Quality of life across the schizotypy spectrum: findings from a large nonclinical adult sample

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Abstract

Objective: It is well documented that patients with schizophrenia have impoverished quality of life (QOL). Efforts to determine the underpinnings of this impoverishment have implicated negative symptoms more than positive or disorganized symptoms. However, only a minority of individuals with the liability to schizophrenia will ever show manifest illness, and it is presently unclear the degree to which QOL is affected in individuals with subclinical symptoms of the disorder (ie, schizotypy). The present study examined the relative contributions of negative, positive, and disorganized schizotypy symptoms to QOL.

Methods: Measures of schizotypal symptoms and subjective and objective QOL were obtained from a sample of 1395 adults.

Results: Measures of schizotypal symptoms significantly corresponded to all measures of QOL, although the magnitude of correlations were significantly larger for subjective than objective measures. The negative symptom dimension explained a substantial portion of unique variance in the social domains of QOL above and beyond that accounted for by the other schizotypy dimensions.

Conclusions: These findings highlight the deleterious impact of schizotypal symptoms, particularly negative symptoms. Further research clarifying the mechanism underlying this relationship is called for.

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1. Introduction

Schizophrenia is a severe mental illness characterized by widespread disruption of central nervous system functions [1], severe functional impairments [2], and impoverished life quality [3,4]. Although schizophrenia is a relatively rare disorder, a substantial segment of the population is considered vulnerable to developing the disorder (estimated to be 10% [5,6]). Most of these “schizotypic” individuals will never develop a diagnosable psychotic disorder but will tend to manifest a host of subclinical schizophrenia-like abnormalities (see references [6-10]). Recent data suggest that they also show functional impairments across a broad range of domains, including academic, social, and occupational settings (eg, see references [9,11-13]). Despite increased understanding of the “real world” dysfunctions associated with schizotypy, many questions remain unanswered about how the lives of these individuals are affected.

A critical gap in our current knowledge about schizotypy concerns quality of life (QOL). Quality of life pertains to an individual’s standard of living and is considered an important indicator of the well-being of people with neuropsychiatric disorders [14]. Although there is considerable variability in how QOL is operationalized across studies, many researchers assert that QOL should be measured across separate objective (concerning tangible features of a person’s life [eg, number of friends, adequate financial resources]) and subjective (concerning appraisals of an individuals satisfaction with their life [eg, satisfaction with number of friends and financial resources]) domains [3,4,14,15]. This subjective vs objective distinction is important because they are only modestly correlated with each other in individuals with schizophrenia [3,15,16]. With respect to schizotypy, it has been reasonably well established that individuals with schizotypy experience attenuations in objective life quality [12,13,17]. However, it has not, to our knowledge, been examined whether subjective life quality is affected.
The issue of how schizotypic symptoms relate to life quality variables takes added importance as one acknowledges that subjective and objective QOL potentially varies across the heterogeneous manifestations of the condition. Both schizophrenia and schizotypy are characterized by a wide array of symptoms that typically cohere into separate positive, negative, and disorganized clusters. In many studies examining QOL, the negative, but not positive or disorganized, symptoms correspond to attenuated QOL in schizophrenia [18–22]. Recent studies that have attempted to explain this relationship in more depth have reported that negative symptoms are associated with attenuated objective but not subjective QOL [3,21,22]. This suggests that patients with negative symptoms experience low QOL but are relatively apathetic about their QOL impoverishment. To our knowledge, an investigation of QOL representing the full range of schizotypic symptoms has not been conducted, and it is presently unclear the degree to which subjective and objective QOL are specific to negative symptoms in this population.

The present study examined the relationship between schizotypal symptoms and subjective and objective QOL in a sample of 1395 young adults recruited from a nonclinical setting. We conducted 3 sets of analyses here. First, we examined the degree to which positive, negative, and disorganized schizotypal symptoms was correlated with subjective and objective QOL. Second, we compared objective vs subjective QOL in their associations to schizotypal symptoms with the expectation that objective QOL would show more robust associations to negative schizotypal symptoms. Finally, we examined the unique relationships between specific schizotypy symptom (ie, positive, negative, or disorganized) dimensions and QOL by statistically controlling for the other 2 dimensions. This set of analyses helped us ascertain which symptom sets were differentially related to which QOL domains; an important analysis given the high expected convergence between the schizotypal scales.

