatment institute whose aim it is to help people with various addictions. This paper focuses on participants’ use of Tactus’s on-line counseling program for alcohol addiction. A special feature of this program is that the participant may choose among four treatment options: self-paid, anonymous (free), insurance-paid, and employer paid.

Because of the limited patient capacity of the anonymous treatment option, however, Tactus wants to motivate more patients to choose the insurance-paid option. This option requires that they disclose their personal identification information, but allows them to start treatment immediately rather than waiting for an indeterminate time period before an opening becomes available in the anonymous treatment option.

Tactus has found, however, that even after informing clients that choosing to remain anonymous will cause a delay in treatment, most clients still choose to remain anonymous. Tactus is seeking to discover why these clients choose to remain anonymous, and how they might be influenced to choose the non-anonymous, insurance-paid treatment option. The purpose of this investigation is to find a starting point for achieving this goal.

## Samenvatting

Sinds maart 2005 is de website Alcoholdebaas.nl online, ontwikkeld door Tactus, een instelling voor verslavingszorg die hulpverlening aan mensen met verslavingen ten doel heeft. Dit rapport richt zich op mensen met een alcoholverslaving die hulp zoeken bij de on-line behandeling, Alcoholdebaas.nl. De populariteit van internetinterventies is voor een belangrijk deel toe te schrijven aan de anonimiteit, waardoor de drempel naar hulp wordt verlaagd.

Al vrij snel na de start van de internetbehandeling in 2005 was er veel animo voor de anonieme versie van Alcoholdebaas.nl. Vanwege de beperkte anonieme behandelcapaciteit, wil Tactus meer mensen stimuleren hun gegevens bij de zorgverzekeraar bekend te maken om de behandeling vergoed te krijgen. Door de inkomsten kan er meer capaciteit aan behandelaars worden ingezet en kunnen meer cliënten worden behandeld. Een belangrijk voordeel van de zorgverzekeringvariant is dat de deelnemers gelijk kunnen starten met de behandeling in plaats van een onbekende wachttijd te ondergaan. Na het informeren van alle geïnteresseerden over de mogelijkheid van vergoeding door de zorgverzekeraar kozen de meeste mensen er toch voor om te wachten.

Het doel van dit onderzoek is inzicht krijgen in de redenen van deelnemers aan AdB om niet voor de zorgverzekeringvariant te kiezen bij het inschrijven voor een behandeling. Tactus wil daarmee achterhalen hoe deelnemers het best gestimuleerd kunnen worden tot het inschrijven voor de zorgverzekeringvariant van de behandeling. Deze kennis is nodig om meer mensen met alcoholproblemen hulp te kunnen bieden via internet.

## Preface

After reading an interesting article about mental e-health, I searched through the available research offers and contacted Nicol Nijland, a PhD student at the University of Twente to ask her about the possibility of writing my Bachelor thesis in this area. I then met with Nicol to discuss my interests, and she forwarded to me a couple of relevant research orders from different organizations in the area. From these research requests in different topics I chose to apply for one placed by Tactus concerning the online treatment of people with alcohol problems.

Following this decision, I did an extensive literature search for the purpose of constructing a questionnaire to examine the motivation for their clients' treatment option choices.

During this period I was also able to personally visit the Tactus offices, and to do much of my research from there. This was quite helpful since it allowed me to meet many of their employees who were all very supportive of my research efforts.

I am very glad that I chose the research request from Tactus, and would like to thank all the kind people there for helping me with this project.

I would like to thank my supervisors, Dr. Nicol Nijland and Dr. Marloes Postel for their kind support, input, and guidance throughout the duration of this work.

I would also like to thank Heleen Westendorp for arranging, assisting, and carrying out the research project. I found it to be a very interesting project which gave me insight into many of the operational processes in a large organization such as Tactus.

Finally, I have to express my utmost gratitude to Steve Crosby and Stefan Schweizer for their willingness to invest time and effort to review my thesis and helping me correct my language.

Hopefully, my research will help to shed some light on the intention of Tactus's clients, and that it will be helpful to Tactus in guiding their clients toward the choice of appropriate treatment options.

Claudia Nowak

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# 1. Introduction

## 1.1 Project framework

It is a goal of the Prevention and Consultation Department of Tactus Verslavingszorg in Twente, (Dutch Institute for Addiction Care) to increase participation in the insurance paid option of their internet alcohol treatment program. In this paper the insurance paid option will be referred as non-anonymous option. Although information about each of their four treatment options is available on the Tactus website, most clients sign up for the anonymous option in which they do not have to disclose personal identifying information. Since the treatment capacity for the anonymous option is limited, however, this choice results in waiting periods of one week to six months or more before treatment is initiated.

The frequent choice of the anonymous option might be due to clients being unaware that they could start treatment immediately by choosing a non-anonymous option, or it could be a conscious preference for anonymity based on some personal reason. In order to better guide client treatment choices, Tactus would like to have a better understanding of the motivation of their clients in choosing this anonymous treatment option.

The goal of this research project, therefore, is to identify the underlying reasons and influencing variables affecting client choice against the non-anonymous option.

### 1.1.1 Composition of Alcoholdebaas.nl

Alcoholdebaas.nl (“lookatyourdrinking”) is a Dutch website which provides extensive information about alcohol and alcohol related topics. It also offers online therapy for individuals who have problems with excessive drinking. Treatment is provided by professional, experienced social workers on the staff of Tactus. Treatment recommendations are determined by a team of counsellors, an addiction-specialised physician, and a psychologist.

The aim of the alcohol counselling program is to motivate clients to change their drinking habits and, if necessary, to get treatment. The ultimate goal is for clients to reduce drinking or to stop drinking altogether.

Alcoholdebaas.nl is a comprehensive treatment program composed of five elements: an informative website, an online forum for discussion of issues with like-minded individuals, an online treatment program, a scientific research section and a chat module geared toward prevention. The design of this website is based on a “Stages of Change” model whose purpose is to explain or predict a person’s success or failure in achieving a proposed behaviour change (Prochaska & Diclemente, 1983).

This method of treatment is grounded in Cognitive Behaviour Therapy (Lange et al., 2003). The therapy is based on the principle that certain ways of thinking can trigger health or psychological problems. The counsellor helps the patient to understand his/her current thought patterns, and to identify harmful thoughts which might trigger problem alcohol behaviour. The aim is then to change this thinking and to avoid harmful ideas.

The internet treatment is available to everyone from eighteen years of age or older who wants to cut down on or stop drinking alcohol. Before filling in the intake questionnaire, the client must agree to the rules of participation. Those rules contain the “Wet op de Geneeskundige Behandelovereenkomst” (WGBO). This law contains several legal agreements about the rights and obligations of consultant and client, including that the client must be eighteen years of age or older, and must check in with the consultant at least every four weeks (otherwise treatment will be cancelled).

After completing the intake questionnaire, the participant can log onto the website and determine his/her own username and password to access his/her own private dossier. The clients can then send and receive messages with a consultant. Homework tasks and the daily registration of an alcohol scripts/diary are also made via the dossier. The intent of the alcohol diary is to enable the client to describe the moments when he feels the demand for consuming alcohol and also to record the times when he/she does drink. After drinking alcohol, the client reports the amount and kind of alcohol consumed.

The treatment consists of two parts, with an average total time duration of 3.5 months. The first part is focused on motivating the client to change their drinking behavior, and on analyzing his/her drinking habits without being asked to change anything. Part one closes with the personal recommendations of the counselor regarding the participant’s drinking and a proposal for follow-up treatment. The participant then decides if he /she wishes to continue with the online counseling.

The client will be determined as ineligible for the second part if the counselor thinks that there is a serious medical risk or an acute danger; if the client doesn’t understand the homework tasks; or if he/she is not able or willing to formulate reasoned goals. If any of the latter conditions are apparent, the client is referred to another, more appropriate form of treatment.

In this second part, the client sets his final goal with regard to alcohol use, and works on changing his/her behavior by using the homework tasks (Keizer et al., 2007).

For six months after finishing the program, the client may continue to use his personal information on the website, may continue to keep his/her alcohol use log, and may continue to stay in contact with his/her fellow clients via the communication forum on the website.

Since 2008 there has also been an option to obtain treatment paid for through the individual's health insurance, provided that the individual was willing to document the required personal identification information to substantiate their insurance coverage. Through this additional insurance reimbursement money, Tactus is able to employ more therapists and to serve more clients. At the moment there are four options available to choose from regarding the online-therapy.

### **Self-payers**

The first option for the client is to pay for the program himself. This option grants an immediate start of the treatment and it is completely anonym to participate in this way. The cost of the internet-treatment is approximately 2700€ for both parts.

### **Anonymous**

Another possibility is to participate via the anonymous variant which is free of charge and doesn't require a physician referral. With this option the participant will be asked to leave his email address and then will be receiving an email when there is a place available to be treated. This option is chosen by most people but the problem is that there are not enough places to treat everyone immediately and therefore there is a waiting list. It is rather unpredictable how long the waiting time for the treatment will be.

### **Insurance-paid (non-anonymous)**

The third option is to get the treatment paid from the health insurance. Therefore, participants have to publish some personal details to assure the payment from their insurance. This option enables the participants to start immediately with the treatment. After introducing this alternative to all the interested people on the waiting list of the anonymous treatment, this possibility didn't seem to be an option for most of them, because fewer than 10% of the people agreed to publish their personal details to receive the paid treatment. Most of the people chose to wait for the anonymous, free treatment without knowing when it will start.

### **Employer-paid**

There is also the possibility register through the employer. Some companies and government offices offer their employees the opportunity to follow the program free of charge and anonymously, covering the costs of treatment themselves. Clients choosing this option may start right away with the treatment.

## 1.2 Relevance of Research

The goal of this study is to investigate why potential clients do not choose the insurance-paid option (non-anonymous) even though this option would provide them with immediate treatment. Tactus wants to know which reasons are of significant importance to these potential clients. With this knowledge Tactus would be in a position to tailor its website and/or the information it provides about treatment options in such a way as to encourage a greater percentage of those potential clients to choose the non-anonymous option.

This is important to Tactus because with increased enrollment in the non-anonymous option, it would have the financial resources necessary to provide treatment to more clients, and it would not lose as many potential clients due to the long wait involved the anonymous option choice. These benefits would be multiplied as online treatment becomes more popular, and a greater number of individuals with alcohol addiction seek assistance.

This research would also benefit the target group of potential clients because they would receive more accurate information about their option choices, and improved incentives for choosing the non-anonymous option. Their attitude and satisfaction would also hopefully improve since they would be able to start treatment without delay.

In order to reach the main goal, to find out the most important reasons for future participants to choose against signing up for the non-anonymous option, an answer has to be given to the research question "How can future participants be stimulated to sign-up for the non-anonymous treatment option (insurance paid)?" Background for this research questions and specifications into sub questions can be found in chapter 2.

## 1.3 Thesis structure

The research project is described and explained in order to advise the organization Tactus in their improvements regarding the presentation of and recruitment for the non-anonymous treatment variant. Therefore the research thesis began with describing theoretical and practical background aspects, leading into the research questions (chapter 1). Furthermore the research thesis contains an extended theoretical framework which describes theories and approaches concerning online therapy, the role of anonymity and barriers and benefits of online treatment (chapter 2). A model that guides the research project is constructed and explained in that chapter as well; however it forms the transition to the next chapter, methods, which take the model as a base. The chapter methods (chapter 3) informs about the research process, including respondents, construction of the

instrument, preliminary and main research and analysis methods. The results from that are shown (chapter 4) and discussed (chapter 5) and lead to specific recommendations for Tactus (chapter 6).

## 2. Theoretical frame

### 2.1 Alcoholism – prevalence and consequences

The National Institute on public health (RIVM, 2003) noted in 2003 that nearly 7.8 % of all adults (18-64 years) in the Netherlands have alcohol abuse and –addiction problems. Overall, the National Institute for Public Health and the Environment data (RIVM) shows that rates of alcohol abuse and dependence in 2005 were substantially higher in men than women (alcohol abuse: 7,3% men, 1,8% women and alcohol addiction: 6,2% by men and 1,1% by women). In 2004 almost 1.800 people died because of alcohol misuse or as result of the serious consequences of long-term alcohol abuse.

The majority of individuals with alcohol use disorders do not enter treatment. The gap between need and actual treatment received for mental disorders is universally large and with 78.1% the widest for alcohol abuse and dependence (Postel, de Jong, & de Haan, 2008). Patients often withhold information because of shame or fear of stigmatization, with the result that many people with mental health problems will never seek or engage in treatment. Reasons for not receiving treatment are access barriers, delay in treatment, stigma associated with treatment, patients not having time, and not knowing where to go for services. Furthermore, people often only seek help at a late stage of abuse, usually after 10 years or more. During this time, the dysfunctional alcohol use has damaged several areas of life including health, work, finances and relationship (Jordan & Oei, 1989).

Long-term alcohol abuse results in a number of negative long-term effects. These manifest themselves as health related problems such as liver disease, cancer, pancreatitis, heart disease and stroke (Latt & Saunders, 2002).

Long term misuse of alcohol can also cause a wide range of mental health effects. Psychiatric disorders are common in alcoholics, especially anxiety and depression disorders with as many as 25% of alcoholics presenting with severe psychiatric disturbances (Cowley, 1992).

The social problems arising from alcoholism can be massive and are caused in part due to the serious pathological changes induced in the brain from prolonged alcohol misuse and partly because of the intoxicating effects of alcohol (Latt & Saunders, 2002).

Substance use disorder is one of the most common mental health problems in the Western world (Hall, Tesson, & Henderson, 1999) with a significant level of unmet treatment needs (Mojtabai, Olfson, & Mechanic, 2002). In the Netherlands, only 10% of the problem drinkers ever get professional help. Research data has shown that higher percentages of women, higher educated people, working people and elderly people are harder to reach for face-to-face care (Postel, de Haan, & de Jong, 2008; Van Laar et al., 2006). Online clients tend to be younger, more educated, and more

likely to have never visited a psychiatric clinic (Bai et al., 2001). Therefore, there exists a great need to understand the people's reasons for not signing up for the non-anonymous treatment.

## 2.2 E-therapy

On-line counselling, "e-therapy" is when a professional counsellor or psychotherapist communicates with a patient over the Internet, to give emotional support, mental health advice or some other professional service (Matthews, 2006). This type of therapy aims to provide treatment through real time or asynchronous correspondence between a human therapist and a client, without face to face contact (King & Moreggi, 1998).

The Internet combines attributes of mass communication (e.g. broad reach) with attributes of interpersonal communication (e.g. interactivity, rapid individual feedback). This combination of qualities simplifies the access to therapeutic interventions. These don't involve all the usual treatment requirements and make the internet an effective means of implementing behavioural health interventions on a far larger scale than previously possible (Postel, de Haan, & de Jong, 2008; Cassell, Jackson, & Chevront, 1998).

The percentage of people with an internet connection in the Netherlands rose enormously over the past years. According to the "Statistics Netherlands" (2008), 91% of the population in the Netherlands had internet access at home. Fogel and colleagues (2002) found out that half of all internet users already looked for health related information on the internet. Psychotherapy and counselling services are now available on-line, expanding rapidly. This relatively new and successful growing opportunity to seek and receive help via the internet is especially interesting for people who wish to remain anonymous, because they won't seek out traditional services (NCI & RWJF, 2001).

Internet-based intervention is attractive to a large population whose alcohol use may be problematic but who have not sought, or are unwilling to seek, traditional treatment (Barak, 1999)

There are a number of ways in which computers and the internet may be used to deliver interventions for mental health disorders. These include stand-alone computers with internet access to find mental health-related information; pre-programmed, interactive software packages available via the internet; or psychotherapy delivered via the internet with live therapist involvement (real time or messaging). The focus of this paper will be on the therapy via secure web messaging.

