Visual Analogue Scale (VAS)

Verscheidene auteurs sinds 1974

Meetinstrument	Visual Analogue Scale
Afkorting	VAS
Auteur	Huskisson, E. C. (1974). Measurement of pain. *Lancet, 2,* 1127-1131.
Thema	Symptoommanagement pijn
Doel	Pijn beoordelen bij de patiënt
Populatie	Niet gespecifieerd
Afname	Zorgverlener
Aantal items	1 item
Aanwezigheid patiënt vereist	Ja
Vindplaats meetinstrument	http://www.ndhcri.org/

Doel

Pijncontrole bij de patiënt aan de hand van zelfrapportage op een één-item schaal.

Doelgroep

De doelgroep waar de Visual Analogue Scale (VAS) zich op richt is divers. Validiteit van het meetinstrument werd reeds bij kinderen/ adolescenten (Stinson, Kavanagh, Yamada, Gill, & Stevens, 2006), bij volwassenen (Bijur, Silver, & Gallagher, 2001; Carey, Turpin, Smith, Whatley, & Haddox, 1997) alsook bij ouderen (Carey, Turpin, Smith, Whatley, & Haddox, 1997; Mawdsley, Moran, & Conniff, 2002; Pautex et al., 2006) onderzocht. Studies valideren het gebruik van de VAS in uiteenlopende patiëntencategorieën zoals chirurgiepatiënten (Gagliese, Weizblit, Ellis,& Chan, 2005; Jensen, Chen, & Brugger; 2002), dementerenden (Pautex et al., 2005; Pautex et al., 2006), patiënten met musculoskeletale problemen (Mawdsley et al., 2002; Pomeroy et al., 2000; Tamiya et al., 2002; Triano, McGregor, Cramer, & Emde, 1993) en andere patiënten met specifieke vormen van pijn (Crossley, Bennell, Cowan, & Green, 2004; Freeman, Smyth, Dallam, & Jackson, 2001; Gallagher, Bijur, Latimer, & Silver; 2002; Gagliese & Katz, 2003).

Bijgevolg kan het gebruik van de VAS, als meetinstrument voor pijnmanagement, gegeneraliseerd worden naar een brede patiëntenpopulatie.

Beschrijving

De VAS is een lijn van 100 mm waarvan de twee uiteinden begrensd zijn door termen ‘Geen pijn’ en ‘Ergst denkbare pijn’. Bedoeling is dat de patiënt de pijnintensiteit die hij/ zij beleeft op het moment van afname, aanduidt op de lijn. Vervolgens wordt de afstand tussen het nulpunt (‘Geen pijn’) en de markering van de patiënt in mm opgemeten door de verpleegkundige.

De meest gekende versie van de VAS heeft een horizontale lijnoriëntatie, hoewel een verticale oriëntatie ook gebruikelijk is het beoordelen van pijn bij de patiënt. Er bestaan talrijke varianten op de oorspronkelijke versie van de VAS. Verschillen zijn o.a. terug te vinden in de terminologie die men hanteert om het eindpunt af te bakenen (vb. extreme pijn, meest verschrikkelijke pijn,…), het voorkomen van scheidingslijntjes op de schaal en de toegepaste lengtemaat (cm of mm).

Betrouwbaarheid

De VAS vertoont een hoge betrouwbaarheid. Dit kan uitvoerig gestaafd worden aan de hand van resultaten van verscheidene studies die dit reeds onderzocht hebben.

Vele studies rapporteren een *intra-rater reliability* van 0.90 en hoger (Bijur et al., 2001; Mawdsley, 2002; Pautex et al. 2005; Pautex et al., 2006). Enkele studies rapporteren zelfs een waarde van 0.99 (Gallagher et al., 2002; McGrath et al., 1985 in Stinson et al., 2006). Het aantal studies met een lage *intra-rater reliability* ($r < 0.75$) is beperkt (Pomeroy et al., 2000; Tamiya et al., 2002). Bovendien valt op dat de herhaalde metingen in deze onderzoeken door grote tijdsintervallen gekenmerkt worden (> 1 dag), wat mogelijks de variabiliteit in de pijnscores verklaart tengevolge veranderingen in de pijnbeleving.

Gunstige resultaten worden eveneens gegenereerd voor de *interrater reliability*. In de teruggevonden studies is deze correlatie steeds hoger dan 0.70 (Benaim et al, 2007; Herr, Spratt, Mobily, & Richardson, 2004; Pautex et al. 2005; Pautex et al., 2006).

Cronbach’s alpha tussen de VAS en andere één-item meetschalen werd nagegaan in de studie van Herr et al. (2004) en in het onderzoek van Carey et al. (1997). De correlatie bedroeg respectievelijk $\alpha = 0.97$ (VAS – Numeric Rating Scale – Verbal Descriptor Scale – Verbal Numeric Scale – Faces Pain Scale) en $\alpha = 0.88$ (VAS – Faces Rating Scale – Numeric Rating Scale).