2. Methods

2.1. Participants

Participants were undergraduate students enrolled at Louisiana State University, Baton Rouge, during spring semester 2007. Freshmen and sophomore students (n = 8993) were approached by email to participate in an online survey and were offered a chance to win monetary compensation (10 prizes of US $25) as part of a lottery. Embedded within this survey were a consent form, basic demographic questions, and measures of schizotypal symptoms and QOL. The response rate was approximately 20% (n = 1775). Of these responses, 21% (n = 380) of the questionnaires was discarded because of questionable validity (detailed below). The final data set included 1395 participants. Demographic and descriptive variables are included in Table 1. This study was approved by the LSU Human Subject Review Board, and all subjects offered informed consent before completing the surveys.

2.2. Schizotypal symptoms

Schizotypal symptoms were assessed using the Schizotypal Personality Questionnaire (SPQ) [8], a measure with good psychometric properties that has been used in a large number of prior schizotypy studies (eg., [23,24]). The SPQ includes 74 statements that are organized into 1 of 9 subscales that mirror the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, schizotypy personality disorder [2], including ideas of reference, excessive social anxiety, odd beliefs or magical thinking, unusual perceptual experiences, odd or eccentric behavior, no close friends, odd speech, constricted affect, and suspiciousness. The original SPQ uses a forced choice “yes” or “no” response format. To address concerns that dichotomous response formats are insensitive to degrees of symptom severity [25,26], we adopted a 5-point Likert scale system that has been used in recent research [26]. Subjects’ response options ranged from “strongly disagree” to “neutral” to “strongly agree.” The Likert scale version of the SPQ has shown high convergence and improved internal reliability (α = .95) when administered in either computer or standard paper and pencil versions compared with the original version.

Informed by findings that SPQ items are best explained by a 3-factor solution (ie, cognitive perceptual, interpersonal,
and disorganized; [23,27]), we computed separate positive (computed as a sum of the odd beliefs, ideas of reference, unusual perceptual experiences and suspiciousness scores), disorganization (computed as a sum of the odd speech and odd or eccentric behavior scores), and negative factor scores for each subject. The negative symptom factor (typically defined as an “interpersonal” factor computed as a sum of the social anxiety, no close friends, emotional blunting, and suspiciousness scales) was computed without the social anxiety and suspiciousness scales. This decision was made based on evidence that negative affective states, such as anxiety and suspiciousness, are attenuated in patients with idiopathic negative symptoms (eg., [28,29]). This reflects an attempt on our part to capture core schizophrenia negative symptoms as opposed to those that might be secondary to depression, social anxiety, or other comorbid psychopathologic states. A total SPQ score was also computed as a sum of all 9 subscales. Internal consistency was good for each of the individual subscales (range of Cronbach’s α values = .80-.90), the factor scores (range of Cronbach’s α = .90-.93), and the total SPQ score (Cronbach’s α = .96). For each of the SPQ measures included in this study, increasing scores reflect more severe symptoms.

2.3. Quality of life

Quality of life was measured using a modified version of Lehman’s Brief Quality of Life Interview [14]. The original brief version of the QOL, involving items tapping subjective QOL across 9 domains and items tapping objective family, social, and financial QOL, was far too lengthy to be used for the present study. Accordingly, we identified critical items necessary for computing summary scores (defined in reference [14]). Nine items were retained that measured subjective QOL across general life, daily living, family, social, finances, daily and vocational activities, safety, and health domains (using a standardized 7-point Likert scale). Ten additional items were retained that measure objective life quality in social (n = 3; α = .66), family (n = 2; α = .48), and financial (n = 5; α = .67) domains. A composite subjective QOL score (α = .84) reflecting all 9 domains was also computed. Range values for each subscale are provided in Table 1.

Although this version of the QOL has been used across a number of published studies (eg., [4,30-32]), some have raised concerns about using self-report data to measure “objectively” defined QOL [33]. In defense of the QOL as a measure of self-reported “objective” QOL, it is worth noting that differentiating between an individual’s appraisals of their satisfaction with various life domains and their self-reported behaviors and tangible assets has proven important for understanding schizophrenia heterogeneity in prior research [3,21,22]. Moreover, concerns that schizophrenia, characterized by a host of maladies that potentially impair an individual’s insight into his or her subjective and objective QOL states, are less relevant for a schizotypy population. Given these considerations, the brief QOL seems an appropriate measure for subjective and objective QOL in the present study.

