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Polygenic prediction of educational attainment within and between families from genome-wide association analyses in 3 million individuals

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We conduct a genome-wide association study (GWAS) of educational attainment (EA) in a sample of ~3 million individuals and identify 3,952 approximately uncorrelated genome-wide-significant single-nucleotide polymorphisms (SNPs). A genome-wide polygenic predictor, or polygenic index (PGI), explains 12–16% of EA variance and contributes to risk prediction for ten diseases. Direct effects (i.e., controlling for parental PGIs) explain roughly half the PGI's magnitude of association with EA and other phenotypes. The correlation between mate-pair PGIs is far too large to be consistent with phenotypic assortment alone, implying additional assortment on PGI-associated factors. In an additional GWAS of dominance deviations from the additive model, we identify no genome-wide-significant SNPs, and a separate X-chromosome additive GWAS identifies 57.

EA is an important dimension of socioeconomic status that features prominently in research by social scientists, epidemiologists and other medical researchers. EA is strongly related to a range of health behaviors and outcomes, including mortality¹. For this reason, and because EA can be measured accurately at low cost, cohort studies used in genetic epidemiology and medical research routinely measure participants' EA.

The most recent GWAS meta-analysis of EA had a combined sample size of ~1.1 million individuals². Here we report and analyze

results from an updated meta-analysis of EA in a combined sample nearly three times larger ($N = 3,037,499$). The increase comes from expanding the sample for the association analyses from 23andMe from ~365,000 to ~2.3 million genotyped research participants. As before, our core analysis is a GWAS of autosomal SNPs. Our updated meta-analysis identifies 3,952 approximately uncorrelated SNPs at genome-wide significance compared to 1,271 in the previous study. The larger sample size yields more accurate effect-size estimates that allow us to construct a genome-wide PGI (also called

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Table 1 | Comparison of previous large-scale GWASs of EA

	Additive GWAS, autosomes						Additive GWAS, X chromosome						Dominance GWAS, autosomes					
	N	No. of SNPs	No. of loci	Mean χ^2	PGI R^2	LDpred, HapMap3 SNPs	C + T, $P < 5 \times 10^{-8}$	No. of SNPs	No. of loci	Mean χ^2	Male	Female	Pooled	N	No. of SNPs	No. of loci	Mean χ^2	
EA1	126,559	2,310,444	4	1.24	2.64%	0.03%	-	-	-	-	-	-	-	-	-	-	-	-
EA2-D	293,723	9,256,490	74	1.46	5.81%	0.46%	-	-	-	-	-	-	-	-	-	-	-	-
EA2-C	405,072	9,918,450	162	1.63	6.91%	0.93%	-	-	-	-	-	-	-	-	-	-	-	-
EA3	1,131,881	10,016,266	1,271	2.91	10.09%	4.03%	694,894	205,865	10	2.60	0.04%	0.00%	0.01%	-	-	-	-	-
EA4	3,037,499	10,675,380	3,952	4.90	13.28%	7.18%	2,713,033	211,581	57	5.24	0.29%	0.10%	0.19%	2,574,253	5,870,596	0	1.00	

Summary overview of GWASs meta-analyses of educational attainment. No. of SNPs is the number of markers included in the final GWAS meta-analysis of number of years of schooling completed; no of Loci is the number of approximately independent SNPs that reached genome-wide significance; and mean χ^2 is the average test statistic for SNPs with MAF > 1% and $N > 0.9 \times N_{\text{max}}$, where N_{max} is the maximum sample size across all SNPs. To maximize comparability across studies, PGIs are generated using SNPs available in all GWASs (all five GWASs for autosomal PGI) and uniform procedures described in the Supplementary Note. C + T stands for clumping and thresholding. The autosomal PGI R^2 values are sample-size weighted averages of the incremental R^2 values from the Health and Retirement Study. The X chromosome PGI R^2 values are the incremental R^2 values from the Health and Retirement Study. The incremental R^2 is the increase in R^2 after adding the PGI to a regression of EA on controls (a full set of dummy variables for year of birth and the first ten principal components of the genomic relatedness matrix). EA1, Rietveld et al.⁶¹; combined meta-analysis of discovery and replication cohorts; EA2-C, Okbay et al.⁶²; meta-analysis of discovery and replication cohorts; EA2-D, Okbay et al.⁶²; meta-analysis of discovery and replication cohorts; EA3, Lee et al.⁶³; meta-analysis of discovery and replication cohorts; EA4, current study.

a polygenic score) that has greater prediction accuracy, increasing the percentage of variance in EA explained from 11–13% to 12–16%, depending on the validation sample, an increase of approximately 20%. In meta-analyses of the expanded 23andMe sample and the UK Biobank (UKB)³, we also conduct an updated GWAS of the X chromosome ($N = 2,713,033$) and the first large-scale ‘dominance GWAS’ (i.e., a SNP-level GWAS of dominance deviations) of EA on the autosomes ($N = 2,574,253$). In our updated X-chromosome GWAS, we increase the number of approximately uncorrelated genome-wide-significant SNPs from 10 to 57. Our dominance GWAS identifies no genome-wide-significant SNPs. Moreover, with high confidence, we can rule out the existence of any common SNPs whose dominance effects explain more than a negligible fraction of the variance in EA. Table 1 summarizes the GWASs conducted in this paper and compares them to previous large-scale GWASs of educational attainment.

The rest of the paper investigates the scope and sources of the PGI’s predictive power. We first document that the EA PGI not only predicts a range of cognitive phenotypes, as has been found in previous work^{2,4}, but also adds nontrivial predictive power for ten diseases we examine, even after controlling for disease-specific PGIs. Next, using a combined sample of ~53,000 individuals with genotyped siblings and ~3,500 individuals with both parents genotyped, we examine the predictive power of the EA PGI controlling for parental EA PGIs. By controlling for parental EA PGIs, we isolate the component of predictive power that is due to direct effects⁵, or the causal effects of an individual’s genetic material on that individual⁶. For EA and 22 other phenotypes, controlling for the parental EA PGIs roughly halves the EA PGI’s association with the phenotype. In contrast, when we examine PGIs for height, body mass index (BMI) and cognitive performance, controlling for parental PGIs has far less impact on their associations with their corresponding phenotype. Thus, the EA PGI stands out as unusual in terms of how much of its predictive power is not due to direct effects.

Finally, we use PGIs to study assortative mating. Using 862 genotyped mate pairs in the UKB and 1,603 pairs in Generation Scotland (GS)⁷, we estimate the correlation between mate-pair PGIs for EA, as well as for height. For height, the correlation between mate-pair PGIs is close to that expected under phenotypic assortment (that is, all similarity between mate pairs on the genetic component of the phenotype arises via matching on the phenotype). Once again, EA is different; the correlation between mate-pair PGIs for EA is much larger than one would expect from phenotypic assortment on EA. We find evidence that population structure captured by principal components (PCs) and assortment on cognitive performance explain some, but not all, of the excess mate-pair PGI correlation. These findings shed further light on the EA PGI’s predictive power for EA and other phenotypes; the factors on which mate pairs assort that are not EA but are correlated with the EA PGI (e.g., geographic location at courtship age (we speculate)) likely also contribute to the PGI’s predictive power.

For a less technical description of the paper and of how it should—and should not—be interpreted, see the frequently asked questions in Supplementary Data 1.

Results

Additive GWAS of EduYears in autosomes. We conducted a sample-size-weighted meta-analysis of association results on EA, measured as number of years of schooling completed (EduYears), by combining three sets of summary statistics: public results from our previous meta-analysis of 69 cohorts ($N = 324,162$, excluding UKB and 23andMe), new association results from 23andMe ($N = 2,272,216$) and new association results from a GWAS we conducted in UKB with an improved coding of the EA measure ($N = 441,121$; Supplementary Note). All analyses were conducted in samples of European genetic ancestries, included controls for

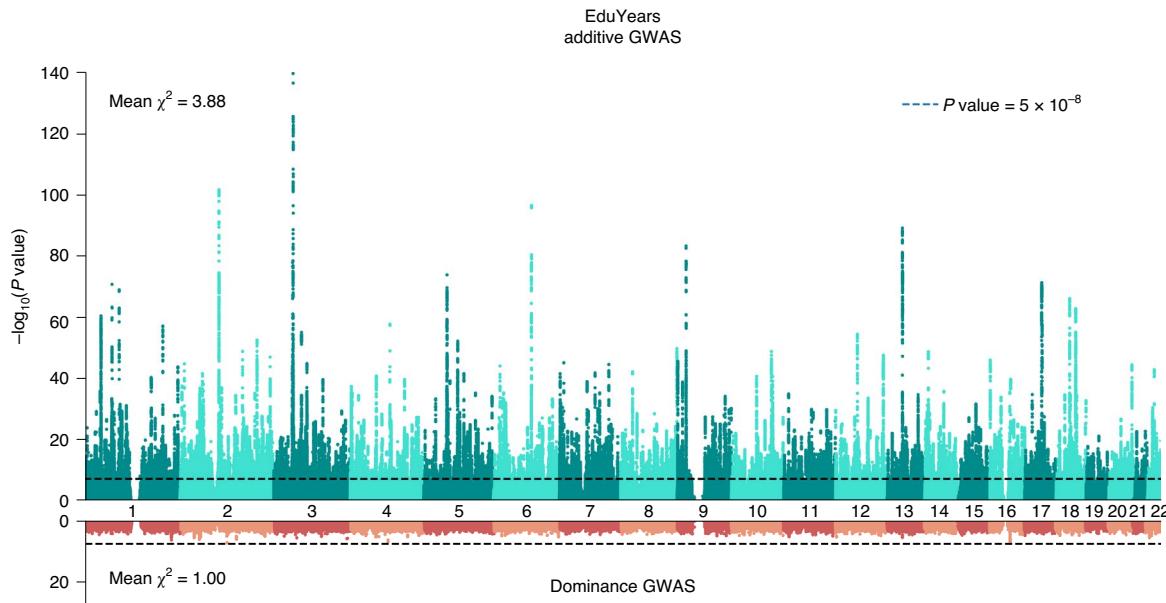


Fig. 1 | Manhattan plots for the additive and dominance GWASs. The top graph (green) shows the additive GWAS ($N=3,037,499$ individuals), and the bottom graph (red) shows the dominance GWAS ($N=2,574,253$ individuals). The P value and mean χ^2 values are based on inflation-adjusted two-sided Z tests. The x axis is chromosomal position, and the y axis is the significance on a $-\log_{10}$ scale. The dashed line marks the threshold for genome-wide significance ($P=5\times 10^{-8}$).

sex, year of birth, their interaction and genetic PCs, and applied a uniform set of quality-control procedures (Supplementary Note contains a comprehensive description). The final meta-analysis contains association results for ~10 million SNPs. The quantile-quantile plot in Extended Data Fig. 1 shows that the P values deviate strongly from the uniform distribution. According to the linkage disequilibrium (LD) score regression⁸ intercept (1.66), confounding accounts for 7% of the inflation, similar to previous GWAS of EA (ref. ²) (Extended Data Fig. 2 shows the LD score plot). The Manhattan plot in Fig. 1 and many of our subsequent analyses are based on test statistics adjusted for the LD score intercept.

We identify 3,952 lead SNPs, defined as approximately uncorrelated (pairwise $r^2 < 0.1$) variants with an association P value below 5×10^{-8} . At the stricter threshold⁹ of $P < 1 \times 10^{-8}$, the number declines to 3,277 (Supplementary Table 1; Supplementary Note contains a description of the clumping algorithm). To assess the sensitivity of our conclusions about the number of independent SNPs, we conducted a conditional and joint (COJO) multiple-SNP analysis¹⁰. This analysis identified 2,925 SNPs (Supplementary Table 2); 41 of these are in LD ($r^2 > 0.1$) with other COJO lead SNPs and may represent secondary associations within a locus. Adjusted for the winner's curse, we find that the effects of our lead SNPs are consistently quite small. On average, an additional copy of the reference allele of the median SNP is associated with 1.4 weeks more schooling: the effects at the 5th and 95th percentiles (in absolute value) are 0.9 and 3.5 weeks, respectively (Supplementary Note contains details on these calculations). We also examined the out-of-sample replicability of the lead SNPs identified in the most recent previous meta-analysis². In the independent 23andMe data, the replication record is broadly in line with theoretical predictions derived from an empirical Bayesian framework described in the Supplementary Note (Extended Data Fig. 3).