### 2.2.2 Limitations and Benefits of Online Treatment

Clearly, this type of psychological counselling has limits and benefits that are different from traditional therapy. On the one hand it is an easy and valid way to supervise counsellors, because the therapy material is always available and it is a simple way to verbally communicate between therapy

partners (Ybarra & Eaton, 2005; Zabinski et al., 2003). It holds the possibility of making the intensity of interaction flexible which can be helpful with regard to the individuality of therapy progress (Barak et al., 2008). It makes it easy to access for people in need for therapy who refrain from using conventional psychological services for a number of reasons (Barak et al., 2008). In contrast to many other psychological treatment programmes you can participate 24 hours a day in the online-therapy, 7 days a week. This makes it easier for clients to integrate the therapist into his or her everyday life instead of waiting for the weekly or annual meeting; the patient can email issues while he or she is actively processing thoughts and feelings (Childress, 2000).

According to Barak et al. (2008), the anonymity plays an important role in the treatment of alcoholism. Anonymity is usually assumed to reduce social desirability and lead to more “honest” answers. The term social desirability means the behaviour of clients of giving social desirable responses rather than truthful responses. This finding is consistent with findings about mental health interventions in general. A research of Ybarra and Eaton (2005) shows that the majority of participants like the anonymity of the internet-based therapy and appear to benefit in terms of relief of psychological symptoms.

Matheson and Zanna (1990) present evidence to suggest that, during computer-mediated communication (CMC), people experience increased private self-awareness (which could explain greater self-disclosure) while simultaneously experiencing reduced public self-awareness. This would suggest that, although self-presentation concerns are reduced (via lower public self-awareness), self-regulation and focus on internal states and standards may be enhanced (via higher private self-awareness) (Joinson, 1999). The anonymity of the online-therapy makes it possible for people who wish to remain anonymous to receive help with their abuse problem through reducing stigma and sense of shame (Winzelberg, 1997; White & Dorman, 2001; Hsiung, 2001; Finn, 1999).

Another advantage of online-treatment is the *online disinhibition effect*, which leads to being more relaxed and unconcerned about expressing personal thoughts, feelings and fears so that people talk more honestly about those things without having to care about what other people might think (Barak et al., 2008).

On the other hand, there are also some negative aspects of online-treatment. The absence of regular face-to-face interaction and the missing nonverbal cues can lead to misunderstandings. It also disallows the flow of communication from body language, voice fluctuation and less productive projection may then be more likely in this nonverbal email therapy environment (Barak, 2008; Childress, 2000).



Obtaining informed consent is also critical because e-mail correspondence is not considered to be confidential and private as the possibility of tapping electronic messages is relatively easy (e.g. third party reads the email) (Barak et al., 2008).

Although these negative aspects may point out some barriers to conducting effective counselling via e-mail, it seems that the actual impact of negative factors is relatively small (Barak et al., 2008).

It has been a repeated and robust finding that people tend to reveal more personal and/or embarrassing information with a computer-administered interview than when interacting with another person face-to-face (Joinson, 1998).

One approach to The “Pathways Disclosure Model” (PDM) predicts the attitude of people regarding treatment and states that people are more willing to participate in a treatment if they don’t need to publish any personal details. The PDM is an approach that articulated the advantages of receiving assistance through the Internet. It implies that online asynchronous treatment hold particular promise for those who experience personal problems where stigma is involved. By availing themselves of online forms of help, individuals essentially control all of the levers of personal disclosure and are, therefore, more likely to “test drive” help-oriented interventions or participate “anonymously” (Cooper, 2004). The role of perceived anonymity is an important one. Prentice-Dunn and Rogers (1982) suggest that deindividuation is caused by two factors – a reduction in *accountability cues* (e.g. leading to a reduced concern about others’ reactions) and a reduction in private self-awareness – which lead to decreased self-regulation and use of internal standards (Joinson, 1998). Anonymity is usually assumed to reduce social desirability and leads to more “honest” answers.

The question arising from these facts is: what are the reasons for people wanting to remain anonymous when it comes to choosing between the anonymous or insurance paid variant for participating in an online treatment. There is a gap in literature concerning this question and therefore this study tries to investigate the underlying factors contributing to this issue.

### **2.3 Responsibility for using the Theory of Reasoned Action**

Numerous studies about the relationship between attitude and behaviour have shown that attitudes of people often are not consistent with their behaviour (Wicker, 1969). This incongruence stimulated researchers to develop models of the influence of attitudes by making all kinds of decisions. One of the most popular models in this area is the “Theory of Reasoned Action” (TRA) (Fishbein & Ajzen, 1975).

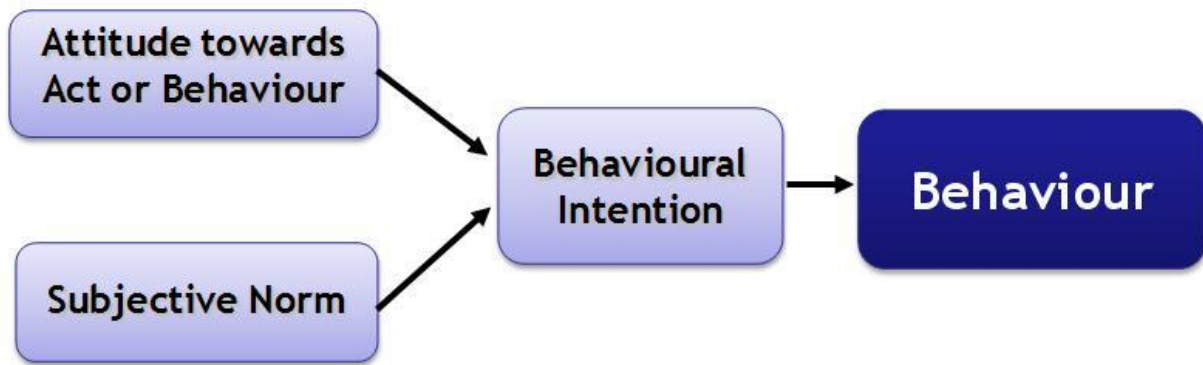


Figure 2.1 Theory of Reasoned Action based on Fishbein and Ajzen (1975)

The “Theory of Reasoned Action” is a model that has its origins in the field of social psychology and holds promise as a conceptual model for understanding help seeking behaviour (Halgin, Weaver, Edell, & Spencer, 1987). It was developed by Fishbein and Ajzen in 1975 and defines the links between beliefs, attitudes, norms, intentions, and behaviours of individuals. It is based upon the assumption that people’s actions are decided through a series of rational judgments (Ajzen & Fishbein, 1980). The model states that a person’s behaviour is determined by its behavioural intention to perform it. The intention is itself determined by the person’s attitudes and his subjective norms toward the behaviour.

According to TRA, the attitude of a person towards a particular behaviour (i.e., the positive and negative feelings about the behaviour) is determined by his outcome beliefs of this behaviour, and multiplied by his evaluation of these consequences. Generally speaking, a person who believes that performing a particular behaviour will mostly lead to positive outcomes will hold more favourable attitude than a person who believes that performing this particular behaviour will lead to mostly negative outcomes. Beliefs are defined by the person’s subjective probability that performing a particular behaviour will produce specific results. This model therefore suggests that external stimuli influence attitudes by modifying the structure of the person’s beliefs. Indeed, consistent with this perspective, studies have shown that the best predictor of help-seeking intent is the person’s attitude toward seeking professional help (Bayer & Peay, 1997; Halgin et al., 1987). Most behaviour is dependent on non-motivational factors as availability of required resources and opportunities (for example: time, money, skills, encouragement of others etc.).

Whether or not a person participates or intends to participate in any behaviour is influenced strongly by people around them. These people may include friends, family or co-workers. Subjective Norm is a person’s perception of what others believe that the individual should do or not. A belief that friends and family sentence the behaviour of undergoing a treatment against alcohol abuse might lead to not participating in that treatment or doing this in an anonymous way.

One of the strengths of the TRA is that it allows comparing the relative influence of each variable isolated. This has implications for persuasive communication programs. If Attitude is substantially more influential than Subjective Norms in prediction of Intention then all communication efforts should be aimed toward gaining the awareness of the harmful consequences of not remaining untreated with an alcohol abuse problem.

For this study a new model was derived to examine the important variables relevant to decision making in favour of the non-anonymous option of the online treatment. These additional variables were added during the literature research while investigating all the variables which might play a role in this context. The additional variables are: Perceived Severity, Motivation to change, Barriers, Information Status, Intention, Solution Suggestions. The definitions of these constructs can be seen in table 2.1 below. The overall goal of this research was to directly examine the role that different variables play in people’s intention to choose against the non-anonymous option.

More specifically, our objective was to assess the relationships among the different factors that influence the Intention to sign up for the non-anonymous variant. We hypothesized that intention to sign up for the non-anonymous variant would be influenced by the participant’s self-perceived severity, self-efficacy, motivation to change, subjective norm, information status, influence of solution suggestions and demographic variables. Further, we hypothesized that outcome beliefs and barriers to treatment would predict the intention to sign up for the anonymous variant.

Because of the fully guaranteed anonymity in this research project it was impossible to link the intention of participants to their actual behaviour. Therefore the behaviour is not included. The intention to choose for the non-anonymous treatment is the target variable to which the correlations and influences must be investigated.

Table 2.1 shows the constructs used for the derived integrative model with references to the literature on which the variables are based on. The full model can be seen in Figure 2.2 in the hypotheses section.

Table 2.1 Constructs and variables in the research model

Construct	Based namely on	Definition	Variables
Psychological factors	Jordon & Oai	Situational and psychological features that give purpose and direction to behavior (alcohol use)	Perceived severity of alcohol abuse Self efficacy to change behavior Motivation to change
Barriers	Corrigan; Jordan & Oai; Codd & Cohen	Psychological and instrumental variables explaining the barriers	Fears of losing Privacy Financial barriers

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		concerning the non-anonymous variant	Stigma
Subjective Norm	Aijzen & Fishbein	Influence of people in one's social environment on his/her behavioral intentions	Subjective norm
Information Status	Tactus	Knowledge about alternative treatment options and waiting time	Employer-paid option Self-paid option Insurance-paid option Waiting time
Attitude towards non-anonymous variant	Codd & Cohen	Range of options which the clients are aware of and the effect of possible solution suggestions	Attitude about suggested solution possibilities Outcome beliefs
Intention	Aijzen & Fishbein	A function of both attitudes and subjective norms toward a behavior, which has been found to predict actual behavior	Intention
Antecedents	Schober & Annis	Situational variables, which will explain the individual background	Demographics (gender, age, education, occupation, country of birth) Status internet therapy

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## 2.4 Research questions and hypotheses

### 2.4.1 Research questions

In order to measure the concepts described in the previous paragraphs and put them into useful information for Tactus, this research is guided by the following research question:

*How can future participants be stimulated to sign-up for the non-anonymous treatment option (insurance paid)?*

The main research question aims to include the target group: future participants of the online treatment, who are willing to register through the anonymous option for being treated.. Also the

non-anonymous treatment option forms a central aspect in the research question. Finally, the stimulation aspect plays a central role in the research question.

The six sub questions are as follows:

1. *What are the reasons of participants for not choosing for the non-anonymous variant?*
2. *Is there a relationship between the Motivation to change and the intention to sign up for the non-anonymous variant?*
3. *Which psychological constructs exert influence on the Intention to sign up for the non-anonymous variant?*
4. *Which Solution Suggestions are perceived as stimulating for people to sign up for the non-anonymous treatment?*
5. *Do participants hold some important suggestion about how to stimulate people to participate via the non-anonymous pathway?*
6. *To what degree do Demographics influence the Intention to sign up for the non-anonymous variant?*

The first sub-question focuses on the people's reasons for choosing against the non-anonymous treatment option and rather signing up instead for the anonymous option. These reasons may include barriers like the feeling of stigma, or insufficient knowledge about the alternative options and are hypothesized to influence the choice of treatment option made by the participant.

The second sub-question investigates the relationship between the general motivation of clients who signed up for the anonymous variant and the intention of those who signed up for the non-anonymous one.

The third sub-question addresses the relationship between the measured psychological constructs (Subjective Norm, Outcome Beliefs etc.) and the Intention of signing up for the non-anonymous treatment. These constructs are expected to influence the Intention.

The fourth sub-question examines the perceived effect of the given Solution Suggestions on the Intention to sign up for the non-anonymous variant.

The fifth sub-question asks about the suggestions participants have about ways to attract people to the non-anonymous variant. This question is examined through a qualitative essay question, and is analyzed by content analysis.

The sixth sub question investigates the relationship between the Demographic variables and the Intention to sign up for the non-anonymous treatment. These are expected to contain more women than man, and high percentage of highly educated and employed people.

### 2.4.2 Hypotheses

This research was approached from the point of view that intention is predicted by attitudes and subjective norms toward a behavior. Because TRA separates behavioral intention from behavior, it also includes the factors that limit the influence of attitudes (or behavioral intention) on behavior. We have therefore adopted the Theory of Reasoned Action as a framework to investigate the persuading and limiting factors when it comes to influencing an attitude toward a behavior. Therefore, variables were added to work out an integrative model. It was supposed that by using this framework the aim of research will be achieved. It was supposed that by using this framework the aim of research will be achieved. This is to successfully model the determining factors influencing the intention of signing up for the non-anonymous treatment. We propose the following hypotheses highlighted in the diagram below; all arrows indicate a hypothesized predictive relationship between a variable and Intention. Where the expected relationships are negative the (-) sign is inserted. The dependent variable (Intention) is in a red box and the boxes of the original variables of the TRA are colored dark blue. Newly added variables are light blue.

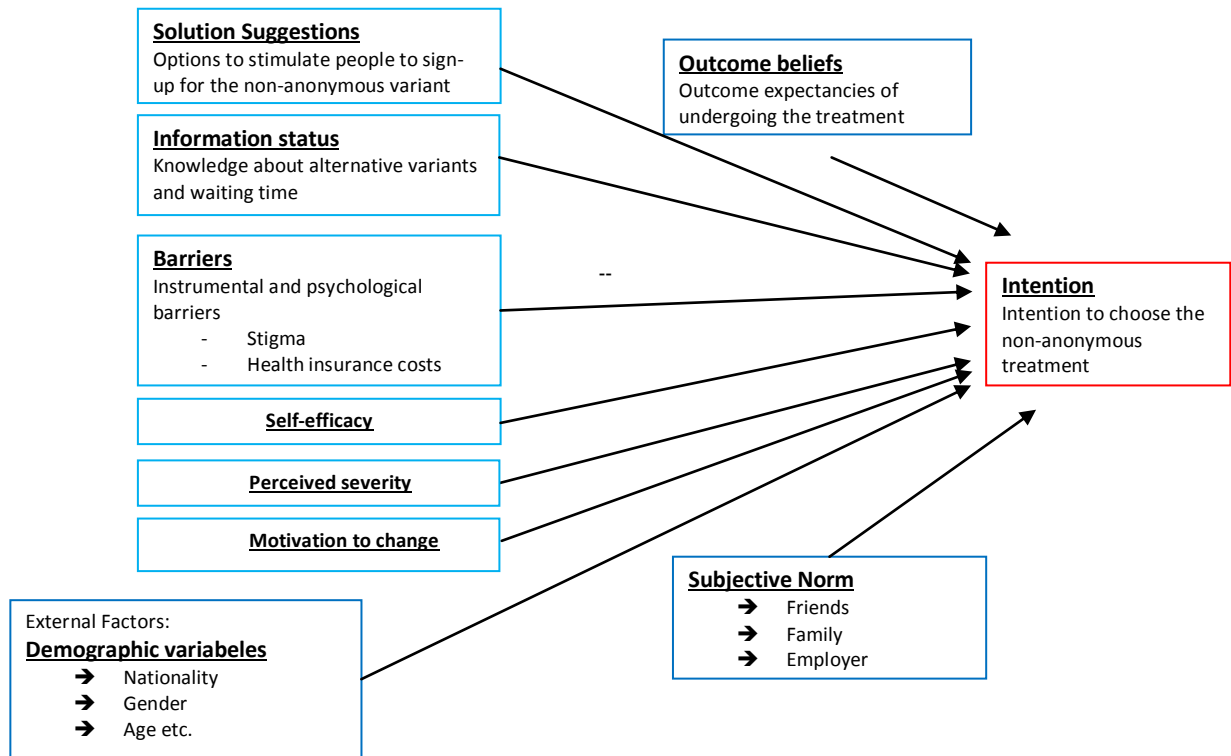


Figure 2.2 Integrative model of hypothesized relationships between constructs

### 3. Methods

The research project focuses on different questions concerning the entering behaviour of the non-anonymous treatment option available. To give answers to the research questions there was an anonymous online questionnaire constructed with mainly quantitative and some qualitative questions. As very different aspects are involved it was decided to use a questionnaire to detect the various underlying reasons why people behave as they do. The construction, distribution and analytical methods are described in this chapter, beginning with the sample build-up, continuing with the instrument and the procedure of the research and ending with the analytical methods.

