**Supplementary Material**

*Descriptions of the schizotypal and affective scales*

Psychosis proneness questionnaires can be used to identify schizotypy in asymptomatic subjects. The most frequently used schizotypy scales are the Wisconsin Schizotypy Scales, including the Magical Ideation Scale (MIS), Perceptual Aberration Scale (PER), Social Anhedonia Scale (SAS) and Physical Anhedonia Scale (PAS) developed by Chapman and colleagues [1,2]. MIS was not included in the field study, but the other three were all used here. The other self-reported psychopathology questionnaires used in this study were the Schizoidia scale (GM) [4] for measuring schizotypy traits, and the Bipolarity II Scale (BIP2) [5] and the Hypomanic Personality Scale (HPS) [6] for affective traits and psychosis proneness, and the Symptom Checklist (SCL, Hopkins Symptom Checklist -25) [8] for affective traits.

The Wisconsin Schizotypy Scales are based on Meehlian theory[7], in which it is assumed that the close relatives of people with schizophrenia have more schizotypal traits and are at greater risk of psychosis than subjects without a schizophrenic relative. The PER measure distorted perceptions of one’s own body and other objects [2] and includes statements such as “Parts of my body occasionally seem dead or unreal”, while high scores on SAS or PAS [1] indicate a lack of pleasure in physical or social matters, e.g. aesthetic, culinary, sexual and athletic sensations and interactions with friends and other people. Examples of statements on these scales are “People are usually better off if they stay aloof from emotional involvements with most others” (SAS), and “There just are not many things that I have ever really enjoyed doing” (PAS). The Schizoidia scale (GM), developed by Golden and Meehl [4], consists of seven items from the Minnesota Multiphasic Personality Inventory (MMPI) that reflect signs that are present in schizotypal individuals. Thus it contains items such as “I have not lived the right kind of life”.

The three scales related to affective disorders were BIP2 [5], HPS [6] and SCL [8]. BIP2 was developed to identify those depressed subjects who are at risk of bipolar disorders, and HPS was developed to measure hypomanic personality. These scales include items such as “My mood often changes from happiness to sadness without my knowing why” (BIP2), and “Sometimes ideas and insights come to me so fast that I cannot express them all” (HPS). Previously, Miettunen and colleagues [9] also found these scales to be useful in predicting psychoses in the general population-based Northern Finland 1966 Birth Cohort (NFBC 1966). The SCL is a shortened, 25-item version of the original 90-item Hopkins Symptom Checklist. It includes questions about anxiety and depression during the last week, the answers to which are scored on a scale from 1 (not bothered) to 4 (extremely bothered) [8].

In the statistical analysis of the present study, continuous and dichotomised variables were used for the psychopathology scales. The cut-off values for the PER, SAS, PAS, GM, BIP2 and HPS scores is based on their distribution, with at least the highest 10% by gender considered to be at risk of future illness. This criterion, which has also been used in the past [10], is in accordance with Meehl’s theory [7], which states that because of a genetic predisposition, approximately 10% of people develop schizotypy, and 10% of these will decompensate to a schizophrenic disorder. In the case of SCL, a mean score of 1.55 was used as a cut-off point, with subjects scoring higher than this being considered possible psychiatric cases [11].

**References for the Supplementary Material**

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