Biological annotation. To compare results from biological annotation of our meta-analysis to that of the most recent previous meta-analysis, we applied stratified LD score regression¹¹ to both sets of summary statistics using a recent set of SNP annotations¹². The results are very similar across the two meta-analyses, but standard errors are smaller when using the current meta-analysis

results, as expected given the larger sample size (Supplementary Fig. 1a-d). Notably, we replicate the unexpected result of relatively weak enrichment of genes highly expressed in glial cells (astrocytes and oligodendrocytes) relative to neurons.

X-chromosome GWAS results. To update the previous X-chromosome analysis, we conducted a sample-size-weighted meta-analysis of mixed-sex association results from UKB and 23andMe ($N=2,713,033$) for ~200,000 SNPs on the X chromosome (Extended Data Fig. 4). We identified 57 lead SNPs with estimated effects in the range 1 to 3 weeks of schooling. Our findings are fully consistent with earlier conclusions: SNP heritability due to the X chromosome of 0.4% and (using sex-stratified association analyses in the UKB) a male-female genetic correlation on the X chromosome close to unity ($r_g = 0.94$, s.e. = 0.03).

Dominance GWAS. We conducted a GWAS of dominance deviations from the additive model (Supplementary Note) by meta-analyzing summary statistics from association analyses conducted in 23andMe and UKB ($N=2,574,253$). Theory and evidence from the quantitative genetics literature, including findings from two recent papers^{13,14} that estimated dominance SNP heritability across dozens of phenotypes (but not EA), suggest that dominance effects explain at most a very small share of the variance in polygenic phenotypes¹⁵. Nevertheless, in the behavior genetics literature, when the phenotypic correlation between monozygotic twins is more than twice as large as the phenotypic correlation between dizygotic twins, it remains common practice to attribute the violation of the additive model to dominance variance.

The Manhattan plot from our dominance GWAS is shown in red in the bottom panel of Fig. 1. There are no genome-wide-significant SNPs. Power calculations indicate that, at genome-wide significance, we had 80% power to detect dominance effects with an R^2 of 0.0015% (Supplementary Note). Such effect sizes would be over an order of magnitude smaller than the largest additive effects ($R^2 \cong 0.04\%$). Therefore, the absence of genome-wide-significant SNPs suggests that dominance effects of common SNPs, taken individually, are negligibly small.

Next, we turn to the combined dominance effects of common SNPs. Applying an adapted version of LD Score regression to the summary statistics, we estimate a SNP heritability of 0.00015 (s.e. = 0.00024), which is statistically indistinguishable from zero ($P = 0.54$). In the Supplementary Note, we report additional analyses (that rely on different assumptions) that similarly conclude that the combined variance explained by dominance deviations in common SNPs is negligible. Our results do not rule out the possibility that rare SNPs have substantial dominance effects.

Even when the phenotypic variance across individuals explained by dominance is negligible, the combined dominance effects on an individual can be substantial when homozygosity (which is deleterious on average) is increased genome-wide due to inbreeding¹⁶. This reduction of fitness-related phenotypic values is called directional dominance, or inbreeding depression (ID). We applied a recently developed method that uses dominance GWAS summary statistics to estimate ID¹⁷. Our estimate implies the offspring of first cousins have on average ~1.0 fewer months of EA ($P = 0.04$) than the offspring of unrelated individuals.

Polygenic prediction. We assessed empirically how well a PGI derived from the autosomal GWAS of additive variation predicts a host of phenotypes related to EA, academic achievement and cognition. We used three European genetic-ancestry holdout samples from the National Longitudinal Study of Adolescent to Adult Health (Add Health)¹⁸, a representative sample of American adolescents followed into adulthood; the Health and Retirement Study (HRS)¹⁹, a representative sample of Americans over age 50 years; and the Wisconsin Longitudinal Study (WLS)²⁰, a sample of individuals who graduated from high school in Wisconsin in 1957. Because of the range restriction for EduYears in WLS, we do not use it to evaluate predictive power for EA. Our measure of prediction accuracy is the ‘incremental R^2 ’, or the gain in coefficient of determination (R^2) when the PGI is added as a covariate to a regression of the phenotype on a set of baseline controls (sex, dummy variables for birth year and/or age at assessment, their interactions and ten PCs of the genomic relatedness matrix). All PGIs that we analyze are based on a meta-analysis that excluded Add Health, HRS and WLS.

A PGI constructed using only genome-wide-significant SNPs has an incremental R^2 of 9.1% in Add Health and 7.0% in HRS (Extended Data Fig. 5). For all PGI analyses hereafter, unless stated otherwise, we use a PGI generated from HapMap3 SNPs using the software LDpred (ref. ²¹). This PGI explains 15.8% of the variance in EduYears in Add Health and 12.0% in HRS (Extended Data Fig. 6). The sample-size-weighted mean is 13.3%. Fig. 2a depicts how the predictive power has increased as GWAS sample sizes have increased. Fig. 2b shows that the prevalence of college completion varies a great deal over PGI deciles (Extended Data Fig. 7a,b shows prevalences of high school completion and grade retention). For example, only 7.3% and 6.8% of individuals in the lowest PGI decile have a college degree in Add Health and HRS, respectively, compared to 70.7% and 53.0% in the highest PGI decile. Fig. 2c, which displays scatterplots of individual EA versus PGIs, shows that throughout the PGI distribution, there is substantial variation in EA at the individual level. Thus, although average EA varies substantially across the PGI distribution, the PGI cannot be used to meaningfully predict an individual’s EA.

Fig. 2 | Polygenic prediction. **a**, Predictive power of the EA PGI as a function of the size of the GWAS discovery sample, with expected predictive power shown by the dashed lines (Supplementary Note section 5.5). **b**, Prevalence of college completion by EA PGI decile, with 95% CIs. **c**, Scatterplot of EA PGI (residualized on ten principal components) and EduYears (residualized on sex, a full set of birth-year dummies, their interactions and ten principal components). Prediction samples for all panels are European-ancestry participants in Add Health ($N = 5,653$) and the HRS ($N = 10,843$). All PGIs were constructed from EduYears GWAS results that exclude Add Health and HRS using the software LDpred and assuming a normal prior for SNP effect sizes. Incremental R^2 is the difference between the R^2 from a regression of EduYears on the PGI and the controls (sex, a full set of birth-year dummies, their interactions and ten principal components) and the R^2 from a regression of EduYears on just the controls. The individual-level data plotted in **c** have been jittered by adding a small amount of noise to each observation.

In post hoc analyses, we found that a PGI generated from ~2.5 million pruned common SNPs using the software SBayesR (ref. ²²) is more predictive than our LDpred PGI. It explains 17.0% of the variance in EduYears in Add Health and 12.9% in HRS, with a sample-size-weighted mean of 14.3% (Supplementary Table 3).

We supplemented our analyses of education outcomes with other cognitive and academic achievement outcomes (Extended Data Fig. 6 and Supplementary Table 4). For example, in Add Health, we found that the PGI explains 8.7% of the variation in Peabody verbal test scores and 12.3% in overall grade point average. In WLS, the PGI explains 6.1% of the variation in Henmon–Nelson test scores and 7.7% in high-school-grade percentile rank.

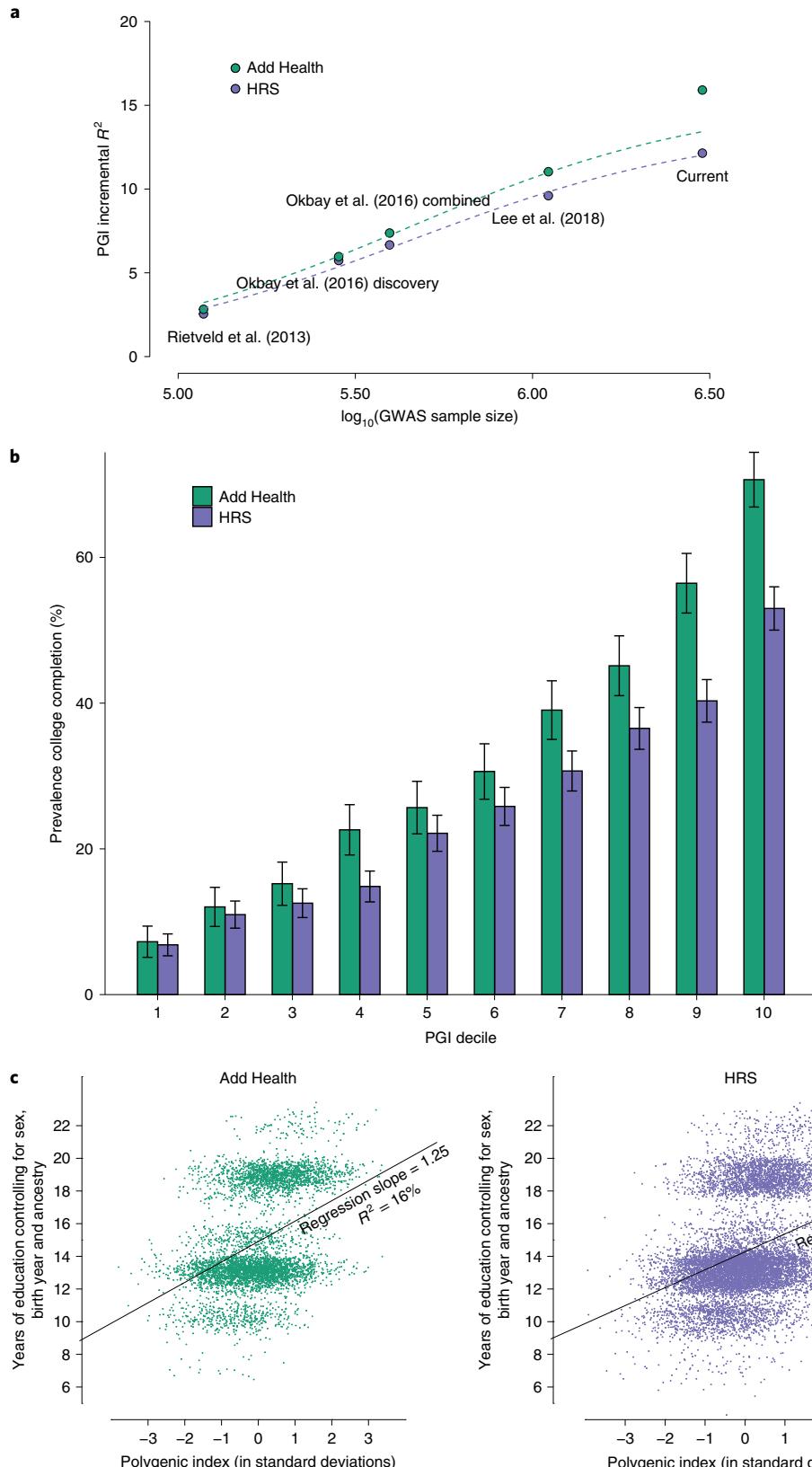
PGIs like ours that are constructed from GWAS in samples of European genetic ancestries are generally found to have much lower predictive power in samples with other genetic ancestries; for example, on average across phenotypes, estimates of relative accuracy (ratio of R^2) in African-genetic-ancestry to European-genetic-ancestry samples have been 22% (ref. ²³) and 36% (ref. ²⁴). When we used our PGI to predict EduYears in samples with African genetic ancestries from the HRS ($N = 2,507$) and Add Health ($N = 1,716$), the incremental R^2 was 1.3% (95% confidence interval (CI), 0.6% to 2.2%) and 2.3% (95% CI, 1.1% to 3.7%), implying that the relative accuracies for EA in the HRS and Add Health are only 11% and 15%, respectively. Using the UKB, we find that the relative accuracy is smaller than would be predicted based on population differences in allele frequencies and LD alone (Online Methods), and this discrepancy is greater for EA than has been found in prior work²⁵ for height, BMI and six other phenotypes (Extended Data Fig. 8 and Supplementary Table 5). The remaining reduction in predictive power is due to factors including epistasis (although epistatic variance is likely small^{13,15}), gene–environment interactions and differences between populations in gene–environment correlations, assortative mating and environmental variance.

Predicting disease risk. Among individuals of European genetic ancestries in the UKB, we estimated the predictive power of the EA PGI for ten common diseases for which large-scale GWASs have been conducted (Fig. 3). Because disease status is dichotomous, we assess predictive power using Nagelkerke’s coefficient of determination²⁶. Consistent with prior work that has estimated nonzero genetic correlations between EA and many diseases and health-related phenotypes²⁷, some using an earlier EA PGI^{1,28,29}, our EA PGI significantly predicts all ten diseases (all ten P values are smaller than 3×10^{-8} ; Supplementary Table 6). The mean incremental R^2 across all ten diseases is 0.63%. This predictive power is nontrivial compared with the average incremental R^2 of 1.19% for disease-specific PGIs constructed using summary statistics from large-scale GWASs of the diseases. Moreover, the EA and disease-specific PGIs contribute roughly independently to predicting disease risk; the incremental R^2 from adding both PGIs and their interaction to the regression model is typically roughly equal to the sum of the incremental R^2 values of each of the two PGIs considered separately. Higher values of the EA PGI correspond to lower relative risk for each of the ten diseases (Extended Data Fig. 9 and Supplementary Tables 7 and 8).

