

Resting-State Functional Connectivity and Psychotic-like Experiences in Childhood: Results From the Adolescent Brain Cognitive Development Study

Nicole R. Karcher, Kathleen J. O'Brien, Sridhar Kandala, and Deanna M. Barch

ABSTRACT

BACKGROUND: Psychotic-like experiences (PLEs) during childhood are associated with greater risk of developing a psychotic disorder (and other mental disorders), highlighting the importance of identifying neural correlates of childhood PLEs. Three major cortical networks—the cingulo-opercular network (CON), default mode network (DMN), and frontoparietal network—are consistently implicated in psychosis and PLEs in adults. However, it is unclear whether variation in functional connectivity is associated with PLEs in school-aged children.

METHODS: Using hierarchical linear models, we examined the relationships between childhood PLEs and resting-state functional connectivity of the CON, DMN, and frontoparietal network, as well as the other networks, using an a priori network parcellation, using data from 9- to 11-year-olds ($n = 3434$) in the ABCD (Adolescent Brain Cognitive Development) study. We examined within-network, between-network, and subcortical connectivity.

RESULTS: Decreased CON and DMN connectivity, as well as cinguloparietal (CPAR) network connectivity, were associated with greater PLEs, even after accounting for family history of psychotic disorders, internalizing symptoms, and cognitive performance. Decreased DMN connectivity was more strongly associated with increased delusional ideation, whereas decreased CON connectivity was more strongly associated with increased perceptual distortions. Increased CON-cerebellar and decreased CPAR-cerebellar connectivity were also associated with increased PLEs, and CPAR-cerebellar connectivity was more strongly associated with increased perceptual distortions.

CONCLUSIONS: Consistent with hypotheses about the dimensionality of psychosis, our results provide novel evidence that neural correlates of PLEs, such as reduced functional connectivity of higher-order cognitive networks, are present even in school-aged children. The results provide further validation for continuity of PLEs across the life span.

Keywords: Delusional ideation, Perceptual distortions, Psychotic-like experiences, Resting-state functional connectivity, Subcortical connectivity, Within-network connectivity

<https://doi.org/10.1016/j.biopsych.2019.01.013>

Psychotic symptoms are experienced by not only individuals with a psychotic disorder, but also a small subset of the general population. Subclinical psychotic symptoms, or psychotic-like experiences (PLEs) (1), are experienced by 13% to 15% of children and adolescents (2,3). Childhood PLEs are associated with greater risk of developing a psychotic disorder later in life (3,4), especially distressing (5) PLEs. PLEs also share multiple risk factors with clinical psychosis, such as increased internalizing symptoms (6,7), cognitive impairments (8–10), and family history of psychosis (11). These findings provide evidence for psychosis as a phenotypic continuum existing across a spectrum of symptom severity, ranging from healthy individuals to chronic psychosis patients (12). To validate this phenotypic continuum both across the life span and across the spectrum of severity, it is critical to determine whether PLEs in childhood are associated with similar neural correlates as found in adults with PLEs or with more severe

clinical manifestations of psychosis. The goal of the current study was to examine the relationships of childhood PLEs to variation in functional brain connectivity.

Resting-state functional magnetic resonance imaging (fMRI) has become an important tool in understanding the functional organization of brain networks as reflected in correlated activity among anatomically distinct brain regions (13,14). A number of studies have found abnormal functional connectivity (FC) present across the psychosis spectrum (15–19), potentially constituting an endophenotype of psychosis (20,21). Particularly, research has identified three major networks associated with higher-order cognition—the cingulo-opercular network (CON), default mode network (DMN), and frontoparietal network (FPN)—that show abnormal FC in both psychotic disorders (22–30) and psychosis risk populations (31–33). Regions of the CON show increased activation during information integration, including salience attribution (34), stable

task control (35,36), and performance monitoring (37). FPN regions show increased activation during attention-demanding tasks, particularly working memory and attention (38), and the FPN is thought to support adaptive task control and goal representation (35,36,39). In contrast, the DMN is a group of functionally correlated brain regions showing decreased activation during goal-oriented or attention-demanding tasks (40) and is involved in self-referential thinking and attention to internal states (41).

Dysfunction of these core networks has consistently been associated with psychotic symptoms in the general population (24). For example, Du *et al.* (16) found a significant stepwise worsening of abnormal connectivity in these networks from healthy control subjects to individuals with psychosis risk to early-onset schizophrenia patients, wherein regions of the CON showed decreasing connectivity and FPN regions showed increasing connectivity. However, the majority of studies find reduced connectivity with the CON and FPN in psychosis (42–45). Similarly, studies have found reduced connectivity in the CON and FPN in psychosis risk (46,47), although other research reports no FPN connectivity impairments (48). The pattern for DMN connectivity is mixed, with some studies finding decreased connectivity for both psychosis and psychosis risk (24,46,49–52) and other studies finding increased connectivity (18,53,54). Despite some variability in results, connectivity findings in psychosis-risk populations suggest that abnormal FC of key brain networks can develop in individuals experiencing subthreshold symptoms and may worsen along the psychosis continuum. Additionally, psychosis-risk individuals also exhibit reduced FC between cortical regions of these networks and subcortical structures, particularly the thalamus (46,55), cerebellum (56), and striatum (57,58). Identifying abnormal FC patterns may aid in detecting early phases of psychosis (59), potentially enhancing treatment outcomes.

This is the first study to examine the relationship between childhood PLEs and resting-state FC (RSFC) of the CON, DMN, and FPN, using data from 9- to 11-year-olds in the ABCD (Adolescent Brain Cognitive Development) study. We tested the *a priori* hypothesis that impaired RSFC within and between these networks, as well as between these cortical networks and subcortical structures, would be associated with increased PLEs in school-aged children. Although the ABCD offers an unprecedented sample size (current sample $n = 3434$), enabling a well-powered and robust examination of FC in PLEs, we examined this *a priori* subset of networks to reduce the statistical problems associated with an exploratory approach (e.g., false positives) and because of the computational challenges of whole-brain analyses in large datasets with dense sampling. However, to examine specificity, we also examined 10 other networks from an *a priori* brain parcellation (“Gordon”) (60–62). Follow-up analyses examined whether the type of PLE (e.g., delusional ideation or perceptual distortion) was differentially associated with altered FC. Importantly, when analyzing the relations between PLEs and FC, we examined multiple other factors that might be associated with FC [and previously shown to be associated with PLEs in the ABCD study sample (63)], such as family history of psychotic disorders, internalizing symptoms, and neuropsychological test performance (with the latter two perhaps arising from connectivity impairments), to better

characterize the nature of the association between childhood PLEs and FC.

METHODS AND MATERIALS

Participants

A sample of 4524 individuals was obtained from the ABCD study, a large-scale study tracking approximately 11,500 children ranging from 9 to 11 years of age recruited from 20 research sites across the United States (see Supplement for study-wide exclusionary criteria) (64). These data were accessed from the National Institute of Mental Health Data Archive (see Acknowledgments and Disclosures). Participants were removed from analyses in the current study either for not having at least one resting-state scan that passed quality-assurance criteria ($n = 332$) or because of missing data ($n = 758$; $n = 523$ missing at least one relevant imaging variable, and $n = 387$ missing income to needs [defined as the ratio of family income to the appropriate poverty threshold]) (see Supplemental Table S1). The final sample size was 3434 individuals (see Table 1).

