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Schizotypy models in relation to subjective health and paranormal beliefs and experiences

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Abstract

The main purpose of this study was to further the understanding of schizotypy by investigating which of two schizotypy models best describes the construct. The quasi-dimensional model views schizotypy as related to psychological ill-health, whereas the fully dimensional model views schizotypy as fundamentally neutral. A schizotypy measure, the Oxford–Liverpool Inventory of Feelings and Experiences (O-LIFE; Mason, Claridge, & Jackson, 1995), a health-related measure, the Sense of Coherence (SOC; Antonovsky, 1991) Scale, and a measure of paranormal beliefs and experiences, the Australian Sheep–Goat Scale (ASGS; Thalbourne & Delin, 1993) were used. The study cluster analysed 88 undergraduate psychology students' responses on three of the O-LIFE dimensions: 'unusual experiences' (UE), 'cognitive disorganisation' (CD), and 'introvertive anhedonia' (IA) (Mason et al., 1995). An agglomerative hierarchical cluster analysis of the O-LIFE sub-scales suggested three separate clusters. These were labelled CD/IA, UE, and LS. One-way ANOVA:s revealed that the CD/IA cluster scored lower on the SOC scale than the other clusters and that the UE cluster scored higher than the LS cluster on the ASGS. The results of this study support the notion of healthy schizotypy and support the fully dimensional model of schizotypy over the quasi-dimensional model.
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Keywords: Schizotypy; Health; Paranormal belief; Paranormal experience; O-LIFE; SOC

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1. Introduction

Recent studies have shown that schizotypy is a multi-factorial construct. In different studies three, and sometimes four factors have emerged consistently (see Mason, Claridge, & Williams, 1997; for a review). The first factor concerns aberrant perceptions and beliefs or in other words paranormal experiences and beliefs. This schizotypy factor taps sub-clinical forms of such positive symptoms of psychosis as hallucinations and delusions. The second schizotypy factor concerns sub-clinical forms of cognitive failures, like thought-blocking and attentional difficulties, together with increased social anxiety. The third factor is that of introvertive anhedonia which taps sub-clinical forms of the negative symptomatology found in psychosis, such as social withdrawal and inability to experience pleasure. The fourth schizotypy factor of asocial behaviour has been found mainly in studies by Claridge and colleagues (McCreery & Claridge, 2002). However, it has been debated whether this factor is a true schizotypy factor or not. It does not seem to be relevant to schizophrenia per se (Loughland & Williams, 1997). Moreover, this fourth factor has been shown to load mostly on Eysenck's psychoticism scale (Eysenck & Eysenck, 1975), which seems to be more related to psychopathy than to schizotypy (Day & Peters, 1999).

Three models have been formulated to describe the construct schizotypy (see Claridge, 1997; McCreery & Claridge, 2002). Within the quasi-dimensional model, or disease model, schizotypy is viewed as a milder form of schizophrenia (Meehl, 1962; Rado, 1953). Thus, people high on one or more schizotypy factors show signs of psychological ill-health. The second model of schizotypy is a personality model developed by Eysenck (1960) who viewed a psychotic person as someone who occupied the extreme upper end of his normality-psychosis continuum. This personality model has been criticised on the grounds that it treats normals and patient groups as qualitatively indistinguishable (Claridge, 1997). The third schizotypy model, the fully dimensional model (Claridge, 1997), can be seen as an extension of the other two. It represents schizotypy as continuously distributed traits. These traits are the sources of healthy variation and also predisposition to psychosis. The fully dimensional model incorporates the quasi-dimensional model in its upper reaches where a second continuum on a different level from the personality traits is formed. This second continuum is the disease continuum found in the quasi-dimensional model and thus displays a spectrum of schizophreniform disorders, from schizotypal personality disorder to schizophrenic psychosis. Within the fully dimensional model, it is possible to view schizotypy as sometimes associated with health and sometimes with ill-health. Therefore, it is possible that people with high scores on one or more schizotypy factors are as healthy as people with low schizotypy scores.

The quasi-dimensional model of schizotypy has been challenged by McCreery and Claridge who have shown that high scores on the aberrant perceptions and beliefs factor of schizotypy can be seen as something positive, and not obviously associated with ill-health. In one study, McCreery and Claridge (1995) compared subjects reporting out-of-the-body experiences with controls and found that the out-of-the-body experients scored significantly higher on scales that load on the aberrant perceptions and beliefs factor of schizotypy. The out-of-the-body experients did not score higher on the cognitive disorganisation measure and scored significantly lower than the control group on physical anhedonia. Moreover, the groups did not differ significantly on neuroticism, which is a well-established risk factor of psychological ill-health (Friedman, 2000; Jorm, Christensen, Henderson, Korten, & Rodgers, 2000; Neeleman, Sytema, & Wadsworth, 2002). The out-of-the-body experients had paranormal experiences and had high scores on one schizotypy factor

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