Within-family analyses. Our next set of analyses, like related prior work^{5,30,31}, aimed to isolate the component of the PGI’s predictive

power that is due to direct effects^{5,6}, or causal effects of an individual's genetic material on that individual. When controls for both parents' PGIs are included, we refer to the coefficient from a regression of an individual's phenotype on the individual's PGI as the direct effect of the PGI; when those controls are omitted, we refer to it as the population effect. (The regression controlling for parental

PGIs gives an equivalent estimate of the direct effect of the PGI as a regression on PGIs constructed from transmitted and nontransmitted parental alleles⁵; Supplementary Note.) The population effect captures the sum of the direct effect, indirect effects from relatives (e.g., genetic influences on parents' education, socioeconomic status and behavior), other gene–environment correlation (i.e., correlation



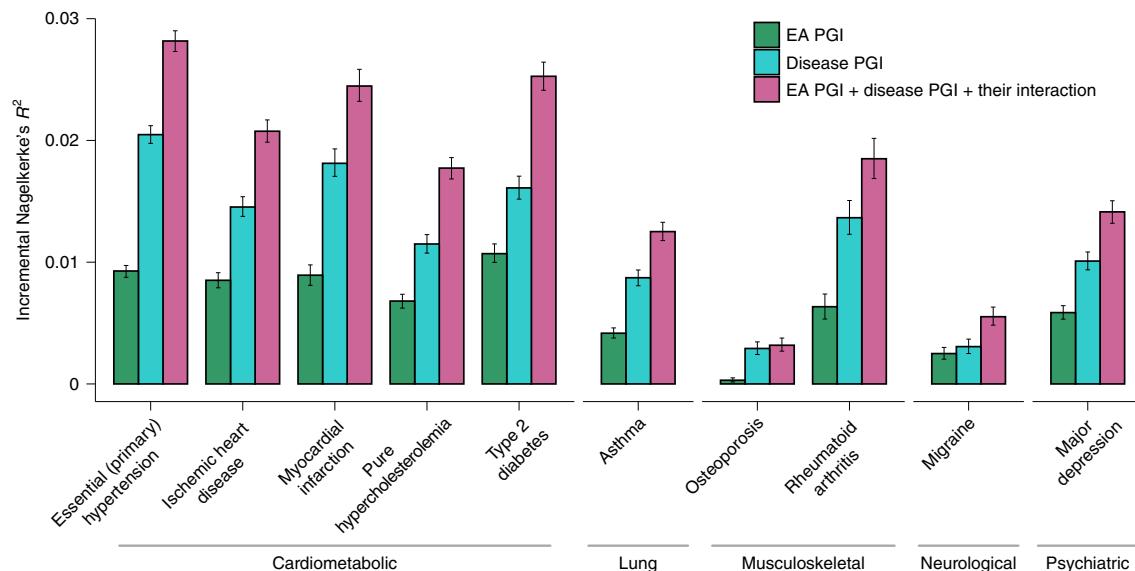


Fig. 3 | Predictive power of the EA PGI and the disease-specific PGI and their combination for ten diseases in the UKB. For each disease phenotype, the figure shows the incremental Nagelkerke's R^2 from adding the EA PGI, the disease PGI or both PGIs and their interaction to a logistic regression of the disease phenotype on covariates. The covariates are sex, a third-degree polynomial in birth year and their interactions with sex, the first 40 PCs and batch dummies. The error bars represent 95% CIs calculated with the bootstrap percentile method, with 1,000 repetitions.

between genotypes and environmental exposure, with population stratification being one possible cause) and a contribution from the genetic component of the phenotype that would be uncorrelated with the PGI under random mating but becomes correlated with the PGI due to the LD between causal alleles induced by assortative mating (Supplementary Note)^{5,32}. Because the PGI is constructed from summary statistics that partly reflect indirect effects and other gene–environment correlation, estimating the direct effect of the PGI is different from estimating the total contribution of direct effects of SNPs^{33,34}, for which relatedness disequilibrium regression³⁵ or summary statistics from within-family GWAS³⁶ could be used.

For this analysis, we used a combined sample of ~53,000 individuals with genotyped siblings and ~3,500 individuals with both parents genotyped (Online Methods and Supplementary Note). Direct-effect estimates from the sibling data may be biased by sibling indirect effects, but estimates of such effects are small, including for some of the phenotypes we study³⁷. The data are from the UKB (ref. ³), GS (ref. ⁷) and the Swedish Twin Registry (STR)³⁸. We did not have sufficient power to study the diseases from Fig. 3 when restricting to these family samples. We instead analyze a set of 23 health, cognitive and socioeconomic phenotypes, which include cardiometabolic and lung biomarkers related to disease risk (Supplementary Tables 9 and 10).

Fig. 4a (and Supplementary Table 10) shows our meta-analysis estimates of the direct and population effects of the EA PGI. For predicting EA, the ratio of direct to population effect estimates is 0.556 (s.e. = 0.020), implying that $100\% \times 0.556^2 = 30.9\%$ of the PGI's R^2 is due to its direct effect. This is smaller than the estimate of 48.9% reported in a previous analysis of Icelandic data⁵. For comparison with EA, we similarly estimate the direct and population effects of PGIs for height, BMI and cognitive performance on their respective phenotypes (Fig. 4a). The ratio of direct to population effect estimates is 0.910 (s.e. = 0.009) for height, 0.962 (s.e. = 0.017) for BMI and 0.824 (s.e. = 0.033) for cognitive performance, implying that 82.8%, 92.5% and 67.9%, respectively, of the PGI R^2 values are due to their direct effects (Supplementary Tables 11–13). The EA PGI has by far the lowest ratio.

We similarly assessed how much of the EA PGI's predictive power for the other 22 phenotypes (other than EA) is due to direct effects.

Fig. 4b shows estimates of the population and direct effects of the EA PGI. Across the phenotypes, the inverse-variance-weighted average ratio of direct to population effects is 0.588 (s.e. = 0.013). This is similar to the ratio of 0.556 for the EA PGI on EA. Thus, both for predicting EA and other phenotypes, a substantial part of the EA PGI's predictive power results from direct effects, but a substantial part results from factors other than direct effects. (For analogous analyses with the PGIs for height, BMI and cognitive performance, see Supplementary Fig. 2a–c, Supplementary Tables 11–13 and Supplementary Note.)

Assortative mating. We also use the PGI to study assortative mating. For this analysis, we use data on genotyped mate pairs in the UKB (862 pairs) and GS (1,603 pairs). Under the (commonly assumed) hypothesis of phenotypic assortment—according to which the mate-pair genetic components are independent conditional on the mate-pair phenotypes^{39,40}—the mate-pair PGI correlation should equal the product of the mate-pair phenotypic correlation, the correlation between the father's phenotype and PGI and the correlation between the mother's phenotype and PGI. We examined whether correlations between mate-pair EA PGIs fit this model (Fig. 5a), and we performed the same analysis for the height PGI (Fig. 5b). Height provides a useful comparison, because its mate-pair phenotypic correlation (0.290, s.e. = 0.018) and mate-pair PGI correlation (0.106, s.e. = 0.020) are somewhat similar to EA's mate-pair phenotypic correlation (0.430, s.e. = 0.017) and mate-pair PGI correlation (0.175, s.e. = 0.020). (For completeness, Supplementary Table 14 also shows results for the BMI and cognitive performance PGIs, but these are less informative because the mate-pair PGI correlations are not statistically distinguishable from zero.)

For height, phenotypic assortment predicts a mate-pair PGI correlation of 0.087 (s.e. = 0.007) (the gray point in the figure), which is only somewhat smaller than the observed estimate of 0.106 and is contained within the 95% CI. In contrast, for EA, the predicted value of 0.031 (s.e. = 0.004) is much smaller than, and statistically distinguishable from, the mate-pair PGI correlation of 0.175. Phenotypic assortment on EA would also imply that after residualizing the PGI on EA, the mate-pair PGI correlation should fall to zero. In fact, the correlation falls by only 37%, to 0.110 (s.e. = 0.021).

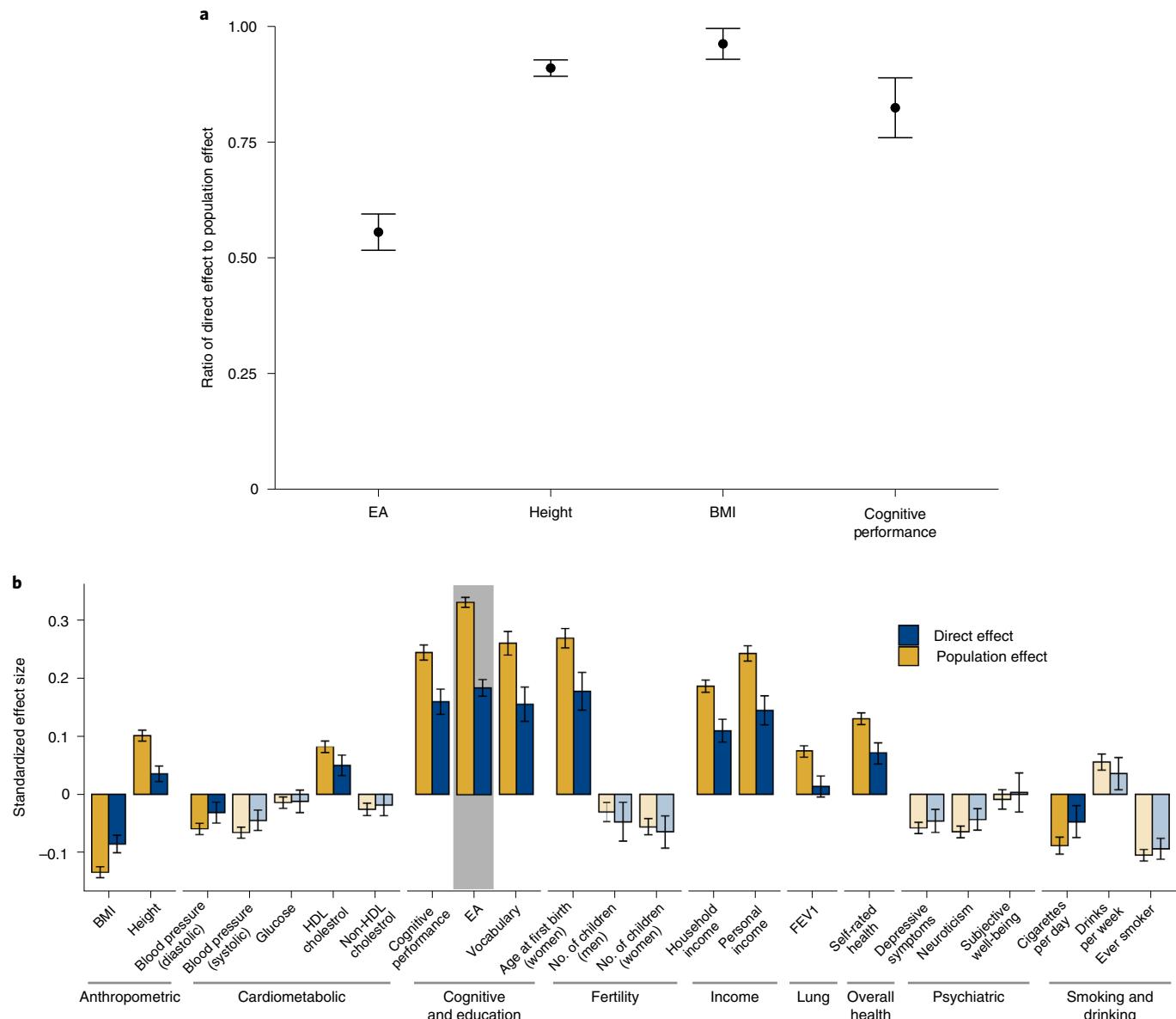


Fig. 4 | Meta-analysis estimates of direct and population effects of PGIs. **a**, For each PGI, the ratio of the direct effect to the population effect on the phenotype from which the PGI was derived. **b**, The effects of the EA PGI on 23 phenotypes. Bars are shaded lighter when the population and direct effects are statistically indistinguishable (two-sided Z test $P > 0.05/23$, where 23 is the number of phenotypes under study). For both panels, estimates are from meta-analyses of UKB, GS, and STR samples of siblings and trios. Phenotypes and the PGIs are scaled to have variance one, so effects correspond to partial correlation coefficients. Error bars represent 95% CIs. See Supplementary Table 9 for details on phenotypes and Supplementary Tables 10–13 for numerical values underlying this figure. FEV1, forced expiratory volume during the first second; HDL, high-density lipoprotein.

