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Mediation of Developmental Risk Factors for Psychosis by White Matter Microstructure in Young Adults With Psychotic Experiences

Mark Drakesmith, PhD; Anirban Dutt, MD; Leon Fonville, MSc; Stanley Zammit, PhD; Abraham Reichenberg, PhD; C. John Evans, PhD; Glyn Lewis, PhD; Derek K. Jones, PhD; Anthony S. David, MD

**IMPORTANCE** White matter (WM) abnormalities have been identified in schizophrenia at the earliest stages of the disorder. Individuals in the general population with psychotic experiences (PEs) may show similar changes, suggesting dysfunction due to aberrant neurodevelopment. Studying such people is a powerful means of understanding the nature of neurodevelopmental problems without the confound of clinical management and allows other potential risk factors associated with the schizophrenia spectrum to be taken into account.

**OBJECTIVES** To compare WM microstructure and myelination in young adults with and without PEs identified from a population-based cohort using diffusion and relaxometry magnetic resonance imaging and to quantify potential mediating effects of WM on several known risk factors for psychosis.

**DESIGN, SETTING, AND PARTICIPANTS** In this case-control study, participants were drawn from the UK Avon Longitudinal Study of Parents and Children. Psychotic experiences were assessed using a semistructured interview. Magnetic resonance imaging was carried out at age 20 years in 123 participants who had PEs and 124 individuals serving as controls. Participants with PEs were subdivided into those with operationally defined suspected PEs, definite PEs, and psychotic disorder.

**MAIN OUTCOMES AND MEASURES** Diffusion tensor magnetic resonance imaging and relaxometry-derived myelin water fractions were used to measure WM microstructure and myelination, respectively. Differences in quantitative WM indices were assessed using tract-based spatial statistics. A binary model and a continuum-like ordinal model of PEs were tested.

**RESULTS** Among the 123 participants who had PEs (mean [SE] age, 20.01 [0.004] years), 37 were male and 86 were female. Among the 124 controls (mean [SE] age, 20.11 [0.004] years), 49 were male and 76 were female. Fractional anisotropy in left frontomedial WM was significantly reduced in individuals with PEs (Montreal Neurological Institute [MNI] coordinates, −18, 37, −2; \( P = .0046 \)). The ordinal model identified a similar but more widespread effect, with a corresponding increase in radial diffusivity (MNI coordinates, −15, 29, 21; \( P = .0042 \)). Low birth weight (\( p = −0.155; P = .015 \)) and childhood IQ (\( p = −0.188; P = .003 \)) were associated with the presence of PEs. Results of mediation analysis were consistent with the association between birth weight (21.1% mediation effect; \( P = 6.20 \times 10^{-3} \)) and childhood IQ (7.9% mediation effect; \( P = .041 \)) and by PEs being mediated by fractional anisotropy changes in these regions.

**CONCLUSIONS AND RELEVANCE** The results of the study imply the presence of abnormal WM microstructure in young adults with PEs. The results are consistent with the hypothesis that neurodevelopmental factors cause alterations in the cellular composition of WM circuits critical to higher cognitive function. Such alterations may first manifest in childhood as reduced IQ and later contribute to PEs in early adulthood.

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White matter (WM) abnormalities have been identified in several structures in schizophrenia using diffusion tensor magnetic resonance imaging (DT-MRI). Among the most heavily implicated regions are the cingulum, corpus callosum, uncinate, and arcuate fasciculi. However, these findings are variable across studies and cover diverse regions. Other studies focusing on specific properties of WM axons, such as myelination, from MRI have implicated reduced myelination in frontomedial WM in patients with schizophrenia.

To delineate structural brain differences related to the development of psychosis, it is important to exclude the confounding effects of medication or chronic illness. Studies of patients with drug-naive or first-episode schizophrenia achieve some control of these confounding effects, as do studies focused on high-risk groups. These groups can include individuals presenting with the At-Risk Mental State, clinical ultra-high risk, schizotypal personality traits, or psychotic experiences (PEs). Such individuals are widely regarded as lying on a psychosis continuum. Studies of WM microstructure in clinically high-risk individuals have found changes in, for example, the genu of the corpus callosum and thalamic radiations, with a general trend for reduced fractional anisotropy (FA) even in the absence of transition to psychosis. The locations of these abnormalities, although dispersed, have tended to be those of late-maturing brain regions that underlie higher-order cognitive functions.

