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# Development of a Cosmetic Procedure Screening Questionnaire (COPS) for Body Dysmorphic Disorder

## Background

Guidelines recommend screening patients for Body Dysmorphic Disorder (BDD) prior to cosmetic surgery to identify those who may require further psychological assessment<sup>1</sup> but there are few validated instruments available. The aim of the current study was therefore to develop a screening questionnaire that (a) was brief, free to download and could identify people with BDD, (b) might predict either dissatisfaction with a cosmetic procedure or no change or deterioration in symptoms of BDD, and (c) may be sensitive to change after an intervention. The new scale was informed by the diagnostic criteria, expert opinion and a previous study that compared patients satisfied with cosmetic rhinoplasty with BDD patients who craved rhinoplasty but had not been able to obtain it.<sup>2</sup>

## Method

Two groups of participants were recruited:

### Community group

We recruited a community group of both genders who were either planning or very motivated to have a cosmetic procedure in the future. The questionnaire was completed by  $n = 108$  participants.

### BDD group

A psychiatrist conducted an interview based on DSM-IV to diagnose BDD in a clinical setting. Ninety-seven patients with BDD seeking a cosmetic procedure were recruited. All participants completed the following:

- 1) Cosmetic Procedure Screening (COPS) questionnaire

The questionnaire asks for the feature(s) that the person finds unattractive, the nature of the cosmetic procedures they are seeking and diagnostic criteria of BDD. The final version of COPS questionnaire comprises 9 items. Items are scored from 0 (least impaired) to 8 (most impaired). The scale and a full version of this paper are available to download from: <http://www.iop.kcl.ac.uk/cadatquestionnaire>. The score is achieved by summing Q 2-10. Items 2, 3 and 5 are reversed. The total ranges from 0 to 72 with a higher score reflecting greater impairment.

- 2) Hospital Anxiety and Depression Scale (HAD)
- 3) Body Image Quality of Life Inventory (BIQLI)
- 4) Body Image Disturbance Questionnaire (BIDQ)

## Results

Items on the COPS that showed a significant difference between the two groups, which did not have a significant group  $\times$  sex interaction and had an effect size (Cohen's  $d$ ) of at least 0.80 were retained in the item discriminatory analysis. Nine items met these criteria and were used to form the final questionnaire (see Table 1).

### Internal consistency

Reliability analysis resulted in an internal consistency of Cronbach's  $\alpha = 0.91$  with corrected item total ranging from 0.41 to 0.86.

### Test-retest reliability

67 participants in the community group repeated the COPS after 1 week. The COPS had good test-retest reliability ( $r = 0.87$ ,  $p < 0.01$ ). First administration ( $M = 27.94$ ,  $SD = 13.89$ ), second administration ( $M = 30.71$ ,  $SD = 14.04$ ).

### Convergent validity

Based on the data from both groups the COPS correlated highly with the HAD depression subscale ( $r = 0.7$ ,  $p < 0.01$ ) and anxiety subscale ( $r = 0.66$ ,  $p < 0.01$ ). COPS also correlated highly with the BIQLI ( $r = -0.68$ ,  $p < 0.01$ ). Thus higher scores on COPS are associated with lower body image quality of life.

### Cut-off value and ROC analysis

Figure 1 represents the ROC curve for BDD patients compared with community controls. The area under the curve (AUC) for this analysis was 0.905 (95% CI = 0.862–0.948) indicating that the COPS is an accurate diagnostic test. Based on the discrimination of BDD patients from the community group, a cut-off value of  $\geq 40$  resulted in a maximal kappa coefficient ( $k = 0.69$ ,  $p < 0.001$ ). On the basis of this cut-off value, 88.9% of BDD patients and 80.6% of the community group were classified correctly.

### Sensitivity to change

We examined sensitivity to change in a sub-sample of 5 patients with BDD who were undergoing cognitive behaviour therapy.<sup>3,4</sup> Scores on the COPS were examined at baseline, 6 weeks, and 12 weeks. The mean and SD on the 9-item COPS was 52.40 ( $SD = 16.70$ ) at baseline and 35.00 ( $SD = 22.88$ ) at 12 weeks. A one-way repeated measures ANOVA was conducted to compare scores across these 3 treatment points. There was a significant effect

**Table 1** Difference between the community group and BDD group, effect size and group  $\times$  sex interaction for all items (items in bold were retained for use in the final questionnaire).

