

Online Research @ Cardiff

This is an Open Access document downloaded from ORCA, Cardiff University's institutional repository: <https://orca.cardiff.ac.uk/id/eprint/101896/>

This is the author's version of a work that was submitted to / accepted for publication.

Citation for final published version:

Gur, RE, Bassett, AS, McDonald-McGinn, DM, Bearden, CE, Chow, E, Emanuel, BS, Owen, M, Swillen, A, Van Den Bree, Marianne Bernadette ORCID: <https://orcid.org/0000-0002-4426-3254>, Vermeesch, J, Vorstman, JAS, Warren, S, Lehner, T, Morrow, B and Niarchou, Maria ORCID: <https://orcid.org/0000-0002-8855-7393> 2017. A neurogenetic model for the study of schizophrenia spectrum disorders: The International 22q11.2 Deletion Syndrome Brain Behavior Consortium. *Molecular Psychiatry* 22 , pp. 1664-1672. file

Publishers page: <http://dx.doi.org//10.1038/mp.2017.161>
<<http://dx.doi.org//10.1038/mp.2017.161>>

Please note:

Changes made as a result of publishing processes such as copy-editing, formatting and page numbers may not be reflected in this version. For the definitive version of this publication, please refer to the published source. You are advised to consult the publisher's version if you wish to cite this paper.

This version is being made available in accordance with publisher policies.

See

<http://orca.cf.ac.uk/policies.html> for usage policies. Copyright and moral rights for publications made available in ORCA are retained by the copyright holders.



Abstract: 158

Article: 4,326

Tables/Fig: 4

References: 101

A neurogenetic model for the study of schizophrenia spectrum disorders:

The International 22q11.2 Deletion Syndrome Brain Behavior Consortium

RE Gur^{1*}, Bassett AS^{2*}, DM McDonald-McGinn³, CE Bearden⁴, E Chow², BS Emanuel³, M Owen⁵, A Swillen⁶, M Van den Bree⁵, J Vermeesch⁶, JAS Vorstman⁷, S Warren⁸, T Lehner⁹, B Morrow¹⁰ and The International 22q11.2 Deletion Syndrome Brain Behavior Consortium**

¹ Perelman School of Medicine and Children' Hospital of Philadelphia, University of Pennsylvania, Philadelphia USA

² Center for Addiction and Mental Health, Toronto General Hospital and the University of Toronto, Canada

³ The Children's Hospital of Philadelphia and the Perelman School of Medicine, University of Pennsylvania, Philadelphia USA

⁴ University of California Los Angeles, USA

⁵ Cardiff University, Wales

⁶ Katholieke University, Leuven, Belgium

⁷ Brain Center Rudolf Magnus, University Medical Center Utrecht, the Netherlands

⁸ Emory University, Atlanta, USA

⁹ National Institute of Mental Health, Bethesda, USA

¹⁰ Albert Einstein College of Medicine, New York, USA

*Contributed equally to the manuscript.

** List of members of The International 22q11.2 Deletion Syndrome Brain Behavior Consortium is provided in the supplement.

Corresponding author: Raquel E. Gur, MD PhD
Department of Psychiatry
3400 Spruce
University of Pennsylvania
Philadelphia PA 19104
Phone: 215.662.2915
Fax: 215.662.7903
Email: Raquel@upenn.edu

Abstract

Rare copy number variants contribute significantly to the risk for schizophrenia, with the 22q11.2 locus consistently implicated. Individuals with the 22q11.2 deletion syndrome (22q11DS) have an estimated 25-fold increased risk for schizophrenia spectrum disorders, compared to individuals in the general population. The International 22q11DS Brain Behavior Consortium is examining this highly informative neurogenetic syndrome phenotypically and genomically. Here we detail the procedures of the effort to characterize the neuropsychiatric and neurobehavioral phenotypes associated with 22q11DS, focusing on schizophrenia and subthreshold expression of psychosis. The genomic approach includes a combination of whole genome sequencing and genome-wide microarray technologies, allowing the investigation of all possible DNA variation and gene pathways influencing the schizophrenia-relevant phenotypic expression. A phenotypically rich data set provides a psychiatrically well-characterized sample of unprecedented size (n=1,616) that informs the neurobehavioral developmental course of 22q11DS. This combined set of phenotypic and genomic data will enable hypothesis testing to elucidate the mechanisms underlying the pathogenesis of schizophrenia spectrum disorders.

INTRODUCTION

Advances in technology for the characterization of entire genomes, e.g. next generation whole genome sequencing (WGS), and the availability of large samples with DNA, promise to propel our mechanistic understanding of neuropsychiatric disorders. Rare structural and other variants, including copy number variants (CNVs), have contributed to recent advances. Large rare CNVs throughout the genome have been identified as contributors to the etiology of schizophrenia, conferring significant risk with large effect sizes.¹⁻⁴ Arguably, none is more clinically relevant or feasible as a model for focused investigation than the recurrent 22q11.2 deletion underlying the 22q11.2 deletion syndrome (22q11DS).⁴