Understanding the role of WM abnormalities in the development of psychosis necessitates consideration of numerous risk factors, many of which have been implicated in altered microstructure. The biological mechanisms whereby such factors contribute to psychosis and how they relate to the brain abnormalities noted above are not clear, and there are most likely multiple pathways. The accumulation of risk across several of these factors significantly influences WM microstructure, although the mediating effects of WM microstructure on PEs are not known. There is some limited evidence that brain volume may be one such intermediate factor.

This study used a large epidemiologic birth cohort to examine the association between WM microstructure and PEs in young adults. We tested the hypothesis that abnormalities in WM are associated with PEs and that they center on pathways critical for higher-order cognitive functions. This approach has several advantages. In particular, it allows the examination of PEs without relying on presentation to clinical services, thereby reducing selection biases around help seeking and secondary effects of illness. The cohort has accrued rich longitudinal data on developmental, clinical, and psychosocial variables that can constitute risk factors for psychosis. The availability of these data provides the opportunity to explore how developmental variables of putative etiologic relevance to psychosis, WM metrics, and PEs might be related. Testing whether the hypothesized association between WM and PEs changes after adjusting for confounders is an important step. However, in this study we went one step further and tested a biologically plausible causal model wherein certain developmental risk factors are considered to be primary factors (eg, birth weight) leading to changes in WM that may in turn partially mediate the appearance of PEs.

### Methods

#### Participants

Participants were recruited from the UK Avon Longitudinal Study of Parents and Children (ALSPAC) cohort (Appendix 1 in the Supplement provides a full description). A total of 126 participants who were previously assessed using the Psychotic-Like Symptoms Semi-Structured Interview and underwent MRI scanning. Psychotic episodes were further categorized as suspected, definite, and clinical disorders. An equal number of individuals without PEs serving as controls were excluded because of poor data quality, reducing the final PE and control group sizes to 123 and 124, respectively. Written informed consent was obtained.

### Table 1. Studies of Relating Environmental and Developmental Factors Indicating an Association With White Matter and Schizophrenia

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Associated With Schizophrenia*</th>
<th>Associated With White Matter*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood IQ</td>
<td>27-30</td>
<td>31</td>
</tr>
<tr>
<td>Depression and anxiety disorders</td>
<td>Reviewed in 12</td>
<td>33-34</td>
</tr>
<tr>
<td>Parental socioeconomic status</td>
<td>35-36</td>
<td>37-38</td>
</tr>
<tr>
<td>Birth weight</td>
<td>10-41</td>
<td>42-45</td>
</tr>
<tr>
<td>Perinatal trauma (eg, hypoxia)</td>
<td>46-48</td>
<td>49-50</td>
</tr>
<tr>
<td>Traumatic childhood events</td>
<td>51-53</td>
<td>54-57</td>
</tr>
<tr>
<td>Handedness</td>
<td>58-60</td>
<td>61</td>
</tr>
<tr>
<td>Tobacco consumption</td>
<td>Reviewed in 52</td>
<td>63-67</td>
</tr>
<tr>
<td>Cannabis consumption</td>
<td>Reviewed in 58</td>
<td>Reviewed in 59</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>Reviewed in 50</td>
<td>Reviewed in 11</td>
</tr>
<tr>
<td>Month of birth</td>
<td>72,73</td>
<td>74</td>
</tr>
</tbody>
</table>

* Numbers indicate references.
Table 2. Descriptive and Inferential Statistics for the Selected Developmental Risk Factors