2.4. Infrequency scale

To screen out responders who provided random or grossly invalid responses, we included 4 questions from the Infrequency Scale [34]. This includes items such as “I believe that most light bulbs are powered by electricity” and “I find that I often walk with a limp, which is the result of a skydiving accident.” Individuals who endorsed 3 or more infrequency items were excluded from this study.

2.5. Academic functioning

All subjects provided a self-report of their grade point average using an 11-point Likert scale, denoting their score from “below 1.00” to “3.75-4.00.” Approximately 55% of subjects indicated they had a 3.0 (B average) or better and approximately 93% indicated a 2.0 (C average) or better.

2.6. Analyses

The analyses were conducted in 4 steps. First, we examined the relationship between demographic variables and schizotypic symptoms. Second, we computed bivariate correlations between the positive, disorganization, negative, and total schizotypy scores and subjective and objective QOL to examine the degree to which schizotypic symptoms were associated with QOL. As part of this set of analyses, objective and subjective QOL were compared in their respective correlations to schizotypal symptoms using Fisher r-to-z transformations. This analysis tested our hypothesis that schizotypic negative symptoms are associated with objective more than subjective QOL impoverishment. Third, to get a sense of the magnitude of differences in QOL between schizotypic individuals and asymptomatic individuals, we compared QOL scores between extreme schizotypy scorers (defined as 1.6 SD [95th percentile] above the mean) to a reference group of asymptomatic individuals (defined as 1.6 SD [5th percentile] below the mean). Finally, we computed partial correlations between each individual symptom dimension and QOL while statistically controlling for the other 2 symptom dimensions. This allowed us to determine the unique contribution each symptom scale made to each individual QOL domain.

3. Results

3.1. Demographic and clinical variables

Means and SDs were computed for the demographic and clinical variables (see Table 1). Males vs females had significantly more severe disorganization (mean ± SD = −4.46 ± 11.59 and −7.77 ± 11.39 respectively, t1390 = 3.31, P < .001), negative (mean ± SD = −17.03 ± 21.07 and −20.03 ± 21.18, respectively, t1390 = 3.27, P < .01), and total
schizotypy (mean ± SD = −36.08 ± 40.29 and −43.34 ± 41.28, respectively, \( t_{1390} = 7.26, P < .001 \)) symptoms. The ethnic groups significantly differed on the disorganization (\( F_{4,1390} = 3.76, P < .01 \)), negative (\( F_{4,1390} = 5.12, P < .001 \)), and total schizotypy (\( F_{4,1390} = 2.71, P < .05 \)) symptom scores and showed significant differences in subjective QOL (\( F_{4,1390} = 7.17, P < .001 \)). Post hoc analysis using Scheffe tests revealed that Asian Americans reported more severe negative and total schizotypy symptoms and worse QOL than all other groups and that African Americans reported more severe disorganization symptoms than whites and Asian-Americans. Age was associated with more severe disorganization symptoms (\( r_{1393} = −0.06, P < .05 \)) and worse subjective QOL (\( r_{1393} = −0.09, P < .01 \)). A recomputation of each of the analyses in this study controlling for age, ethnicity and sex did not change the interpretation of our data. These analyses are omitted for brevity sake.

3.2. Schizotypy symptoms and QOL

Table 2 contains the bivariate correlations between the schizotypy scores and the QOL variables. There are several notables. First, the schizotypy dimension scores were modestly intercorrelated with each other suggesting some, but not total overlap in coverage. Second, increasing severity of each of the schizotypy dimensions was significantly associated with more QOL impoverishment for each of the measures. Each of these correlations were in the small to medium effect size range (0.10–0.50 using [35]) except for the large effect sizes observed for the social QOL domain and the negative symptoms scores and the total QOL score and the negative and total schizotypy dimension scores. Finally, worse self-reported academic functioning was significantly associated with more severe positive and total schizotypy symptoms, but none of the other schizotypy dimensions.