Measures

Prodromal Questionnaire–Brief Child Version. Participants completed the Prodromal Questionnaire–Brief Child Version (PQ-BC), a 21-item self-report questionnaire (see Supplemental Table S2) (63). The PQ-BC demonstrates validity in the ABCD study sample (63). Children first answered each question either yes or no. For each “yes,” children were asked, “Did it bother you?” For each “yes,” children were subsequently asked, “Please choose the number below the appropriate picture that shows us how much that bothered you when it happened,” with the numbers corresponding to the pictures ranging from 1 to 5. Missing data were coded as “no” (see Supplement for details) (65).

Table 1. Demographic Characteristics ($n = 3434$)

Variable	Value
Income to Needs ^a	4.78 ± 2.89 (0.12–16.58)
Age, Years	10.04 ± 0.61 (9–11)
Average Motion, mm ^b	0.25 ± 0.23 (0.03–1.91)
Female	1646 (47.9)
Ethnicity	
Caucasian	2119 (61.7)
African American	295 (8.6)
Hispanic	626 (18.2)
Other	394 (11.5)
Scanner Manufacturer	
Siemens	2120 (61.7)
Philips Healthcare	462 (13.5)
GE Healthcare	852 (24.8)
PQ-BC Distress Scores	
Distress	5.96 ± 10.11 (0–96)
Log-transformed distress	0.52 ± 0.52 (0–1.97)

Values are mean ± SD (range) or n (%).

PQ-BC, Prodromal Questionnaire–Brief Child Version.

^aIncome to needs is defined as the ratio of family income to the appropriate poverty threshold.

^bAverage motion is defined as average framewise displacement.

Distress scores were calculated as the total number of endorsed questions weighted by level of distress (i.e., 0 = no, 1 = yes [but no distress], 2–6 = yes [1 + score on distress scale]), consistent with previous research (63,65,66). For follow-up analyses, PQ-BC distress scores were also divided into two separate scores, one for questions pertaining to delusional ideation and another for perceptual distortions (see Supplemental Table S2).

Internalizing Symptoms. The youth versions of the validated Kiddie Schedule for Affective Disorders and Schizophrenia for DSM-5 (67,68) were used in current analyses as measures of internalizing psychopathology (64). We examined an internalizing symptoms composite (i.e., summation of depression and generalized anxiety disorder symptoms), which has been previously used in the ABCD study sample (63).

Family History of Psychosis. The history of psychotic disorder in first-degree relatives was assessed using the parent-rated Family History Assessment Module screener (69), scored as either present or absent.

Neuropsychological Test Battery. Participants completed all tests within the National Institutes of Health Toolbox Cognitive Battery (NIHTB-CB) [see Supplement and Weintraub *et al.* (70) for descriptions of individual NIHTB-CB tests] (71). The current study utilized uncorrected NIHTB-CB scores, but all analyses include age and sex as covariates. Since we were interested in examining the association between “overall” cognitive functioning with PQ-BC scores and connectivity, scores from each of the NIHTB-CB tasks were included in a principal components analysis, and the first component was used as a measure of higher-order cognitive ability (38.41% of the total variance).

Imaging Procedure

ABCD imaging procedures have been detailed in the literature (72). All subjects were imaged using a 3T scanner—Prisma (Siemens, Munich, Germany), Discovery MR750 (GE Healthcare, Chicago, IL), or Achieva dStream or Ingenia CX (Philips Healthcare, Andover, MA)—with a 32-channel head coil and completed T1-weighted and T2-weighted structural scans (0.7-mm isotropic). Participants also completed four 5-minute resting-state blood oxygen level-dependent scans, with their eyes open and fixated on a crosshair. Resting-state images were acquired in the axial plane using an echo-planar imaging sequence. Other resting-state image parameters varied by 3T scanner and have been previously detailed (https://abcdstudy.org/images/Protocol_Imaging_Sequences.pdf) (72).

A data analysis pipeline, using the Multi-Model Pressing Stress software package, was created to analyze RSFC data [see Supplement and (73,74) for details]. Pairwise correlations were examined for regions of interest (ROIs) within functionally defined parcellations (i.e., Gordon networks) (60) and subcortical ROIs (i.e., cerebellum, thalamus, caudate, and putamen) (75). The Fisher Z transformation of the correlation values were examined within and between each network, and between networks and subcortical ROIs. Subcortical ROIs focused on the cerebellum, thalamus, caudate, and putamen, as there was

an a priori reason to believe that these subcortical ROIs would be associated with psychosis spectrum symptoms (45,55,57,76,77).

Statistical Analyses

Hierarchical linear models were conducted in R version 3.5.0 lme4 package (R Foundation for Statistical Computing, Vienna, Austria) (78), with family unit and the 20 research sites modeled as random intercepts [to account for nonindependence of observations (e.g., $n = 419$ siblings)], and age, sex, income to needs, average motion, scanner type, and ethnicity included as covariates. All analyses were false discovery rate (FDR) corrected for multiple comparisons. Hierarchical linear models analyzed the associations between PQ-BC scores and 1) within-network connectivity for each of the 13 Gordon networks (60) (auditory network, CON, cinguloparietal network [CPAR], DMN, dorsal attention network, FPN, none [also referred to as the unassigned network], retrosplenial-temporal network, salience network, sensorimotor-hand network, sensorimotor-mouth network, ventral attention network, visual network; 13 FDR-corrected comparisons; follow-up analyses also examined whether PQ-BC scores also predicted family history of psychosis, internalizing symptoms, and neuropsychological test performance; furthermore, subsequent analyses were conducted for any network with significant within-network connectivity associations with PQ-BC scores); 2) between-network connectivity, focusing on connectivity among the CON, DMN, and FPN with each of the other 12 Gordon networks (12 FDR-corrected comparisons per network); and 3) subcortical connectivity to the CON, DMN, and FPN, focusing on connectivity to the cerebellum, thalamus, caudate, and putamen (both bilaterally [8 FDR-corrected comparisons per network] and by using an average of the two hemispheres [4 FDR-corrected comparisons per network]). For all results passing FDR correction, follow-up analyses also examined whether the delusional ideation or perceptual distortion PQ-BC questions were associated with altered connectivity. Differences between significant correlations with all other network correlations were examined using Meng's Z-test procedures (79). Variables were examined for violations of normality assumptions and, based on previous recommendations (80), any variable with substantial (>1.96) positive skewness was logarithmically transformed [formula = $\text{LG10}(X + 1)$; PQ-BC distress score skewness = 3.01; DMN within-network connectivity skewness = 2.41]. Results are expressed as standardized estimates (β s) with 95% bootstrapped (5000 iterations) confidence intervals, and effect sizes are expressed as R^2 (both full model and partial model with just the variable of interest). For Figure 1, PQ-BC scores were binned using the R OneR package (81). Inclusion of total intracranial volume, number of usable scans, or exclusion of observations with residuals >2.5 SDs did not significantly alter any results.