Validiteit

De VAS is een valide meetinstrument in het beoordelen van pijn. Meerdere studies hebben VAS-scores van pijnpatiënten vergeleken met scores op andere pijnschalen (Benaim et al, 2007; Freeman et al., 2001; Hicks, von Baeyer, Spafford, Korlaar, & Goodenough, 2001; Gagliese et al., 2005; Kim & Buschmann, 2006; Mawdsley et al., 2002; Pautex et al. 2005; Pautex et al., 2006; Stinson et al., 2006; van Dijk, Koot, Saad, Tibboel, & Passchier, 2002). De eerder sterke significante correlatie tussen de VAS en overige valide pijnschalen, bevestigt de *concurrent validity* van de schaal.

Om de *construct validity* van de VAS na te gaan, hebben Gagliese et al. (2005) en Herr et al. (2004) een *principale componenten analyse* uitgevoerd. In beide studies werd 1 factor geabstraheerd uit de pijnscores op de verschillende één-item meetinstrumenten.

Tevens werden significante correlaties gerapporteerd tussen VAS-scores en het toedienen van analgetica (Abu-Saad & Holzemer in Stinson et al., 2006; Aradine et al. in Stinson et al., 2006; Gagliese & Katz, 2003; Tyler et al. in Stinson et al., 2006), het CRP gehalte (Tamiya et al., 2002), intensiteit van de toegediende pijnprikkel (Herr et al., 2004), gedragsobservaties bij pijnpatiënten (Koho, Aho, Watson, & Hurri, 2001),…

De *sensitiviteit* van de VAS wordt bevestigd door studies met een *repeated measures design* (Crossley et al., 2004; Jensen et al., 2002). Deze onderzoeken hebben de VAS-scores van patiënten gecorreleerd aan pijnregistraties tussen de verschillende metingen. De door de patiënt gerapporteerde evoluties in pijn ('mijn pijn is toe- of afgenomen') waren significant gecorreleerd aan de VAS-scores.

Gebruik VAS bij kinderen

De VAS werd reeds uitgebreid bestudeerd bij kinderen en vertoont een goede validiteit voor het merendeel van de kinderen vanaf 8 jaar (Champion et al. in Stinson et al., 2006). De VAS is echter minder aangewezen voor kinderen jonger dan 8. De betrouwbaarheid van het meetinstrument neemt af in deze leeftijdscategorie (Beyer and Aradine in Stinson et al., 2006; Shields et al. in Stinson et al., 2006). De Faces Pain Scale kan een mogelijk alternatief betekenen in de populatie kinderen jonger dan 8 jaar.

Gebruik VAS bij ouderen

Onderzoek toont aan dat ouderen moeilijkheden kunnen ervaren bij het invullen en begrijpen van de VAS (Freeman et al., 2001; Herr, Mobily, Kohout & Wagenaar, 1998; Jensen & Karoly in Dworkin et al., 2005; Pautex et al., 2005; Pautex et al., 2006). Dit in het bijzonder voor ouderen met een verhoogde leeftijd en dementerenden waarvoor bijvoorbeeld de Faces Pain Scale of de Verbal Rating Scale meer aangewezen zal zijn.

Ook worden er meer problemen gerapporteerd in het gebruik van de horizontale VAS in vergelijking met de verticale VAS. De verticale VAS wordt aanbevolen aangezien dit meetinstrument minder foutieve afnames zou genereren en beter begrijpbaar zou zijn voor ouderen (Gagliese et al., 2005).

Gebruiksvriendelijkheid

De gebruiksvriendelijkheid van de VAS werd beoordeeld door 33 verpleegkundigen, tewerkgesteld op de afdelingen medische oncologie/ radiotherapie en pediatrische oncologie van het U.Z. Gent.

94% van de bevraagden stelt dat de VAS in minder dan 3 minuten kan afgenomen worden. Daarnaast is het merendeel van de verpleegkundigen van oordeel dat de VAS eenvoudig in te vullen is (85%) alsook helder en eenduidig is (91%). De handleiding is eveneens duidelijk voor 94% van de verpleegkundigen. De evaluatie

van de gebruiksvriendelijkheid van de VAS is dan ook uitermate positief. Merkwaardig is echter dat 1 op 2 verpleegkundigen van mening is dat een bijkomende opleiding vereist is in het gebruik van het meetinstrument.

Opmerkingen

Meerdere studies rapporteren moeilijkheden bij patiënten om de VAS in te vullen (Gagliese et al., 2005; Herr et al., 2004; Paice & Cohen 1997; Pautex et al., 2006). Vergelijkingen tussen de VAS en de Numeric Rating Scale (NRS) duiden op minder problemen in het hanteren van de laatstgenoemde schaal. Daarnaast geniet de NRS eveneens een hoge en vergelijkbare betrouwbaarheid/validiteit. Bovendien geven patiënten zelf aan dat de NRS en ander pijnschalen hun voorkeur verdient op de VAS (Carey et al., 1997; Dworkin et al., 2005; Gagliese et al., 2005; Herr et al., 2004; Paice & Cohen 1997). Dit kan er op wijzen dat de NRS meer aangewezen is dan de VAS in het beoordelen van pijn. Meerdere validatiestudies bevelen de NRS dan ook aan als het meest geschikte instrument in het beoordelen van pijn (Downie et al., 1978; Dworkin et al., 2005; Jensen et al., 2003). Dit dient enigszins genuanceerd te worden aangezien geen enkele pijnschaal bij alle vormen van pijn of voor alle leeftijdscategorieën gebruikt kan worden.