<table>
<thead>
<tr>
<th>Variable</th>
<th>Descriptive Statisticsa</th>
<th>Inferential Statisticsb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PEs</td>
<td>Suspect</td>
</tr>
<tr>
<td>Standard Covariates (Included in All Analyses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>125</td>
<td>44</td>
</tr>
<tr>
<td>Proportion tested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>14</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>30</td>
</tr>
<tr>
<td>Age, y</td>
<td>20.11 (0.004)</td>
<td>20.14 (0.013)</td>
</tr>
<tr>
<td>Variables Included in Mediation Analyses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Childhood IQ</td>
<td>111.44 (0.12)</td>
<td>104.65 (0.31)</td>
</tr>
<tr>
<td>2. CIS-R Score</td>
<td>6.30 (0.05)</td>
<td>9.16 (0.17)</td>
</tr>
<tr>
<td>3. Parental social classc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>II</td>
<td>54</td>
<td>10</td>
</tr>
<tr>
<td>III(N)</td>
<td>52</td>
<td>24</td>
</tr>
<tr>
<td>III(M)</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>IV</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>V</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. Highest maternal educational leveld</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Vocational</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>O-level</td>
<td>39</td>
<td>16</td>
</tr>
<tr>
<td>A-level</td>
<td>34</td>
<td>7</td>
</tr>
<tr>
<td>Degree</td>
<td>35</td>
<td>8</td>
</tr>
<tr>
<td>5. Birth weight, g</td>
<td>3466.2 (4.0)</td>
<td>3323.4 (12.6)</td>
</tr>
<tr>
<td>6. Resuscitated at birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>33</td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>7. Stressful life events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>111</td>
<td>36</td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>8. Handedness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>92</td>
<td>36</td>
</tr>
<tr>
<td>No dominance</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>Left</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>9. Tobacco consumption (cigarettes per day)e</td>
<td>0.59 (0.02)</td>
<td>1.27 (0.08)</td>
</tr>
<tr>
<td>10. Cannabis consumptionf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>87</td>
<td>28</td>
</tr>
<tr>
<td>Once or twice</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Less than monthly</td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td>Monthly or more</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

(continued)
Table 2. Descriptive and Inferential Statistics for the Selected Developmental Risk Factors (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>PEs</th>
<th>Descriptive Statisticsa</th>
<th>Inferential Statisticsb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2-Group Binary Classification</td>
<td>4-Group Ordinal Classification</td>
<td>Proportion Imputed</td>
</tr>
<tr>
<td></td>
<td>No PEs</td>
<td>Suspect</td>
<td>Definite</td>
</tr>
<tr>
<td>11. Alcohol consumptionc</td>
<td>No PEs</td>
<td>Suspect</td>
<td>Definite</td>
</tr>
<tr>
<td>Never</td>
<td>16</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Once or twice</td>
<td>23</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Less than monthly</td>
<td>12</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Monthly</td>
<td>52</td>
<td>21</td>
<td>19</td>
</tr>
<tr>
<td>Weekly or more</td>
<td>22</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>12. Month of birthd</td>
<td>2.30</td>
<td>1.72</td>
<td>1.31</td>
</tr>
<tr>
<td></td>
<td>(7.52)</td>
<td>(7.31)</td>
<td>(7.50)</td>
</tr>
</tbody>
</table>

Abbreviations: CA, Cochrane-Armitage; CIS-R, revised Clinical Interview Schedule; M, manual labor; N, nonmanual labor; NA, not applicable; PEs, psychotic experiences.

a Descriptive statistics for continuous variables are reported as mean (SE) for each group. Descriptive statistics for ordinal and categorical variables are reported as frequencies.

b Inferential statistics for the 2-group classification uses the t test for continuous variables, the χ² test for categorical variables, and the Cochrane-Armitage χ² test (denoted χ²CA) for ordinal variables. Inferential statistics for the 4-group ordinal classification uses the Spearman ρ correlation for continuous and ordinal variables and the χ²CA test for categorical variables.

c Based on the Office of Population Censuses and Surveys. Classes are I, professional; II, managerial and technical; III(N), nonmanual skilled; III(M), manual skilled; IV, partly skilled; and V, unskilled.

d Typical atteniments for secondary education and postcompulsory further education in the United Kingdom.

e The mean number of cigarettes that the participant smoked every day in the past 30 d.

f From a multiple-choice question asking how many times the participant used cannabis in the past 12 mo (all substance use data gathered at ages 17-18 years).

g Six or more units of alcohol in the past year.

h As a scale from 0 (January 1) to 12 (December 31). A Watson-Williams, 2-sample F test and circular-linear ρ correlation were performed using the circular statistics toolbox.82

obtained prior to scanning, and participants received financial compensation. Approval was granted by the Cardiff University and the ALSPAC Ethics Committees.

