Title

100. Converging Evidence for Social Functioning Deficits as a Neurodevelopmental Risk Factor in High-Risk Youth

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increase at the 12-week follow-up in total hours worked in competitive jobs, $t(25)= -2.40$, $P = .02$; and total wages earned, $t(24) = -2.36$, $P = .02$.
Conclusion: Preliminary findings suggest that the CBTw program may be an effective augmentation to existing VA vocational services, assisting veterans to reach their community employment goals.

99. AN INTEGRATIVE APPROACH TO TEST THE RELATIONSHIP BETWEEN SOCIAL IMPAIRMENT AND THE DEVELOPMENT OF PSYCHOSIS

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Background: Despite the known importance of impaired social functioning in the pathway to psychosis, there is no clear understanding about the etiological underpinnings of this relationship. A number of hypothesis have been proposed, including the idea that (1) social impairment is an independent contributor to psychosis risk, (2) social impairment and psychosis are two independent outings of the same genetic vulnerability, and that (3) social impairment may be the confounding results from brain abnormalities that are directly associated with psychosis risk. Our objective was to combine imaging, clinical and genome-wide association data to dissect how early disruptions in social functioning are related to psychotic experiences.
Methods: We combined data on social functioning, the social brain (fMRI faces task), SCZ and ASD polygenic risk scores (PRS) and psychotic experiences (CAPE scores) from 2,257 participants (mean age 14.4 (SD = .41)) of the multi-centered IMAGEN study (Schumann et al., 2010) that were followed-up between from age 14 to 18. By means of univariate analyses of covariance and regression analyses, we mapped the severity and developmental trajectories of social functioning (assessed at age 14, 16, and 18) and examined the interrelationship between genetic vulnerability, deviations in the social brain areas and psychotic experiences at age 18.
Results: We found compelling evidence for the first hypothesis, indicating independent associations between social functioning problems ($t = -10.69$, $P < .001$), and between PRS for psychosis ($P = .001$) and the development of psychotic experiences at age 18. There was no significant interaction between PRS * social functioning, which may indicate that peer problems and high polygenic risk are 2 independent pathways to psychotic experiences. Our data are currently being linked to data on deviations in the social brain, which will be presented at ICOSR as well.
Conclusion: Our results underscore both the significance and complexity of premorbid social functioning in the pathway to psychosis and may indicate that early social impairment and high polygenic risk are two independent pathways to psychotic experiences. There is a paucity of knowledge about the genetic contribution to the development of social impairment in psychosis and our findings may provide important new directions to this field.

100. CONVERGING EVIDENCE FOR SOCIAL FUNCTIONING DEFICITS AS A NEURODEVELOPMENTAL RISK FACTOR IN HIGH-RISK YOUTH

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Background: Social functioning deficits are present prior to the onset of psychosis and predict psychosis conversion in high-risk youth (Cornblatt et al, 2015; Cannon et al, 2008). In addition, past research from the Recognition and Prevention (RAP) Program found that social skill deficits are lifelong traits related to poor functional outcome in general (Cornblatt et al, 2015; Carrion et al, 2013). This poster reassesses the implications of social skill deficits as a developmental trait by examining change in social functioning.
Methods: Subjects include 88 clinical high risk (CHR) participants enrolled in Phase 1 of the RAP Program and 347 CHR participants enrolled in the North American Prodrome Longitudinal Study 2 (NAPLS2). Social functioning deficits were assessed with the Global Functioning: Social (GF:S) scale, an interview measure of social interactions rated from 1–10 with higher scores indicating better functioning (Cornblatt et al, 2007). Associations between GF:S scores and baseline demographics, SIPS attenuated positive and negative symptoms, and Axis I diagnoses were examined. Conversion to psychosis and functional outcome were assessed at follow up (RAP = 3 years, NAPLS2 = 2 years). CHR participants were divided according to whether their GF:S score improved, did not change, or declined over follow up. GF:S scores were also dichotomized into Good (GF:S ≥ 7) vs Poor (GF:S ≤ 6) functioning at baseline and follow up.
Results: For the RAP sample, there were no significant differences between groups on demographic variables or SIPS symptoms. The Improver and No Change groups were significantly more likely to be diagnosed with Social Phobia compared to Decliners (Ps < .01). Similar results were found in the larger NAPLS2 sample for demographic variables, SIPS symptoms, and Axis I diagnoses (all ns). Significantly more Decliners in both samples converted to psychosis (RAP 32%, NAPLS2 36%) compared to the Improvers (RAP 10.5%, NAPLS2 10%; Ps ≤ .03). Decliners were also more likely to convert than the No Change (8%) group (RAP, $P = .03$; NAPLS, trend). In addition, No Change subjects were more likely to have poor functioning at baseline and outcome (RAP 72%, NAPLS2 51%).
Conclusion: As expected, CHRs with decline in social functioning are at greatest risk for psychosis. In contrast, CHRs who improve over time are likely not at risk for either psychosis or functional disability. The remaining subjects display stable poor functioning, but are less likely to develop psychosis, suggesting their risk is for long term functional disability. Only one clinical variable, Social Phobia, differentiated groups, indicating that social anxiety is more likely found in false positives. These findings have two major implications: (1) stable social skill deficits appear to relate to long-term disability and (2) change in adolescence is predictive of psychosis.

101. DOES COGNITIVE REMEDIATION THERAPY PREVENT RELAPSES IN STABILIZED SCHIZOPHRENIA OUTPATIENTS? A 1-YEAR RCT FOLLOW-UP STUDY

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Background: Relapses do not only add psychological burden to the individuals, their friends and families, but also are costly to the government and the health-care system. Thus, relapse prevention is a major concern and goes along with the primary goal of any treatment: remission of positive and also negative symptoms within functional recovery. The Remission in Schizophrenia Working Group (RSWG) defines remission as mild or less severe symptoms for a period of at least 6 months. Besides medication,