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Vindplaats meetinstrument

http://www.ndhcri.org/

VISUAL ANALOGUE SCALE (VAS)

VERSCHEIDENE AUTEURS SINDS1974

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Pautex, S., Michon, A., Guedira, M., Emond, H., Le Lous, P., Samaras, D. et al. (2006)	Geriatrics hospital and a geriatric psychiatry service.	129 patients aged 65 and older hospitalized during a 15 month-period who met DSM criteria for dementia, with a Mini-Mental State Examination score less than 11 and a Clinical Dementia Rating of 3 or greater. (n = 129)	Repeated measures design: Patients were asked to indicate their current level of pain on different scales (VAS, Faces Pain Scale and Verbal Rating Scale). This was repeated 30 minutes later either by the same investigator (50% of the cases) or by a different examiner who was blinded to the first assessment.	S E	CrV
Gagliese, L., Weizblit, N., Ellis, W., & Chan, V. W. (2005)	Toronto General Hospital, University Health Network and Mount Sinai Hospital, Toronto, Ontario.	Patients scheduled to receive patient-controlled analgesia following general surgery. (n = 504)	Comparative study: the VAS was compared with the Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) and the pain intensity measures of the McGill Pain Questionnaire (MPQ).		FV CrV CsV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(S) *Intra-rater reliability:* R = 0.98 (p < 0.001) **(E)** *Interrater reliability:* R = 0.88 (p < 0.001)	**(CrV)** *Concurrent validity:* - Correlation between VAS and different scales at first assessment: 13. Correlation VAS – Verbal Rating Scale: r = 0.67 (p<0.001) 14. Correlation VAS – Faces Pain Scale: r = 0.45 (p<0.001) 15. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.25 (p<0.001) - Correlation between VAS and different scales at second assessment: 16. Correlation VAS – Verbal Rating Scale: r = 0.73 (p<0.001) 17. Correlation VAS – Faces Pain Scale: r = 0.66 (p<0.001) 18. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.24 (p<0.001)	Weak correlations between VAS and Doloplus 2. A significant better comprehension of the Verbal Rating Scale (VRS) and the Faces Pain Scale (FPS) scale was found. This might suggest that the VAS is not the most appropriate pain assessment scale for patients with severe dementia.
	(FV) *Face validity;* Patients rated the VAS as the least accurate and least preferred instrument for future assessments.The VAS had the highest proportion of patients making errors (p ≤ 0.005). **(CrV)** *Concurrent validity:* - Correlation between VAS and VDS and NRS: 5. Patients aged > 60 years: r = 0.60-0.93 (p<0.001) 6. Patients aged ≤ 60 years: r = 0.72-0.91 (p<0.001) - Correlation between VAS and MPQ was lower. **(CsV)** *Principal components analysis:* A one-factor model was extracted from the different measurement scales and accounted for 82% of the total variance in the young group and 85% of the variance in the older group. Factor loadings were 0.95 for horizontal VAS and 0.91 for vertical VAS.	The vertical VAS was associated with lower error rates and greater face validity than the horizontal VAS.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Freeman, K., Smyth, C., Dallam, L., & Jackson, B. (2001)	Hospital.	Adults who had one or more stage 1 to 4 pressure ulcer, and had some ability to explain their pain experience. (n = 44)	Comparative study: the VAS was compared with the Faces Rating Scale (FRS).		CrV
Gallagher, E. J., Bijur, P. E., Latimer, C., & Silver, W. (2002)	2 urban emergency departments.	Convenience sample of patients with the chief complaint of acute abdominal pain. (n = 101)	Repeated measures design: VAS measurements 1 minute apart every 30 minutes over two hours.	S	Sen
Jensen, M. P., Chen, C., & Brugger, A. M. (2002)	Not specified.	123 patients who had undergone knee surgery and 124 women who had undergone a laparatomy . (n = 227)	Repeated measures design. Baseline measurement with 16 additional measures up to 24h following surgery.		Sen

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
	(CrV) *Concurrent validity:* A mathematical transformation of the FRS in a numeric value was highly correlated with the VAS (r = 0.92). There was a significant increase in variability in VAS with increasing values of the FRS ($p < 0.05$).	
(S) *Intrarater reliability:* r = 0.99 (95% CI 0.989 to 0.992). *Bland-Altman analyses:* 50 percent of the differences between the repeated VAS scores (time 0 and 1 minute later) were between -3mm and +2mm, 90 % were between -8mm and + 9mm, and 95% of the scores were within ±11mm of the 100 mm VAS.	**(Sen)** After completing the VAS at the end of each 30 minute interval, patients were also asked to contrast current pain with their pain at the previous using one of 5 categorical descriptors: 'much less pain', 'a little less pain', 'about the same pain', 'a little more pain', or 'much more pain'. Differences in VAS scores increased linearly as pain descriptors escalated from 'much less' to 'much more pain' ($F = 79.4$, $p < 0.001$).	
	(Sen) *Repeated measures ANOVA:* Dependent variables: VAS and VRS pre- to post treatment difference scores Independent variables: time and analgeticum treatment - VAS tended to be more sensitive than VRS showing the smallest F values ($p < 0.001$). - A composite measure made up of a standardized average of three measures of outcome (VAS difference score, VRS difference score and a pain relief rating was not more sensitive to treatment effects (analgetica) than any one measure.	