#### 3.1 Respondents

The sample needed to be chosen in a way that allowed generalization about the actual target group. To recruit the respondents an email was sent to approximately 250 participants. This email contained an introduction to the research project and also explained the procedure. Two groups of individuals exhibiting alcohol-related problems were enrolled into the study: persons who were already receiving the treatment (Treatment receivers) and people waiting for treatment (Treatment waiters). To maintain their anonymity both groups were recruited via email. There were approximately 140 persons from the waiting list for the anonymous treatment and 110 persons already receiving the treatment were recruited via email. The email contained a text introducing the research project and assuring the anonymity of the participants. A link to the questionnaire was contained in the email through which the participants were able to directly access the questionnaire. The survey was completed by N=62 patients in total, N=31 in each group. Participants who didn't fill in the whole survey were automatically excluded from the programme.

#### 3.2 Instrument

Using Ajzen en Fishbein's (1980) theory, there was an instrument constructed (based on detailed literature research) that assessed the ten variables theorized to influence help-seeking behaviour for alcohol abuse: (1) Subjective Norm, (2) Outcome Beliefs, (3) Perceived Severity, (4) Motivation to change, (5) Barriers, (6) Information Status, (7) Intention, (8) Solution Suggestions and (9) Demographics measured the primary determinants of the decision process to choose against the non-anonymous variant.

People were informed that participation was voluntary and anonymous. They were told that the procedure would involve answering questions regarding their thoughts about the online-treatment Alcoholdebaas.nl. Research participants completed the revised questionnaire for the anonymous participation of the online treatment for alcohol problems.



The questionnaire consists of 51 items, most of them with five point Likert-rating scales or check boxes, including one open-ended question asking the participants about solution suggestions aiming to stimulate more people to sign up for the non-anonymous treatment.

In order to investigate the questions concerning the two different groups, two versions of the questionnaire were developed. The versions were almost the same except for specific wording adjustments of the questions.

How the questionnaire was constructed can be found in table 3.1. The two versions of the questionnaire can be found in appendix A and B.

Table 3.1 Constructs and variables in the questionnaire

Unit	Construct	Variables	Questions	Method
Unit A	Treatmentstatus	Status of treatment (started or waiting)	1	1 question (checking box)
	Perceived severity	The perceived severity of own alcohol misuse	2-3	2 questions on a five point Likert scale (1=strongly agree to 5= strongly disagree)
	Perceived self-efficacy	Person's belief about capability to change behavior	4	1 questions on a five point Likert scale (1=strongly agree to 5= strongly disagree)
	Subjective norm	Influence of people's beliefs in one's social environment	5	1 questions on a five point Likert scale (1=strongly agree to 5= strongly disagree)
	Motivataion to change	Motivation to change drinking behavior under the anonymous treatment	6	1 questions on a five point Likert scale (1=strongly agree to 5= strongly disagree)
	Outcome beliefs	Expectancies about treatment results	7-17	10 items on a five point Likert scale (1=strongly agree to 5= strongly disagree)
Unit B	Barriers	Impact of different reasons for choosing the anonymous variant including stigma	18-32	15 items on a five point Likert scale (1=strongly agree to 5= strongly disagree)
	Information	Knowledge about	33--36	4 items with checking

	status	alternative options and about the possibility to start directly with the treatment		boxes (1=yes, 2=no)
Unit C	Intention afterwards	Intention to sign up for the non-anonymous variant after being informed	37	1 item on a five point Likert scale (1=definitely to 5=definitely not)
	Solution suggestions	Ideas stated to stimulate the client to choose the non-anonymous treatment	38-46	8 items on a five point Likert scale (1=strongly agree to 5= strongly disagree) and 1 essay question
Unit D	Demographics	gender, age, education, nationality, occupation	47-51	5 questions (checking boxes)

### 3.2.1 Treatment status

It was important to investigate the treatment status of the participants to know whether they were still waiting for treatment, had already started or had finished the treatment. This was measured by a simple check box question.

### 3.2.2 Perceived severity towards abuse

The most common reasons given by people for delaying help-seeking was the belief that their drinking was not serious enough (Jordan & Oei, 1989).

Many individuals are aware that they have a drinking problem, but they do not decide that change is needed. They may engage in minimization of the negative impact that drinking has on their lives.

Perceived Severity towards abuse was measured by asking participants to rate how they perceive their alcohol consumption in comparison to “most people” and how long they have thought about changing this problem. One item is: “Ik denk dat ik meer drink dan de meeste mensen”. This was measured by two items on a five point Likert-scale ranging from “strongly agree” to “strongly disagree”.

### 3.2.3 Perceived self-efficacy

Perceived Self-efficacy reflects people’s beliefs about whether they think they can perform a given activity which, in this study, would be “changing drinking behaviour.” Perceived Self-efficacy portrays individuals’ beliefs in their capability to exercise control over challenging demands and over their

own functioning (Bandura, 2000). According to Bandura (2000) Perceived Self-efficacy involves the regulation of thought processes, affective states, motivation, behaviour, or changing environmental conditions. Self-efficacy relates to the estimation of one's ability to perform the necessary actions to change the relevant (i.e., consuming alcohol) behaviour. It is not about real skills but about one's own estimation of one's ability and whether you can rely on your abilities regardless of skills. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. This variable is measured by one item "Ik denk dat ik goed in staat ben mijzelf ertoe te zetten mijn huidige alcoholgebruik te veranderen," and is based on the scale developed by Schwarzer and Jerusalem (1995).

### 3.2.4 Subjective norm

As a Subjective Norm, the decision-maker has subjective assumptions about other's expectations. These may be organizational, professional, local or otherwise shared norms regarding accepted and expected behaviour. In case of the decision-making about participating in an alcohol treatment program, it is about social influence in terms of social barriers which are reported as a greater reason for not seeking treatment for an alcohol problem than for an emotional problem (Codd & Cohen, 2003). With respect to the present matter in question it is about social influences of family, friends and colleagues at work. Also the insurance and family doctor seem to play a role when it comes to choosing the treatment variant for receiving help. Therefore it is important to ask the patient about his perceived reactions and attitudes toward the treatment to find out the real impact of the direct environment. Subjective Norms can be inhibitive or facilitative and it is important to examine the relationship between perceived social norms and the outcome behaviour.

The Subjective Norms of those close to us for seeking help was measured with the question derived from an item by Bayer and Pay (1997). It asks participants to rate on a 5 point Likert-type scale ranging from "strongly agree" to "strongly disagree" the item "De meeste mensen die belangrijk voor mij zijn zouden graag willen dat ik de behandeling ga volgen." Bayer and Pay found that this Subjective Norm uniquely predicted help-seeking intent such that those who were likely to seek help responded to this item more favorably. This item was used as a single observed indicator of the Subjective Norm latent variable.

In this research, the Subjective Norm refers to the influence of the direct environment of the patient with an alcohol abuse problem to undergo the online treatment. In the TRA, the Subjective Norm is being determined through environmental influences of the client. In this research, the Subjective Norm refers to the expectancies of clients about the judgments of people about being treated for an alcohol abuse problem.

### 3.2.5 Motivation to change

Motivation is a set of reasons that determines one to engage in a particular behavior (Fishbein & Aijzen, 1986). The motivation to change the problematic drinking behavior was measured with one item: “Ik ben heel gemotiveerd om mijn drinkgedrag te veranderen”, on a five point Likert-scale ranging from strongly agree to strongly disagree. Regarding the item, general Motivation to change the drinking behavior is measured. It has to be taken into account that when filling-in the questionnaire, the participants already signed up for the anonymous variant. This shows that the “general motivation” has to be linked to the fact that the participants are more or less motivated to change their drinking behavior under the condition that they are treated through the anonymous variant because that is what they signed up for in the first place.

### 3.2.6 Outcome beliefs

Attitudes are predicted by a person’s outcome expectations (Ajzen & Fishbein, 1980). For example, if a person anticipates a positive outcome for a certain behaviour (e.g. choosing the non-anonymous variant will enable them to start the treatment right away which will lead to more control over their drinking behaviour), then they will have a positive attitude (e.g. choosing for the non-anonymous training is a good thing). Conversely, if a person anticipates harmful outcome for a certain behaviour (“If I seek help, others will think I am crazy”), then they will have a more negative attitude (e.g., seeking help is a bad thing). These outcome expectancies can be the most influential beliefs in the motivation to change (Suls & Wallston, 2003).

This construct consists of 10 items with possible outcomes of the online treatment as “alcohol consumptie reduceren” or “relatie met vrienden en familie verbeteren“. As orientation for these construct, we used the modal set of salient beliefs identified in Study 1 of Codd and Cohen (2003).

### 3.2.7 Barriers towards signing up for the non-anonymous variant

Attitudes and social stereotypes about people and alcohol use can create barriers to the detection and treatment of alcohol abusers. Barriers against treatment seeking might be congruent with barriers against signing up for the non-anonymous variant. These are reasons people have against utilizing specialized addiction treatment services or modifying the target problem behaviours (Bandura, 1986). Barriers inhibit an individual’s motivation to modify the addictive behaviour (Schober & Annis, 1996.). Research has found several barriers that prevent help-seeking behaviours for alcohol abuse among the general population. Stigma yields two kinds of harm that may impede treatment participation: It diminishes self-esteem and robs people of social opportunities (Corrigan et al., 2005). Social barriers (social stigma) were reported as a greater reason for not seeking treatment for an alcohol problem than it was for an emotional problem (Vogel & Wester, 2003).

Participants' experience of Barriers to the non-anonymous treatment was evaluated via a questionnaire created for this study. 12 items listing possible Barriers to treatment, based on literature research were sent to them. Our conceptualization of the treatment barriers include two components: Instrumental barriers and psychological barriers (stigma).

Instrumental barriers are operationalized in this study by using well thought-out items chosen on basis of the literature read about this subject. Respondents were asked to indicate the extent to which they agreed with statements like "Ik ben geen Nederlander en anders wordt de behandeling niet vergoed" and "Ik ben niet bereid om de eigen bijdrage te betalen." Response categories used were "strongly agree," "agree," "do not agree/do not disagree," "disagree," and "strongly disagree."

We operationalized stigma using a four item scale ( $\alpha = 0,705$ ). Item content focuses on being avoided, feeling guilty of their alcohol problem or being judged negatively by people because of having a problem with alcohol. The items of the stigma were obtained by using the two strongest items of the 5-item Stigma Scale for Receiving Psychological Help (Komiya, Good, & Sherrod, 2000). The version used is a shortened 5-item revision of the original 12 item measure. Items are rated on a 5-point Likert-type scale ranging from strongly agree to strongly disagree. By asking the respondent to report on the perspective of "most people," the scale enables stigmatizing beliefs that are not socially acceptable to be endorsed.

Each item was answered with a 5-point Likert scale anchored at "strongly agree," "agree," "do not agree/do not disagree," "disagree," "strongly disagree" (see Appendix for item wording).

The separate constructs of instrumental and psychological barriers were combined to one construct because of the large overlap of items.

### **3.2.8 Information status**

Information Status is one of the psychological variables which can be seen as an important determinant of behavior. According to Brug and colleagues (2003) insight and knowledge only lead to behavior change in people who are willing to do something but don't really know how they can reach the goal or what the behavior would be. In our case the supposed knowledge gaps include the possibility of being able to start immediately with the program when choosing the non-anonymous variant, knowledge about who will be involved in treatment process, and who has insight in the personal data and reports.

### **3.2.9 Intention to sign up for the non-anonymous variant afterwards**

Ajzen and Fishbein (1980) operationally defined intention as the person's subjective probability judgment of how he or she intends to behave. Items assessing behavioral intention thus need to

assess the strength of the person's intention on an appropriate probability dimension. Intention to sign up for the non-anonymous variant was measured with an item asking the respondent to rate how likely, ranging from "very likely" to "very unlikely," they would be to sign up for the non-anonymous variant after getting some information about the payment through the insurance. This item is based on a recommendation of Ajzen and Fishbein (1980) who say that an Intention statement should be rated as "unlikely" or "likely." (Terry, Gallois, & McCamish, 1993).

### **3.2.10 Solution suggestions**

Based on the observed (literature) reasons for participants to make the decision to not sign up for the insurance-paid option, there were some relevant Solution Suggestions devised to find out how these propositions are accepted by the participants. Thereby it was aimed to explore the effectiveness in practice of the different options.

In addition to the quantitative rated items, an open question was also added to this construct to extend the answer possibilities and to gain some important insights into the ideas of participants. The qualitative answers to these questions are analysed via content analysis.

### **3.2.11 Demographic factors**

In Demographics respondents had to check their gender and indicate their age (Van Hooft et al., 2005), education level, occupation and country of birth in check box questions.

Most demographic questions were written for the survey, and several include response options suggested during the expert review. Some questions for these items were taken from existing demographic measuring scales used by Tactus for the intake questionnaire.

## **3.3 Expert review**

In order to find out which items should be used and how they could be adjusted to fit into the questionnaire, preliminary research in the form of an expert review was held. Expert review is an empirical pre-testing method because it involves the systematic collection and processing of reviews from sources outside the immediate design team (Ramirez, 2002). As a pre-test the questionnaire was given to 5 experts, most of them working for Tactus and also to my tutor at the University. The questionnaire was given to a general questionnaire design expert who has considerable experience in writing and evaluating questionnaires and in communicating with the target group. The expert reviewed the wording of the questions, the structure of questions, the response alternatives, the order of questions, instructions to interviewers for administering the questionnaire, and the navigational rules of the questionnaire. The questionnaire was also given to three additional subject

matter experts who know about the topic under investigation. Those experts assessed whether the content of the questions was appropriate for measuring the intended concepts (Groves et al., 2004).

The experts were instructed to fill in the questionnaire, thereby using the plus-and-minus method (De Jong & Schellens, 2000). Putting down plus and minus symbols where something positive or negative was noticed it was possible to keep the normal flow of filling in the questionnaire and still get feedback on the construction of the questionnaire. In the follow-up interview, a couple of comments were made - mostly positive about the content and statement of the questions, and mostly negative about the phrasing. This was not surprising since the Dutch questionnaire items were either translated from an English questionnaire, or self-constructed by a native German. With the help of the pre-test feedback, the questionnaire was revised. The instructions and outcome protocol of expert review can be found in appendix D and E.

### 3.4 Pre-test

As pre-test the adapted questionnaire was send to 10 people from the waiting list and 10 people who had already started the treatment. There were five additional questions added at the end of the questionnaire to evaluate the clarity and structure of the questions. There was also the opportunity given to comment on positive or negative aspects of the questionnaire and report about expected or missing questions. The pre-test can be found in Appendix C. The pre-test was filled in by 9 participants in total and there were no negative comments made about the questionnaire. Respondents rated the questionnaire as understandable and easy to fill in. Respondents rated the phrasing of the questions as clearly and did not miss an important question.

### 3.5 Reliability

Different constructs were measured in the questionnaire which needed to be tested as to their reliability. A Cronbach's alpha of minimal .60 for constructs of minimal three items was hereby required (De Vellis, 2003). Constructs with less than three items were tested on their correlation instead of Cronbach's alpha. The results are presented in table 3.2.

Table 3.2: Reliability of constructs

	Reliability/Correlation	N	Number of items
Perceived Severity	$r = .635^{**}$	62	2
Outcome Beliefs	$\alpha = .775$	62	10
Barriers	$\alpha = .756$	62	10
Solution Suggestions	$\alpha = .799$	62	10
Information Status	$\alpha = .856$	62	4

*Note. For constructs with less than 3 items correlation was analyzed instead of Cronbach's alpha*

*\*\* $p < .001$*



## 4. Results

The results are shown in relationship with the constructs from the model and the research questions. Parts of the analysis are based on Codd and Cohen (2003) who measured relationships between the “Theory of Reasoned Action” variables and the intention of professional help seeking services for alcohol abuse.