RESULTS

Within-Network Connectivity

As predicted, reduced within-network connectivity in both the CON and DMN were correlated with increased PQ-BC scores ($\beta \geq -.05$, FDR-corrected p s $< .05$; full-model R^2 s = .03, partial

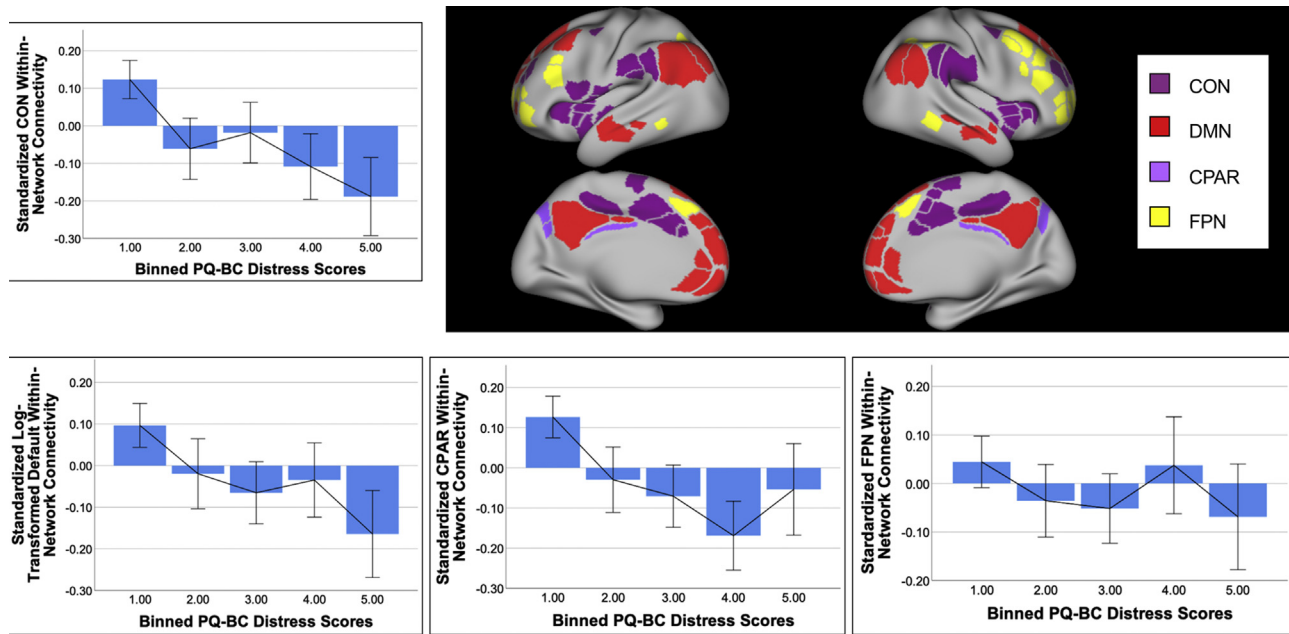


Figure 1. The relation between mean $\pm$ SE binned log-transformed Prodromal Questionnaire–Brief Child Version (PQ-BC) scores and standardized within-network connectivity for four Gordon networks: the cingulo-opercular network (CON), log-transformed default mode network (DMN), frontoparietal network (FPN), and cinguloparietal network (CPAR). The line on the graphs depicts spline interpolation.

R^2 s $\geq .004$) (see Table 1 for information about overall PQ-BC scores; Figure 1 and Table 2; Supplemental Figure S1 for scatterplots). Of the covariates, greater motion, less income to needs, being younger, and being African American were all associated with greater PQ-BC scores (Supplemental Table S3). However, we did not see the predicted relation with reduced FPN connectivity. Unexpectedly, reduced connectivity within the CPAR was also associated with increased PQ-BC scores ($\beta = -.07$, FDR-corrected $p < .001$; full-model $R^2 = .04$, partial $R^2 = .009$) (Figure 1 and Table 2). Associations between CON, DMN, and CPAR connectivity and PQ-BC scores were significantly stronger than the associations between PQ-BC scores and FPN,

unassigned network, sensorimotor-hand network, sensorimotor-mouth network, ventral attention network, and visual network connectivity (Z s > 1.91 , $ps < .05$). Additionally, the associations between both CON and CPAR connectivity and PQ-BC scores were also significantly stronger than the associations between auditory, dorsal attention, and salience connectivity and PQ-BC scores (Z s > 1.73 , $ps < .05$). Last, the association between CPAR connectivity and PQ-BC scores was significantly stronger than the association between retrosplenial-temporal connectivity and PQ-BC scores ($Z = 2.11$, $p = .02$).

When examining PLE symptom type, reduced CON within-network connectivity was significantly associated with both

Table 2. Model Estimates for Within Network Connectivity Relationships to Psychotic-like Symptoms

Network	β	95% CI	$t_{3,379}$	p	FDR-Corrected p
Auditory	-.02	-.05 to .01	-1.24	.22	.47
Cingulo-opercular	-.06 ^a	-.09 to -.02 ^a	-3.31 ^a	.001 ^a	.007 ^a
Cinguloparietal	-.07 ^a	-.11 to -.04 ^a	-4.34 ^a	<.001 ^a	<.001 ^a
Default Mode	-.05 ^a	-.08 to -.02 ^a	-2.84 ^a	.005 ^a	.022 ^a
Dorsal Attention	-.02	-.06 to .01	-1.38	.17	.44
Frontoparietal	-.01	-.05 to .02	-0.73	.47	.76
None	.00	-.04 to .03	-0.22	.82	.89
Retrosplenial-Temporal	-.03	-.06 to .01	-1.60	.11	.36
Sensorimotor-Hand	.00	-.03 to .03	0.14	.89	.89
Sensorimotor-Mouth	.00	-.04 to .03	-0.29	.78	.89
Salience	-.01	-.04 to .02	-0.78	.44	.76
Ventral Attention	.00	-.04 to .03	-0.17	.87	.89
Visual	-.01	-.04 to .03	-0.39	.70	.89

CI, confidence interval; FDR, false discovery rate.

^aSignificant model estimates.

increased delusional ideation ($\beta = -.04, p < .05$) and perceptual distortions ($\beta = -.07, p < .001$). However, in a model with both delusional ideation and perceptual distortions, perceptual distortions ($\beta = -.007, p < .001$), but not delusional ideation ($\beta = .001, p = .97$), significantly predicted reduced CON connectivity. Reduced DMN within-network connectivity was also significantly associated with both increased delusional ideation ($\beta = -.05, p < .01$) and perceptual distortions ($\beta = -.04, p < .05$), although in a model with both perceptual distortions and delusional ideation, delusional ideation ($\beta = -.04, p < .05$), but not perceptual distortions ($\beta = -.01, p = .65$), significantly predicted reduced DMN connectivity. Reduced CPAR within-network connectivity was also significantly associated with both increased delusional ideation ($\beta = -.06, p < .001$) and perceptual distortions ($\beta = -.06, p < .001$), though neither delusional ideation ($\beta = -.01, p = .10$) nor perceptual distortions ($\beta = -.01, p = .14$) significantly predicted reduced CPAR connectivity when both were in the model. Overall, there is evidence that perceptual distortions were significantly more associated with reduced CON within-network connectivity than was delusional ideation, while the opposite was found for DMN within-network connectivity.