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Pautex, S., Herrmann, F., Le Lous, P., Fabjan, M., Michel, J. P., & Gold, G. (2005)	The inpatient dementia consultation of the Geneva Geriatric Hospital.	Elderly who met DSM criteria for dementia. (n = 160)	Repeated measures design: Patients were asked to indicate their current level of pain on different scales (horizontal/ vertical VAS, Faces Pain Scale and Verbal Rating Scale). This was repeated 30 minutes later either by the same investigator (50% of the cases) or by a different examiner who was blinded to the first assessment.	S E	CrV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(S) *Intra-rater reliability horizontal VAS*: r = 0.95 (p < 0.001) *Intra-rater reliability vertical VAS:* r = 0.94 (p < 0.001) **(E)** *Interrater reliability horizontal VAS:* r = 0.90 (p < 0.001) *Interrater reliability vertical VAS:* r = 0.87 (p < 0.001)	**(CrV)** *Concurrent validity:* - Correlation between horizontal VAS and different scales at first assessment: 9. Correlation VAS – Verbal Rating Scale: r = 0.91 (p<0.001) 10. Correlation VAS – Faces Pain Scale: r = 0.88 (p<0.001) 11. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.35 (p<0.001) - Correlation between horizontal VAS and different scales at second assessment: 12. Correlation VAS – Verbal Rating Scale: r = 0.85 (p<0.001) 13. Correlation VAS – Faces Pain Scale: r = 0.87 (p<0.001) 14. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.36 (p<0.001) - Correlation between vertical VAS and different scales at first assessment: 9. Correlation VAS – Verbal Rating Scale: r = 0.89 (p<0.001) 10. Correlation VAS – Faces Pain Scale: r = 0.89 (p<0.001) 11. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.40 (p<0.001) - Correlation between vertical VAS and different scales at second assessment: 12. Correlation VAS – Verbal Rating Scale: r = 0.89 (p<0.001) 13. Correlation VAS – Faces Pain Scale: r = 0.90 (p<0.001) 14. Correlation VAS – Doloplus 2 (observational pain scale): r = 0.39 (p<0.001)	Weak correlations between VAS and Doloplus 2. The authors reported a trend towards better comprehension of the horizontal VAS.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Bijur, P. E., Silver, W., & Gallagher, E. J. (2001)	Two emergency departments.	Convenience sample of adults with acute pain as a component of their chief complaint. (n = 69)	Repeated measures design: VAS measurements 1 minute apart every 30 minutes over two hours.	S	Sen
Pomeroy, V. M., Frames, C., Faragher, E. B., Hesketh, A., Hill, E., Watson, P. et al. (2000)	Nursing homes among other things.	Stroke patients experiencing shoulder pain. (n = 33)	Repeated measures design: 3 measures in one week.	S E	

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(S) *Intra-rater reliability:* r = 0.97 (95% CI 0.96 to 0.98) *Bland-Altman analyses:* 50 percent of the differences between the repeated VAS scores (time 0 and 1 minute later) were within 2mm, 90 % were within 9mm, and 95% of the scores were within 16mm of the 100 mm VAS.	**(Sen)** *Convergent validity:* After completing the VAS at the end of each 30 minute interval, patients were also asked to contrast current pain with their pain at the previous using one of 5 categorical descriptors: 'much less pain', 'a little less pain', 'about the same pain', 'a little more pain', or 'much more pain'. Differences in VAS scores increased linearly as pain descriptors escalated from 'much less' to 'much more pain' (F = 79.4, p < 0.001).	
(S) *Intra-rater reliability:* r = 0.70 **(E)** *Interrater reliability:* r = 0.79		Examination of the raw data indicated that 27% of the ratings were in exact agreement because all raters gave a score of zero. Day-to-day variation could account for some of the lack of intra-rater agreement.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Herr, K. A., Spratt, K., Mobily, P. R., & Richardson, G. (2004)	Subjects were recruited through college bulletin board displays, community faith centers, senior-citizen centers, senior-housing, and long-term facilities.	86 younger adults (age 25-55) and 89 older adults (age 65-94). (n = 175)	Repeated measures design: Noxious heat stimili were delivered to the ventral forearm by an electronically controlled contact thermode. The heat stimili were programmed to last 5 seconds and to present randomly 43°C, 45°C, 46°C, 47°C, 48°C, 49°C or 51°C. A 2 minute trial interval followed each stimulus presentation during which the subject rated the stimulus on 5 scales.	IC E	CsV Sen