### 4.1 Antecedents

In order to know central tendencies, frequency tables about antecedents were made. Most of the data in this paragraph are nominal, which facilitates the differentiation into groups like “males” and “females”. Additionally to analyzing the frequencies of the demographic variables, the data of the anonymous participants was compared to the data of non-anonymous participants. The aim of this analysis was to detect the possible differences between the demographic details of participants between the two treatment options.

#### 4.1.1 Demographics

Most participating clients (N=62) had Dutch origin (91,9%). The participants’ gender is female for the most part. About 70% of the participants were aged between 36-55 years and 15% are older than 55 years. The results show that the highest percentage of the respondents had higher education. Concerning the occupation status it can be seen that most respondents are employed. The exact distribution can be seen in table 4.1

Table 4.1 Demographics of respondents

Gender		
	Clients (N=62)	Percent (%)
Male	22	35,5
Female	40	64,5
Total	62	100

Treatment status		
	Clients (N=62)	Percent (%)
Treatment completed	1	1,6
Busy with treatment	33	53,2
Waiting for treatment	27	43,5
Other treatment started	1	1,6
No need anymore	0	0
Total	62	100

Nationality		
-------------	--	--

	Clients (N=62)	Percent (%)
Other countries	5	8,1
Netherlands	57	91,9
Total	62	100

Age		
	Clients (N=62)	Percent (%)
18-25	1	1,6
26-35	3	4,8
36-45	22	35,5
46-55	27	43,5
56 >	9	14,5
Total	62	100

Education		
	Clients (N=62)	Percent (%)
Elementary school	0	0
LBO/MBO	4	6,5
HAVO/VWO	12	19,4
MBO	11	19,2
HBO	25	40,1
WO	9	14,5
Total	62	100

Occupation		
	Clients (N=62)	Percent (%)
full-time job	24	38,7
part-time job	15	24,2
student	1	1,6
housewife/man	1	1,6
unemployed	4	6,5
inability to work	3	4,8
retired	5	8,1
self-employed	9	14,5
Total	62	100

#### 4.1.2 Demographics compared

The groups are compared using the Chi-Square test to detect the differences between the anonymous and non-anonymous group in demographics. The differences will be confirmed if a statistically significant ( $p < 0.05$ ) difference is found between the two groups.

Table 4.2 shows the different percentages for participants in the anonymous and non-anonymous groups after having applied a Chi Square test for independent samples. The results indicate that there is a statistically significant difference between the anonymous and non-anonymous treatment option in gender distribution ( $\chi^2(1) = 7.323$ ;  $p = 0.007$ ). The gender distribution differs significantly between the anonymous and non-anonymous treatment variant. There are significantly more women and less men participating in the anonymous treatment in comparison to the non-anonymous treatment where the gender distribution is reversed. For the remaining variables there could not be found a significant difference between the anonymous and non-anonymous variant.

Table 4.2 Demographics compared between anonymous and non-anonymous treatment options

Variable			Anonymous (N=62)	Non-anonymous (N=243)	Total	$\chi^2$	P
Gender	1	Men	35.5%	54.8%	50,8%	7.323	.007**
	2	Women	64.5%	45.3%	49,2%		
Age	1	younger than 18	-	-	-	7.935	.094
	2	19-25	1.6%	3.3%	3,0%		
	3	25-35	4.8%	16.9%	14,4%		
	4	36-45	35.5%	30.5%	31,5%		
	5	46-55	43.5%	32.1%	34,4%		
	6	older than 56	14.5%	17.3%	16,7%		
Education	1	Elementary school	1.6%	1.2%	1,3%	6.439	.266
	2	LBO/MBO	6.5%	11.5%	10,5%		
	3	HAVO/VWO	19.4%	9.5%	11,5%		
	4	MBO	19.2%	25.1%	23,9%		
	5	HBO	40.3%	35.8%	36,4%		
	6	WO	14.5%	16.9%	16,4%		
Occupation	1	full-time job	38.7%	35.4%		6.819	.556
	2	part-time job	24.2%	30.0%			
	3	student	1.6%	1.6%			
	4	volunteer work	-	2.5%			
	5	housewife/man	1.6%	2.1%			
	6	unemployed	6.5%	4.9%			
	7	inability to work	4.8%	8.6%			
	8	retired	8.1%	4.9%			
	9	self-employed	17.7%	9.9%			

Note. N=305.

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .

## 4.2 Characteristics of variables

In the following section the results are highlighted in detail and related to the variables used in this research. These are variables drawn from the “Theory of Reasoned Action”. These variables are hypothesized as being predictive of the Intention to sign-up for the non-anonymous variant. Most variables were measured on a 5-point Likert scale from “strongly disagree” to “strongly agree” with a mean rate of 3. Mean scores smaller than three are entitled as low and scores higher than three as high.

### 4.2.1 Perceived severity

One of the variables which is believed to influence the Intention to sign-up for the non-anonymous variant is Perceived Severity of alcohol abuse. Perceived Severity measured the level of seriousness and urgency of the client to undergo the online treatment. It had a mean of 4.41. This was exemplified in the response on one of the questions measuring this dimension: “Ik denk dat ik meer drink dan de meeste mensen.” The mean response to this question was 4.34 which is very high.

### 4.2.2 Perceived self-efficacy

Perceived Self-Efficacy is another variable which was hypothesized to exert some influence on the intention to sign-up for the non-anonymous treatment variant. It measured the person’s belief in his or her ability to succeed in the aspired behavior which, in this case, is changing the drinking pattern in this case. The item measuring this variable was “Ik denk dat ik goed in staat ben mijzelf ertoe te zetten mijn huidige alcoholgebruik te veranderen” and had a mean score of 3.74

### 4.2.3 Subjective norm

Subjective Norm as a variable was derived from the Theory of Reasoned Action and is a predictor of Intention to sign up for the non-anonymous treatment. It measured the normative influence or the influence of significant others on participants’ decisions with regard to choosing to undergo the treatment or not. The mean score was 2.7. This tells us that most people did not agree with the statement “De meeste mensen zouden graag willen dat ik deze behandeling volg”. This is true for 45.2% who do “not agree” or “strongly disagree” with this point.

### 4.2.4 Motivation to change

Motivation to change measured the degree to which the participants are willing to change their behavior in general. The item to measure this variable was “Ik ben heel gemotiveerd om mijn drinkgedrag te veranderen.” The mean score for this item was 4.05 which is a relatively high score with 70.9% of the people agreeing to being highly motivated to change their drinking pattern.

#### 4.2.5 Outcome beliefs

Outcome Beliefs were also derived from the Theory of Reasoned Action. It is theorized as being a predictor of Intention to sign-up for the non-anonymous treatment and had a mean score of 3.95. This variable measured the impact of several outcome beliefs people were holding about the purpose of the online treatment. The goal of this construct was also to find out which Outcome Beliefs were of greatest and least importance for participants. The items with the highest means and therefore most important for people were about wanting to learn techniques to deal with the problem “Ik wil technieken leren, die mij helpen om met mijn alcoholprobleem om te gaan” (4.55), aiming to regain control over oneself “Ik wild at de behandeling mij help tom weer controle te krijgen over mijn drinkgedrag” (4.53), and wanting to lower the general alcohol consumption “Ik wil minder alcohol drinken” (4.50). The least important outcome belief was to improve the relationship with family and friends “Ik wil de relatie met mijn vrienden en familie verbeteren” (3.06). Two other items also scored fairly low for wishing to stop the alcohol consumption “Ik wil stoppen met het drinken van alcohol” (3.08) and wanting to work more efficiently at one’s job “Ik wil beter kunnen functioneren op mijn werk” (3.13).

#### 4.2.6 Barriers towards signing up for the non-anonymous variant

Another variable in the modified model is Barriers against signing up for the non-anonymous variant. It was hypothesized that this variable would influence the intention to sign up for the non-anonymous variant. This construct examined the barriers derivable from taking all the probable negative impairments when signing up for the non-anonymous variant. The mean score for this variable is 3.19.

The item with the highest mean was “Ik kan kiezen dus dan liever anonym” (4.42) which states that the opportunity to choose between anonymous and non-anonymous is a great barrier when it comes to feeling intended to sign-up for the non-anonymous variant. There were two other items with relative high means. These items relate to the problem of the employer “Ik wil niet dat mijn werkgever weet dat ik alcohol problemen heb” (4.14) and the social environment knowing about the alcohol abuse problem “Ik wil niet dat mensen uit mijn omgeving van min alcoholproblem weten” (4.13). Items with the lowest mean scores were items about having no health insurance in the Netherlands “Ik ben Nederlander maar niet in Nederland verzekerd en dan wordt de behandeling niet verged” (2.48), not having the Dutch nationality therefore not eligible to receive reimbursement from the health insurance “Ik ben geen Nederlander en anders wordt de behandeling niet verged” (2.66), not having known about the possibility to choose for another treatment option “Ik weet niet zeker of de behandeling helemaal door mijn zorgverzekering wordt vergoed” (2.71), and not be

willing to pay the contribution for health insurance “Ik ben niet bereid om de eigen bijdrage te betalen” (2.76).

#### 4.2.7 Information status

Information Status is one of the new variables we introduced into the model. It has been hypothesized that if participants only have insufficient information about the alternative treatment variants, that they won't sign-up for these, because they don't know about them or they don't know about the implications and advantages of these alternatives. The question was whether or not participants had read the information about the three alternative treatment options, employer-paid, insurance-paid and self-paid option. The outcome percentage for not reading the information was 58.1% for the employer-paid option, 48.4% for the insurance-paid one and 51.6% for the self-payers. Also, 61.3% of the participants didn't know that when choosing one of the alternative options, they would be able to start the treatment directly.

#### 4.2.8 Intention

Intention is another variable in the Theory of Reasoned action, which we adopted for completeness. This variable measures the level of effort one is willing to exert to attain a behavioral goal. The item used to measure the Intention was “Nu u weet wat er met uw gegevens gebeurt: zou u bereid zijn om u in te schrijven voor de zorgverzekeringsvariant in plaats van anonym te blijven?” The mean score is of 2.15 the lowest score among all the variables and implies that most participants are not willing to sign up for the non-anonymous treatment even if they know a bit more about how their personal data is used and stored. 67.7% respond that they do not intend to sign up for the non-anonymous treatment in the foreseeable future and only 20.9% state that they are willing or perhaps willing to sign-up for the non-anonymous treatment anytime soon.

#### 4.2.9 Solution suggestions

Solution Suggestions is another construct we believed would influence the intention to sign up for the non-anonymous treatment option. It measures the importance of different problem solving possibilities to participants seeming to prefer the anonymous variant. These participants have to wait a long time for treatment while there is the possibility of non-anonymous treatment were they could start directly. The mean score of this construct is 3.23 which shows a general tendency to the usefulness of these Solution Suggestions as the mean is higher than 3. Our goal with these items also was to discover the most influential solution suggestions for participants. The item with the highest mean contains the option of deleting all the personal details of a client after finishing the therapy “Ik zou eerder geneigd zijn om me voor de zorgverzekeringsvariant op te geven als mijn gegevens achteraf vernietigd worden” (3.87). Close to this score were the items about having more control

about what happens to the personal details afterwards “Ik zou eerder geneigd zijn om me voor de zorgverzekeringsvariant op te geven als ik meer controle zou hebben over wat achteraf met mijn gegevens gebeurt” (3.73) and the possibility of not getting the general practitioner involved in the procedure “Ik zou eerder geneigd zijn om me voor de zorgverzekeringsvariant op te geven als de huisarts het niet te weten zou komen” (3.39). The item with the lowest mean stated that the enrolment for the non-anonymous variant should be more easy “Ik zou eerder geneigd zijn om me voor de zorgverzekeringsvariant op te geven als de aanmeldingsprocedure voor de zorgverzekeringsvariant makkelijk zou zijn” (2.73).

### 4.3 Relations between the constructs

A correlation matrix was constructed showing all important constructs against each other to see whether there are any correlations between them. The demographic variables are not included because there were no significant results found. After that a regression analysis was conducted.

#### 4.3.1 Correlations

Correlations between psychological variables are shown in Table 4.2

Table 4.3 Correlaion Matrix for variables against Intention

	Intention	Outcome beliefs	Perceived severity	Solution suggestions	Information status	Self-efficacy	Barriers	Motivation	Subjective Norm
Intention	1	.111	.040	.307*	-.340**	.185	.065	.033	.195
Outcome beliefs	.111	1	.572**	-.003	.000	.356**	.180	.430**	.125
Perceived severity	.040	.572**	1	.079	.070	.307*	.195	.437**	-.104
Solution suggestions	.307*	-.003	.079	1	-.207	-.061	.279*	-.085	-.055
Information status	-.340**	.000	.070	-.207	1	-.080	.104	.129	-.100
Self-efficacy	.185	.356**	.307*	-.061	-.080	1	-.071	.376**	.228
Barriers	.065	.180	.195	.279*	.104	-.071	1	-.011	.087
Motivation	.033	.430**	.437**	-.085	.129	.376**	-.011	1	.231
Subjective Norm	.195	.125	-.104	-.055	-.100	.228	.087	.231	1

Note. N=62

\*p< .05 \*\*p< .01

In this section we only looked at linear relationships. These only show which variables are related and the direction of the relationship. However, for us to understand which independent variables determined a particular dependent variable we need to look for relationships based on causality. Causality is essential to differentiating which variables are related by chance and those that are predictive. In the next section we use multiple regression analysis to enable us to highlight causal relationships among the variables under study.

### 4.3.2 Regression analysis

In this section regression analysis is used to plot the significant determinant pathways between the various variables and their relationship with Intention to sign-up for the non-anonymous variant. The variables that correlated significantly with in bivariate analyses were included in the regression analysis.

Table 4.4 Regression analysis for Solution Suggestions and Information Status against Intention

Items	b	SE	Beta	p
Information status	-.886	.371	-.289	.020*
Solution Suggestions	.395	.194	.247	.046*
R <sup>2</sup>		.417		
F(df=6)		6.217		
Sig.		.004*		

Note. N=62

\*p <.05 \*\*p< .01

In total, two variables had a significant correlation with Intention (see correlation matrix. These were Solution Suggestions (r= .307, p<.05) and Information Status (r=-.340, p<.05).

Using the regression analysis we found two main predictors of Intention to sign up for the non-anonymous treatment variant. These were, Information Status (b=-.289, p<.05) and Solution Suggestions (b=.247, p<.05). The two variables together account for about 40% (r<sup>2</sup>=.417) of the variance of Intention.

The beta figures show what each variable contributed to the model. Solution Suggestions had a positive relationship with Intention. Information Status has a negative relationship with Intention. If people indicate that they are well informed about the different variants, they are less likely for having the intention to sign up for non-anonymous variant.



## 4.4 Content analysis

Open question data were analyzed according to the principles of content analysis, as Gillham (2000) suggests. Qualitative content analysis is data driven, which means that the codes generated come from the data itself during the course of the study. Following his method the first step in this analysis consisted of reading the answers to determine an initial understanding of the different meanings contained in the answers. The text was then re-read and any sentences, phrases or words describing the specified content were marked and condensed into categories. The researcher immersed herself in the data and let “ad hoc” categories develop spontaneously from her consideration of the data. This method enables a more objective evaluation of the data than by comparing content based on the impressions of the researcher. While listing all the responses received there are tentative categories forming in mind. For each question, these categories are listed and then each statement is checked against these categories. The final categories and frequency of occurrence are entered in an analysis grid shown below in Table 4.4-4.7. The answers are ordered from high to low frequency so that the most frequent answers are at the top of the table. Most of the open questions are actually half-open questions as there was the option given to explain the answer given in the closed questions. Most of the possible answers were already given through the close questions and therefore there were only a few people filling in the open questions as it was not compulsory in continuing with the questionnaire. The statements made in these open questions are very helpful and explorative. Even if the analysis of open questions is sometimes a bit hard it was very useful for our purpose to include these extra questions to gain some additional information. The full answers to all open questions can be found in Appendix G and H.