We explore two plausible explanations of the high mate-pair EA PGI correlation. The first is mate pairs tending to share genetic ancestry. Not all forms of social homogamy generate a mate-pair PGI correlation⁴¹, but social homogamy that is related to genetic ancestry (e.g., due to geographic proximity that tracks genetic structure in the population) will do so if there are components of genetic ancestry correlated with the PGI. After residualizing the EA PGI on 40 PCs of the genomic relatedness matrix in addition to EA, we find that the mate-pair PGI correlation falls to 0.091 (s.e. = 0.021). This implies that some, but not most, of the mate-pair PGI correlation is due to assortment on genetic ancestry captured by the PCs (or some factor correlated with the PCs). In the UKB, further adjustment for birth coordinates and the center where participants were assessed (Online Methods) resulted in a slight reduction of the correlation between mate-pair PGIs (Supplementary Table 14), suggesting that

geographic factors not captured by the top 40 PCs also contribute to the high mate-pair EA PGI correlation. The second explanation is assortment on a phenotype or composite of phenotypes that is more strongly correlated with the EA PGI than EA itself. The GS cohort contains high-quality measures of cognitive performance and vocabulary, proxies for plausible candidates of such a composite. In this cohort, after residualizing on these proxies as well as on EA and 40 PCs, the mate-pair PGI correlation is 0.083 (s.e. = 0.027) compared to 0.113 (s.e. = 0.026) when residualizing on EA and PCs alone, which leaves a substantial remainder of the mate-pair PGI correlation unexplained. This remainder is due to assortment on phenotypes correlated with the EA PGI other than EA, cognitive performance and vocabulary—possibly including various personality traits^{42–44}—and sources of social homogamy other than genetic ancestry captured by the top 40 PCs—possibly including

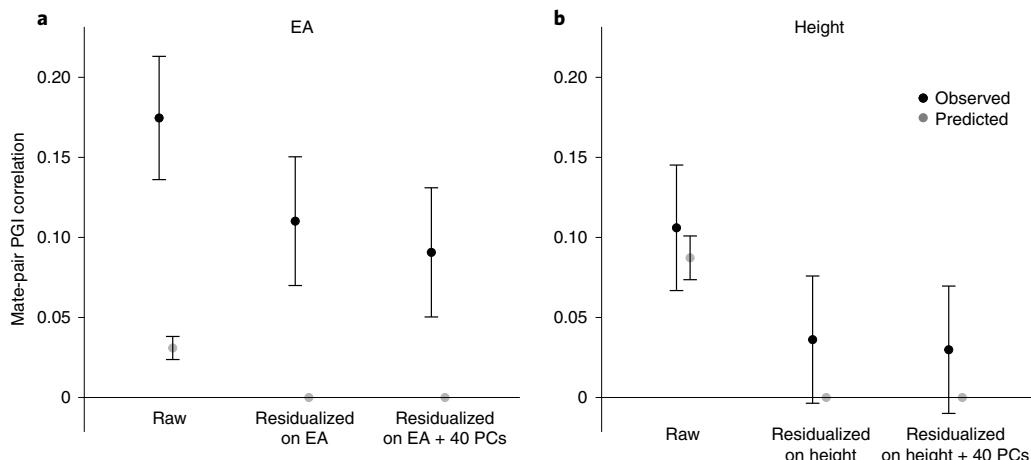


Fig. 5 | Correlations between mate-pair PGIs. **a**, Black dots show the correlation between mate-pair EA PGIs (raw) and the correlation between the residuals of the mate-pair EA PGIs after regressions with the listed regressors. Gray dots show the predicted correlations under phenotypic assortment; that is, all correlations between mate-pair EA PGIs are explained by assortment on EA itself. $N = 2,344$ (861 from UKB and 1,483 from GS). **b**, Analogous but for the height PGI and predictions under phenotypic assortment on height. $N = 2,451$ (858 from UKB and 1,593 from GS). For both panels, error bars represent 95% CIs. See Supplementary Table 14 for numerical values underlying this figure.

geographic location at courtship age^{45,46}, socioeconomic status and social class⁴⁷.

Any factor that contributes to explaining the mate-pair PGI correlation must be correlated with the EA PGI. Therefore, these factors likely contribute to the EA PGI's predictive power for EA and other phenotypes. Moreover, assortative mating on these factors increases the variance of the component of the EA PGI with which they are correlated, which amplifies their contribution to the EA PGI's predictive power.

Discussion

The results of previous large-scale GWAS of EA have proven useful across many different areas of research, including medicine⁴⁸, epidemiology^{49,50}, psychology⁴², economics^{51,52} and sociology^{47,53,54}. The substantial increase in power from our large sample size will make the summary statistics from the current paper even more useful. Beyond increasing power, the GWAS reported in this paper also included extensive dominance, within-family and assortative mating analyses. These analyses illustrate how, as GWAS have advanced from relatively small samples (by today's standards) that identify just a few SNPs to well-powered analyses of most of the variation from common SNPs, it has become possible to address an ever-increasing set of questions. For example, we find that the EA PGI has predictive power across a broad range of educational, cognitive and health-related phenotypes and diseases. Our results show that this predictive power derives both from direct genetic effects and from gene–environment correlation (likely including indirect genetic effects from relatives), with assortative mating amplifying the predictive power over what would be expected under random mating.

Our findings are also relevant for informing some decades-old debates in the behavior genetics literature. Because the parameters of a general biometric model cannot be separately identified from a small number of phenotypic correlations among different types of relatives, researchers typically have to assume that some of the parameters equal zero in order to estimate other parameters. In the 1970s, for example, researchers from the Birmingham School^{55,56}, researchers from the Hawaii School^{57,58} and the sociologist Sandy Jencks famously came up with strikingly different explanations for a set of kinship correlations on cognitive test scores assembled by Jencks et al.⁵⁹. A careful analysis by Loehlin⁶⁰ showed that the three sets of researchers arrived at different explanations for the same

data primarily due to their divergent assumptions about dominance, assortative mating, and special twin environments.

Although our results concern EA rather than cognitive test scores, we believe they are relevant for evaluating the plausibility of some of the assumptions underlying the modeling approaches that have been used to explain familial resemblance in EA and cognitive phenotypes. Three of our findings are especially relevant: (1) dominance variance due to common variants is negligible, (2) much of the predictive power of the EA PGI is not explained by direct effects and (3) the mate-pair PGI correlation is far too strong to be consistent with assortative mating purely on phenotype. Overall, these findings suggest that any model of EA that requires substantial dominance to fit the data, restricts gene–environment correlations to zero or assumes assortative mating is purely based on phenotype is likely to be misspecified. Thus, our analyses demonstrate how results from large-scale GWAS and the resulting PGIs can be used to improve the identifiability of behavior–genetic models.

The sample size of the GWAS of EA reported in this paper is the largest published to date. For some purposes, such as attaining greater predictive power for the PGI, there are clearly diminishing returns. However, even larger samples will enable other analyses that have not yet been adequately powered, such as estimating differences in SNP effect sizes across phenotypes or populations and estimating the fraction of variance explained by epistatic interactions¹³.

Online content

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References

- Marioni, R. E. et al. Genetic variants linked to education predict longevity. *Proc. Natl Acad. Sci. USA* **113**, 13366–13371 (2016).
- Lee, J. J. et al. Gene discovery and polygenic prediction from a genome-wide association study of educational attainment in 1.1 million individuals. *Nat. Genet.* **50**, 1112–1121 (2018).
- Bycroft, C. et al. The UK Biobank resource with deep phenotyping and genomic data. *Nature* **562**, 203–209 (2018).

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68. McCarthy, S. et al. A reference panel of 64,976 haplotypes for genotype imputation. *Nat. Genet.* **48**, 1279–1283 (2016).
69. Purcell, S. & Chang, C. PLINK 2.0. *cog-genomics* <http://www.cog-genomics.org/plink/2.0/> (2022).
70. Zeng, J. et al. Signatures of negative selection in the genetic architecture of human complex traits. *Nat. Genet.* **2018** *50*, 746–753 (2018).
71. de Vlaming, R. et al. Meta-GWAS accuracy and power (MetaGAP) calculator shows that hiding heritability is partially due to imperfect genetic correlations across studies. *PLoS Genet.* **13**, e1006495 (2017).
72. Manichaikul, A. et al. Robust relationship inference in genome-wide association studies. *Bioinformatics* **26**, 2867–2873 (2010).

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Author contributions

A.O., L.Y., D. Cesaroni, P.T., P.M.V., J.P.B., D.J.B. and A.I.Y. designed and oversaw the study. A.O. was the study's lead analyst, responsible for GWAS, quality control, meta-analyses, analyzing the predictive power of the PGI for EA and cognition outcomes and creating the PGIs used in other analyses (except for the disease PGIs). M.B. and H.K. conducted the recoding of the educational attainment measure in the UKB. A.O. and J.P.B. performed the GWAS replication. J.P.B. calculated the winner's-curve-adjusted effect sizes. L.Y. conducted the analysis of predicted and actual PGI accuracy in the African-genetic-ancestry sample in the UKB. H.J. ran the bioinformatics analysis, under J.J.L's guidance. A.O., N.W., L.Y. and J.P.B. conducted the dominance GWAS meta-analysis. A.O., J.S. and P.M.V. oversaw and ran the X chromosome meta-analysis. Y.W. analyzed the predictive power of the PGI for disease phenotypes. S.M.N., R.A., S.O. and A.I.Y. conducted the within-family analyses. H.J., D. Cesaroni and A.I.Y. conducted the assortative mating analyses. Besides the contributions explicitly listed above, N.W., H.J., M.B., G.G. and T.G. assisted for several subsections. C.W. coordinated data organization, and J.J. organized the computing infrastructure. D. Conley, P.D.K., M.J., D.L. and M.N.M. provided important input and feedback on various aspects of the study design. All authors contributed to and critically reviewed the manuscript.

Competing interests

Y.J., B.H., C.T., D.A.H. and the members of the 23andMe Research Team are current or former employees of 23andMe, Inc. All other authors declare no competing interests.

Additional information

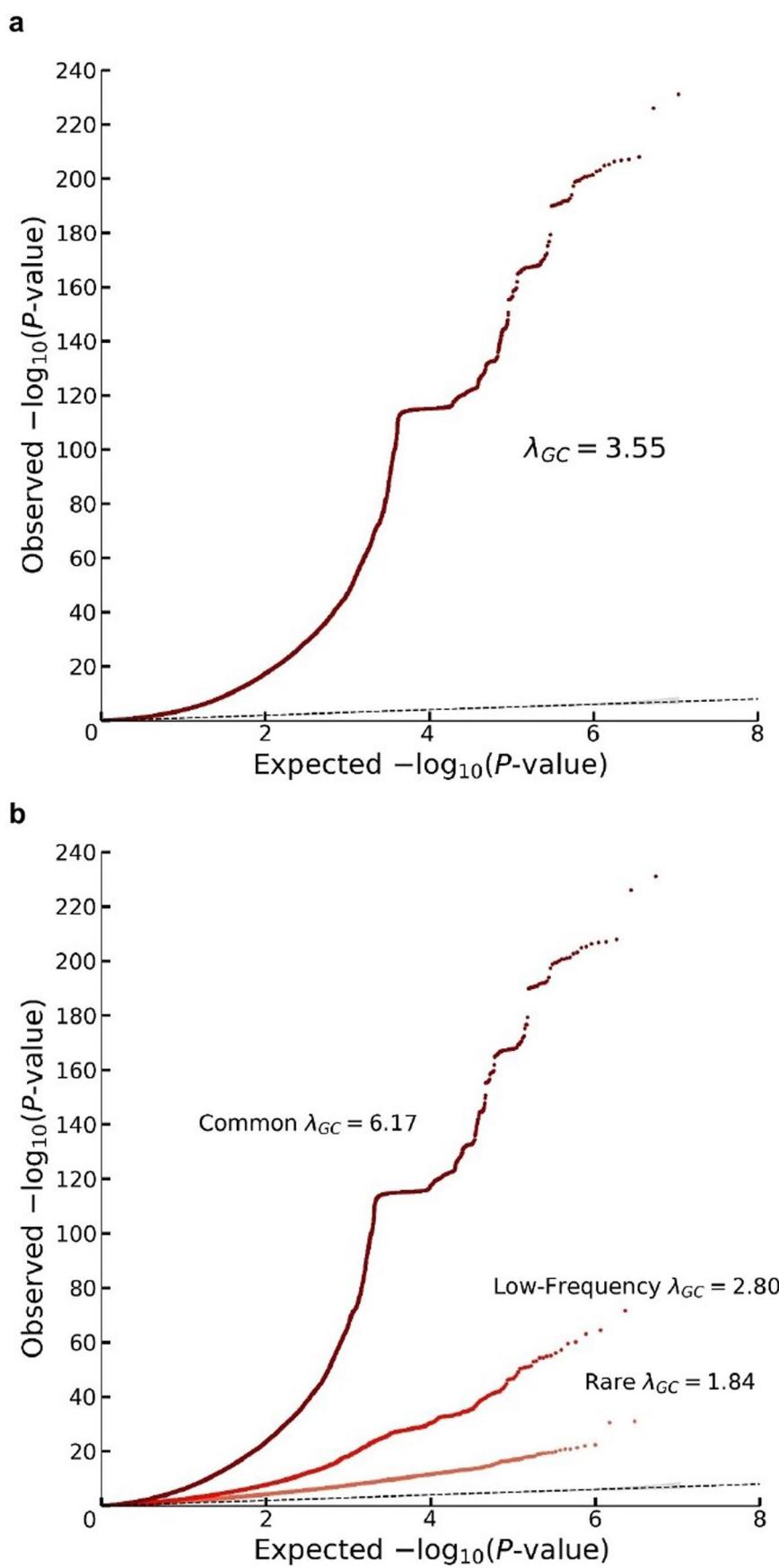
Extended data is available for this paper at <https://doi.org/10.1038/s41588-022-01016-z>.