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(IC) *Internal consistency:* Intercorrelations between the scales were all statistically significant at every temperature ($p < 0.001$). *Cronbach's alpha within each scale across the 7 temperature values:* VAS: 0.88 NRS: 0.88 VDS: 0.86 VNS: 0.88 FPS: 0.88 *Cronbach's alpha within temperature across the 5 scales:* 43°C: 0.96 45°C: 0.96 46°C 0.96 47°C: 0.97 48°C: 0.97 49°C: 0.97 51°C: 0.97 **(E)** *Interrater reliability:* VAS: 93.5% agreement NRS: 100% agreement VDS: 100% agreement VNS: 100% agreement FPS: 100% agreement	**(CsV)** *Principal components analysis:* A one-factor model was extracted from the different measurement scales. The correlation of each scale to the isolated factor was as follows: VAS: 0.94 NRS: 0.96 VDS: 0.95 VNS: 0.95 FPS: 0.86 **(Sen)** Each tool demonstrated significant increases in score associated with increase in temperature ($p < 0.001$).	The VAS had a significant higher failure rate (6.7%) in comparison with the NRS, VDS, VNS, and FPS. The VNS demonstrated significantly higher levels of pain report than the other 4 scales. The psychometric scale evaluation was conducted using an experimental pain stimulus instead of using clinical pain stimili. The scales most preferred in order by the total sample: NRS (35.3%); VDS (25.3%); VNS (15.9%); FPS (12.9%); VAS (10.6%).

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Van Dijk, M., Koot, H. M., Saad, H. H., Tibboel, D., & Passchier, J. (2002)	Not specified.	9 studies were reviewed on reliability; 6 studies were reviewed on validity.	Review.	E	CrV
Carey, S. J., Turpin, C., Smith, J., Whatley, J., & Haddox, D. (1997)	Inpatient units of the Crawford Long Hospital, Atlanta.	The admitted diagnosis for 39.5% of the sample was acute pain, 40.3 with chronic pain and 20.2 with no pain. (n = 267)	Comparative study: The VAS was compared with FRS and NRS.	IC	
Mawdsley, R. H., Moran, K. A., & Conniff, L. A. (2002)	An outpatient setting.	Elderly with musculoskeletal injury or disorders with pain aged 61 to 84. (n = 32)	Repeated measures design: VAS and NRS measurements 15 minutes apart.	E	
Hicks, C. L., von Baeyer, C. L., Spafford, P. A., van, K., I, & Goodenough, B. (2001)	Two urban jewelry stores.	Children aged 5 to 12. (n = 76)	Validation study. To validate a revised version of the FPS (FPS-R) with 6 faces instead of 7.		CrV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(E) *Inter-observer reliability:* Inter-observer reliability between professionals' VAS ratings (nurses, physician or researcher): r = 0.42 to 0.91 (median = 0.75) Inter-observer reliability between professionals and parents' VAS ratings: r = 0.36 to 0.85 (median = 0.52)	**(CrV)** *Concurrent validity:* Correlation coefficients between self reported VAS of children (VAS sr) and VAS results of observational professionals ranged from 0.23 to 0.85 (median 0.53). Correlation coefficients between VAS sr and VAS results of observational parents ranged from 0.46 to 0.83 (median 0.70). Correlation VAS results of observers and other pain instruments: r = 0.42 to 0.86 (median = 0.68)	
(IC) *Cronbach's alpha:* Intercorrelations between 3 scales was α = 0.88.		Patients selected the FPS as 'easiest to use' (48.6%), followed by the NRS (35.3%) and the VAS (16.1%).
(S) *Intra-rater reliability NRS:* r = 0.74 *Intra-rater reliability VAS:* r = 0.92		
	(CrV) *Concurrent validity:* A strong positive correlation (r = 0.93, p < 0.001) was found between the ratings of pain intensity on the VAS and FPS-R.	The psychometric scale evaluation was conducted using an experimental pain stimulus instead of using clinical pain stimili.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Triano, J. J., McGregor, M., Cramer, G. D., & Emde, D. L. (1993)	The National College of Chiropractic Center.	Patients presenting to the National College of Chiropractic Center for the first time, as well as those who had not been seen in outpatient clinic within the previous 6 months. A total of 145 of 186 completed the final 6 weeks follow up. 41 subjects completed only the first follow up. (n = 186)	Repeated measures design: VAS and other outcome measures (Oswestry Low Back Pain Disability Questionnaire, Modifief Zung Depression Scale, Pain Drawing, Modified Somatic Perception Questionnaire and Pain Locus of Control) for use with back pain patients were administered (a) prior to clinical evaluation for chief compliant of the patient (b) immediately after clinical evaluation and before treatment and (c) 6 weeks later.		Sen
Crossley, K. M., Bennell, K. L., Cowan, S. M., & Green, S. (2004)	General community and private practice.	71 persons with patellofemoral pain were used to evaluate the VAS' validity; a subset of 17 persons was used to assess the reliability. (n = 71)	RCT. The experimental treatment was a physiotherapy intervention (quadriceps muscle retraining, patellar tape, stretching, education) and the placebo treatment consisted of a sham ultrasound. Outcome measures: - VAS for usual pain (VAS-U) - VAS for worst pain (VAS-W) - VAS for pain on 6 aggravating activities: walking, running, squatting, sitting, ascending and decending stairs (VAS-activity)	S	CsV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
	(Sen) There was a statistically significant difference between VAS scores at time 1 vs. time 3 ($F = 53.23$, $p < 0.001$) and at time 2 vs. 3 ($F = 47.84$, $p < 0.001$). Correlation between VAS at time 1 and VAS at time 2 was high ($r = 0.87$) and decreased substantially when measured between VAS at time 2 and VAS at time 3 ($r = 0.26$).	The Oswestry Low Back Pain Disability Questionnaire and VAS were both more valid and reliable than other instruments for application for treatment of musculoskeletal disorders.
(S) *Intra-rater reliability:* Participants completed a second set of questionnaires within 7 days of the original assessment but before their first appointment for a treatment session. *Intra-rater reliability VAS-U:* $r = 0.56$ *Intra-rater reliability VAS-W:* $r = 0.76$ *Intra-rater reliability VAS-activity*: $r = 0.83$	**(CsV)** *Convergent validity:* Measures were completed at baseline and at the conclusion of the 6-week treatment program. The change from baseline to final assessment was calculated. The mean change scores were moderately correlated with a global rating of change as perceived by the patient: Δ VAS-U: $r = -0.67$ Δ VAS-W: $r = 0.69$ Δ VAS-Activity: $r = -0.68$	