In addition, reduced CON within-network connectivity ($\beta > -.05, p < .01$), DMN within-network connectivity ($\beta > -.05, p < .01$), and CPAR within-network connectivity ($\beta > -.05, p < .001$) continued to predict increased PQ-BC scores in models that included family history of psychotic disorder, internalizing symptoms, and neuropsychological test performance [note that family history of psychotic disorder ($\beta > .05, ps < .005$), internalizing symptoms ($\beta = .27, ps < .001$), and neuropsychological test performance deficits ($\beta > -.11, ps < .001$) all significantly predicted increased PQ-BC scores].

Between-Network Connectivity

Next, we examined whether PQ-BC scores were associated with alterations in between-network connectivity. Given our a priori hypotheses regarding networks of interest (i.e., CON, DMN, and FPN), coupled with exploratory within-network findings (i.e., significant CPAR within-network deficits), the subsequent analyses focused on the connectivity among these four and the other 12 Gordon networks. No hypothesized between-network associations with PQ-BC scores survived FDR-correction (Supplemental Tables S4–S7; see Supplemental Tables S8–S16 for results for other networks).

Subcortical Connectivity

We then examined whether connectivity between Gordon networks and subcortical regions were associated with PQ-BC scores, again focusing on the CON, DMN, FPN, and CPAR (see Supplemental Tables S17–S20). In terms of connectivity between the CON and subcortical region, increased CON to average cerebellum connectivity was associated with increased PQ-BC scores ($\beta = .04, p < .01$, FDR-corrected $p = .03$; full-model $R^2 = .03$, partial $R^2 = .003$). The relationship of CON-cerebellar connectivity with PQ-BC scores was significantly stronger than the relationships of PQ-BC scores and cerebellar connectivity to both the FPN and CPAR ($Zs > -2.17, ps < .05$; for DMN: $Z = -1.45, p = .07$), and stronger than the relationships between PQ-BC scores and

CON connectivity to the other subcortical structures (i.e., caudate, putamen, and thalamus; $Zs > -1.86, ps < .05$). Decreased CON to average cerebellum connectivity also predicted both increased delusional ideation ($\beta = .04, p < .01$) and increased perceptual distortions ($\beta = .05, p < .01$), though neither delusional ideation ($\beta = .02, p = .42$) nor perceptual distortions ($\beta = .03, p = .14$) significantly predicted increased connectivity when both were in the model.

Decreased CPAR to average cerebellum connectivity was significantly associated with increased PQ-BC scores ($\beta = -.07, p < .001$, FDR-corrected $p < .001$; full-model $R^2 = .04$, partial $R^2 = .007$). The relationship between PQ-BC scores and CPAR-cerebellar connectivity was significantly stronger than the relationships between PQ-BC scores and cerebellar connectivity in the other three networks (i.e., CON, DMN, and FPN; $Zs > 2.51, ps < .01$) and stronger than the relationships between PQ-BC scores and CPAR connectivity to the other subcortical structures ($Zs > 2.69, ps < .005$). Decreased CPAR to average cerebellum connectivity also predicted both increased delusional ideation ($\beta = -.05, p < .001$) and increased perceptual distortions ($\beta = -.07, p < .001$), although in a model with both, perceptual distortions ($\beta = -.06, p < .01$), but not delusional ideation ($\beta = -.01, p = .66$), significantly predicted increased connectivity. No connectivity to subcortical regions with either the DMN or FPN were significant ($ps \geq .08$).

DISCUSSION

The current study is the first to examine FC and PLEs in school-age children. The results indicate that early manifestations of nonclinical psychosis risk already show evidence of an association with alterations in FC that are analogous to those seen in individuals with psychotic disorders. The current study found novel evidence that reduced connectivity in the CON, DMN, and CPAR was associated with increased childhood PLEs. Importantly, the associations were not better accounted for by demographic factors, cognitive impairments, or general psychopathology. For subcortical connectivity, both increased CON-cerebellar and reduced CPAR-cerebellar connectivity were associated with increased PLEs. Finding associations between connectivity alterations and increased distressing PLEs provides further validation of the psychosis phenotypic continuum of FC impairments across the spectrum of psychosis.

The current study demonstrated that alterations in within-network connectivity in several networks associated with higher-order cognitive functioning are associated with increased distressing PLEs. These findings are largely consistent with work finding reduced connectivity for the CON and DMN associated with PLEs in adults (48), youths (47,52), and clinical high-risk groups (82,83). The CON has been linked to switching between large-scale brain networks (i.e., mediating between the DMN and FPN), stable task control (36), and conflict detection (37). Therefore, impaired connectivity may lead to disrupted integration of information (84). One speculative hypothesis is that early mild impairments of information integration and performance monitoring in childhood may cascade into further impairments in cognition and lead to exacerbation of PLEs in early adulthood.

The current study also found evidence that reduced connectivity within the DMN, a network associated with attention to internal states and self-referential thinking (41), was associated with increased PLEs. As previously noted, the evidence regarding the direction (i.e., increased or decreased) of impaired DMN connectivity in psychosis risk is inconsistent, with several studies finding hyperconnectivity (18,54,85) and others, similar to the current study, finding hypoconnectivity within the DMN associated with the endorsement of PLEs (48,86). It is unclear what drives the variability in the directionality of DMN connectivity impairments associated with psychosis. Key factors may include characteristics of the sample assessed (e.g., stage of illness, severity of symptoms) or the degree to which sufficient methods for motion control were implemented. As the DMN is thought to regulate attention to internal states, altered connectivity may result in impairments in self-referential thoughts and internally generated thinking, cognitive activities that may be important in the early development of PLEs.

Last, reduced connectivity in the CPAR was associated with increased PLEs. The CPAR consists of portions of the posterior cingulate cortex and the precuneus (60). Regions of the CPAR have also been found to be activated during cognitive tasks, including visuospatial information processing and mental imagery (87). Coupled with the CON findings, the association between increased PLEs and reduced CPAR connectivity might suggest a role for disruptions in higher-order cognition in the early development of PLEs. However, the FPN, consistently implicated in higher-order cognition, such as adaptive task control (35,36,39), was not significantly associated with PLEs, consistent with other research on PLEs in adults (48). Importantly, the fact that only a specific subset of networks showed relationships to PLEs, with these relationships being significantly stronger than the relationships with other networks, suggests a level of specificity in terms of functional brain networks associated with childhood PLEs. These results also raise the possibility that early deficits in networks such as the CON, DMN, and CPAR may be early harbingers of deficits in other networks that may emerge with either greater severity or duration of illness. Perhaps as connectivity impairments in these networks worsen, it gives rise to impairments in other networks, such as the FPN, which in turn leads to worsening of symptoms and cognitive functioning (88). Alternatively, FPN connectivity impairments may only emerge after prefrontal lobe maturation (e.g., in later adolescence and/or adulthood).

In addition to finding evidence for CON, DMN, and CPAR hypoconnectivity associated with increased PLEs, the current study also found evidence that altered connectivity within these networks was associated with specific types of PLEs (i.e., either perceptual distortions or delusional ideation). Hypoconnectivity of the CON was more strongly associated with perceptual distortions, consistent with evidence that the CON, and specifically the insula, is activated during hallucinations (89). The CON is critical for the attribution of salience to environmental stimuli (34,90), and therefore impaired connectivity may be associated with the misattribution of importance to stimuli, leading to the development and maintenance of perceptual distortions. Likewise, several previous studies have linked DMN dysfunction to positive symptoms (53,91),

including both delusions and hallucinations. We found evidence that the DMN was associated with both delusional ideation and perceptual distortions, although it was more strongly associated with delusional ideation. As previously mentioned, the DMN is involved in self-referential thinking, such as perspective taking (92). Early mild within-network DMN hypoconnectivity may contribute to disruptions in self-referential and internally generated cognitive impairments, which may be important in the generation of delusional ideation.