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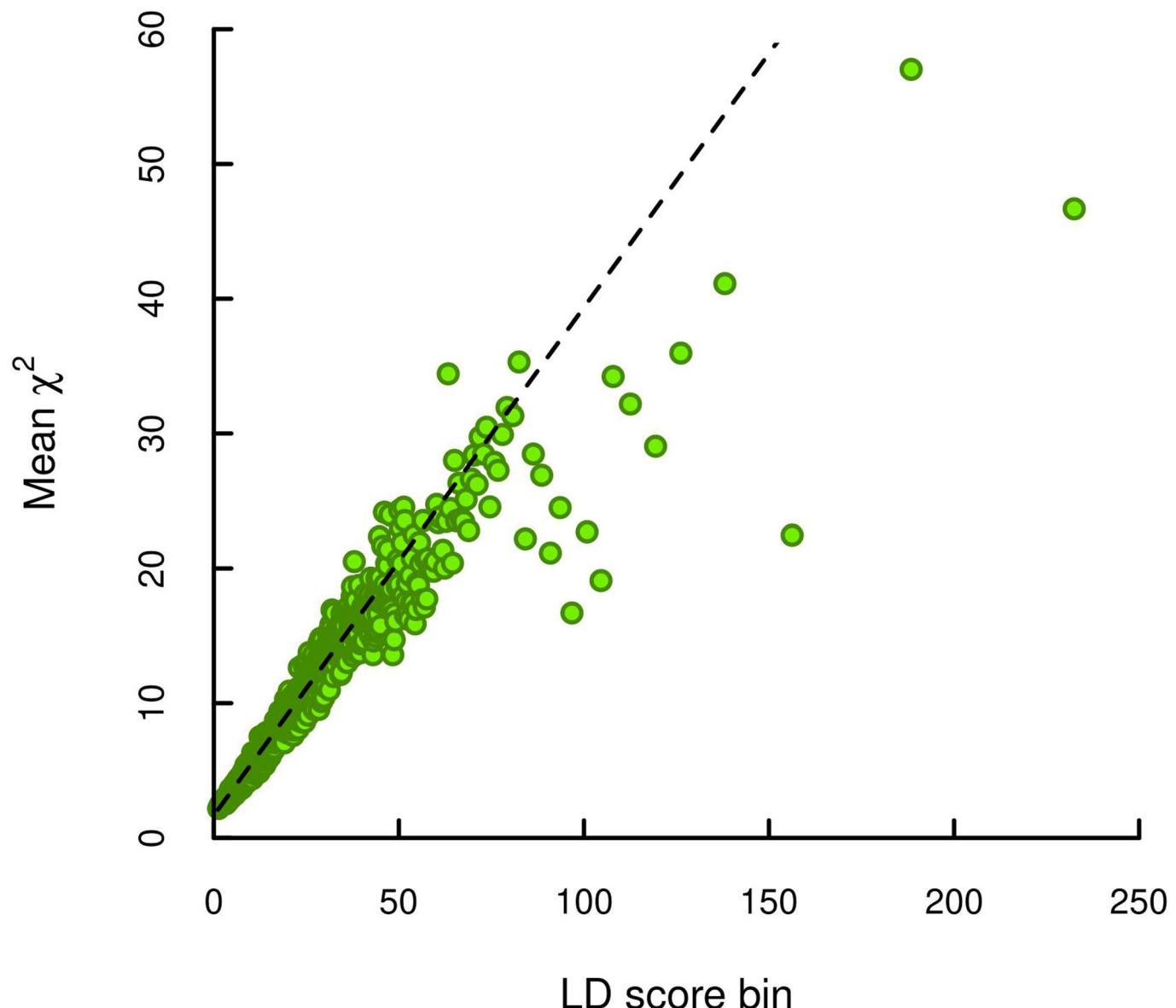
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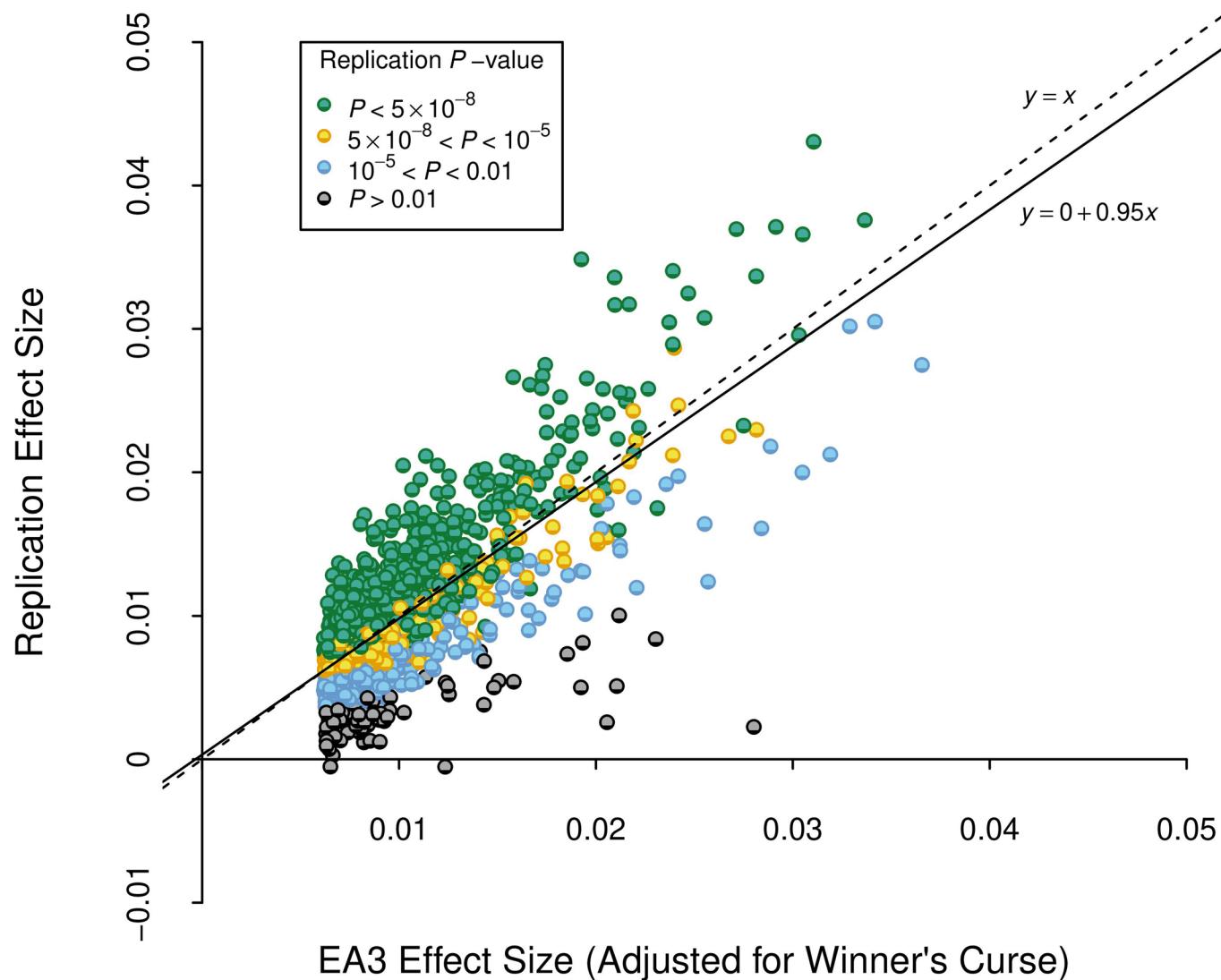


Extended Data Fig. 1 | See next page for caption.