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Gagliese, L. & Katz, J. (2003)	Not specified.	Men scheduled for radical prostatectomy and who were eligible for postoperative patient controlled analgesia. Two groups, younger and older, were formed based on a split of the sample at the median age of 62 years. (n = 95)	Repeated measures design: VAS assessed intensity of pain at rest (VAS-R) and in response to a standard mobilization exercise (VAS-M) after sitting upright from a lying position and taking two maximal inspirations, McGill Pain Questionnaire (MPQ) and Present Pain Intensity (PPI) were compared on postoperative day 1 (POD1) and postoperative day 2 (POD2).		CrV CsV
Tamiya, N., Araki, S., Ohi, G., Inagaki, K., Urano, N., Hirano, W. et al. (2002)	Patients were recruited during routine return visits to the clinic of a rheumatoid specialist in Tokyo.	Female rheumatoid arthritis (RA) patients. (n = 145)	Comparative study: VAS was compared with affect measurements (VAS Anxiety, VAS Depression and VAS Life satisfaction).	S	CsV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
	(CrV) *Concurrent validity:* There were significant moderate interscale correlations in both age groups. In the older group, on POD 1, the correlations between MPQ and both VAS ratings, and between PPI and VAS-M, failed to reach significance. The remaining correlations were significant. On POD 2, the only nonsignificant correlation was between VAS-M and MPQ. The magnitude of the correlations did not differ between the groups except for VAS-R and MPQ. On both POD 1 ($p \leq 0.05$) and POD 2 ($p \leq 0.004$), this correlation was lower in older than younger patients. **(CsV)** *Convergent validity:* On all scales, there was a significant decrease in scores with time. The amount of morphine self-administered also decreased over time in both groups but the decrease (POD 1 minus POD 2) was greater in the younger (27.68 ± 22.93 mg) than the older (20.51 ± 19.58 mg) patients ($p \leq 0.02$).	
(S) *Intra-rater reliability VAS Pain at the same day of administration (n = 47):* r = 0.84 (95% CI = 0.78–0.88) *Intra-rater reliability VAS Pain measured 7 days after the initial measurement (n = 47):* r = 0.64 (95% CI = 0.43–0.78)	**(CsV)** *Convergent validity:* - VAS Pain was moderately positively correlated with VAS Anxiety (0.49, $p < 0.001$) and VAS Depression (0.36, $p < 0.001$) and moderately negatively correlated with VAS Life satisfaction (-0.23, $p < 0.05$). - VAS Anxiety explained 30% of the variance in pain ($F = 21.1$; d.f. = 1, 49; $p < 0.001$). - VAS Depression explained 17% of the variance in VAS Pain ($F = 9.8$; d.f. = 1, 49; $p = 0.003$). - Higher CRP levels were associated with greater pain ($F = 6.09$; d.f. = 4, 95; $p = 0.015$).	Day-to-day variation could account for some of the lack of intra-rater agreement 7 days after the initial measurement.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Stinson, J. N., Kavanagh, T., Yamada, J., Gill, N., & Stevens, B. (2006)	Not appropriate (review).	Children aged 3 – 18 years.	Review on self report measures of single-item ratings of pain intensity for use in clinical trials in children and adolescents.	S	CrV Sen
Koho, P., Aho, S., Watson, P., & Hurri, H. (2001)	Patients were referred by the Social Insurance Institute to the chronic pain management programme at ORTON Rehabilitation Centre in Helsinki, Finland.	Patients (45.5%) had radiation of pain below the level of the knee. Other signs of root compression e.g. reflex changes or neurological defences were observed in 38.6% of the patients. (n = 51)	Comparative study: Observations of pain behaviour were compared with VAS and other outcome measures indirect related to pain (e.g. depression, disability,…).		CsV
Paice, J. A. & Cohen, F. L. (1997)	A large tertiary care hospital.	A convenience sample of 50 adult oncological patients with pain. (n = 50)	Comparative study: the VAS was compared with NRS and Simple Descriptor Scale (SDS).		CrV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(S) *Intra-rater reliability:* Test - retest evidence for VAS indicated a moderate to strong positive median correlation (r = 0.70) between pain intensity ratings reported by 5–6 year olds over a two-week interval (McGrath et al. in Stinson et al., 2006). The strength of the median between-session correlation increased in children aged 13 - 15 years (r = 0.99).	**(CrV)** *Concurrent validity:* VAS have demonstrated moderate to strong correlations (r = 0.63 – 0.90) with several other pain measures (e.g., Faces Pain Scale and Oucher) (Beyer & Aradine in Stinson et al., 2006; Tyler et al. in Stinson et al., 2006; Goodenough et al. in Stinson et al., 2006; Migdal et al. in Stinson et al., 2006). **(Sen)** VAS have also shown responsivity to change following surgery (Tyler et al. in Stinson et al., 2006), administration of analgesics (Abu-Saad and Holzemer in Stinson et al., 2006; Aradine et al. in Stinson et al., 2006; Tyler et al. in Stinson et al., 2006) and following application of a local anesthetic (Migdal et al. in Stinson et al., 2006).	
	(CsV) *Convergent validity:* VAS-scores demonstrated weak correlations with observations of pain behaviour: r = 0.40 ($p < 0.05$).	
	CrV) Concurrent validity: -The strong positive correlation between the VAS and the NRS was statistically significant: r = 0.847, $p < 0.001$. -VAS was also correlated to SDS: r = 0.708, $p < 0.001$	A majority of subjects (50%) preferred the use of the NRS when comparing the three scales used to measure pain intensity. Fewer patients preferred the SDS (38%), with the VAS chosen least often (12%). Eleven subjects (20%) in this study were unable to complete the VAS or did so with great difficulty. All subjects were able to complete the NRS and SDS without apparent difficulty.