Fisher r-to-z transformations were then used to compare the correlations between the schizotypy symptom scales and subjective vs objective QOL scores [36]. Each of the values were statistically significant (all \( z \) scores > 2.03, \( P \)’s < .05) except for those involving disorganization symptoms and subjective and objective financial QOL (\( z \) score = 1.21, \( P = .11 \)). In every case, the correlations for subjective QOL were significantly larger than those for objective QOL. Thus, in contrast to expectations, negative symptoms were associated with subjective more than objective QOL.

3.3. The magnitude of impoverishment in schizotypy

To quantify the magnitude of declination in QOL associated with schizotypy, we identified extreme scorers on the total schizotypy dimension and compared their QOL to a group of asymptomatic subjects. Cohen \( D \) effect size scores were medium-large for each of the objective QOL dimensions (range of values = 0.76–1.02) and large for the subjective dimensions (range of values = 0.89–2.08). The effect size for total subjective QOL was also quite large (Cohen \( D = 2.45 \)), suggesting a relatively dramatic difference between individuals with schizotypy symptoms and those without.

3.4. Unique contributions of schizotypy symptoms to QOL

The results of the partial correlations are in Table 3. The partial correlations for the negative symptoms were larger than the positive and disorganized partial correlations for 2 of the 3 objective and 5 of the 8 subjective QOL measures. These differences were particularly pronounced for the objective and subjective family, objective and subjective social, and the subjective daily activities and total concerns scales (all \( z \) scores of Fisher r-to-z transformations > 4.44, \( P \)’s < .001). Positive symptoms showed significant but small relations to most of the QOL measures and was the only symptom dimension to show association with academic functioning. Disorganization symptoms were not related

Table 2
Zero-order correlations for positive, disorganization, negative, and total schizotypal factor scores and correlations between schizotypal factor scores, QOL, and academic functioning measures

<table>
<thead>
<tr>
<th>Schizotypy factor scores</th>
<th>Schizotypy factor score</th>
<th>Positivea</th>
<th>Disorganizationa</th>
<th>Negativea</th>
<th>Totalb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positivea</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorganizationa</td>
<td>0.65**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negativea</td>
<td>0.49**</td>
<td>0.56**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totalb</td>
<td>0.87**</td>
<td>0.83**</td>
<td>0.78**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>QOL measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective family relationsb</td>
<td>−0.10**</td>
<td>−0.16**</td>
<td>−0.16**</td>
<td>−0.15**</td>
<td></td>
</tr>
<tr>
<td>Objective social relationshipsb</td>
<td>−0.11**</td>
<td>−0.10**</td>
<td>−0.33**</td>
<td>−0.21**</td>
<td></td>
</tr>
<tr>
<td>Objective financial issuesb</td>
<td>−0.18**</td>
<td>−0.16**</td>
<td>−0.16**</td>
<td>−0.20**</td>
<td></td>
</tr>
<tr>
<td>Subjective family relationsb</td>
<td>−0.28**</td>
<td>−0.31**</td>
<td>−0.33**</td>
<td>−0.35**</td>
<td></td>
</tr>
<tr>
<td>Subjective social relationshipsb</td>
<td>−0.27**</td>
<td>−0.26**</td>
<td>−0.51**</td>
<td>−0.40**</td>
<td></td>
</tr>
<tr>
<td>Subjective financial issuesb</td>
<td>−0.24**</td>
<td>−0.19**</td>
<td>−0.21**</td>
<td>−0.25**</td>
<td></td>
</tr>
<tr>
<td>Subjective home concerns</td>
<td>−0.28**</td>
<td>−0.28**</td>
<td>−0.24**</td>
<td>−0.31**</td>
<td></td>
</tr>
<tr>
<td>Subjective daily activities</td>
<td>−0.35**</td>
<td>−0.34**</td>
<td>−0.52**</td>
<td>−0.47**</td>
<td></td>
</tr>
<tr>
<td>Subjective legal concerns</td>
<td>−0.21**</td>
<td>−0.16**</td>
<td>−0.16**</td>
<td>−0.22**</td>
<td></td>
</tr>
<tr>
<td>Subjective health concerns</td>
<td>−0.26**</td>
<td>−0.28**</td>
<td>−0.29**</td>
<td>−0.32**</td>
<td></td>
</tr>
<tr>
<td>Subjective total concernsb</td>
<td>−0.43**</td>
<td>−0.42**</td>
<td>−0.54**</td>
<td>−0.54**</td>
<td></td>
</tr>
<tr>
<td>Academic functioning</td>
<td>−0.10**</td>
<td>−0.02</td>
<td>−0.02</td>
<td>−0.06**</td>
<td></td>
</tr>
</tbody>
</table>

a Increasing scores reflect increasing symptoms severity.
b Increasing scores reflect better QOL.
c Increasing scores reflect better academic performance.
d \( P < .05 \).