Risk Factors

Variables hypothesized to contribute to psychosis risk were identified from the ALSPAC database (http://www.bristol.ac.uk/alspac/researchers/access/). These variables included demographic, environmental, and other risk factors: (1) IQ at age 8 years estimated from the Wechsler Intelligence Scale for Children,83 (2) current general psychopathology at age 17 to 18 years measured using the computerized revised Clinical Interview Schedule (CIS-R),84 (3) parental social class using occupational categories based on the Office of Population Censuses and Surveys (I, professional; II, managerial and technical; III(N), nonmanual skilled; III(M), manual skilled; IV, partly skilled; V, unskilled; 1991 Census; https://census.ukdataservice.ac.uk/media/51162/1991_defs.pdf), (4) maternal educational attainment (I, professional; II, managerial and technical; III(N), nonmanual skilled; III(M), manual skilled; IV, partly skilled; and V, unskilled), (5) current occupational status in the United Kingdom, (6) social class using the Office of Population Censuses and Surveys (I, professional; II, managerial and technical; III(N), nonmanual skilled; III(M), manual skilled; IV, partly skilled; V, unskilled; 1991 Census; https://census.ukdataservice.ac.uk/media/51162/1991_defs.pdf), (7) current general psychopathology at age 17 to 18 years measured using the computerized revised Clinical Interview Schedule (CIS-R),84 (8) handedness, (9) tobacco use, (10) cannabis consumption, (II) alcohol consumption, and (12) month of birth. Missing data points for each participant were estimated using regression imputation66 across the entire cohort. Prior to imputation, nonordinal categorical variables were recoded as sets of binary variables. Consistency of imputation and generalizability of the MRI sample to the full cohort were tested (eAppendix 2 and eAppendix 3 in the Supplement). Descriptive and inferential statistics of all selected variables are detailed in Table 2.

Diffusion MRI

The MRI data were acquired on a 3-T MRI system (HDx; GE Medical Systems). High angular resolution, diffusion-weighted images87 with 60 gradient orientations (b = 1200 seconds/mm²) were acquired and corrected for motion and field distortions88,89 (eAppendix 4 and eAppendix 5 in the Supplement). Diffusion tensors were estimated, and FA, axial diffusivity, radial diffusivity (RD), and mean diffusivity were computed.

MRI Relaxometry

Myelination was estimated using multicomponent-driven, equilibrium single-pulse observation of T1 and T2 (mcDESPOT).90 Data were corrected for head motion and field distortions (eAppendix 4 in the Supplement). Maps of myelin water fraction and longitudinal relaxation rate (R1 = 1/T1) were computed.

Tract-Based Spatial Statistics

Differences in WM metrics were analyzed using tract-based spatial statistics in the FMRIB Software Library.91 All participants’ FA maps were normalized, and a mean FA image was computed and thinned to create a mean FA skeleton, which represents the centers of all tracts common to the group. Each participant’s aligned DT/mcDESPOT data were then projected onto this skeleton.

Statistical Analysis

Voxelwise statistics were performed on the skeletonized images using the general linear model. Multiple comparisons were corrected for using permutation testing92 with threshold-free cluster enhancement (5000 permutations).93 Regions of
significant effect were labeled using The Johns Hopkins University WM atlas54 (eAppendix 6 in the Supplement).

Two designs were tested. The first design treats PE status as a binary classification (PEs vs without PEs). The second model uses a 4-point ordinal scale (no PEs > suspected PEs > definite PEs > clinical disorder). In both cases, age and sex were treated as covariates. Maps of permutation-corrected P values were computed for each microstructural metric (eg, FA and myelin water fraction) and each design. Effects are treated as significant at corrected P < .05.

To further examine the effects of putative risk factors on the association between WM and PEs, the ordinal analysis was repeated but with each factor specified as a covariate. Within the region of interest of significant effects, the change in effect size between the results with and without the additional covariate was estimated from the corrected P values using the inverse Gaussian cumulative density function.

To test the hypothesis that possible risk factors for PEs are mediated by WM abnormalities, mediation analysis was applied to the variables listed in Table 2 (except age and sex) and the tract-based spatial statistics data42,55 (eAppendix 7 in the Supplement). First, regions of significant mediation were identified, where corrected P value maps showed (1) a significant association between the risk factor and PEs, (2) a significant association between the risk factor and WM, (3) a significant association between WM and PEs after covarying for the risk factor, and (4) a reduced association between the risk factor and PEs when the effects of WM were controlled for. Second, in regions satisfying these criteria, the 95% CIs of the mediation effect and corresponding P values following permutation-based correction were estimated.96

Results

MRI Findings and Psychotic Experiences

Binary Classification

There was a significant decrease in FA in a region of left anterior, medial-frontal WM (Figure 1) in association with the presence of PEs. The region incorporates the genu and anterior portion of the corpus callosum and the left anterior corona radiata (peak effect: Montreal Neurological Institute [MNI] coordinates, −18, 37, −2; P = .0046 corrected). There were no significant effects in other DT-MRI indices or in R1 or myelin water fraction.