In terms of between-network connectivity, none of the hypothesized associations in the current study survived FDR correction. These findings are in contrast to several other studies of PLEs, which have found impaired connectivity among the CON, CPAR, and DMN with a number of other regions, including sensory regions and other higher-order cognitive networks (e.g., dorsal attention network, ventral attention network, FPN) (46,47,86). Again, one intriguing possibility is that there is a developmental cascade of disruptions in FC, with within-network disruptions appearing earlier than between-network disruptions. Longitudinal studies following children with early PLEs will be needed to test such a hypothesis.

For connectivity to subcortical regions, increased CON-cerebellar and decreased CPAR-cerebellar connectivity were associated with increased PLEs (and CPAR-cerebellar connectivity was more strongly associated with perceptual distortions than delusional ideation). These CON-cerebellar findings are consistent with first-episode psychosis research (93). In contrast to the findings of the current study, previous research has found increased connectivity between CPAR regions (e.g., posterior cingulate cortex and precuneus) and the cerebellum in both individuals with schizophrenia and their siblings (76) as well as individuals at high risk for psychosis (19). Again, the discrepancies with previous research in terms of direction of connectivity alterations may be due to several factors, including the stage of illness, or methodological concerns, including quality control methods and motion control. Importantly, we also did not see evidence for a relationship between PLEs and reduced connectivity between the FPN and subcortical regions, as has been seen in prior work (55,88,94).

Several limitations should be noted. The ABCD study data are cross-sectional. Without longitudinal data, the nature of associations between RSFC and PLEs cannot be fully understood, including whether RSFC variation predicts the course of PLEs. Further, as expected, PLEs in this sample of school-aged children are most frequently of mild severity (e.g., not diagnosable). It will be important for future research to confirm the associations between RSFC and PLEs using a greater range of severity of PLEs (i.e., from mild PLEs to full psychotic symptoms) to further characterize the phenotypic continuum of psychosis and its relationship to functional brain differences. Future research should also examine FC in sibling and/or twin pairs discordant for PLEs, to better understand heritability of the associations between connectivity impairments and PLEs. In addition, future research should examine subregions within subcortical structures [e.g., cerebellum (95), striatal regions (96), and thalamus (55)] to investigate specificity of associations with PLEs, and examine the results using another parcellation definition [e.g., Yeo atlas (26)] to examine the generalizability of results. Last,

ideally, all participants would have been run using identical scanning protocols (e.g., FIRMM software; <https://firrm.io>).

Conclusions

The results of the current study demonstrate that distressing PLEs in childhood are associated with altered connectivity in several networks previously implicated in the development of psychotic symptoms. The results indicate that associations between alterations in FC in higher-order cognitive networks and PLEs may be evident as early as 9 years of age, with within-network connectivity alterations potentially representing an endophenotype of psychotic disorders. While associations between within-network connectivity and PLEs were in the small range ($\beta_s \leq -.07$), this is expected for nonclinical symptoms assessed before the onset of significant functional impairment. The current study helps characterize the relations between connectivity alterations and PLEs in school-aged children, indicating that abnormal FC may be detectable in nonclinical PLEs. These results are consistent with a neurodevelopmental model in which connectivity deficits emerge and worsen over the course of development, perhaps owing in part to genetic factors that may influence neural factors (e.g., the gene C4 may contribute to synaptic alterations in adolescence) (97,98). Thus, the networks implicated in childhood PLEs (e.g., CON, CPAR, DMN, connectivity with the cerebellum) may be particularly vulnerable to synaptic alterations in adolescence.

ACKNOWLEDGMENTS AND DISCLOSURES

This work was supported by National Institute on Drug Abuse Grant No. U01DA041120 (to DMB) and National Institutes of Health Grant No. MH014677 (to NRR).

Data used in the preparation of this article were obtained from the ABCD study, held in the National Institute of Mental Health Data Archive. This is a multisite, longitudinal study designed to recruit more than 11,500 children 9 to 10 years of age and follow them over 10 years into early adulthood. The ABCD study is supported by National Institutes of Health (and additional federal partners) Grant Nos. U01DA041022, U01DA041025, U01DA041028, U01DA041048, U01DA041089, U01DA041093, U01DA041106, U01DA041117, U01DA041120 (to DMB), U01DA041134, U01DA041148, U01DA041156, U01DA041174, U24DA041123, and U24DA041147. A full list of supporters is available at <https://abcdstudy.org/nih-collaborators>. A listing of participating sites and a complete listing of the study investigators can be found at <https://abcdstudy.org/principal-investigators.html>. The ABCD Research Consortium investigators designed and implemented the study and/or provided data but did not necessarily participate in analysis or writing of this report. This manuscript reflects the views of the authors and may not reflect the opinions or views of the National Institutes of Health or ABCD Research Consortium investigators. The ABCD study data repository grows and changes over time. The ABCD study data used in this report came from <http://dx.doi.org/10.15154/1460410>.

The authors report no biomedical financial interests or potential conflicts of interest.

ARTICLE INFORMATION

From the Department of Psychiatry (NRR, KJO, SK, DMB) and Department of Radiology (DMB), Washington University School of Medicine in St. Louis, and Department of Psychology (DMB), Washington University in St. Louis, St. Louis, Missouri.

Address correspondence to Nicole R. Karcher, Ph.D., Washington University in St. Louis, 1 Brookings Drive, Campus Box 1125, St. Louis, MO 63130; E-mail: nkarcher@wustl.edu.

Received Oct 9, 2018; revised Dec 17, 2018; accepted Jan 14, 2019.

Supplementary material cited in this article is available online at <https://doi.org/10.1016/j.biopsych.2019.01.013>.