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Benaim, C., Froger, J., Cazottes, C., Gueben, D., Porte, M., Desnuelle, C., & Pelissier, J. Y. (2007)	2 rehabilitation units.	Patients who suffered a first unilateral middle cerebral artery stroke. A distinction was made between left and right hemispheric stroke patients (LHSP –RHSP). (n = 127)	5 year period prospective study. FPS was compared with vertical VAS and Verbal Ratings Scale (VRS).	S E	CrV
Hicks, C. L., von Baeyer, C. L., Spafford, P. A., van, K., I, & Goodenough, B. (2001)	A children's hospital.	Children aged 4 to 12 and who were hospitalized for surgical treatment in 68 cases (75%) including abdominal (n = 18), ear/ nose/ throat (n = 12), orthopedic (n = 12), urological (n = 7), and other (n = 19). The remaining 22 cases (25%) were hospitalized for non-surgical painful conditions: abdominal (n = 5), respiratory (n = 5), orthopedic/ rheumatological (n = 4), and other (n = 8). (n = 90)	Validation study. To validate a revised version of the FPS (FPS-R) with 6 faces instead of 7.		CrV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
(S) *Intra-rater reliability (n = 33):* Kappa coefficients for FPS were 0.74 (0.13) and 0.53 (0.10) in LHSP and RHSP, respectively. Kappa coefficients for VRS were 0.39 (0.14) and 0.57 (0.15) in LHSP and in RHSP, respectively. ICC for VAS were 0.78 (0.46–0.92) and 0.90 (0.74–0.96) in LHSP and in RHSP, respectively. **(E)** *Interrater reliability (n = 43):* Kappa coefficients for FPS were 0.64 (standard error = 0.11) and 0.44 (0.09) in LHSP and RHSP, respectively. Kappa coefficients for VRS were 0.46 (0.12) and 0.52 (0.12) in LHSP and in RHSP, respectively. ICC for VAS were 0.72 (95% CI = 0.44–0.88) and 0.86 (0.68–0.94) in LHSP and in RHSP, respectively.	**(CrV)** *Concurrent validity (n = 51):* LHSP scores on the FPS were highly correlated with VAS ($r = 0.82$, $p < 0.001$) and with VRS scores ($r = 0.65$, $p < 0.01$). In the RHSP group, correlations were also high ($r = 0.72, 0.72$; $p < 0.001$ respectively).	Among 71 patients, most LHSP preferred FPS (16/32) to VAS (6/32) and VRS (10/32), most RHSP preferred VAS (18/39) to FPS (11/39) and VRS (10/39). The difference was statistically significant ($p < 0.05$).
	(CrV) *Concurrent validity:* The child was asked to estimate his or her current pain on the FPS-R, followed by either the VAS or the colored analogue scale (CAS). Each child was randomly assigned to use either the VAS or the CAS. Correlations between the FPS-R and the CAS and between the FPS-R and the VAS were respectively $r = 0.84$ and $r = 0.92$.	

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Author (year)	Setting	Sample (n)	Design	Reliability	Validity
Kim, E. J. & Buschmann, M. T. (2006)	A general hospital and an oriental medical hospital in Korea.	85 older adults with chronic pain (i.e., a state of pain ≥ 6 months duration and for which the cause of the pain could not be removed) were recruited. (n = 85)	Comparative study.		CrV

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Results reliability	Results validity	Commentary
	(CrV) *Concurrent validity:* Results indicate that pain intensities by the FPS, the NRS and the VAS were not significantly different ($F(1.00, 68.00) = 2.93$, $p = 0.09$); likewise the tools were not different in reporting the intensity of patient's pain. The VAS had moderately strong correlation with the FPS ($r = 0.73$, $p < 0.001$) and the NRS ($r = 0.91$, $p < 0.001$). Correlation between the VAS and the NRS of the cognitively impaired group ($r = 0.88$, $p < 0.001$) was weaker than the correlation of the cognitively intact group ($r = 0.92$, $p < 0.001$), correlation between the FPS and the NRS of the cognitively impaired group ($r = 0.75$, $p< 0.001$) was slightly stronger than correlation of the cognitively intact group ($r = 0.70$, $p< 0.001$).	