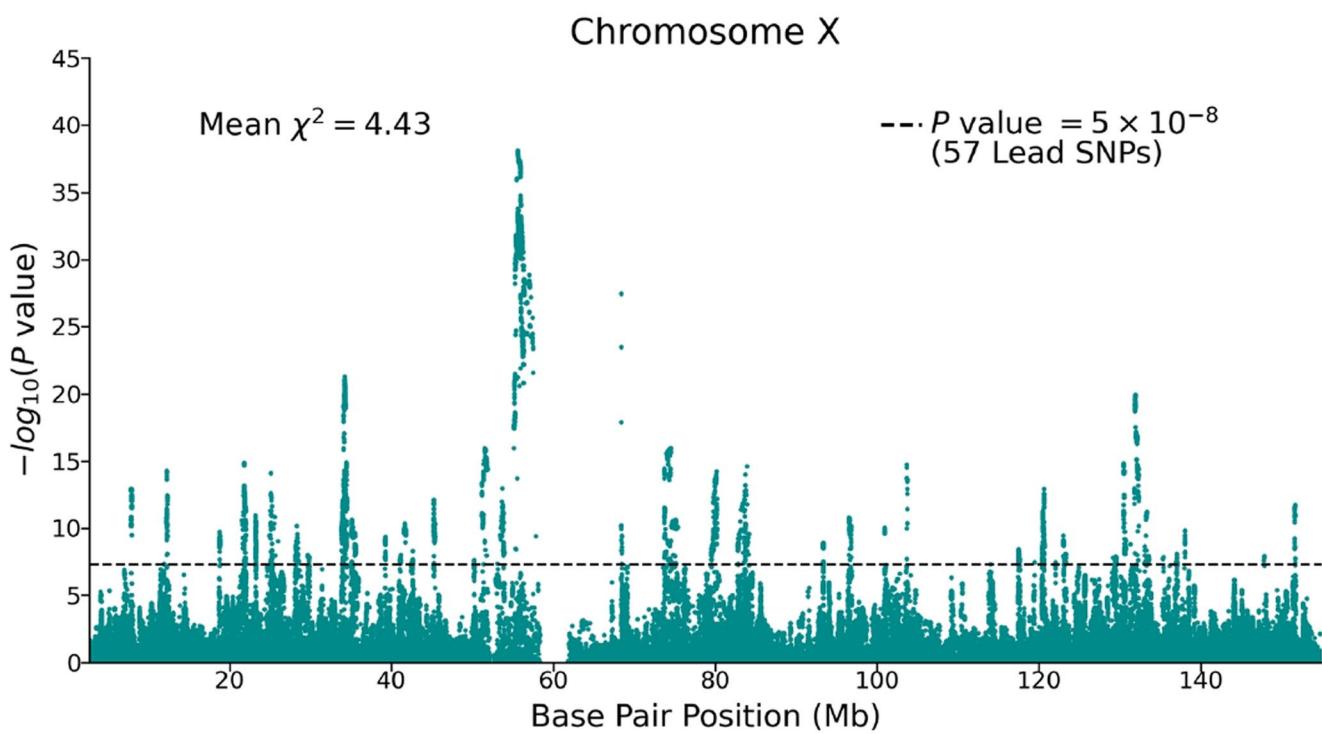
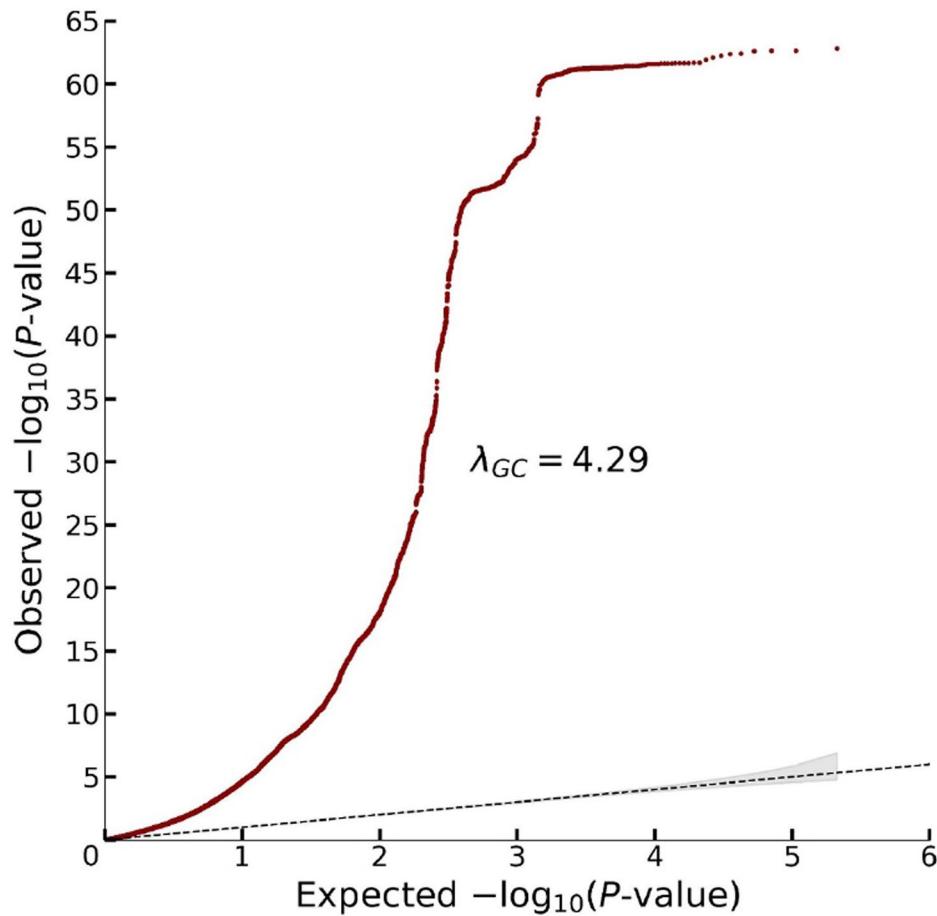
Extended Data Fig. 1 | Quantile-quantile plots for the additive GWAS meta-analysis. The panels display Q-Q plots, which show the $-\log_{10}(P\text{-values})$ based on a two-sided Z-tests for **(a)** all SNPs and **(b)** SNPs grouped by minor allele frequency (MAF): rare (<1%), low frequency (1–5%) and common (>5%). The plots and λ_{GC} numbers are based on the unadjusted GWAS summary statistics (that is with standard errors that were *not* inflated by the square root of the estimated LD Score intercept). The dotted line represents the expected $-\log_{10}(P\text{-values})$ under the null hypothesis. The (barely visible) gray shaded areas in the Q-Q plots represent the 95% confidence intervals under the null hypothesis. The flat horizontal region in the plots is an inversion region in chromosome 17 (17q21.31).



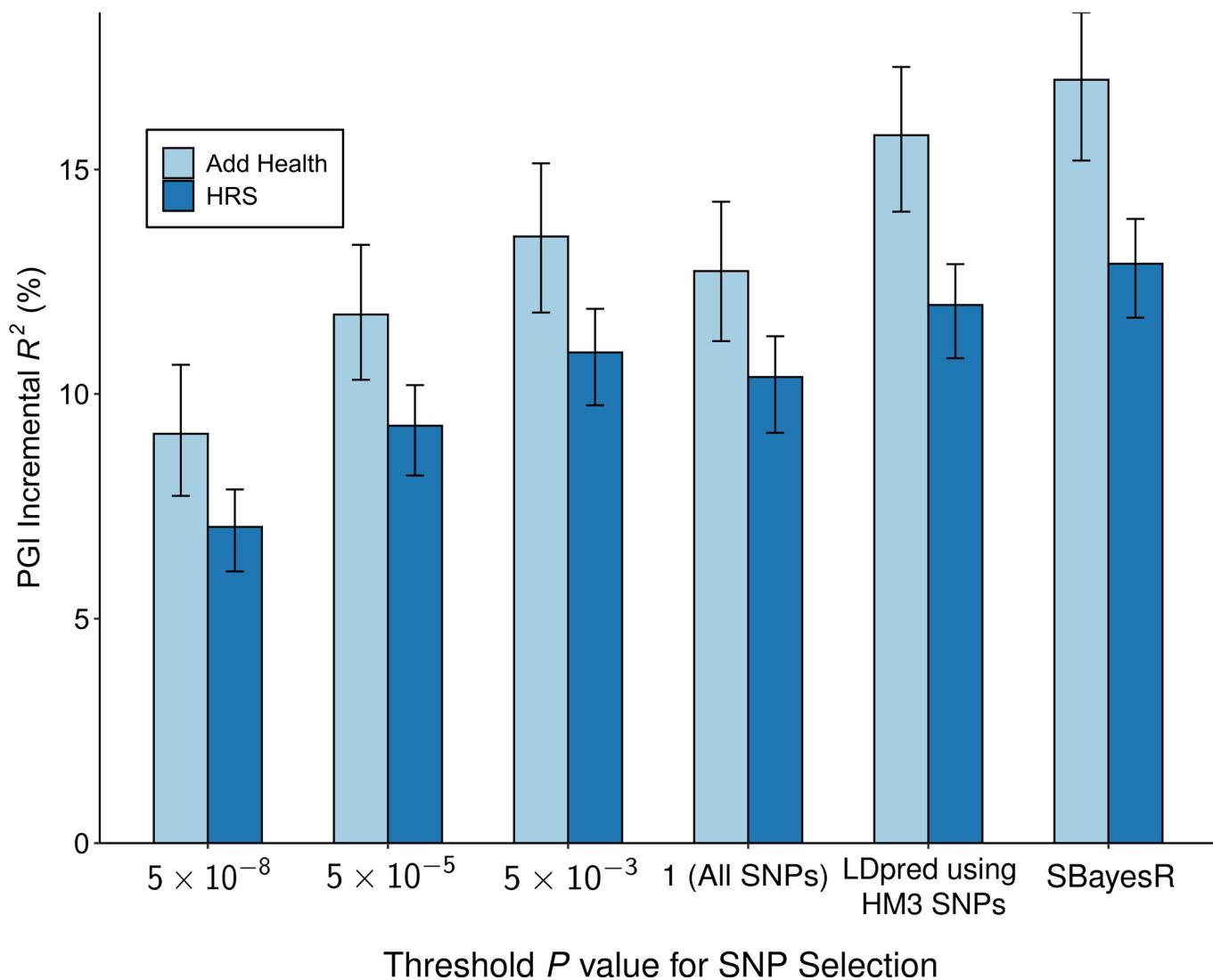
Extended Data Fig. 2 | LD score plot from the additive GWAS meta-analysis. Each point represents an LD score quantile containing 1000 SNPs (except for the last quantile, which contains 709). The x and y coordinates of each point are the mean LD score and the mean statistic of SNPs in that quantile. The LD score regression intercept is 1.663, suggesting that biases due to stratification or cryptic relatedness explain roughly 7% of the inflation in test statistics (see Supplementary Note section 2.2.6).



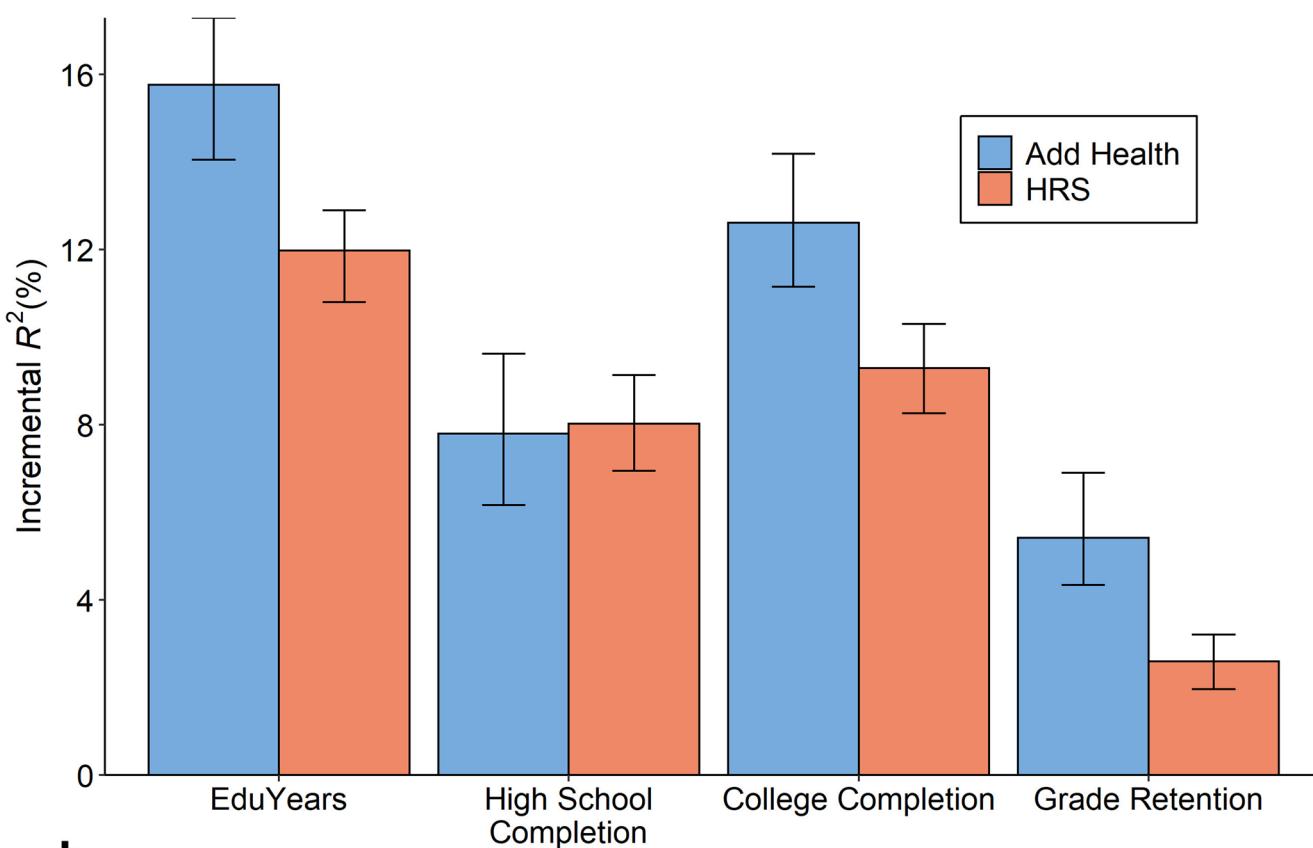
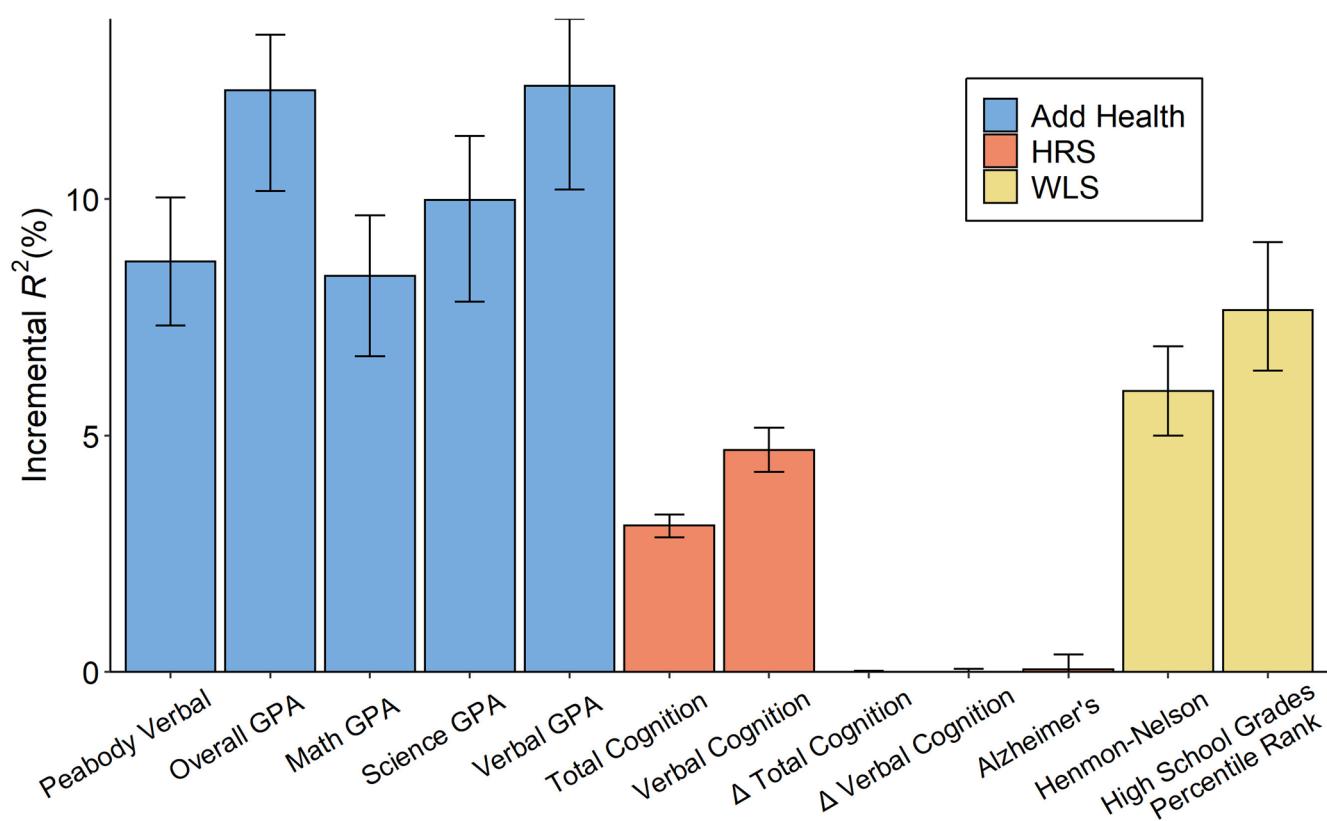
Extended Data Fig. 3 | Replication of EA3 lead SNPs. We examined the out-of-sample replicability of the 1,504 lead SNPs identified at genome-wide significance in a version of our previously published GWAS meta-analysis of *EduYears* (EA3), with the UKB GWAS in that analysis replaced by a UKB GWAS that uses the new phenotype coding explained in Supplementary Note section 1.1. Prior to clumping, we dropped SNPs that had a sample size smaller than 80% of the maximum sample size in the updated EA3 data ($N_{EA3,max} = 1,130,819$), or that had a sample size in the new data smaller than 80% of the maximum sample size of the new data ($N_{new,max} = 2,272,216$). The x axis is the winner's curse-adjusted estimate of the SNP's effect size in the updated EA3 study (calculated using shrinkage parameters estimated using summary statistics from EA3). The y axis is the SNP's effect size estimated from the subsample of our data that did not contribute to the EA3 GWAS. All effect sizes are from a regression where the phenotype has been standardized to have unit variance. The reference allele is chosen to be the allele estimated to increase EA in EA3. The dashed line is the identity, and the solid line is the fitted regression line. P -values are based on two-sided Z-tests.