REFERENCES

- van Os J, Linscott RJ, Myin-Germeys I, Delespaul P, Krabbendam L (2009): A systematic review and meta-analysis of the psychosis continuum: Evidence for a psychosis proneness-persistence-impairment model of psychotic disorder. *Psychol Med* 39:179–195.
- Laurens KR, Hodgins S, Maughan B, Murray RM, Rutter ML, Taylor EA (2007): Community screening for psychotic-like experiences and other putative antecedents of schizophrenia in children aged 9–12 years. *Schizophr Res* 90:130–146.
- Poulton R, Caspi A, Moffitt TE, Cannon M, Murray R, Harrington H (2000): Children's self-reported psychotic symptoms and adult schizophreniform disorder: A 15-year longitudinal study. *Arch Gen Psychiatry* 57:1053–1058.
- Welham J, Scott J, Williams G, Najman J, Bor W, O'Callaghan M, et al. (2009): Emotional and behavioural antecedents of young adults who screen positive for non-affective psychosis: A 21-year birth cohort study. *Psychol Med* 39:625–634.
- Kline E, Thompson E, Bussell K, Pitts SC, Reeves G, Schiffman J (2014): Psychosis-like experiences and distress among adolescents using mental health services. *Schizophr Res* 152:498–502.
- Laurens KR, Hobbs MJ, Sunderland M, Green MJ, Mould GL (2012): Psychotic-like experiences in a community sample of 8000 children aged 9- to 11 years: An item response theory analysis. *Psychol Med* 42:1495–1506.
- Yamasaki S, Usami S, Sasaki R, Koike S, Ando S, Kitagawa Y, et al. (2017): The association between changes in depression/anxiety and trajectories of psychotic-like experiences over a year in adolescence. *Schizophr Res* 195:149–153.
- Blanchard MM, Jacobson S, Clarke MC, Connor D, Kelleher I, Garavan H, et al. (2010): Language, motor and speed of processing deficits in adolescents with subclinical psychotic symptoms. *Schizophr Res* 123:71–76.
- Kelleher I, Murtagh A, Clarke MC, Murphy J, Rawdon C, Cannon M (2013): Neurocognitive performance of a community-based sample of young people at putative ultra high risk for psychosis: Support for the processing speed hypothesis. *Cogn Neuropsychiatry* 18:9–25.
- Mollon J, Reichenberg A (2018): Cognitive development prior to onset of psychosis. *Psychol Med* 48:392–403.
- Hanssen M, Krabbendam L, Vollema M, Delespaul P, Van Os J (2006): Evidence for instrument and family-specific variation of subclinical psychosis dimensions in the general population. *J Abnorm Psychol* 115:5–14.
- van Os J, Linscott RJ (2012): Introduction: The extended psychosis phenotype-relationship with schizophrenia and with ultrahigh risk status for psychosis. *Schizophr Bull* 38:227–230.
- Rosazza C, Minati L (2011): Resting-state brain networks: Literature review and clinical applications. *Neurol Sci* 32:773–785.
- van den Heuvel MP, Hulshoff Pol HE (2010): Exploring the brain network: A review on resting-state fMRI functional connectivity. *Eur Neuropsychopharmacol* 20:519–534.
- Dong D, Wang Y, Chang X, Luo C, Yao D (2018): Dysfunction of large-scale brain networks in schizophrenia: A meta-analysis of resting-state functional connectivity. *Schizophr Bull* 44:168–181.
- Du Y, Fryer SL, Fu Z, Lin D, Sui J, Chen J, et al. (2018): Dynamic functional connectivity impairments in early schizophrenia and clinical high-risk for psychosis. *Neuroimage* 180:632–645.
- Schmidt A, Diwadkar VA, Smieskova R, Harrisberger F, Lang UE, McGuire P, et al. (2014): Approaching a network connectivity-driven classification of the psychosis continuum: A selective review and suggestions for future research. *Front Hum Neurosci* 8:1047.
- Shim G, Oh JS, Jung WH, Jang JH, Choi CH, Kim E, et al. (2010): Altered resting-state connectivity in subjects at ultra-high risk for psychosis: An fMRI study. *Behav Brain Funct* 6:58.
- Wang H, Guo W, Liu F, Wang G, Lyu H, Wu R, et al. (2016): Patients with first-episode, drug-naïve schizophrenia and subjects at ultra-high