Ordinal Model

There was a significant negative effect in FA in widespread regions of WM with some left lateralization (Figure 2A-C) in association with the presence of PEs. Participants with the highest PE scores had the lowest FA compared with the controls. Effects were seen mostly in the genu, anterior part of the corpus callosum (peak effect: MNI coordinates, −18, 37, −2; P = .0012 corrected), and to a lesser extent, the anterior thalamic radiation, anterior parts of left cingulum, left superior longitudinal fasciculus, and fornix. There was a similar spatial pattern of positive effects noted in RD (peak effect: MNI coordinates, −15, 29, 21; P = .0042), which extended into cerebellar WM. Mean diffusivity was also implicated in a small region of right frontomedial WM. No effects were seen in other DT-MRI or myelin metrics.

Social and Developmental Risk Factors

The association between PEs and each hypothesized risk factor are summarized in Table 2. Childhood IQ, CIS-R scores, parental social class, and maternal educational level all showed strong evidence of association with both binary and ordinal classifications of PEs (all P < .01). Evidence of an association was also observed for birth weight (P < .05) and for stressful life events (P < .05 only in the ordinal model) but not for the other factors examined.

Confounding Effect of Risk Factors

Changes in effect size owing to covariation for each risk factor in the 2 regions identified in the ordinal analysis are presented in Figure 2D-E. All risk factors showed small changes in effect size (<0.5 SDs) when controlled for except for CIS-R, which showed a large reduction (approximately 1 SD) in both FA and RD.
Mediation Effects
Results from the mediation analysis were consistent with FA partially mediating the effects of childhood IQ and birth weight on PEs. Mediation of childhood IQ peaked in the left anterior thalamic projections, the genu, and anterior portions of the corpus callosum and the left internal capsule (Figure 3). The mediation by FA in these regions constituted 7.9% of the total effect size (μ = 0.051; β11 = −0.710; P = .041 corrected). The mediation of birth weight extended further into the corpus callosum and constituted 21.1% of the total effect size (μ = 0.004; β11 = −0.019; P = 6.20 × 10−3). No other significant mediation effects were identified.

Discussion
We used DT-MRI and multicomponent relaxometry to identify changes in WM microstructure associated with PEs in a large nonclinical sample of young adults included in the ALSPAC cohort. Furthermore, we applied a novel voxelwise
mediation analysis to test whether WM microstructure abnormalities mediate the effect of some putative risk factors for psychosis. This type of analysis provides insights into the developmental and pathologic mechanisms by which PEs and psychosis can arise.

A simple binary model of psychosis was compared with a continuum-based ordinal model. Both models showed an apparent reduction in FA compared with healthy controls in predominantly frontomedial pathways. The ordinal model revealed a more widespread pattern of affected regions both in FA and RD. One interpretation of this finding is that, although WM microstructure is affected in individuals with PEs, this effect is expressed in varying degrees related to the severity of PEs (Figure 2B and C). Alternatively, the continuum model may afford greater statistical power to detect the association. In any event, the continuum model could be seen as a better approach to detecting pathologic substrates along the spectrum of PEs and provide biological evidence for a continuum of psychosis.

The location of WM changes in predominantly medial-frontal structures is consistent with previous studies in early-stage schizophrenia and associated at-risk groups. Our results for FA, although in the expected direction (i.e., reduced FA in patients with PEs), implicate pathways different from those recently reported in a population-based cohort with PEs. This difference could be due to the modest sample size of that study and their younger age (13-16 years).

The application of mediation analysis to DT-MRI data requires additional analyses based on previous studies. However, the design of the study does not allow explicit differentiation of mediation effects from confounder effects, and causality cannot be conclusively determined. Such interpretations rely on assumptions regarding the likely direction of causality of effects, which may be multidirectional and interactive. A related limitation is that, although repeated measures of many variables and PEs are available in ALSPAC, MRI has been performed only once. Nevertheless, such analyses may help in understanding the data and generating hypotheses that may be tested in studies with longitudinal designs. Such studies will shed light on how developmental and resilience factors can lead to both positive and negative changes in microstructural indices and how these changes can manifest in the development of psychosis.