### 4.4.1 Open questions

#### 4.5 Content analysis of Outcome Beliefs

Reasons for signing up for the online-treatment	Frequency
reducing alcohol consumption	2
win back control	2
being a role-model	1

The stated reasons for signing up for the online-treatment in general were mostly the wish to reduce the overall alcohol consumption, or to come back to a normal alcohol intake level in order to win back control over behavior. One person said that her driving force would be the wish to be a good role-model for her son.

#### 4.6 Content analysis of reasons for anonymous variant

Reasons for signing up for the <b>anonymous</b> variant	Frequency
simply to remain anonym	2

feeling of shame in relation to general practitioner, health insurance, social environment	1
easy solution	1

In order to find out the Motivation for people to sign up for the anonymous variant and not for the non-anonymous one, there was a question designed to investigate the importance of different reasons given. There was the option to add personal reasons which were not covered in the given ones. Participants indicated that the desire to remain anonymous while being treated was an important point for them without explaining the reason for this desire. Also named was a feeling of shame in relation to the general practitioner, health insurance and social environment. One person said that this way was the easiest solution without having to worry about anything.

#### 4.7 Content analysis of Intention

Intention to sign up for the non-anonymous variant instead of the anonymous one after being informed about the handling of the personal details	Frequency
<b>Low intention to sign up:</b>	
don't want my general practitioner to be informed	6
don't want my health insurance to know	4
uncertainties concerning privacy	4
fear of wrong conclusions being drawn on the basis of the alcohol problems regarding future health problems	4
don't want my social environment to know (family, friends, partner)	3
Stigma	3
don't want my employer and colleagues to know	2
bad relation with general practitioner	2
not sure about compensation	2
live abroad	1
follow-up treatment	1
<b>High intention to sign up:</b>	
waiting time too long	1

When it came to indicating the Intention to sign up for the non-anonymous variant after being informed about the handling of identification information, most participants indicated a low Intention to sign up for the treatment. The reason most frequently stated was that they didn't want their general practitioner to be informed about their alcohol problems followed by the items regarding the health insurance, uncertainties concerning privacy and the fear of wrong conclusions being drawn from the alcohol-problem background with regard to future health problems. Three people indicated that they didn't want their social environment to know about the alcohol problems and that they are afraid of being stigmatized or labeled by people. Another named reason was that

people are afraid that their employer or colleagues might learn about their problems. Some people stated that their relationship to their general practitioner was too bad and that they didn't want to inform him about their alcohol problems. Furthermore, people were often unsure about the costs of the treatment being covered by the insurance and therefore rather signed up for the anonymous treatment where they wouldn't have to worry about this. Only one person reports to be living abroad and therefore being unable to undergo the non-anonymous treatment. For another person this treatment is an additional treatment to an insurance covered face-to-face. The person wants to follow this second treatment to stay alert and isn't sure about here health insurance covering the costs a second time. One participant with a high intention to sign up for the anonymous variant stated as a reason that the waiting time of 5 months is too long and that she would rather publish her details and start the treatment immediately than waiting such a long time.

**4.4.2 Essay Question**

4.8 Content analysis of Solution Suggestions

Suggestions how people can be stimulated to sign up for the non-anonymous variant:	Frequency
Replace non-anonymous with anonymous variant through letting all the insurance companies and the government pay for it	3
No idea	3
Indicating the advantage regarding the shorter waiting time more clearly	2
Taking out the necessity of a referral letter from general practitioner	2
Elimination of personal details in every case	2
no personal details at all	2
Indicate that the treatment will be paid for by the insurance more clearly	1
Remaining anonym in front of health insurance	1

The open question asking about suggestions to stimulate people's Intention to sign up for the non-anonymous variant brought some useful points forward. Three participants suggested that all the insurance companies and the government be included in this project and that they pay for the treatment. In this way the non-anonymous variant can be replaced with the anonymous variant and the possibility of more treatment places in that variant. Some people indicated that they don't really know what to answer because they were not familiar with the system and how everything comes together. Participants said it might be helpful to indicate the shorter waiting time of the non-anonymous variant more clearly and that also the necessity of a referral letter from the general practitioner should be taken out. As also stated in the closed questions above, people find it very important that all the personal details are eliminated after finishing the treatment or that there are no personal information necessary at all. It was also suggested to indicate more clearly that the non-anonymous treatment will be paid by the insurance and that remaining anonymous in front of the

health insurance might ease the entering of the non-anonymous treatment. The complete answers to this question can be found in Appendix H.

## 5. Conclusion

The aim of this study was to examine the reasons and motives for people to choose against the non-anonymous treatment option when entering the online therapy for alcohol problems. This was done by identifying the demographic factors, social cognitive and psychological variables which are associated with the enrolment behavior of participants.

The study yielded that respondents have different reasons for preferring the anonymous treatment towards the non-anonymous one. Despite the fear of stigma, most respondents were afraid that they don't have any control over where and how their identification information are stored and who has access to them. There were other factors such as Perceived Self-efficacy, Subjective Norm, Motivation to undergo the anonymous variant and Outcome Beliefs, that altogether might have influenced the Intention to sign up for the non-anonymous treatment.

Results show relations between the specified constructs and the qualitative responses bring in some additional points to think about such as the often stated fear of abuse of privacy when giving up identification information. Conclusions from these results will be drawn and developed into concrete recommendations for Tactus.

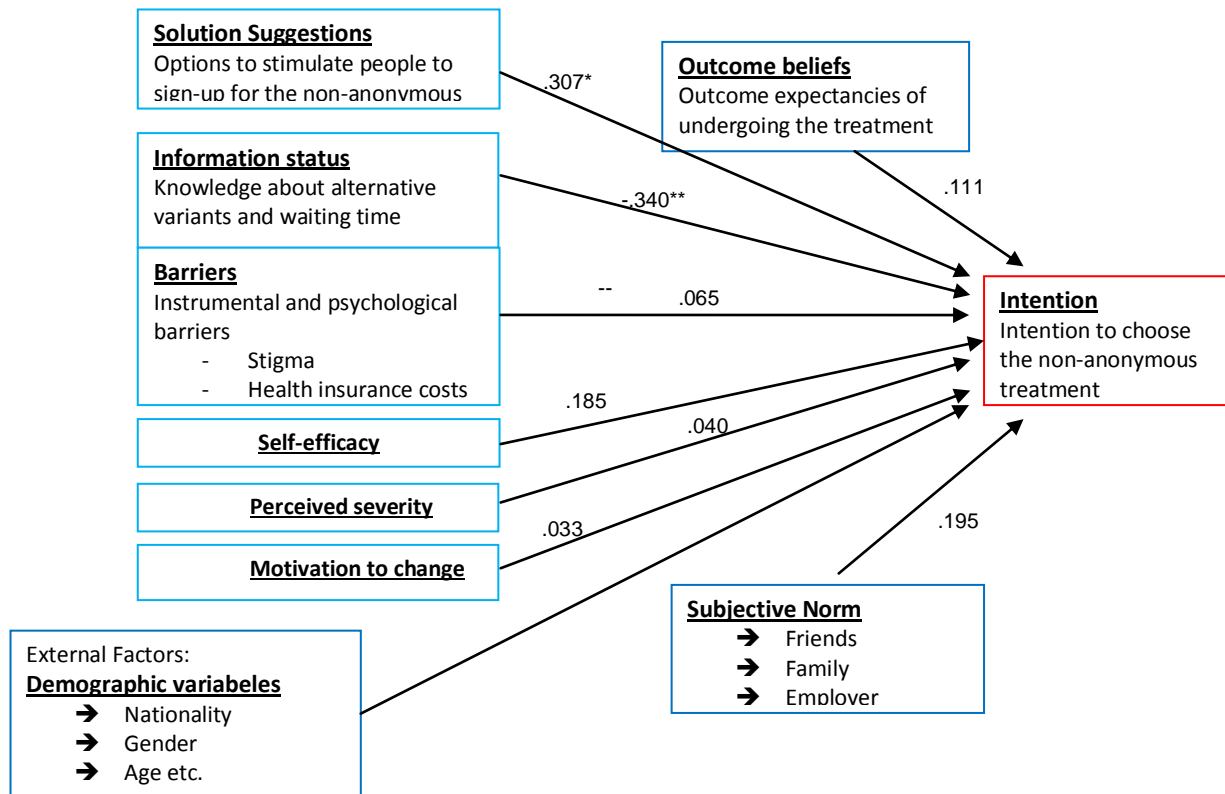


Table 5.1. Resulting correlations between constructs and dependent variable

## 5.1 Conclusions about sub questions

In chapter 2 a research question with six sub questions was constructed. Answers to these are given per category from integrative research model (chapter 2).

### 5.1.1 Reasons for remaining anonym

In the first place the results give an answer to the first sub question: *What are the reasons of participants for not choosing for the non-anonymous variant?*

Through analyzing the questionnaire it has been shown that there are several reasons and motives for people wanting to stay anonymous. The analysis of the psychological and instrumental Barriers proved that the option to choose between the anonymous variant and the other treatment variants represents the main barrier for participants. The opportunity to choose between anonymous and non-anonymous seems to be an important reason why people do not participate non-anonymously. Furthermore, participants' stated having a problem with their employer and their social environment knowing about their alcohol abuse problem which can be related to their fear of stigmatization. The mean score result (4.00) of the stigma item "De meeste mensen denken negatief over mensen met een alcoholprobleem" showed that the fear of being stigmatized is a relevant Barrier for participants

when thinking about signing up for the non-anonymous variant. Additionally, participants indicated that they did not want their general practitioners and health insurance to know about their abuse problem and that they are concerned about their privacy. People were also afraid that there could be wrong conclusions drawn on the basis of their alcohol problem regarding their future health problems and care. These fears contributed to the participants' behavior of avoiding the non-anonymous treatment variant to avoid these fears.

Items regarding the fear or uncertainty of additional insurance costs resulted in low mean scores. Having to pay a contribution to health insurance did not appear to be no reason for participants to choose against the non-anonymous variant. This finding might also be related to the fact that most participants are well earning.

Concerning the Information Status, there seems to be a wide knowledge gap with approximately half of the participants not having read the information about the alternative treatment options. Also, 61% of the participants stated that they did not know that they could start immediately when choosing one of the alternative options. These results show that the insufficient knowledge status and advantages about the alternative options are given.

After providing the sufficient information about the procession of identification information and the advantage of no waiting time only 21% of the participants stated that they were intended to sign up for the non-anonymous variant. This number seems low but it means that two out of ten people can be persuaded to sign up for the non-anonymous variant providing being sufficiently informed. Therefore we can conclude that the waiting time did not play a role for participants when deciding about their treatment variant.

### 5.1.2 Intention

The second sub question in the study was: *Is there a relationship between the Motivation to change and the Intention to sign up for the non-anonymous variant?*

The correlation between general Motivation and Intention to sign up for the non-anonymous variant was positive but very small (.033). There was no significant relationship found between these variables. Most participants indicated that they do not intent signing up for the non-anonymous option after having read the additional information about the advantages and conditions of the non-anonymous option. This shows that even if most people are highly motivated to change their drinking behavior through participating in the anonymous treatment, they do not perceive the waiting time as a big barrier when it comes to choosing between anonymous and non-anonymous

variant. That might be due to their unawareness of the actual waiting time duration and their perceived advantage to take part anonymously.

For most respondents the intention to sign up for the non-anonymous variant was low. Nevertheless, there was a small group who did indicate that they would sign up for the non-anonymous variant after being informed about the actual enrolment procedure and storage of personal details. This finding suggests that factors like Solution Suggestions and Information Status exert some influence on participants Intention to sign up for the non-anonymous variant. This assumption has been confirmed by linear regression analysis.

### 5.1.3 Psychological constructs

Furthermore the results gave answer to the third sub question: *Which psychological constructs exert influence on the Intention to sign up for the non-anonymous variant?*

Correlation analysis showed that the intention to sign up for the non-anonymous variant is namely dependent on Solution Suggestions and Information Status of the participant. There had been no significant correlation between any of the other constructs and Intention.

The Subjective Norm didn't seem to play an important role in the outcome behavior of participants. This is implied by the fact that despite most of their family and friends wouldn't want them to follow the treatment, respondents still signed up for the treatment. This finding was also grounded by the mean score of the Subjective Norm item. It was found to be 2.73, meaning that the positive perceptions of Subjective Norm about the online treatment is relatively low

If there should be an influence of Subjective Norm on the intention to sign up for the treatment it would be a negative correlation. But the participating people had already signed up for the online treatment and therefore it might not have played such a big role in decision making. This might be the reason though, why most people wish to remain anonymous. Being known as an alcoholic is not a socially desirable.

The resulting mean score of the Perceived Severity variable (4.41) shows that most participants perceived their alcohol abuse problem as a serious problem and that they were thinking about doing something about their alcohol consumption for some time. Although participants rate their Perceived Severity of alcohol abuse as high (=serious), this variable seems to have no influence on the Intention of people concerning the enrolment-attitude for the non-anonymous variant.

The construct Perceived Self-efficacy had a mean score of 3.74, which shows that participants generally see themselves as able to change their drinking behavior. There is also no significant correlation found between Perceived Self-efficacy and Intention.

The findings about the Outcome Beliefs of treatment have shown to be consistent with the findings of Subjective Norm. These findings state that attitude of family and friends had no impact on the Intention of participants which variant to follow. With the Outcome Beliefs the least important one was to improve the relationship with family and friends. People don't aim to improve their relations with family and friends through the treatment. Participants added the goal to reduce their alcohol consumption, win back the control over alcohol consumption and being a role model for their children in the open part of the question.

#### 5.1.4 Solution Suggestions

The fourth sub question: *Which Solution Suggestions are perceived as stimulating for people to sign up for the non-anonymous treatment?*

Respondents who rated the Solution Suggestions high were also more likely to indicate having the Intention of signing up for the non-anonymous variant.

Our goal with this construct was to find the most influential Solution Suggestions for participants. These important Solution Suggestions would then be manifested through research and will form the basis for further adjustments and changes of all important aspects of the program. The results indicated that clients would like to have more control about the handling of their data. The suggestion to automatically delete the identification information of every participant after finishing therapy was rated very high. This finding confirms our assumptions about participants' resistance of giving up their identification information and is also consistent with the predictions of the "Pathway Disclosure Model." This model states that people are going to be more willing to participate in a treatment if they do not to publish any identification information. In this way people remain in control of their identification information and do not have to worry about losing their anonymity. These findings show that perceived control about identification information plays an important role for people when deciding about signing up for a treatment option.

#### 5.1.5 Solution Suggestions made by participants

The fifth sub question: *Do participants hold some important suggestions about how to stimulate people to participate via the non-anonymous pathway?* was given by qualitative results.

Some participants mentioned the idea of replacing the non-anonymous variant with a larger anonymous one through letting all the insurance companies and the government pay for it. In that way the anonymous option would have more places of patient intake. Other suggestions hold the idea of indicating the advantage of the shorter waiting time more clearly, taking out the necessity of a referral letter from general practitioner and automatically deleting all the personal details after



finishing the treatment. These additional Solution Suggestions given from participants contain the tendency of a larger anonymous variant instead of improving the acceptance of the non-anonymous one. Only one participant stated that she would sign-up for the non-anonymous variant when having known about the waiting time of five month. This finding is consistent with earlier findings about the weak impact of waiting time on Intention to sign up for the non-anonymous variant.

### 5.1.6 Demographics

Finally the results gave answer to the sixth sub question: *To what degree do Demographics influence the intention to sign up for the non-anonymous variant?*

The distribution of gender was as expected, twice as many women than men participated in the survey and the education level is also higher than average with most participants in higher applied education (HBO). About 75% of the participants work in a full- or part time job or are self employed. No significant relationship could be observed between Demographics and Intention through the statistical analysis.

The comparison of the anonymous and non-anonymous group to detect the significant differences of participants resulted in interesting outcomes. Women are highly represented in the anonymous variant. Here, there is a clearly difference between the distribution of man and women. In the non-anonymous variant, the gender differences are not that wide. For the remaining variants, there could not been detected a significant difference between the groups. Although it can be seen (in the frequency table 4.2) that there are about three times as many participants in the age group from 25-35 years undergoing the non-anonymous treatment in comparison to the anonymous one. The differences in education and occupation are minimal. There can no conclusions be drawn from this analysis because it is not based on recent literature in the field and requires further investigation.