- risk of psychosis shared increased cerebellar-default mode network connectivity at rest. *Sci Rep* 6:26124.
20. Khadka S, Meda SA, Stevens MC, Glahn DC, Calhoun VD, Sweeney JA, *et al.* (2013): Is aberrant functional connectivity a psychosis endophenotype? A resting state functional magnetic resonance imaging study. *Biol Psychiatry* 74:458–466.
21. Li T, Wang Q, Zhang J, Rolls ET, Yang W, Palaniyappan L, *et al.* (2017): Brain-wide analysis of functional connectivity in first-episode and chronic stages of schizophrenia. *Schizophr Bull* 43:436–448.
22. Baker JT, Holmes AJ, Masters GA, Yeo BT, Krienen F, Buckner RL, *et al.* (2014): Disruption of cortical association networks in schizophrenia and psychotic bipolar disorder. *JAMA Psychiatry* 71:109–118.
23. Palaniyappan L, Deshpande G, Lanka P, Rangaprakash D, Iwabuchi S, Francis S, Liddle PF (2018): Effective connectivity within a triple network brain system discriminates schizophrenia spectrum disorders from psychotic bipolar disorder at the single-subject level [published online ahead of print Feb 2]. *Schizophr Res*.
24. Rotarska-Jagiela A, van de Ven V, Oertel-Knochel V, Uhlhaas PJ, Vogeley K, Linden DE (2010): Resting-state functional network correlates of psychotic symptoms in schizophrenia. *Schizophr Res* 117:21–30.
25. Sheffield JM, Kandala S, Tamminga CA, Pearson GD, Keshavan MS, Sweeney JA, *et al.* (2017): Transdiagnostic associations between functional brain network integrity and cognition. *JAMA Psychiatry* 74:605–613.
26. Tu PC, Hsieh JC, Li CT, Bai YM, Su TP (2012): Cortico-striatal disconnection within the cingulo-opercular network in schizophrenia revealed by intrinsic functional connectivity analysis: A resting fMRI study. *Neuroimage* 59:238–247.
27. Wang YM, Zou LQ, Xie WL, Yang ZY, Zhu XZ, Cheung EFC, *et al.* (2019): Altered functional connectivity of the default mode network in patients with schizo-obsessive comorbidity: A comparison between schizophrenia and obsessive-compulsive disorder. *Schizophr Bull* 45:199–210.
28. Watsky RE, Gotts SJ, Berman RA, McAdams HM, Zhou X, Greenstein D, *et al.* (2018): Attenuated resting-state functional connectivity in patients with childhood- and adult-onset schizophrenia [published online ahead of print Jan 6]. *Schizophr Res*.
29. Yang GJ, Murray JD, Wang XJ, Glahn DC, Pearson GD, Repovs G, *et al.* (2016): Functional hierarchy underlies preferential connectivity disturbances in schizophrenia. *Proc Natl Acad Sci U S A* 113:E219–E228.
30. Yu Y, Shen H, Zhang H, Zeng LL, Xue Z, Hu D (2013): Functional connectivity-based signatures of schizophrenia revealed by multiclass pattern analysis of resting-state fMRI from schizophrenic patients and their healthy siblings. *Biomed Eng Online* 12:10.
31. Amico F, O'Hanlon E, Kraft D, Oertel-Knochel V, Clarke M, Kelleher I, *et al.* (2017): Functional connectivity anomalies in adolescents with psychotic symptoms. *PLoS One* 12:e0169364.
32. Su J, Shen H, Zeng LL, Qin J, Liu Z, Hu D (2016): Heredity characteristics of schizophrenia shown by dynamic functional connectivity analysis of resting-state functional MRI scans of unaffected siblings. *Neuroreport* 27:843–848.
33. Wotruba D, Michels L, Buechler R, Metzler S, Theodoridou A, Gerstenberg M, *et al.* (2014): Aberrant coupling within and across the default mode, task-positive, and salience network in subjects at risk for psychosis. *Schizophr Bull* 40:1095–1104.
34. Palaniyappan L, Liddle PF (2012): Does the salience network play a cardinal role in psychosis? An emerging hypothesis of insular dysfunction. *J Psychiatry Neurosci* 37:17–27.
35. Dosenbach NU, Fair DA, Cohen AL, Schlaggar BL, Petersen SE (2008): A dual-networks architecture of top-down control. *Trends Cogn Sci* 12:99–105.
36. Dosenbach NU, Fair DA, Miezin FM, Cohen AL, Wenger KK, Dosenbach RA, *et al.* (2007): Distinct brain networks for adaptive and stable task control in humans. *Proc Natl Acad Sci U S A* 104:11073–11078.
37. Becerra KE, Barch DM (2013): Conflict and error processing in an extended cingulo-opercular and cerebellar network in schizophrenia. *Neuroimage Clin* 3:470–480.
38. Cabeza R, Nyberg L (2000): Neural bases of learning and memory: Functional neuroimaging evidence. *Curr Opin Neurol* 13:415–421.
39. Braver TS (2012): The variable nature of cognitive control: A dual mechanisms framework. *Trends Cogn Sci* 16:106–113.
40. Whitfield-Gabrieli S, Ford JM (2012): Default mode network activity and connectivity in psychopathology. *Annu Rev Clin Psychol* 8:49–76.
41. Raichle ME (2015): The brain's default mode network. *Annu Rev Neurosci* 38:433–447.
42. Pettersson-Yeo W, Allen P, Benetti S, McGuire P, Mechelli A (2011): Dysconnectivity in schizophrenia: Where are we now? *Neurosci Biobehav Rev* 35:1110–1124.
43. Zhou Y, Ma X, Wang D, Qin W, Zhu J, Zhuo C, *et al.* (2015): The selective impairment of resting-state functional connectivity of the lateral subregion of the frontal pole in schizophrenia. *PLoS One* 10:e0119176.
44. Repovs G, Csernansky JG, Barch DM (2011): Brain network connectivity in individuals with schizophrenia and their siblings. *Biol Psychiatry* 69:967–973.
45. Giraldo-Chica M, Rogers BP, Damon SM, Landman BA, Woodward ND (2018): Prefrontal-thalamic anatomical connectivity and executive cognitive function in schizophrenia. *Biol Psychiatry* 83:509–517.
46. Orr JM, Turner JA, Mittal VA (2014): Widespread brain dysconnectivity associated with psychotic-like experiences in the general population. *Neuroimage Clin* 4:343–351.
47. Satterthwaite TD, Vandekar SN, Wolf DH, Bassett DS, Ruparel K, Shehzad Z, *et al.* (2015): Connectome-wide network analysis of youth with psychosis-spectrum symptoms. *Mol Psychiatry* 20:1508–1515.
48. Sheffield JM, Kandala S, Burgess GC, Harms MP, Barch DM (2016): Cingulo-opercular network efficiency mediates the association between psychotic-like experiences and cognitive ability in the general population. *Biol Psychiatry Cogn Neurosci Neuroimaging* 1:498–506.
49. Jang JH, Jung WH, Choi JS, Choi CH, Kang DH, Shin NY, *et al.* (2011): Reduced prefrontal functional connectivity in the default mode network is related to greater psychopathology in subjects with high genetic loading for schizophrenia. *Schizophr Res* 127:58–65.
50. Jukuri T, Kiviniemi V, Nikkinen J, Miettinen J, Maki P, Jaaskelainen E, *et al.* (2013): Default mode network in young people with familial risk for psychosis—the Oulu Brain and Mind study. *Schizophr Res* 143:239–245.
51. Orlicac F, Naveau M, Joliot M, Delcroix N, Razafimandimby A, Brazo P, *et al.* (2013): Links among resting-state default-mode network, salience network, and symptomatology in schizophrenia. *Schizophr Res* 148:74–80.
52. Schreiner M, Forsyth JK, Karlsgodt KH, Anderson AE, Hirsh N, Kushan L, *et al.* (2017): Intrinsic connectivity network-based classification and detection of psychotic symptoms in youth with 22q11.2 deletions. *Cereb Cortex* 27:3294–3306.
53. Whitfield-Gabrieli S, Thermenos HW, Milanovic S, Tsuang MT, Faraone SV, McCarley RW, *et al.* (2009): Hyperactivity and hyperconnectivity of the default network in schizophrenia and in first-degree relatives of persons with schizophrenia. *Proc Natl Acad Sci U S A* 106:1279–1284.
54. Peeters SC, Gronenschild EH, van Amelsvoort T, van Os J, Marcelis M, Kahn R, *et al.* (2016): Reduced specialized processing in psychotic disorder: A graph theoretical analysis of cerebral functional connectivity. *Brain Behav* 6:e00508.
55. Woodward ND, Heckers S (2016): Mapping thalamocortical functional connectivity in chronic and early stages of psychotic disorders. *Biol Psychiatry* 79:1016–1025.
56. Anticevic A, Haut K, Murray JD, Repovs G, Yang GJ, Diehl C, *et al.* (2015): Association of thalamic dysconnectivity and conversion to psychosis in youth and young adults at elevated clinical risk. *JAMA Psychiatry* 72:882–891.
57. Dandash O, Fornito A, Lee J, Keefe RS, Chee MW, Adcock RA, *et al.* (2014): Altered striatal functional connectivity in subjects with an at-risk mental state for psychosis. *Schizophr Bull* 40:904–913.
58. Fornito A, Harrison BJ, Goodby E, Dean A, Ooi C, Nathan PJ, *et al.* (2013): Functional dysconnectivity of corticostriatal circuitry as a risk phenotype for psychosis. *JAMA Psychiatry* 70:1143–1151.
59. Schmidt A, Borgwardt S (2013): Abnormal effective connectivity in the psychosis high-risk state. *Neuroimage* 81:119–120.
60. Gordon EM, Laumann TO, Adeyemo B, Huckins JF, Kelley WM, Petersen SE (2016): Generation and evaluation of a cortical area parcellation from resting-state correlations. *Cereb Cortex* 26:288–303.