** \( P < .001 \).
Academic functioning is associated with a host of maladies such as impaired QOL measures important for understanding QOL than positive or disorganized symptoms showed more modest correlations with QOL. This pattern of relationships mirrors that seen across the positive, negative, and disorganized symptoms. Generally speaking, negative symptoms were associated with subjective more so than objective QOL; a finding seemingly discordant with the extant schizophrenia literature. When interpreting this finding, it is notable that some core idiopathic negative symptoms associated with schizophrenia are difficult to disentangle from symptoms of comorbid depression. In particular, social withdrawal, anhedonia, psychomotor retardation, and blunt affect are hallmarks of both disorders and can appear similar during cross-sectional assessments [29,42]. Thus, it could be the case that depression, which often presents in the schizophrenia prodrome [20,43], was driving the significant correlations between negative symptoms and subjective QOL. In support of this interpretation, a number of studies have demonstrated that depression in patients with schizophrenia is associated with impoverished QOL. In support of this conjecture, neurocognitive impairments have been associated with worse QOL in patients with schizophrenia [3,41]. An important next step in this line of research would be to examine the relationship between cognitive and affective variables and QOL in a sample of schizotypic individuals.

An unexpected finding of this study was that negative symptoms were associated with subjective more so than objective QOL; a finding seemingly discordant with the extant schizophrenia literature. When interpreting this finding, it is notable that some core idiopathic negative symptoms associated with schizophrenia are difficult to disentangle from symptoms of comorbid depression. In particular, social withdrawal, anhedonia, psychomotor retardation, and blunt affect are hallmarks of both disorders and can appear similar during cross-sectional assessments [29,42]. Thus, it could be the case that depression, which often presents in the schizophrenia prodrome [20,43], was driving the significant correlations between negative symptoms and subjective QOL. In support of this interpretation, a number of studies have demonstrated that depression in patients with schizophrenia is associated with impoverished QOL. In support of this conjecture, neurocognitive impairments have been associated with worse QOL in patients with schizophrenia [3,41]. An important next step in this line of research would be to examine the relationship between cognitive and affective variables and QOL in a sample of schizotypic individuals.

Table 3
Partial correlations for positive, disorganization, and negative schizotypal symptoms and QOL, and academic functioning measures

<table>
<thead>
<tr>
<th>Schizotypy symptoms</th>
<th>Positive(^a) controlling for disorganized/negative</th>
<th>Disorganization(^a) controlling for positive/negative</th>
<th>Negative(^a) controlling for positive/disorganized</th>
</tr>
</thead>
<tbody>
<tr>
<td>QOL measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective family relationships(^b)</td>
<td>0.03</td>
<td>–0.07(^*)</td>
<td>–0.12(^**)</td>
</tr>
<tr>
<td>Objective social relationships(^b)</td>
<td>0.05</td>
<td>0.07(^*)</td>
<td>–0.39(^**)</td>
</tr>
<tr>
<td>Objective financial issues(^b)</td>
<td>–0.10(^**)</td>
<td>–0.01</td>
<td>–0.07</td>
</tr>
<tr>
<td>Subjective family relationships(^b)</td>
<td>–0.07(^**)</td>
<td>–0.09(^**)</td>
<td>–0.20(^**)</td>
</tr>
<tr>
<td>Subjective social relationships(^b)</td>
<td>–0.05</td>
<td>0.07(^*)</td>
<td>–0.47(^**)</td>
</tr>
<tr>
<td>Subjective financial issues(^b)</td>
<td>–0.16(^**)</td>
<td>0.01</td>
<td>–0.10(^**)</td>
</tr>
<tr>
<td>Subjective home concerns</td>
<td>–0.14(^**)</td>
<td>–0.08(^*)</td>
<td>–0.07(^*)</td>
</tr>
<tr>
<td>Subjective daily activities</td>
<td>–0.12(^**)</td>
<td>–0.02</td>
<td>–0.43(^**)</td>
</tr>
<tr>
<td>Subjective legal concerns</td>
<td>–0.14(^**)</td>
<td>0.01</td>
<td>–0.07(^*)</td>
</tr>
<tr>
<td>Subjective health concerns</td>
<td>–0.08(^*)</td>
<td>–0.07(^*)</td>
<td>–0.16(^**)</td>
</tr>
<tr>
<td>Subjective total concerns(^b)</td>
<td>–0.19(^**)</td>
<td>–0.03</td>
<td>–0.38(^**)</td>
</tr>
<tr>
<td>Academic functioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade point average(^c)</td>
<td>–0.12(^**)</td>
<td>–0.03</td>
<td>–0.02</td>
</tr>
</tbody>
</table>