## 6. Recommendations

These conclusions allow giving an answer to the main research question: *How can future participants be stimulated to sign-up for the non-anonymous treatment option (insurance paid)?*

The research was an exploration into the factor influencing the Intention of participants to sign up for the online treatment. The executed research resulted in several conclusions which are summarized in the following recommendations. The following general recommendations address any deficiencies in the participants score in the examined factors to enhance participation in the non-anonymous treatment option.

Participants indicated that the possibility to choose between the anonymous and the non-anonymous options represents the largest barrier regarding the enrolment Intention for the non-anonymous option. As long as there is an anonymous option, people will rather go for that one than facing all the perceived fears of participating non-anonymous. Therefore, it is recommended to either leave the anonymous option out, to rename the options or to enlarge the number of clients for whom will be paid for under the anonymous treatment. If it should be possible for everyone to participate in treatment even Dutchman living abroad or people without a health insurance covering the treatment there could still be arranged the “emergency-option” where people have to explain their reasons of not being able to take part through one of the other options.

The information and advantages about the alternative options should be presented more eye-catching because about 50% of the respondents stated that they didn’t read the information of the alternative options. Instead of placing the four alternative option-buttons on one page next to each other there could be a new division of the options. Also, the fact that there is a waiting list for the anonymous variant and that participants may start immediately when choosing the non-anonymous variant should be stated more clearly on the website.

Only one person out of sixty-two stated that the long waiting time would be a reason for her to sign up for the non-anonymous variant if she would have to decide again. Beforehand most people either don’t know about the differences in waiting time among the variants or have no idea how long it will take to get a place in the treatment. Therefore, the aspect of waiting time should be stated more clearly and people should be able to get an idea about how long the waiting time would be before signing up and be given the possibility to start immediately through the non-anonymous option.

Participants’ fears regarding their loss of privacy have to be taken serious. There has to be found a way to give them a feeling of control about their identification information. Many respondents rated the Solution Suggestion “deleting the personal details after finishing the treatment” very high. This possibility should be taken into account and it could be tried to find an agreement between the

participants and the health insurance needs to promote participation in the non-anonymous treatment.

Eventually, further research needs to be conducted to further clarify the “impact of waiting time.” In this study it was found that about 60% of the participants were not aware about the fact that there is no waiting time for the non-anonymous variant. It has been shown that even when people are aware of this advantage, most of them didn’t intend to sign up for the non-anonymous variant. This shows that the disadvantage of having to wait for treatment doesn’t seem to be an important barrier for participants influencing their Intention. Thereby, the question arises whether the participants feel and think like that (feelings and thoughts are caused/supported) due to their insufficient knowledge about the duration of waiting time or because they perceived advantage of anonymity outweighs the perceived disadvantage of having to wait for treatment. Furthermore it would be interesting to examine the threshold of tolerated waiting time.

The following central points should be considered by Tactus:

- Take out the anonymous option to intensify the participants attention on the non-anonymous one
- Rename the options so that the emphasis is on the non-anonymous option and not on the anonymous option
- Clients desire more information about the alternative options and new innovative ways of delivering this should be adopted
- Difference between the options concerning the waiting time should be stated more clearly on the website
- Restructure the sectioning and naming of treatment alternatives
- State the duration of actual waiting time more clearly
- Try to find an agreement with the health insurance companies regarding the identification information of participants after finishing treatment
- Pursue further research to clarify the “impact of waiting time” and the corresponding threshold of tolerated waiting time
- Investigate the reasons for gender and age differences between the anonymous and non-anonymous group

## Literature

- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior* (1th ed.). New York: Prentice-Hall.
- Ajzen, I. (1988). *Attitude, Personality and Behavior* (1st ed.). England: Open University Press.
- Andrews, G., Hall, W., Teeson, M., Henderson, S. (1999). *The mental health of Australians National Survey of Mental Health and Well-being Report 2* (1st ed.) Canberra: Mental Health Branch, Commonwealth Department of Health and Aged Care
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Engelwood Cliffs, New York, Prentice-Hall.
- Bandura, A. (2000). Health promotion from the perspective of social cognitive theory. In P. Norman, C. Abraham, & M. Conner (Eds.), *Understanding and changing health behaviour* (pp. 299-339). Reading, UK: Harwood.
- Barak, A. (1999). Psychological applications on the Internet: A discipline on the threshold of a new millennium. *Applied and Preventive Psychology*, 8, 231-246.
- Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, 26, 109-160.
- Bai, Y. M., Lin, C. C., Chen, J. Y., & Liu, W. C. (2001). Virtual psychiatric clinics. *American Journal of Psychiatry*, 158, 1160–1161.
- Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry*, 31, 501-513.
- Brug, J., Oenema, A., Campbell, M. (2003). Past, present, and future of computer-tailored nutrition education. *American Journal of Clinical Nutrition*, 77, 1028S–1034.
- Cassell, M., Jackson, C., & Chevront, B. (1998). Health communication on the Internet: An effective channel for health behavior change? *Journal of Health Communication*, 3, 71–79.
- Centraal Bureau voor de Statistiek (2008). *1,2 miljoen Nederlanders hebben thuis geen internet*. Retrieved April 15, 2009, from <http://www.cbs.nl/nl-NL/menu/themas/vrije-tijd-cultuur/publicaties/artikelen/archief/2008/2008-2641-wm.htm>.
- Childress, C. A. (2000). Ethical issues in providing online psychotherapeutic interventions. *Journal of Medical Internet Research*, 2, 1-6.
- Codd, R. T., & Cohen, B. N. (2003). Predicting college student intention to seek help for alcohol abuse. *Journal of Social & Clinical Psychology*, 22, 168-190.
- Cooper, G. (2004). Exploring and understanding online assistance for problem gamblers: The pathways disclosure model. *International Journal of Mental Health & Addiction*, 1, 32-38.

- Corrigan, P. W., Demming Lurie, B., Goldman, H. H., Slopen, N., Medasani, K., & Phelan, S. (2005). How adolescents perceive the stigma of mental illness and alcohol abuse. *Psychiatric Services, 56* (5), 544-550.
- Cowley, D. S. (1992). Alcohol abuse, substance abuse, and panic disorder. *The American journal of medicine, 92*, 41-48.
- De Jong, M., & Schellens, P. J. (2000). Toward a document evaluation methodology: What does research tell us about the validity and reliability of evaluation methods? *IEEE Transactions on Professional Communication, 43*, 242-260.
- De Vellis, R. F. (2003). *Scale development: Theory and applications* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Finn, J. (1999). An exploration of helping processes in an online self-help group focusing on issues of disability. *Health and Social Work, 24*, 220-231.
- Fishbein, M. A., & Ajzen, I. (1975). *Belief, attitude, intention and behavior: an introduction to theory and research*, Reading, MA, Addison Wesley.
- Fogel, J., Albert, S. M., Schnabel, F., Ditkoff, B. A., & Neugut, A. I. (2002). Internet use and social support in women with breast cancer. *Health Psychology, 21*(4), 398-404.
- Gillham B. (2000), *Developing a Questionnaire* (2nd. ed.). Continuum International Publishing Group Ltd.
- Groves R. M., Flower, F. J., Couper M. P., Lebrowski, J. M., Singer, E. Tourangeau, R. (2004) *Survey Methodology* (2nd. ed.). Wiley-Interscience.
- Halgin, R. P., Weaver, D. D., Edell, W. S., & Spencer, P. G. (1987). Relation of depression and help-seeking history to attitudes toward seeking professional help. *Journal of Counseling Psychology, 34* (2), 177-185
- Hsuing, R. C. (2001). Suggested principles of professional ethics for the online provision of mental health services. *Studies in Health Technology and Informatics, 84*, 1296–1300.
- Joinson, A. (1998). Causes and implications of disinhibition behaviors on the Internet. In J. Gackenbach (Ed.), *Psychology and the Internet* (pp. 43–58). New York: Academic.
- Joinson, A. (1999) Social desirability, anonymity, and Internet-based questionnaires. *Behavior Research Methods, 31* (3), 433-438
- Jordan C. M., & Oei, T. P. S. (1989), Help-seeking Behavior in Problems Drinkers: A Review, *British Journal of Addiction, 84*, 979 - 988.
- Keizer, H., Postel, M., Westendorp, H., & Brenninkmeijer, M. (2007). *Ontwikkeling Alocholdebaas.nl internetbehandeling: resultaten scoren 2007*. Amersfoort: GGZ Nederland

- King, S. A., & Moreggi, D. (1998). Internet therapy and self help groups - the pros and cons. In J. Gackenbach (Ed.), *Psychology and the Internet: Intrapersonal, Interpersonal and Transpersonal Implications* (pp. 77-109). San Diego, CA: Academic Press.
- Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*, 138–143.
- Lange, D., Rietdijk, M., Hudcovicova, J.-P., van den Ven, B., Schrieken, A., & Emmelkamp, P.M.G. (2003). Interapy: A controlled randomized trial of the standardized treatment of posttraumatic stress through the Internet, *Journal of Consulting and Clinical Psychology, 71*, 901–909.
- Latt, N. Saunders, J. B., (2002) Alcohol misuse and dependence - Assessment and management Australian Family Physician Vol. 31, No. 12
- Matthews, S. (2006). On-line professionals. *Ethics and Information Technology, 8*, 61-71.
- Matheson, K., & Zanna, M. P. (1990). Computer-mediated communications: the focus is on me. *Social Science Computer Review, 8*, 1–12.
- Mojtabai, R., Olfson, M., Mechanic, D. (2002). Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry, 59*, 77-84.
- NCI & RWJF (2001). *Online behavior change and disease management: A research dialogue*. National Institute of Cancer & Robert Wood Johns Foundation. Retrieved April 15, 2009, from: [http://www.hetinitiative.org/content/Behav\\_Chng\\_and\\_Disease\\_Mgt.pdf](http://www.hetinitiative.org/content/Behav_Chng_and_Disease_Mgt.pdf)
- Prentice-Dunn, S., & Rogers, R. W. (1982). Effects of public and private self-awareness on deindividuation and aggression. *Journal of Personality and Social Psychology, 43*, 503-513
- Postel, M. G., de Haan, H. A., & de Jong, C. A. J. (2008). E-therapy for mental health problems: A systematic review. *Telemedicine and e-Health, 14*, 707-714.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and Processes of Self-Change in Smoking: Toward an Integrative Model of Change. *Journal of Consulting and Clinical Psychology, 51*, 390-395.
- Rijksinstituut voor Volksgezondheid en Milieu (2008). *Afhankelijkheid van alcohol – Nationaal Kompas Volksgezondheid*. Retrieved March 23., 2009, from: [http://www.rivm.nl/vtv/object\\_class/kom\\_afhankelijk\\_alc.html](http://www.rivm.nl/vtv/object_class/kom_afhankelijk_alc.html)
- Schober, R., & Annis, H. M. (1996). Barriers to help-seeking for change in drinking: A gender-focused review of the literature. *Addictive-Behavior, 21*, 81–92.
- Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35-37). Windsor, UK: NFER-NELSON.
- Statistics Netherlands (2009), Retrieved March 26., 2009, from: <http://www.cbs.nl/nl-NL/menu/themas/vrije-tijd-cultuur/publicaties/artikelen/archief/2008/2008-2641-wm.htm>

- Suls, J. M. & Wallston, K. A. (2003). *Social Psychological Foundations of Health and Illness* (1st ed.). Wiley-Blackwell.
- Takeuchi, D. T., Leaf, P. J., & Kuo, H. (1988). Ethnic differences in the perception of barriers to help-seeking. *Social Psychiatry & Psychiatric Epidemiology*, *23*, 273-280.
- Terry, D. J., Gallois, C. & McCamish M. (1993) The theory of reasoned action: Its application to AIDS-preventive behavior. Pergamon Press, Oxford.
- Van Hooft, E. A., Born, M. P., Taris, T. W., & Van der Flier, H. (2005). Predictors and outcomes of job search behavior: The moderating effects of gender and family situation. *Journal of Vocational Behavior*, *6*, 133-12.
- Van Laar, M. W., Cruts, A. A. N., Verdurmen, J. E. E., Van Ooyen-Houben, M. M. J., & Meijer, R. F. (2007). *Nationale Drug Monitor. Jaarbericht 2006*. Utrecht: Trimbos-instituut.
- Vogel, D. L., Wester, S. R. (2003). To Seek Help or Not to Seek Help: The Risks of Self- Disclosure. *Journal of Counseling Psychology*, *50* (3), 351-361.
- White, M., and Dorman, S. M. (2001). Receiving social support online: implications for health education. *Health Education Research*, *16*, 693-707.
- Wicker, A. W. (1969). Attitudes versus actions: The relationship of verbal and overt behavioral responses to attitude objects. *Journal of Social Issues*, *25* (4), 41-78.
- Winzelberg, P. (1997). The analysis of an electronic support group for individuals with eating disorders. *Computers in Human Behavior*, *13*, 393-407.
- Ybarra, M. & Eaton, W. W. (2005). Internet-based mental health interventions. *Mental Health Services Research*. *7*(2), 75-87.
- Zabinski, M. F., Celio, A.A., Wilfley, D.E., and Taylor, C.B. (2003). Prevention of eating disorders and obesity via the internet. *Cognitive Behaviour Therapy*, *32*, 137-150.

## Appendix A: Questionnaire for „treatment waiters“

### Internetbehandeling Alcoholdebaas.nl

Beste deelnemer,

Tactus Verslavingszorg is voortdurend bezig om de verschillende internetbehandelingen te evalueren en te verbeteren. Het huidige onderzoek evalueert, in samenwerking met de Universiteit Twente, de internetbehandeling Alcoholdebaas.nl. Het doel van het onderzoek is om meer inzicht te krijgen in de redenen van deelnemers om wel of niet hun zorgverzekeringgegevens te verstrekken.

De vragenlijst bestaat uit vier onderdelen A t/m D. U kunt antwoord geven door uw keuze aan te vinken. We willen u verzoeken de vragen zorgvuldig te lezen en eerlijk te beantwoorden. In het onderzoek gaat het om uw mening en er zijn dus geen goede of foute antwoorden. Alle gegevens worden anoniem verwerkt.

Het invullen van de vragenlijst zal ongeveer 10 minuten in beslag nemen.

Alvast bedankt voor uw medewerking!

Met vriendelijke groet,  
Claudia Nowak  
Universiteit Twente

#### Onderdeel A

Als eerste zijn we benieuwd hoe u denkt over uw eigen alcohol gebruik. Ook willen we graag weten wat uw verwachtingen zijn of waren ten aanzien van de internetbehandeling.

1. Heeft u de internetbehandeling reeds gevolgd?  
 Ja, en ik heb deze intussen afgerond  
 Ja, en ik ben er op dit moment mee bezig  
 Nee, ik wacht nog op de behandeling  
 Nee, ik ben al met een andere behandeling gestart  
 Nee, ik heb er ook geen behoefte meer aan

2. Geef bij de volgende uitspraken aan in hoeverre u het er mee eens bent.

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	Ik denk dat ik meer drink dan de meeste mensen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Ik denk er al langer over na om iets te ondernemen tegen mijn overmatige alcoholgebruik	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



3	Ik denk dat ik goed in staat ben mijzelf ertoe te zetten mijn huidige alcoholgebruik te veranderen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	De meeste mensen die belangrijk voor mij zijn zouden graag willen dat ik deze behandeling volg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik ben heel gemotiveerd om mijn drinkgedrag te veranderen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Geef bij de volgende uitspraken aan in hoeverre u het er mee eens bent.

Wat zijn de redenen waarom u zich heeft opgegeven voor de internetbehandeling?