Functional Connectivity and Psychotic-like Experiences in Childhood

61. Power JD, Cohen AL, Nelson SM, Wig GS, Barnes KA, Church JA, *et al.* (2011): Functional network organization of the human brain. *Neuron* 72:665–678.
62. Yeo BT, Krienen FM, Sepulcre J, Sabuncu MR, Lashkari D, Hollinshead M, *et al.* (2011): The organization of the human cerebral cortex estimated by intrinsic functional connectivity. *J Neurophysiol* 106:1125–1165.
63. Karcher NR, Barch DM, Avenevoli S, Savill M, Huber RS, Simon TJ, *et al.* (2018): Assessment of the Prodromal Questionnaire-Brief Child Version for measurement of self-reported psychoticlike experiences in childhood. *JAMA Psychiatry* 75:853–861.
64. Barch DM, Albaugh MD, Avenevoli S, Chang L, Clark DB, Glantz MD, *et al.* (2018): Demographic, physical and mental health assessments in the Adolescent Brain and Cognitive Development Study: Rationale and description. *Dev Cogn Neurosci* 32:55–56.
65. Loewy RL, Pearson R, Vinogradov S, Bearden CE, Cannon TD (2011): Psychosis risk screening with the Prodromal Questionnaire-brief version (PQ-B). *Schizophr Res* 129:42–46.
66. Cicero DC, Krieg A, Martin EA (2019): Measurement invariance of the Prodromal Questionnaire-Brief among White, Asian, Hispanic, and multiracial populations. *Assessment* 26:294–304.
67. Kaufman J, Birmaher B, Brent D, Rao U, Flynn C, Moreci P, *et al.* (1997): Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. *J Am Acad Child Adolesc Psychiatry* 36:980–988.
68. Kobak KA, Kratochvil CJ, Stanger C, Kaufman J (2013): Computerized screening of comorbidity in adolescents with substance or psychiatric disorders. Presented at the 33rd Anxiety Disorders and Depression Conference, April 6, La Jolla, California.
69. Rice JP, Reich T, Bucholz KK, Neuman RJ, Fishman R, Rochberg N, *et al.* (1995): Comparison of direct interview and family history diagnoses of alcohol dependence. *Alcohol Clin Exp Res* 19:1018–1023.
70. Weintraub S, Dikmen SS, Heaton RK, Tulsky DS, Zelazo PD, Bauer PJ, *et al.* (2013): Cognition assessment using the NIH Toolbox. *Neurology* 80:S54–S64.
71. Weintraub S, Dikmen SS, Heaton RK, Tulsky DS, Zelazo PD, Slotkin J, *et al.* (2014): The cognition battery of the NIH toolbox for assessment of neurological and behavioral function: Validation in an adult sample. *J Int Neuropsychol Soc* 20:567–578.
72. Casey BJ, Cannonier T, Conley MI, Cohen AO, Barch DM, Hertzog MM, *et al.* (2018): The Adolescent Brain Cognitive Development (ABCD) study: Imaging acquisition across 21 sites. *Dev Cogn Neurosci* 32:43–54.
73. Fair DA, Miranda-Dominguez O, Snyder AZ, Perrone AA, Earl EA, Van AN, *et al.* (2018): Correction of respiratory artifacts in MRI head motion estimates [published online ahead of print June 7]. *bioRxiv*.
74. Hagler DJ, Hattori SN, Makowski C, Cornejo MD, Fair DA, Dick AS, *et al.* (2018): Image processing and analysis methods for the Adolescent Brain Cognitive Development Study [published online ahead of print Nov 4]. *bioRxiv*.
75. Fischl B, Salat DH, Busa E, Albert M, Dieterich M, Haselgrove C, *et al.* (2002): Whole brain segmentation: Automated labeling of neuroanatomical structures in the human brain. *Neuron* 33:341–355.
76. Guo W, Zhang F, Liu F, Chen J, Wu R, Chen DQ, *et al.* (2018): Cerebellar abnormalities in first-episode, drug-naïve schizophrenia at rest. *Psychiatry Res Neuroimaging* 276:73–79.
77. Jaspers E, Balsters JH, Kassraian Fard P, Mantini D, Wenderoth N (2017): Corticostriatal connectivity fingerprints: Probability maps based on resting-state functional connectivity. *Hum Brain Mapp* 38:1478–1491.
78. Bates D, Mächler M, Bolker B, Walker S (2015): Fitting linear mixed-effects models using lme4. *J Stat Softw* 67. Available at: <https://www.jstatsoft.org/index.php/jss/article/view/v067i01/v67i01.pdf>. Accessed March 6, 2018.
79. Meng X-L, Rosenthal R, Rubin DB (1992): Comparing correlated correlation coefficients. *Psychol Bull* 111:172–175.
80. Howell D (2007): *Statistical Methods for Psychology*. Belmont, CA: Thomson Wadsworth.
81. von Jouanne-Diedrich H (2017): OneR: One rule machine learning classification algorithm with enhancements. R package version 22. Available at: <https://rdrr.io/github/vonjd/OneR/>. Accessed September 2, 2018.
82. Du Y, Fryer SL, Lin D, Sui J, Yu Q, Chen J, *et al.* (2018): Identifying functional network changing patterns in individuals at clinical high-risk for psychosis and patients with early illness schizophrenia: A group ICA study. *Neuroimage Clin* 17:335–346.
83. Pelletier-Baldelli A, Andrews-Hanna JR, Mittal VA (2018): Resting state connectivity dynamics in individuals at risk for psychosis. *J Abnorm Psychol* 127:314–325.
84. Uddin LQ (2015): Salience processing and insular cortical function and dysfunction. *Nat Rev Neurosci* 16:55–61.
85. Fryer SL, Woods SW, Kiehl KA, Calhoun VD, Pearlson GD, Roach BJ, *et al.* (2013): Deficient suppression of default mode regions during working memory in individuals with early psychosis and at clinical high-risk for psychosis. *Front Psychiatry* 4:92.
86. Barber AD, Lindquist MA, DeRosier P, Karlsgodt KH (2018): Dynamic functional connectivity states reflecting psychotic-like experiences. *Biol Psychiatry Cogn Neurosci Neuroimaging* 3:443–453.
87. Zhang S, Li CS (2012): Functional connectivity mapping of the human precuneus by resting state fMRI. *Neuroimage* 59:3548–3562.
88. Tu PC, Lee YC, Chen YS, Li CT, Su TP (2013): Schizophrenia and the brain's control network: Aberrant within- and between-network connectivity of the frontoparietal network in schizophrenia. *Schizophr Res* 147:339–347.
89. Jardri R, Pouchet A, Pins D, Thomas P (2011): Cortical activations during auditory verbal hallucinations in schizophrenia: A coordinate-based meta-analysis. *Am J Psychiatry* 168:73–81.
90. Kapur S, Mizrahi R, Li M (2005): From dopamine to salience to psychosis-linking biology, pharmacology and phenomenology of psychosis. *Schizophr Res* 79:59–68.
91. Camchong J, MacDonald AW 3rd, Bell C, Mueller BA, Lim KO (2011): Altered functional and anatomical connectivity in schizophrenia. *Schizophr Bull* 37:640–650.
92. Buckner RL, Carroll DC (2007): Self-projection and the brain. *Trends Cogn Sci* 11:49–57.
93. Mallikarjun PK, Lalouis PA, Dunne TF, Heinze K, Reniers RL, Broome MR, *et al.* (2018): Aberrant salience network functional connectivity in auditory verbal hallucinations: A first episode psychosis sample. *Transl Psychiatry* 8:69.
94. Zhou Y, Liang M, Jiang T, Tian L, Liu Y, Liu Z, *et al.* (2007): Functional dysconnectivity of the dorsolateral prefrontal cortex in first-episode schizophrenia using resting-state fMRI. *Neurosci Lett* 417:297–302.
95. Bernard JA, Orr JM, Mittal VA (2017): Cerebello-thalamo-cortical networks predict positive symptom progression in individuals at ultra-high risk for psychosis. *Neuroimage Clinical* 14:622–628.
96. Choi EY, Yeo BT, Buckner RL (2012): The organization of the human striatum estimated by intrinsic functional connectivity. *J Neurophysiol* 108:2242–2263.
97. Kopczynska M, Zelek W, Touchard S, Gaughran F, Di Forti M, Mondelli V, *et al.* (2019): Complement system biomarkers in first episode psychosis. *Schizophr Res* 204:16–22.
98. Sekar A, Bialas AR, de Rivera H, Davis A, Hammond TR, Kamitaki N, *et al.* (2016): Schizophrenia risk from complex variation of complement component 4. *Nature* 530:177–183.