a**b****Extended Data Fig. 4 | See next page for caption.**

Extended Data Fig. 4 | Meta-analysis of X chromosome SNPs ($N = 2,713,033$ individuals). The meta-analysis was conducted by combining summary statistics from (pooled-sex) association analyses conducted in UK Biobank ($N = 440,817$ individuals) and 23andMe ($N = 2,272,216$ individuals); see Supplementary Note section 3.4 for details. Panel **(a)**: Manhattan plot, in which P values are based on summary statistics adjusted for inflation using the LD score intercept estimated from an autosomal association analysis of UKB and 23andMe. The solid line indicates the threshold for genome-wide significance ($P = 5 \times 10^{-8}$ based on a two-sided Z-test adjusted for multiple comparisons). Panel **(b)**: Q-Q plot, in which P values are based on unadjusted Z-test statistics. The dotted line represents the expected $-\log_{10}(P\text{-values})$ under the null hypothesis. The (barely visible) gray shaded area represents the 95% confidence intervals under the null hypothesis.

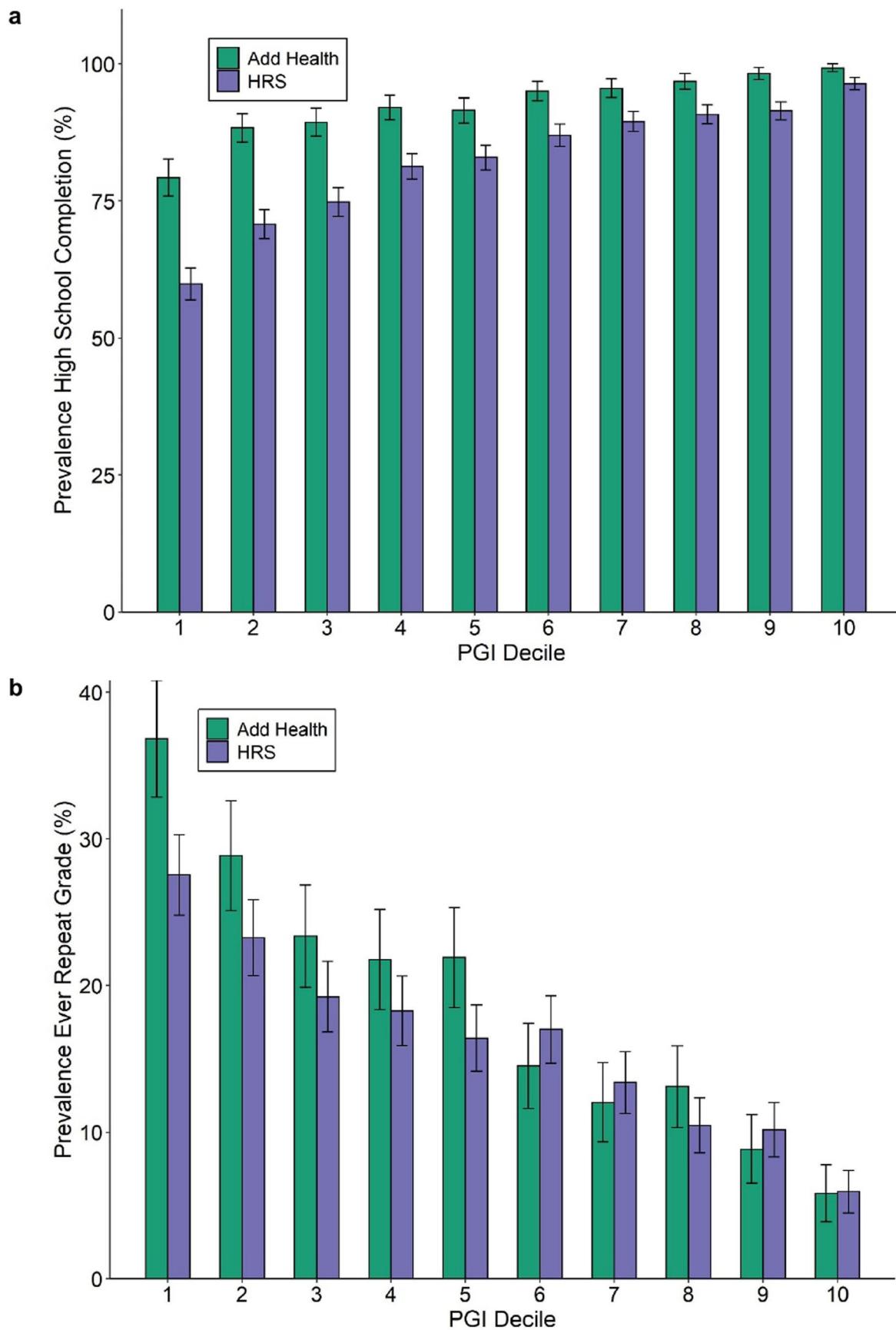


Extended Data Fig. 5 | Predictive power of the EduYears PGI as a function of pruning at different P value thresholds. Each bar represents the incremental R^2 with error bars showing the 95% confidence intervals bootstrapped with 1,000 iterations each. Each clumping and thresholding PGI is based on a set of approximately independent SNPs identified using the clumping algorithm defined in **Supplementary Note** section 2.2.6. For HRS ($N = 10,843$ individuals) and Add Health ($N = 5,653$ individuals) respectively, the number of SNPs included in the PGI is (with P value threshold in parentheses): 3,806 and 3,843 (5×10^{-8}); 10,852 and 10,897 (5×10^{-5}); 33,159 and 32,693 (5×10^{-3}); 281,087 and 247,329 (1); 1,137,480 and 1,170,675 (All HapMap3 SNPs, LDpred); 2,540,570 and 2,548,339 (SBayesR). P -values are based on two-sided Z-tests. Incremental R^2 is the difference between the R^2 from a regression of EduYears on the PGI and the controls (sex, birth-year dummies, their interactions, and 10 PCs) and the R^2 from a regression of EduYears on just the controls.

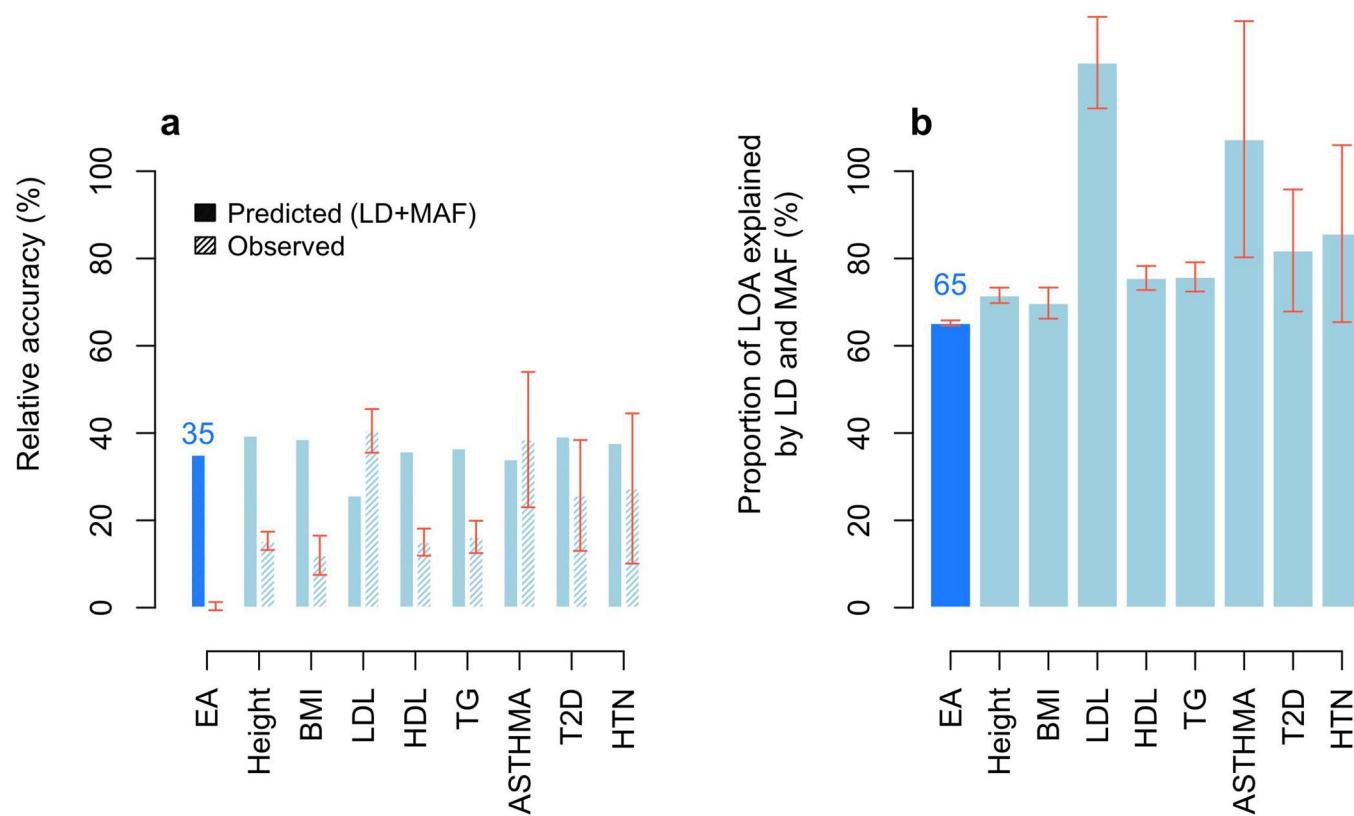
a**b**

Extended Data Fig. 6 | See next page for caption.