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	Ik verwacht dat deze behandeling me zal helpen om mijn alcoholprobleem onder de knie te krijgen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Ik wil mijn fysieke gezondheid verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Ik wil mijn emotionele welzijn verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Ik wil in staat zijn om de kern van mijn probleem te begrijpen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik wil minder alcohol drinken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Ik wil stoppen met het drinken van alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Ik wil technieken leren, die mij helpen om met mijn alcoholprobleem om te gaan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Ik wil dat de behandeling mij helpt om weer controle te krijgen over mijn drinkgedrag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Ik wil beter kunnen functioneren op mijn werk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Ik wil de relatie met mijn vrienden en familie verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anders, namelijk

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## Onderdeel B

In dit onderdeel gaat het om uw motieven om voor de anonieme internetbehandeling te kiezen en niet voor de zorgverzekeringsvariant.

4. In hoeverre spelen onderstaande redenen een rol bij uw keuze voor de anonieme internetbehandeling?

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens	n.v.t.
1	Ik weet niet zeker of de behandeling helemaal door mijn zorgverzekering wordt vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Het is mij niet bekend dat ik voor een andere variant kan kiezen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Ik ben niet bereid om de eigen bijdrage te betalen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Ik wil niet dat mijn werkgever weet dat ik alcohol problemen heb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik kan kiezen, dus dan kies ik liever anoniem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Ik wil niet dat mensen uit mijn omgeving van mijn alcoholprobleem weten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Ik ben bang dat mijn gegevens ergens in een database worden opgeslagen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Ik ben bang dat anderen mijn gegevens kunnen inzien	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Ik ben geen Nederlander en anders wordt de behandeling niet vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Ik ben Nederlander maar niet in Nederland verzekerd en dan wordt de behandeling niet vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anders, namelijk

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5. Geef uw mening t.a.v. onderstaande stellingen over mensen met een alcoholprobleem.

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	De meeste mensen met een alcoholprobleem zijn zelf schuldig aan hun problemen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	De meeste mensen denken negatief over mensen met een alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Het is een teken van sociale zwakte als je je alcoholgebruik niet onder controle hebt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Het is verstandiger om niet te vertellen dat je hulp zoekt bij je alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Anderen beoordelen iemand minder positief als zij weten dat hij/zij hulp zoekt vanwege een alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Onderdeel C

U heeft gekozen voor de anonieme variant van de internetbehandeling. Maar we willen u ook graag een aantal vragen stellen over uw mening ten opzichte van de zorgverzekeringvariant.

6. Heeft u de informatie op de website gelezen over onderstaande alternatieve varianten om de online-behandeling te volgen?

		Ja	Nee
1	Vergoeding door werkgever	<input type="checkbox"/>	<input type="checkbox"/>
2	Vergoeding door zorgverzekering	<input type="checkbox"/>	<input type="checkbox"/>
3	Zelf betalen	<input type="checkbox"/>	<input type="checkbox"/>

7. Weet u dat u meteen kunt beginnen met de behandeling als u de zorgverzekeringvariant of werkvariant kiest?

Ja

Nee

**8. Informatie over vergoeding van de internetbehandeling door uw zorgverzekering:**

Als u voor de zorgverzekeringvariant kiest, kunt u direct starten met de behandeling. De behandeling wordt, na opgave van uw persoonsgegevens, door uw zorgverzekeraar vergoed (m.u.v. eigen bijdrage). Binnen drie werkdagen krijgt u een hulpverlener toegewezen. Alcoholdebaas.nl heeft naast uw gegevens een verwijzing van uw huisarts nodig. Dit laatste wordt voor u geregeld na uw toestemming. U hoeft dan niet zelf naar de huisarts voor een afspraak.

Deze vergoeding geldt alleen voor Nederlandse zorgverzekeraars.

Wat gebeurt er met uw gegevens?

Naast de betrokken hulpverleners van het internetbehandelteam, is alleen uw zorgverzekeraar en uw huisarts op de hoogte van uw deelname. De Wet Bescherming Persoonsgegevens beschermt uw persoonsgegevens. Behalve uzelf en de direct betrokken hulpverleners heeft niemand toegang tot uw persoonlijke online dossier. Al het berichtverkeer tussen u en uw hulpverlener verloopt via uw beveiligde persoonlijke dossier waarop u kunt inloggen, dus niet via e-mail.

Nu u weet wat er met uw gegevens gebeurt: zou u bereid zijn om u in te schrijven voor de zorgverzekeringvariant in plaats van anoniem te blijven?

Ja, zeker – Misschien wel – ik weet het niet – Waarschijnlijk niet – Nee, zeker niet

Wilt u uw keuze even toelichten?

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9. Hieronder staan een aantal mogelijkheden om de zorgverzekeringvariant aantrekkelijker te maken. Wij willen graag uw mening hierover weten.

Ik zou eerder geneigd zijn om me voor de zorgverzekeringvariant op te geven als...

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	de ernst van mijn verslaving groter zou zijn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	ik meer informatie zou krijgen over de zorgverzekeringvariant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	de aanmeldingsprocedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	voor de zorgverzekeringvariant makkelijker zou zijn					
4	ik minder gegevens zou moeten opgeven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	de huisarts het niet te weten zou komen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	ik meer controle zou hebben over wat achteraf met mijn gegevens gebeurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	mijn gegevens achteraf vernietigd worden	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	er geen anonieme variant bestond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Heeft u suggesties op welke manier meer mensen kunnen worden gestimuleerd voor de zorgverzekeringsvariant?

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## Onderdeel D

In dit gedeelte vragen we u nog een aantal achtergrondgegevens.

11. Wat is uw leeftijd?

- Jonger dan 18 jaar
- 18-25 jaar
- 26-35 jaar
- 36-45 jaar
- 46-55 jaar
- Ouder dan 56 jaar

12. Wat is uw geslacht?

- Man  
 Vrouw

13. Wat is uw nationaliteit?

- Nederlands  
 Anders, namelijk \_\_\_\_\_

14. Wat is uw belangrijkste dagbesteding?

- Betaalde fulltime baan  
 Betaalde parttime baan  
 Studerend, schoolgaand  
 Vrijwilligerswerk  
 Huisvrouw of huisman  
 Werkloos  
 Arbeitsongeschikt  
 (Vroegtijdig) pensioen  
 Zelfstandig ondernemer  
 Anders, namelijk \_\_\_\_\_

15. Wat is de hoogste opleiding die u met een diploma heeft afgesloten?

- Basisschool  
 LBO/MAVO  
 HAVO/VWO  
 MBO  
 HBO  
 WO  
 Anders, namelijk \_\_\_\_\_

*Bedankt voor het invullen van de vragenlijst!*

## Appendix B: Questionnaire for „treatment receivers“

### Internetbehandeling Alcoholdebaas.nl

Beste deelnemer,

Tactus Verslavingszorg is voortdurend bezig om de verschillende internetbehandelingen te evalueren en te verbeteren. Het huidige onderzoek evalueert, in samenwerking met de Universiteit Twente, de internetbehandeling Alcoholdebaas.nl. Het doel van het onderzoek is om meer inzicht te krijgen in de redenen van deelnemers om wel of niet hun zorgverzekeringgegevens te verstrekken.

De vragenlijst bestaat uit vier onderdelen A t/m D. U kunt antwoord geven door uw keuze aan te vinken. We willen u verzoeken de vragen zorgvuldig te lezen en eerlijk te beantwoorden. In het onderzoek gaat het om uw mening en er zijn dus geen goede of foute antwoorden. Alle gegevens worden anoniem verwerkt.

Het invullen van de vragenlijst zal ongeveer 10 minuten in beslag nemen.

Alvast bedankt voor uw medewerking!

Met vriendelijke groet,

Claudia Nowak

Universiteit Twente

#### Onderdeel A

Als eerste zijn we benieuwd hoe u denkt over uw eigen alcohol gebruik. Ook willen we graag weten wat uw verwachtingen zijn of waren ten aanzien van de internetbehandeling.

1. Heeft u de internetbehandeling reeds gevolgd?

- Ja, en ik heb deze intussen afgerond
- Ja, en ik ben er op dit moment mee bezig
- Nee, ik wacht nog op de behandeling
- Nee, ik ben al met een andere behandeling gestart
- Nee, ik heb er ook geen behoefte meer aan

2. Geef bij de volgende uitspraken aan in hoeverre u het er mee eens bent.

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	Ik denk dat ik meer drink/dronk dan de meeste mensen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Ik dacht er al langer over na om iets te ondernemen tegen mijn overmatige	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	alcoholgebruik					
3	Ik dacht dat ik goed in staat ben mijzelf ertoe te zetten mijn huidige alcoholgebruik te veranderen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	De meeste mensen die belangrijk voor mij zijn wilden graag dat ik deze behandeling volg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik was heel gemotiveerd om mijn drinkgedrag te veranderen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Geef bij de volgende uitspraken aan in hoeverre u het er mee eens bent.

Wat zijn de redenen waarom u zich heeft opgegeven voor de internetbehandeling?

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	Ik verwachtte dat deze behandeling me zal helpen om mijn alcoholprobleem onder de knie te krijgen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Ik wilde mijn fysieke gezondheid verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Ik wilde mijn emotionele welzijn verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Ik wilde in staat zijn om de kern van mijn probleem te begrijpen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik wilde minder alcohol drinken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Ik wilde stoppen met het drinken van alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Ik wilde technieken leren, die mij helpen om met mijn alcoholprobleem om te gaan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Ik wilde dat de behandeling mij helpt om weer controle te krijgen over mijn drinkgedrag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Ik wilde beter kunnen functioneren op mijn werk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Ik wilde de relatie met mijn vrienden en familie verbeteren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anders, namelijk

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## Onderdeel B

In dit onderdeel gaat het om uw motieven om voor de anonieme internetbehandeling te kiezen en niet voor de zorgverzekeringsvariant.

4. In hoeverre spelen onderstaande redenen een rol bij uw keuze voor de anonieme internetbehandeling?

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens	n.v.t.
1	Ik wist niet zeker of de behandeling helemaal door mijn zorgverzekering wordt vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Het was mij niet bekend dat ik voor een andere variant kan kiezen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Ik was niet bereid om de eigen bijdrage te betalen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Ik wilde niet dat mijn werkgever weet dat ik alcohol problemen heb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Ik kon kiezen, dus dan liever anoniem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Ik wilde niet dat mensen uit mijn omgeving van mijn alcoholprobleem weten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Ik was bang dat mijn gegevens ergens in een database worden opgeslagen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Ik was bang dat anderen mijn gegevens kunnen inzien	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Ik ben geen Nederlander en anders wordt de behandeling niet vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Ik ben Nederlander maar niet in Nederland verzekerd en dan wordt de behandeling niet vergoed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Anders, namelijk

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5. Geef uw mening t.a.v. onderstaande stellingen over mensen met een alcoholprobleem.

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	De meeste mensen met een alcoholprobleem zijn zelf schuldig aan hun problemen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	De meeste mensen denken negatief over mensen met een alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Het is een teken van sociale zwakte als je je alcoholgebruik niet onder controle hebt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Het is verstandiger om niet te vertellen dat je hulp zoekt bij je alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Anderen beoordelen iemand minder positief als zij weten dat hij/zij hulp zoekt vanwege een alcoholprobleem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Onderdeel C

U heeft gekozen voor de anonieme variant van de internetbehandeling. Maar we willen u ook graag een aantal vragen stellen over uw mening ten opzichte van de zorgverzekeringvariant.

6. Heeft u de informatie op de website gelezen over onderstaande alternatieve varianten om de online-behandeling te volgen?

		Ja	Nee
1	Vergoeding door werkgever	<input type="checkbox"/>	<input type="checkbox"/>
2	Vergoeding door zorgverzekering	<input type="checkbox"/>	<input type="checkbox"/>
3	Zelf betalen	<input type="checkbox"/>	<input type="checkbox"/>

7. Wist u dat u meteen kunt beginnen met de behandeling als u de zorgverzekeringsvariant of werkvariant kiest?

Ja

Nee

**8. Informatie over vergoeding van de internetbehandeling door uw zorgverzekering:**

Als u voor de zorgverzekeringvariant kiest, kunt u direct starten met de behandeling. De behandeling wordt, na opgave van uw persoonsgegevens, door uw zorgverzekeraar vergoed (m.u.v. eigen bijdrage). Binnen drie werkdagen krijgt u een hulpverlener toegewezen. Alcoholdebaas.nl heeft naast uw gegevens een verwijzing van uw huisarts nodig. Dit laatste wordt voor u geregeld na uw toestemming. U hoeft dan niet zelf naar de huisarts voor een afspraak.

Deze vergoeding geldt alleen voor Nederlandse zorgverzekeraars.

Wat gebeurt er met uw gegevens?

Naast de betrokken hulpverleners van het internetbehandelteam, is alleen uw zorgverzekeraar en uw huisarts op de hoogte van uw deelname. De Wet Bescherming Persoonsgegevens beschermt uw persoonsgegevens. Behalve uzelf en de direct betrokken hulpverleners heeft niemand toegang tot uw persoonlijke online dossier. Al het berichtverkeer tussen u en uw hulpverlener verloopt via uw beveiligde persoonlijke dossier waarop u kunt inloggen, dus niet via e-mail.

Nu u weet wat er met uw gegevens gebeurt: zou u bereid zijn geweest om u in te schrijven voor de zorgverzekeringvariant in plaats van anoniem te blijven?

Ja, zeker – Misschien wel – ik weet het niet – Waarschijnlijk niet – Nee, zeker niet

Wilt u uw keuze even toelichten?

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9. Hieronder staan een aantal mogelijkheden om de zorgverzekeringvariant aantrekkelijker te maken. Wij willen graag uw mening hierover weten.

Ik zou eerder geneigd zijn om me voor de zorgverzekeringvariant op te geven als...

		Helemaal mee eens	Mee eens	Niet mee eens/niet mee oneens	Mee oneens	Helemaal mee oneens
1	de ernst van mijn verslaving groter zou zijn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	ik meer informatie zou krijgen over de zorgverzekeringvariant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3	de aanmeldingsprocedure voor de zorgverzekeringvariant makkelijker zou zijn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	ik minder gegevens zou moeten opgeven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	de huisarts het niet te weten zou komen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	ik meer controle zou hebben over wat achteraf met mijn gegevens gebeurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	mijn gegevens achteraf vernietigd worden	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	er geen anonieme variant bestond	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Heeft u suggesties op welke manier meer mensen kunnen worden gestimuleerd voor de zorgverzekeringsvariant?

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## Onderdeel D

In dit gedeelte vragen we u nog een aantal achtergrondgegevens.

11. Wat is uw leeftijd?

- Jonger dan 18 jaar
- 18-25 jaar
- 26-35 jaar
- 36-45 jaar
- 46-55 jaar
- Ouder dan 56 jaar

12. Wat is uw geslacht?

- Man  
 Vrouw

13. Wat is uw nationaliteit?

- Nederlands  
 Anders, namelijk. \_\_\_\_\_

14. Wat is uw belangrijkste dagbesteding?

- Betaalde fulltime baan  
 Betaalde parttime baan  
 Studerend, schoolgaand  
 Vrijwilligerswerk  
 Huisvrouw of huisman  
 Werkloos  
 Arbeitsongeschikt  
 (Vroegtijdig) pensioen  
 Zelfstandig ondernemer  
 Anders, namelijk \_\_\_\_\_

15. Wat is de hoogste opleiding die u met een diploma heeft afgesloten?

- Basisschool  
 LBO/MAVO  
 HAVO/VWO  
 MBO  
 HBO  
 WO  
 Anders, namelijk \_\_\_\_\_

*Bedankt voor het invullen van de vragenlijst!*

## Appendix C: Pretest of questionnaire

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In dit laatste gedeelte vragen wij naar uw oordeel over de vragenlijst.

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16. Zijn de instructies begrijpelijk?

Ja

Nee

Zo nee, wat is er onduidelijk?

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17. Zijn de betekenissen van de vragen duidelijk?

Ja

Nee

Zo nee, wat is er onduidelijk?

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18. Zijn de termen begrijpelijk?

Ja

Nee

Zo nee, welke termen zijn onbegrijpelijk?

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19. Was het makkelijk om de vragen te beantwoorden?

Ja

Nee

Zo nee, kunt u even toelichten wat u moeilijk vond?

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20. Ontbreekt er een belangrijke vraag?