Reliability: Stability (S), Internal consistency (IC), Equivalence (E)
Validity: Face validity (FV), Content validity (CtV), Criterion validity (CrV), Construct validity (CsV)
Sensitivity (Sen), Specificity (Sp), Positive Predictive Value (PPV), Negative Predictive Value (NPV), Receiver Operating Curve (ROC), Likelihood Ratio (LR), Odds Ratio (OR)

Horizontal VAS

Bron: Huskisson, E. C. (1974). Measurement of pain. *Lancet, 2,* 1127-1131.

Instructions: Show and read the pain scale to the resident. Explain to the resident to place a mark along the line to indicate their current pain level. Wait for a verbal reply or for the resident to mark their current level of pain. Repeat the directions if the resident is having difficulty; use words other than “pain”: aching, cramping, sore, uncomfortable, stiff, dull, pressure, burning, shooting. If the resident does not like it or understand it, switch to another pain rating scale. Always use the same scale for each follow-up assessment. Document the scale used as the Visual Analogue Scale.

No pain _____ The worst imaginable pain

Vertical VAS

Bron: Huskisson, E. C. (1974). Measurement of pain. *Lancet, 2,* 1127-1131.

Instructions: Show and read the pain scale to the resident. Explain to the resident to place a mark along the line to indicate their current pain level. Wait for a verbal reply or for the resident to mark their current level of pain. Repeat the directions if the resident is having difficulty; use words other than “pain”: aching, cramping, sore, uncomfortable, stiff, dull, pressure, burning, shooting. If the resident does not like it or understand it, switch to another pain rating scale. Always use the same scale for each follow-up assessment. Document the scale used as the Visual Analogue Scale.

No pain

The worst imaginable pain

Vertaling Horizontale VAS

Instructies: Toon de schaal aan de patiënt. Vraag de patiënt een markering aan te brengen op de lijn, overeenkomstig zijn/ haar huidige pijnbeleving. Indien de patiënt moeilijkheden ervaart om de VAS te begrijpen of te scoren, kunnen de instructies herhaald worden. Maak gebruik van andere woorden dan pijn; gebruik termen zoals lijden, krampen, zeer, ongemakkelijk, stroef, dof, druk, brandend, schietend. Indien de patiënt de schaal nog steeds niet begrijpt of een ander meetinstrument verkiest, kan overgegaan worden tot een andere pijnschaal. Belangrijk is echter wel dat steeds dezelfde schaal gebruikt wordt in het controleren van pijn bij de patiënt.

Geen pijn _____ Ergst denkbare pijn

Vertaling Verticale VAS

Instructies: Toon de schaal aan de patiënt. Vraag de patiënt een markering aan te brengen op de lijn, overeenkomstig zijn/ haar huidige pijnbeleving. Indien de patiënt moeilijkheden ervaart om de VAS te begrijpen of te scoren, kunnen de instructies herhaald worden. Maak gebruik van andere woorden dan pijn; gebruik termen zoals lijden, krampen, zeer, ongemakkelijk, stroef, dof, druk, brandend, schietend. Indien de patiënt de schaal nog steeds niet begrijpt of een ander meetinstrument verkiest, kan overgegaan worden tot een andere pijnschaal. Belangrijk is echter wel dat steeds dezelfde schaal gebruikt wordt in het controleren van pijn bij de patiënt.

Geen pijn

Ergst denkbare pijn

Wat is BEST?

BEST staat voor BElgian Screening Tools en is een studie uitgevoerd door de Universiteit Gent, afdeling Verplegingswetenshap in opdracht van de Federale Overheidsdienst Volksgezondheid, Veiligheid van de voedselketen en Leefmilieu, en in samenwerking met de Université Catholique de Louvain.

Doel van BeST

Bedoeling van het project is het oprichten van een databank met wetenschappelijk gevalideerde meetinstrumenten. Met het oog op het objectiveren van de diagnostiek en van de resultaten van verpleegkundige interventies, zijn valide en betrouwbare meetinstrumenten een basisvoorwaarde om effectieve verpleegkundige zorg te kunnen bieden. Onze aandacht gaat uit naar meetinstrumenten voor de verpleegkundige interventies die bij de Minimale Verpleegkundige Gegevens gescoord worden.

Wat kan u vinden in dit rapport?

In dit rapport wordt de inhoud van het project alsook de gehanteerde methodologie beschreven. Vervolgens worden de verschillende meetinstrumenten per thema besproken. Bovendien wordt het instrument ter beschikking gesteld indien we hiertoe toestemming verkregen. Meetinstrumenten met een hoge betrouwbaarheid en validiteit werden tevens naar het Nederlands en het Frans vertaald.

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Gelieve bij elk gebruik van dit rapport als volgt te refereren:

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