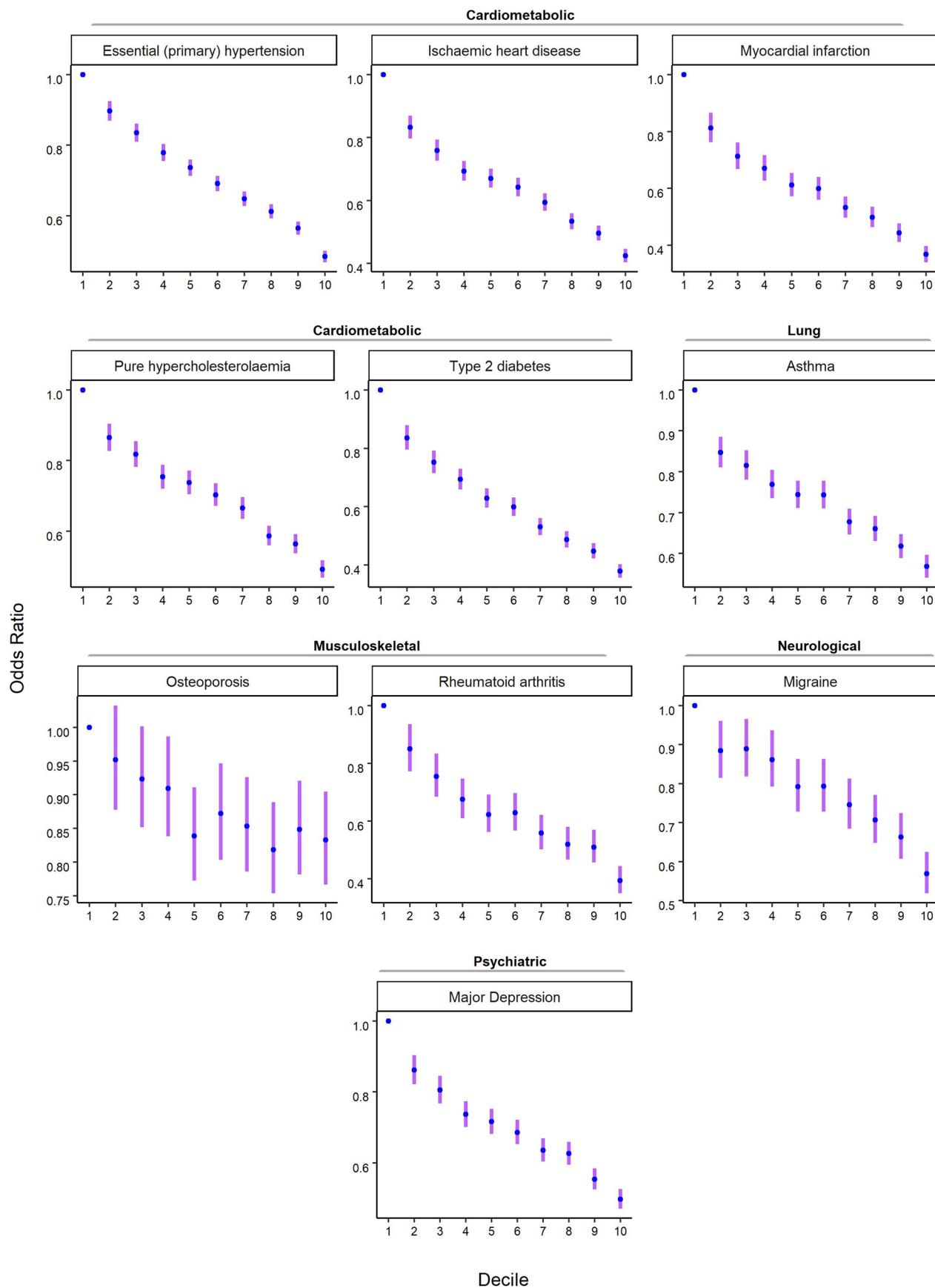
Extended Data Fig. 6 | PGI prediction in Add Health, HRS and WLS. Predictive power of the PGI constructed from the current *EduYears* GWAS results in three independent prediction cohorts: *Add Health* ($N = 5,653$), *HRS* ($N = 10,843$), and *WLS* ($N = 8,395$). For binary phenotypes, the y-axis is incremental Nagelkerke R^2 . Panel **(a)**: Results for education phenotypes available in *Add Health* and *HRS*. Panel **(b)**: Results for cognitive and academic achievement phenotypes available in either *Add Health*, *HRS* or *WLS*. “ Δ Total Cognition” and “ Δ Verbal Cognition” are wave to wave changes in total and verbal cognition. In both panels, error bars show 95% confidence intervals for the incremental R^2 , bootstrapped with 1000 iterations each. The number of individuals in the prediction sample for each regression can be found in Supplementary Table 4.



Extended Data Fig. 7 | Prevalence of schooling outcomes by EduYears PGI decile. Each decile contains approximately 1,085 respondents in HRS and 565 in Add Health. Total sample sizes for these phenotypes in each prediction cohort are in Supplementary Table 4. Decile 1 contains the lowest PGI values; decile 10, the highest. Error bars show 95% confidence intervals. Panel (a): High school completion. Panel (b): Grade retention.



Extended Data Fig. 8 | European genetic ancestries to African genetic ancestries relative accuracy. Panel (a) plots the relative accuracy (RA) with error bars representing confidence intervals with $+/- 1$ standard error. Panel (b) plots the proportion of the loss of accuracy (LOA) explained by LD and MAF calculated as $100\% \times (1 - RA_{pred(LD+MAF)}) / (1 - RA_{obs})$ with error bars representing confidence intervals with $+/- 1$ standard error. RA refers to the European genetic ancestries to African genetic ancestries ratio of prediction accuracies (R^2) of PGIs trained in a large sample of European-genetic-ancestry UKB participants ($N = 425,231$). The accuracy in European-genetic-ancestry participants was assessed in a holdout sample of 10,000 unrelated individuals, while the accuracy in African-genetic-ancestry participants was assessed in a holdout sample of 6,514 unrelated individuals. Phenotype labels: EA (Educational Attainment), Height (standing height), BMI (body mass index), LDL (low-density lipoprotein cholesterol), HDL (high-density lipoprotein cholesterol), TG (triglycerides), ASTHMA (diagnosed asthma), T2D (diagnosed type 2 diabetes) and HTN (diagnosed hypertension). See Supplementary Note section 7 in Wang et al. for additional details. Data underlying this Figure are reported in Supplementary Table 5.



Extended Data Fig. 9 | Odds ratio for selected diseases by deciles of the EA PGI in the UKB. The EA PGI was discretized into deciles (1 = lowest, 10 = highest), and nine dummy variables were created to contrast each of deciles 2–10 to decile 1 as the reference. Odds ratio and 95% confidence intervals (the error bars) were estimated using logistic regression while controlling for covariates (sex, a third-degree polynomial in birth year and interactions with sex, the top 40 PCs, and batch dummies).

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Software and code

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Data collection	No software was used for data collection.
Data analysis	The following software packages were used for data analysis: Python version 3.7.4 with packages pandas 0.25.1, scipy 1.3.1, numpy 1.17.2, matplotlib 3.1.1 and argparse 1.1 (https://anaconda.org); R version 4.0.3 with packages EasyQC 9.2, plotrix 3.7.8, tidy 1.1.3 and readstata13 0.9.2, R version 3.6 (https://www.r-project.org); GCTA 1.93.2beta (https://yanglab.westlake.edu.cn/software/gcta/#Overview); GCTB 2.03 (https://cnsgenomics.com/software/gctb/#Overview); Stata 16.1 (https://www.stata.com); PLINK 1.9 (https://www.cog-genomics.org/plink/1.9); PLINK 2 (https://www.cog-genomics.org/plink/2.0); LDpred 1.0.11 (https://github.com/bvilhjal/LDpred); METAL release 2011-03-25 (https://genome.sph.umich.edu/wiki/METAL_Documentation); BOLT-LMM 2.3 (https://alkesgroup.broadinstitute.org/BOLT-LMM/BOLT-LMM_manual.html); LDSC 1.0.1 (https://github.com/bulik/LDSC); SNIPar (https://github.com/AlexTISYoung/SNIPar/tree/EA4).

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GWAS summary statistics can be downloaded from <http://www.thessgac.org/data> subject to a Terms of Use to ensure responsible use of the data. We provide association results for all SNPs that passed quality-control filters in autosomal, X chromosome, and dominance GWAS meta-analyses that excludes the research

participants from 23andMe. SNP-level summary statistics from analyses based entirely or in part on 23andMe data can only be reported for up to 10,000 SNPs. For the complete dominance GWAS meta-analysis, which includes 23andMe, clumped results for the 1,000 SNPs with the smallest P values are provided. For the complete autosomal and X chromosome GWAS meta-analyses, respectively, clumped results for the 8,617 and 143 SNPs with $P < 10^{-5}$ are provided; this P value threshold was chosen such that the total number of SNPs across the analyses that include data from 23andMe does not exceed 10,000. The full GWAS summary statistics from 23andMe will be made available through 23andMe to qualified researchers under an agreement with 23andMe that protects the privacy of the 23andMe participants. Please visit <https://research.23andme.com/collaborate/#dataset-access/> for more information and to apply to access the data.

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Study description	This is a genome-wide association study (GWAS) meta-analysis of educational attainment (EA) in a sample of ~3 million individuals. All data used in this study (genetic and phenotype data) are quantitative.
Research sample	The research sample consists of ~3 million individuals from 71 research cohorts. We meta-analyzed three sets of summary statistics: publicly available results from Lee et al. (2018) that exclude 23andMe and UKB ($N = 324,162$), new association results from 23andMe ($N = 2,272,216$), and new association results from a GWAS we conducted in UKB with an improved coding of the EA measure ($N = 441,121$). The large study sample was required for us to have sufficient statistical power in detecting single nucleotide polymorphisms (SNPs) with small effect sizes and for our follow-up analyses.
Sampling strategy	We obtained the largest sample we could.
Data collection	Data collection was performed independently by each participating cohort.
Timing	Data was collected from multiple cohorts with variable data collection periods.
Data exclusions	All observations reporting less than seven years of schooling were dropped to exclude outliers (there were fewer than 50 such observations; see Supplementary Note 1.1.4).
Non-participation	No participants dropped out or declined participation.
Randomization	Participants were not allocated into experimental groups.

Reporting for specific materials, systems and methods

We require information from authors about some types of materials, experimental systems and methods used in many studies. Here, indicate whether each material, system or method listed is relevant to your study. If you are not sure if a list item applies to your research, read the appropriate section before selecting a response.

Materials & experimental systems		Methods	
n/a	Involved in the study	n/a	Involved in the study
<input checked="" type="checkbox"/>	<input type="checkbox"/> Antibodies	<input checked="" type="checkbox"/>	<input type="checkbox"/> ChIP-seq
<input checked="" type="checkbox"/>	<input type="checkbox"/> Eukaryotic cell lines	<input checked="" type="checkbox"/>	<input type="checkbox"/> Flow cytometry
<input checked="" type="checkbox"/>	<input type="checkbox"/> Palaeontology and archaeology	<input checked="" type="checkbox"/>	<input type="checkbox"/> MRI-based neuroimaging
<input checked="" type="checkbox"/>	<input type="checkbox"/> Animals and other organisms		
<input type="checkbox"/>	<input checked="" type="checkbox"/> Human research participants		
<input checked="" type="checkbox"/>	<input type="checkbox"/> Clinical data		
<input checked="" type="checkbox"/>	<input type="checkbox"/> Dual use research of concern		

Human research participants

Policy information about [studies involving human research participants](#)

Population characteristics	See above.
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Recruitment

Recruitment strategies were particular to each cohort.

Ethics oversight

All analyses are on anonymized, secondary data. Nonetheless, the analyses reported in the paper fall under National Bureau of Economic Research IRB protocols 19_434, 19_465, and 20_041.

Note that full information on the approval of the study protocol must also be provided in the manuscript.