For birth weight, it seems reasonable to infer that FA measured at age 20 years lies on the causal pathway between obstetric variables and PEs. A recent study has shown that cumulative risk based on a range of psychosis risk factors can contribute to microstructural changes in WM. The theoretical mediation effect on IQ, although measured in childhood years before the imaging, is less easy to interpret. It is possible that IQ at age 8 was affected by preexisting PEs or WM abnormalities at that age. One construal of the mediation analysis is that common neurodevelopmental factors may be associated with alterations in WM circuitry that manifest in childhood as reduced intellectual capacity and later contribute to PEs in early adulthood. Furthermore, the spatial overlap with mediation of birth weight indicates that such pathology may be related to obstetric difficulties. Indeed, the association between low birth weight, schizophrenia, and cognitive impairment is well established, with hypoxia at birth being perhaps the critical factor.

The regions implicated in this study are consistent with cognitive deficits seen in psychosis and brain changes observed in those with obstetric difficulties. For example, the genu of the corpus callosum is important for prefrontal executive function and social cognition, anterior thalamic projections for motivation and alertness, and the genu for executive dysfunction. The same cohort has previously
shown altered connectome topology\textsuperscript{112} similar to that seen in schizophrenia. The present study provides a neuropathologic basis for the alterations in connectome topology in that abnormal axon morphology is most likely impaired, contributing to dysconnectivity at the whole-brain level.

Birth weight and childhood IQ in our sample were within the reference ranges and thus not inherently pathologic. However, the combination of highly sensitive WM imaging techniques and the continuum approach to psychopathology may have uncovered associations that might have otherwise escaped detection.

Another interesting finding is the apparent absence of mediation of the CIS-R score, a measure of common psychopathology, despite correlating with PEs\textsuperscript{113} and DT-MRI indices across many brain regions (eAppendix 8 in the Supplement). There is a marked reduction in effect size when the measure is controlled for (Figure 2E), indicating that CIS-R is a confounder (ie, depression contributes to both PEs and changes in WM) or a collider factor (both PEs and WM contribute to depression).

Other risk factors did not yield any significant associations with either PEs or WM. In the case of substance use (eg, cannabis), this lack of association may reflect its biochemically mediated effects\textsuperscript{114} that do not, over the timescales considered and levels of consumption\textsuperscript{115} in our participants aged 20 years, cause structural changes in WM.\textsuperscript{116} Frequency of consumption may be insufficient to characterize risk exposure; age of first use and total lifetime consumption may be more predictive. In addition, our drug consumption variables had a high proportion of missing values that were imputed, which may contribute to false-negatives. Finally, it has been proposed\textsuperscript{117} that psychosis associated with cannabis clusters separately from typical neurodevelopmental risk factors, such as low IQ.

No effects were apparent in myelination indices (myelin water fraction or RI), but the indices did correlate with childhood IQ (eAppendix 8 in the Supplement). Taken at face value, the absence of myelination effects on PEs could mean that changes in DT-MRI metrics could reflect a pathologic process that precedes the loss of myelination,\textsuperscript{119,120} and that manifest only at more advanced disease states. Another explanation is that there may be different sensitivities of mmDESPOT to myelination compared with magnetization transfer ratio\textsuperscript{121} and DT imaging.\textsuperscript{122}

This study has several advantages over previous work. To our knowledge, it is the first to identify and localize (using statistical mapping) mediation effects in WM of specific risk factors for psychosis. This study goes beyond reporting associations between risk factors and changes in WM.\textsuperscript{76} In addition, we used a large, well-characterized homogeneous cohort, which afforded us considerable statistical power. The nature of the cohort may, however, be a limitation in terms of the generalizability of the findings. Attrition and missing data are also a problem in such cohorts, which can be only partially mitigated using multiple imputation.

Finally, as noted, although our analysis points strongly to the role of WM as a mediator between risk factors and PEs, the direction of causation cannot be conclusively determined from the available data.

Conclusions

We have shown that WM alterations, similar to those seen in schizophrenia, are present in a large epidemiologic cohort of young adults with PEs\textsuperscript{20} who were not identified from a selected help-seeking clinical population.

The regions implicated comprise pathways critical to higher order cognitive function. We propose that atypical developmental trajectories contribute to behavioral and cognitive abnormalities, such as those seen in psychosis, via abnormalities in this WM circuitry. We recommend that future studies focus on mediation to further unravel the associations between PEs, risk factors for psychosis, and brain structure.
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