\(^a\) Increasing scores reflect increasing symptoms severity.
\(^b\) Increasing scores reflect better QOL.
\(^c\) Increasing scores reflect better academic performance.

\(^*\) \(P < .05\).
\(^**\) \(P < .01\).
\(^***\) \(P < .001\).

much with the QOL measures (all effect sizes in the negligible range). In sum, negative symptoms showed the most striking unique contributions to QOL, particularly those domains associated with social relationships.

4. Discussion

The present study is the first that we are aware of to systematically examine subjective and objective QOL across the heterogeneous manifestations of schizotypy. Each of the schizotypy dimensions examined here was significantly associated with impoverished QOL. This impoverishment was global in the sense that it was observed in both subjective and objective modes across a wide range of domains. Of particular relevance, individuals with extreme schizotypy scores showed subjective QOL that was 2.5 SDs below that of the asymptomatic comparison group. These findings highlight the potentially deleterious consequences of schizotypy.

Pronounced differences in the magnitude of QOL were observed across the positive, negative, and disorganized forms of schizotypy. Generally speaking, negative symptoms showed the most robust relations to QOL, particularly those domains pertaining to social activity. Conversely, positive and disorganized symptoms showed more modest correlations to QOL. This pattern of relationships mirrors that seen in schizophrenia, namely, that negative symptoms are more important for understanding QOL than positive or disorganized ones. What is presently unclear is the mechanism underlying this relationship. Insofar as negative schizotypy is associated with a host of maladies such as impaired neurocognition [13], impaired social cognition [37], and affective and motivational liabilities [38-40], an attractive explanation is that schizotypic individuals with negative symptoms are less equipped to deal with the demands of their environment and, consequently, experience impoverished QOL. In support of this conjecture, neurocognitive impairments have been associated with worse QOL in patients with schizophrenia [3,41]. An important next step in this line of research would be to examine the relationship between cognitive and affective variables and QOL in a sample of schizotypic individuals.

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markedly as objective QOL does). In other words, patients become apathetic to their deteriorating life quality. Further research will be required to clarify the interface between subjective and objective QOL in schizotypy.

An important strength of this study is the sample size, which presumably allowed for considerable variability in symptom expression across subjects. Nonetheless, it is notable that this sample was composed of college students who are not typical of all individuals at-risk for schizophrenia spectrum disorders. Another potential limitation concerns ambiguity in the negative symptom dimension in that these symptoms could reflect environmental or comorbid conditions that are secondary to core schizotypy pathology. Negative schizotypy was operationalized without regard to social anxiety and suspiciousness, 2 features of negative affect that are attenuated in schizophrenia patients with core negative symptoms [29]. This may have helped to limit the potential confounds of secondary negative symptoms in our analyses. Nonetheless, it would be important to replicate the present findings controlling for severity of depressive symptoms. On the contrary, our use of only 2 of the 4 subscales from the SPQ “interpersonal” factor could raise eyebrows in that our negative symptom definition is not supported from factor analytic studies of the SPQ. For reasons outlined above, we felt that our “theory-based” negative symptom definition was more meaningful for capturing the core negative schizotypy symptoms. Finally, it is worth noting that the negative symptom subscale used here is based in part on reduced social behavior. Thus, the correlations between the negative symptom and social-based subjective and objective QOL could reflect, in part, shared method variance.

In summary, the present findings highlight the impact of subclinical negative symptoms on the lives of individuals with subclinical schizophrenia symptoms. Further research can help clarify the causal relationship between these symptoms and impoverished QOL. Ultimately, these results can inform the development of interventions designed to improve the well-being of individuals across the spectrum of schizophrenia disorders.

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References