Ja

Nee

Zo ja, welke vraag?

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*Bedankt voor het invullen van de vragenlijst!*

## Appendix D: Expert review instruction letter

Hallo,

Ik vraag u om de vragenlijst voor mij te lezen en beoordelen. Ik weet namelijk niet of alles wat er in staat even duidelijk is en ik wil graag weten of het nodig is deze vragenlijst te verbeteren en op welke punten dat nog kan. Daarbij kunt u me helpen.

De opmaak van de vragenlijst speelt hierbij geen rol omdat deze online wordt afgenomen via surveymonkey. Ik vraag u nu deze vragenlijst een keer rustig door te lezen. Ik wil u vragen om tijdens het lezen plusjes en minnen bij de tekst te zetten. Een + bij elk stukje of onderdeel waarvan u denkt: "Dat vind ik interessant", "Daar ben ik het mee eens", "Dat vind ik prettig om te lezen", of "Ik vind het goed dat dit erin staat".

Een – bij elk stukje waarvan u denkt "dat vind ik niet relevant voor deze vragenlijst", "Daar ben ik het niet mee eens", "Dit stukje is lastig om te lezen", "Dit hoeft er van mij niet in te staan" of "Dit moest ik twee keer lezen om het te begrijpen.

U mag net zo veel plussen en minnen zetten als u wilt. Het zou ook goed zijn als u bij een – gelijk kunt aangeven wat er verbeterd kan worden en waarom u een min erbij hebt gezet.

Bedankt voor uw hulp!



## Appendix E: Expert review protocol

General comments:

- Length is good, not too long
- Easy understandable
- Seems to be constructed well, like checking boxes
- Some sentences sound wrong
- One answering option seems to be the same as another one

Feedback about introduction and email text

- structure differently: explain first why clients receive the email and then how we got their email address
- language correction
- text is too formal; needs to be written in a more accessible style to stimulate people to participant

Feedback about part A-D of the questionnaire:

- correcting language errors
- rephrasing proposal for some items
- Erasing one item because its seems to be the same as another one
- change scale weighting
- suggestion for additional item
- add not available (n.v.t.) option
- rephrase item
- use questions from the “intake questionnaire” for demographics

## Appendix F: Text Email

Geachte heer/mevrouw,

Tactus Verslavingszorg is voortdurend bezig om de diverse internetbehandelingen te evalueren en te verbeteren. In het kader van onderzoek in samenwerking met de Universiteit Twente wordt ook de internetbehandeling Alcoholdebaas.nl geëvalueerd. U ontvangt deze email omdat u een tijdje geleden uw emailadres heeft achtergelaten op de website [www.alcoholdebaas.nl](http://www.alcoholdebaas.nl) en wij in ons onderzoek nu geïnteresseerd zijn naar uw houding ten aanzien van het verstrekken van persoonsgegevens bij de internetbehandeling Alcoholdebaas.nl.

De opgave van persoonsgegevens is een vereiste van de zorgverzekeringvariant van de internetbehandeling voor vergoeding. Voor sommige deelnemers vormt het verstrekken van deze persoonsgegevens een bezwaar, andere deelnemers hebben er geen problemen mee. Tactus wil graag meer zicht krijgen op de argumenten van deelnemers om wel of niet hun zorgverzekeringsgegevens te verstrekken. Dit onderzoek richt zich zowel op mensen die nog op de behandeling wachten als op mensen die al met de behandeling zijn gestart.

We willen u daarom vragen om deze vragenlijst in te vullen. In de vragenlijst wordt niet naar uw naam en adres gevraagd. De informatie die u geeft zal dus nooit te herleiden zijn tot u als persoon. De vragenlijst kunt u online invullen zonder vermelding van gegevens zodat uw **anonimiteit** gewaarborgd wordt. U kunt de vragenlijst starten door op de onderstaande link te klikken. Het invullen van de vragenlijst zal ongeveer 10 minuten in beslag nemen.

Ik ben 3<sup>de</sup> jaar studente Psychologie aan de Universiteit Twente en in het kader van mijn studie voer ik een opdracht van Tactus Verslavingszorg uit. Ik doe onderzoek naar de internetbehandeling Alcoholdebaas.nl van Tactus. Het zou me erg helpen als u de vragenlijst wilt invullen.

**Link naar de vragenlijst:**

[https://www.surveymonkey.com/s.aspx?sm=SZx76rTxLMjZy06aHozLMg\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=SZx76rTxLMjZy06aHozLMg_3d_3d)

Uiteraard doet Tactus er alles aan om u de behandeling zo spoedig mogelijk aan te kunnen bieden. Mocht u vragen hebben over de behandeling dan kunt u een email sturen naar [Alcoholdebaas@tactus.nl](mailto:Alcoholdebaas@tactus.nl).

*Alvast bedankt voor uw medewerking!*

Claudia Nowak

Universiteit Twente

[c.nowak@tactus.nl](mailto:c.nowak@tactus.nl)

## Appendix G: Open questions

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Geef bij de volgende uitspraken aan in hoeverre u het er mee eens bent. Wat waren de redenen waarom u zich heeft opgegeven voor de internetbehandeling?

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- Ik deed het voor mijn partner voor mijn zoon en voor mezelf. Ik wil een goed voorbeeld zijn voor mijn zoon
  - Ik wil wel sociaal blijven drinken, maar niet meer dan 2 tot 3 glazen per avond.
  - Ik ben gelukkig fysiek in uitstekende conditie is laatst uit een sporttest gebleken. Ook op het werk ondervind ik geen problemen van alcoholgebruik in de avond ervoor. Toch wil ik minderen en op de norm voor de gemiddelde vrouw proberen te komen. Daar zit ik nu boven.
  - Ik wil de controle terug krijgen. Nu is alcohol de baas en ik wil een vrije vrouw zijn!
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In hoeverre speelden onderstaande redenen een rol bij uw keuze voor de anonieme internetbehandeling?

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- Ik wil, uit schaamte gevoel, echt helemaal anoniem blijven. Voor mijn arts en mijn zorgverzekeraar en de rest van mijn omgeving
  - Het is een gemakkelijke oplossing, naar een arts stappen is een veel grotere stap
  - Ik ben Nederlander en hier verzekerd dus de laatste 2 vragen niet van toepassing voor mij
  - Ik wilde anoniem meedoen. Ik heb hiervoor wel maandenlang op een wachtlijst gestaan, zoveel animo was er kennelijk
  - Ik wilde gewoon totaal anoniem blijven
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Nu u weet wat er met uw gegevens gebeurt: zou u bereid zijn (geweest) om u in te gaan schrijven voor de zorgverzekeringvariant in plaats van anoniem te blijven?

Wilt u uw keuze even toelichten?

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- Ik heb ruim 5 mnd moeten wachten op de behandeling en dat was erg lang
  - Op het moment van aanmelden was ik zelf werkzaam bij een zorgverzekering. Ik wilde niet dat collega's mijn dossier wat betreft alcohol zomaar in zouden kunnen zien
  - Misschien woden er wel behandelingen niet meer vergoed als drank een oorzaak is van klachten
  - Ik wil volledig anoniem deelnemen. Ik wil dus niet dat mijn huisarts er van af weet. Ik ben bang dat ik een stempel krijg en dat als er in de toekomst wat mocht gebeuren er snel gezegd zal worden door mijn of andere huisarts dat het komt door mijn
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alcoholverslaving. Deze ervaring heb ik n.l. ook met de psychiatrie. 20 jaar geleden had ik hepatitis B (niet door alcoholgebruik). Zelf zag ik het aan de kleur van mijn ogen en het moe voelen. Toen ik er mee naar een arts ging werd het niet geloofd. Het zou tussen mijn oren zitten, want ik was onder behandeling van een psychiater. Hetzelfde gold voor huidkanker. ik eerste instatie werd ook dat niet geloofd. Ook dat zou tussen mijn oren zitten. Nog een voorbeeld was alopecia areata. Alledrie de ziektes heb ik naar later bleek weldegelijk gehad, en ben ik ook voor behandeld. Ik zeg dus omdat wanneer dit soort gegevens bij een huisarts of behandelaar terecht komen, deze snel andere conclusies trekt.

- Blijf het een persoonlijk probleem vinden waar de huisarts en verzekeraar niets mee te maken hebben, en angst dat het bij de huisarts eeuwig aan me zou blijven kleven, en dan eventuele andere toekomstige klachten geweten zouden worden aan problemen in emotionele sfer, dat je daar dan bekend om staat, terwijl het dan misschien om hele reguliere fysieke aandoeningen zou kunnen gaan
- Mijn zorgverzekeraar heeft er niets mee te maken. Mocht ik n.a.v. het alcoholgebruik gezondheidsproblemen krijgen wil ik niet door mijn zorgverzekeraar op de vingers getikt worden
- Ik wil per se anoniem blijven
- Zorgverzekeraars gaan veel minder discreet met gegevens om dat men denkt. Ik heb er zelf gewerkt! Bovendien worden gegevens wel verstrekt door verzekeraars in bijzondere gevallen, zoals een medische keuring. Vertrouwen is goed, controle beter. En controle in zo'n systeem heb ik niet dus zou ik nooit mijn gegevens achterlaten.
- Wil niet dat mijn partner op de hoogte is.
- Maar ik vind het zo prima, dus ik hoef niet te veranderen.
- Schaamte tov huisarts
- Liever anoniem een poging wagen om het drinken te minderen
- Ik ben van mening dat de privacy van mensen steeds meer in het gedrang komt en dat alles te commercieel benadert wordt en dit niet ten goede komt van de mensen
- Mijn zorgverzekeraar vergoed reeds een behandeling die ik onderga bij Parnassia. Een tweede, bij Alcoholdebaas zou bij de zorgverzekeraar niet in goede aarde zijn gevallen.
- Ik vind het belangrijk dat deze disciplines op de hoogte zijn, het voelt vertrouwd
- Ik wil niet dat mijn huisarts hiervan op de hoogte is, kies alleen voor de 100% anonieme behandeling.
- Het is voor mij niet mogelijk om voor de zorgverzekeringsvariant te kiezen omdat ik in het buitenland leef en in Nederland niet verzekerd ben

- 
- ik wil niet dat bij de huisarts, zorgverzekeraar of werkgever de behandeling bekend is/wordt
  - Ben werkzaam in de medische sector, inzage in mijn med. gegevens in het HIS systeem door collega's is mogelijk. Dat is gebeleden uit het "snuffelverslag" van het HIS (huisartsen informatie systeem)
  - Het is voor mij een vervolgtraject om alert te blijven
  - Ik weet helemaal niet wat er met mijn gegevens gedaan wordt. Ik vind deze vragen irrelevant.
  - Ik ben geen bekende Nederlander maar mijn naam is wel opvallend. Bovendien werk ik zelf in de verslavingszorg
  - slecht contact met huisarts
  - Ja, mijn huisarts vindt niet dat ik een alcoholprobleem heb (heb ik wel eens proberen te bespreken met hem). Daarnaast zitten onze kinderen bij elkaar in de klas, en daardoor vind ik het moeilijk dit door te zetten. Daarnaast ben ik ook bang voor een stigma, wanneer mijn verzekering dit geregistreerd heeft
  - Ik wil dat niemand het weet, ook mijn huisarts niet. Ken hem vrij goed en wil dit liever niet met hem delen.
  - Ik wil eigenlijk dat zo min mogelijk mensen van mijn alcoholprobleem weten, zeker mijn huisarts niet. Je krijgt wel erg snel een stempel opgeplakt
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Wat is uw nationaliteit?

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- Belg
  - Belg
  - Duits
  - Belgische
- 

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Wat is uw belangrijkste dagbesteding?

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- Betaalde parttime baan en daarnaast zelfstandig ondernemer
  - sport
-

- 
- en schoolgaand
  - Gepensioeerd op 67-jarige leeftijd (dus niet vroegtijdig)
  - Webdesigner, databaseprogrammeur
- 

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Wat is de hoogste opleiding die u met een diploma heeft afgesloten?

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- Universiteit Belgie
  - Universitair
  - Hoger onderwijs korte type
-

## Appendix H: Open essay question

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Heeft u suggesties op welke manier meer mensen kunnen worden gestimuleerd voor de zorgverzekeringsvariant?

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- Eigenlijk niet. Ik vind het heel goed dat de verzekeraar deze mogelijkheid biedt. Die is alleen niet voor iedereen geschikt en daarom vind ik het nog geweldiger dat er een anonieme behandeling bestaat.
  - Misschien informatie hoe je wordt of kan worden begeleid als je lichamelijke reacties hebt bij het stoppen of minderen met drinken?
  - nee
  - Als ook de zorgverzekeraar niet te weten komt welke van zijn klanten problemen heeft met alcohol.
  - Geen idee, je moet toch altijd iets kenbaar maken, al is het maar je huisarts! En de behandeling voelt voor mij dan ook een stuk anders als ik het via een zorgverzekeraar zou doen!
  - ja het is heel belangrijk bij een ernstige verslaving dat je gelijk aan de slag kan, bij de zorgverzekeraar kan je na 3 dagen beginnen, dat is mijn ervaring, en binnen 3 maanden ben je dan een heel eind op weg, het scheelt een hele hoop ellende dat je geen maanden hoeft te wachten.
  - Als deze variant zonder het verstrekken van persoonsgegevens kan plaatsvinden (intermediair / fonds)
  - Nee want ik ben van mening dat de zorgverzekeraars niet overal hun slaatje, uit hoeven te slaan, alles wordt al duurder en de vergoedingen worden minder terwijl de middelen in kwaliteit afnemen! Ik ben van mening dat er meer moet worden gesubsidieerd, vanuit de overheid, de particulieren betalen genoeg!!! Dit is dus mijn suggestie!! Ook ben ik van mening dat de anonimiteit gewaarborgd moet blijven, want doordat alle gegevens worden opgeslagen krijgen particulieren steeds meer een stempel waardoor het voor hen in de maatschappij steeds moeilijker wordt de ommekeer in hun leven te vinden doordat ze telkens met hun negatieve gedragingen/verleden en huidige problemen worden geconfronteerd.  
Er zou meer en beter geluisterd moeten worden naar de cliënten, zodat de juiste middelen en behandelingen beter worden toegepast op het individu zonder dat zij hier ook nog eens financieel voor moeten bloeden!  
Ik wens jou veel succes met het onderzoek.
  - Neen
  - Eerlijk gezegd heb ik hier nooit over nagedacht, wist verder ook niet dat je dit via je
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zorgverzekering kon doen, had het wel gelezen toen ik mij aanmeldde bij alcoholde baas, maar heb het idee dat deze gegevens dan een rol gaan spelen bij de verzekering en dat men daar dan minder zorgvuldig met deze gegevens zouden omgaan.

1. Haal de noodzaak tot doorverwijzing via huisarts eruit
  2. Altijd vernietiging van gegevens zodra de behandeling is afgerond
  3. Vooraf een getekende verklaring dat de gegevens nooit, onder geen enkele omstandigheid of uitzonderingsregel, verstrekt zullen worden aan derden, overheid, particulieren of commerciële instellingen.
- Nee. Niemand wil graag dat de diagnose van zijn psychische problemen of verslaving bij de zorgverzekeraar terechtkomen.
  - Door alle zorgverzekeraars of de overheid te laten meebetalen aan een anonieme variant. De zorgverzekervariant wordt dan een anonieme variant die wordt bekostigt door de verzekeraars
  - kenbaar maken dat het vergoed wordt
  - Absolute anonimiteit, al zou ik niet weten hoe.
  - Ik denk dat als er duidelijk wordt aangegeven dat je heel snel behandeld kunt worden dat het alleen maar meewerkt aan de ontwenning als je voor de zorgverzekering kiest in mijn geval heb ik er 5 mnd op moeten wachten en dat is best heel lang
  - weet ik echt niet. Moeilijk te antwoorden.
  - Vooral -zoals je zoals ik -anoniem wil blijven is dit erg lastig.
  - Voor mij geldt duidelijk, dat ik voor de zorgverzekeringsvariant zou kiezen als:
    1. mijn huisarts niet ingelicht zou worden.
    2. mijn gegevens na afloop vernietigd zouden worden.
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