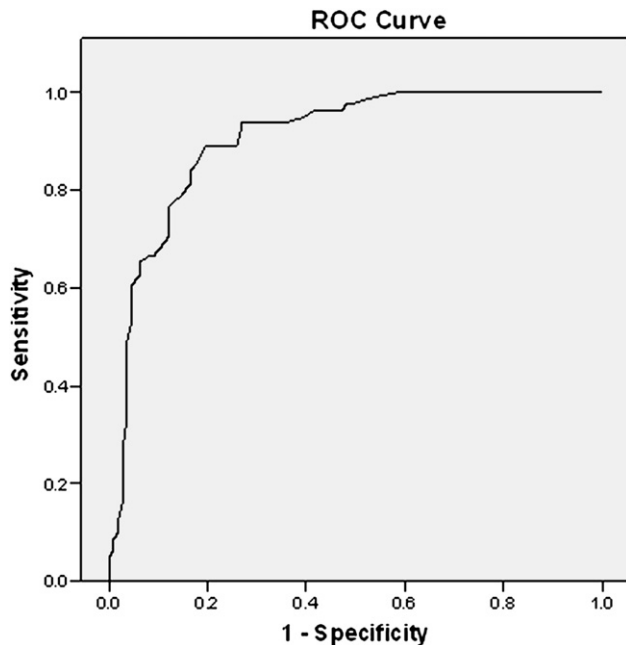
Variable	Community group	BDD Group	Difference between Groups		Effect Size (d)	Group $\times$ Sex interaction
	M (SD)	M (SD)	U value	p value		p value
1. Avoid looking at my feature(s)	3.32 (2.71)	3.00 (2.62)	4346.5	0.615 ns	0.12	Men: >0.05 ns Women: >0.05 ns
2. Frequency of checking feature(s)	<b>2.82 (2.05)</b>	<b>5.15 (1.66)</b>	<b>2891</b>	<b>&lt;0.001</b>	<b>1.25</b>	<b>Men: &lt;0.01</b> <b>Women: &lt;0.001</b>
3. How ugly, unattractive or 'not right' feature(s) are	<b>4.83 (2.19)</b>	<b>7.15 (1.60)</b>	<b>2615.5</b>	<b>&lt;0.001</b>	<b>1.22</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
4. Distress caused by feature(s)	<b>3.92 (2.27)</b>	<b>7.05 (1.1)</b>	<b>1640</b>	<b>&lt;0.001</b>	<b>1.84</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
5. Avoid situations or activities because of feature(s)	<b>2.64 (2.43)</b>	<b>5.95 (1.9)</b>	<b>2609</b>	<b>&lt;0.001</b>	<b>1.53</b>	<b>Men: &lt;0.01</b> <b>Women: &lt;0.001</b>
6. Preoccupation with feature(s)	<b>3.28 (2.14)</b>	<b>7.15 (1.27)</b>	<b>993</b>	<b>&lt;0.001</b>	<b>2.26</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
7. Interference with relationship/dating	<b>3.10 (2.74)</b>	<b>6.25 (1.62)</b>	<b>2008</b>	<b>&lt;0.001</b>	<b>1.79</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
8. Interference with sexual relationship	2.68 (2.74)	3.7 (3.13)	2257	<0.001	0.35	Men: <0.05 Women: <0.001
9. Inability to work/study due to feature(s)	<b>1.32 (4.22)</b>	<b>5.25 (1.86)</b>	<b>1231</b>	<b>&lt;0.001</b>	<b>0.83</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
10. Interference with social life	<b>2.42 (2.4)</b>	<b>6.2 (1.77)</b>	<b>1301.5</b>	<b>&lt;0.001</b>	<b>1.8</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>
11. Noticeability of feature(s) to other people	4.74 (2.43)	5.95 (2.28)	3067.5	<0.001	0.51	Men: <0.01 Women: <0.001
12. Frequency of comparing feature(s) to other people	4.33 (1.7)	6.2 (1.32)	1606.5	<0.001	0.62	Men: <0.001 Women: <0.001
13. Trying to please self or others by having procedure	6.44 (1.53)	7.35 (0.93)	2251	<0.001	0.74	Men: <0.01 Women: <0.01
14. Amount of discouragement from having procedure	4.03 (2.8)	3.7 (2.9)	2405	0.54 ns	0.11	Men: >0.05 ns Women: >0.05 ns
15. Understanding from family/friends about feature(s)	4.3 (2.47)	4.92 (2.50)	3064	0.086 ns	0.25	Men: >0.05 ns Women: >0.05 ns
16. Importance of appearance in defining who you are	<b>3.77 (1.79)</b>	<b>5.65 (1.97)</b>	<b>1900.5</b>	<b>&lt;0.001</b>	<b>0.96</b>	<b>Men: &lt;0.001</b> <b>Women: &lt;0.001</b>

across the 3 treatment points [ $F(1.10, 4.38) = 7.35$ ,  $p = 0.047$ ].

## Discussion

We have developed a brief (nine item) screening questionnaire (COPS) that can be used in a cosmetic procedure setting to screen patients with BDD. The scale has acceptable internal consistency, test-retest reliability, and convergent validity. It has a high sensitivity for the

diagnosis of BDD in people who are likely to seek a cosmetic procedure. Individuals who score 40 or more should be referred for further assessment. The COPS was also sensitive to change in patients receiving cognitive behaviour therapy.<sup>3,4</sup> It may therefore be used as an outcome measure after any treatment (including cosmetic procedures) to determine (a) if there is any improvement in symptoms of BDD on a continuous dimension (b) whether it may predict persistence of symptoms or dissatisfaction with a cosmetic procedure (in the absence of any surgical complications).



**Figure 1** Receiver operating characteristics plot of COPS scores of BDD patients compared with community controls.

### Conflict of interest

None.

### Funding

None.

### Ethical approval

Brighton and Sussex Ethics Committee.

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## Do patients undergoing minor local anaesthetic plastic surgery procedures really need an MRSA swab?☆

### Introduction

As patients with Meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation are at risk of subsequent infection, pre-morbid identification and decolonisation should reduce infection and transmission.<sup>1</sup> Therefore, the Department of Health in England introduced screening of all elective patients for MRSA in a 2009 working framework, suggesting this may be cost-effective.<sup>2</sup> The original guidance made certain clear exceptions, including minor dermatology, commenting that MRSA infection rates were sufficiently low to negate cost economy.

Plastic surgery at our hospital is limited to local anaesthetic day case procedures; complex cases or those requiring general anaesthesia are treated at a regional centre. Typical patients include benign and malignant skin excisions with direct wound closure, or utilising local flaps or skin grafts. MRSA screening of elective patients (nose, throat, axilla and groin) was introduced in 2009 as this speciality was not explicitly exempt. As a practical and

☆ This study has not been published or presented elsewhere.