The link between 22q11DS and schizophrenia has long been recognized.⁵⁻¹¹ Multiple studies confirm that ~1 in 4 individuals with 22q11DS develop schizophrenia, and that ~1 in 100-200 individuals with schizophrenia in community samples have a 22q11.2 deletion.^{12,13} These observations led a large international group of investigators to collaborate with the goal of identifying the underlying mechanisms of schizophrenia expression in 22q11DS that may be applicable to idiopathic schizophrenia in the general population. They agreed to share phenotypic information and existing DNA samples. Recognizing the potential of this collaboration to provide a wealth of data on the link between 22q11DS and schizophrenia spectrum disorders, the U.S. National Institute of Mental Health (NIMH) has forged a collaborative effort to investigate this important neurogenetic syndrome through the newly established International 22q11DS Brain Behavior Consortium (IBBC). Here we provide the goals and underlying hypotheses of the IBBC, an overview of clinical aspects of 22q11DS, and the rationale for focusing on this condition. We outline the phenotypic procedures and the genetics workflow, and summarize early findings.

GOAL OF THE CONSORTIUM

The IBBC is taking a multifaceted unbiased genome-wide approach to uncover genetic variation that contributes to the expression and high prevalence of schizophrenia in 22q11DS. The overarching hypothesis is that taking advantage of the magnifying effect of the 22q11.2 deletion and comprehensively studying genetic variation across the genome may elucidate genes and, more plausibly, gene networks and functional biological pathways that contribute to the etiology of schizophrenia and other neuropsychiatric phenotypes in 22q11DS and in the general population. A related hypothesis is that the study of youths with 22q11DS allows for the identification of early behavioral and/or cognitive markers associated with schizophrenia but preceding the onset of the first psychotic episode. It is expected that youths with 22q11DS and greater cognitive decline will share some of the genetic factors identified in individuals with schizophrenia. The expectations are that the biological pathways identified may be similar to those for individuals with schizophrenia without the 22q11.2 deletion, and that the elevated risk in 22q11DS will provide an enhanced effect size to identify the salient genetic factors and systems involved.¹⁴⁻¹⁶

THE 22q11.2 DELETION SYNDROME

The 22q11.2 deletion is the most common chromosomal microdeletion (~1:4000 live births; ~1/1000 fetuses) associated with a highly penetrant genomic syndrome.¹³ Over 90% of affected individuals have a ~3 million base pair (Mb) hemizygous deletion encompassing 46 protein-coding and 44 additional genes (Figure 1).^{13,17,18} Some have smaller nested deletions within the interval.¹³ The deletion typically occurs as a *de novo* event arising by non-allelic homologous recombination between chromosomes during meiosis, mediated by chromosome-specific low-

copy repeats across the chromosome 22q11.2 region.¹⁹⁻²¹

The phenotypic presentation is heterogeneous, often involving multiple systems including cardiac, palatal, endocrine, immune, gastrointestinal, skeletal and, most commonly, neuropsychiatric abnormalities.¹³ Brain dysfunction may be expressed as developmental delay and/or elevated prevalence of developmental neuropsychiatric disorders including attention deficit hyperactivity (ADHD), autism spectrum, anxiety and psychotic disorders.²²⁻²⁶ The ~25-fold increased risk for psychotic illness in 22q11DS is far greater than the estimated 3-fold increased risk of psychotic illness associated with general developmental delay.^{6,27} Therefore, 22q11DS provides a unique opportunity to investigate mechanisms underlying the evolution of schizophrenia and schizophrenia spectrum features across the lifespan. The existence of mouse models of individual or multiple genes within the region of synteny to the human 22q11.2 region also lays the foundation for a broad array of translational research to understand molecular mechanisms.^{17,18, 28-32}

The fact that the genetic risk is identifiable prenatally and postnatally,¹³ coupled with comparable age at onset, symptom pattern and early clinical signs, including neurocognitive deficits, all similar to idiopathic disease, support 22q11DS as a particularly promising genetic model for schizophrenia.¹⁴

SCHIZOPHRENIA SPECTRUM AND BRAIN BEHAVIOR PARAMETERS IN 22q11DS

As in the general population, schizophrenia in 22q11DS commonly emerges in late adolescence to early adulthood and is characterized by positive symptoms (hallucinations, delusions), negative symptoms (amotivation, asociality) and disorganized behavior.³³⁻³⁵ Within the context of the syndrome, response to antipsychotic medications appears similar to that in schizophrenia in the general population, considering the context of a multisystem disorder.^{36, 37}

Youths at risk for psychosis in the general population have been studied in help-seekers^{38,39} and community samples.^{40,41} Neurocognitive measures and neuroimaging parameters show abnormalities in at-risk individuals, suggesting the presence of neurobiological aberrations early in the psychosis process.⁴²⁻⁴⁴ With a known high risk for schizophrenia, 22q11DS provides the opportunity to systematically investigate early abnormalities in development as well as the emergence of psychotic illness in cross-sectional and prospective studies of individuals who share the same genetic abnormality.⁴⁵⁻⁴⁷ Investigations applying standard procedures to assess subthreshold psychotic symptoms in 22q11DS have reported their presence across samples.⁴⁸⁻⁵⁰ Integration of phenotypic parameters with genomics may generate mechanistic insights that lead to improved clinical diagnosis and offer new therapies.

Neurocognitive dysfunction is a central feature of schizophrenia⁵¹ with intellectual decline evident years prior to the emergence of psychotic symptoms.^{52,53} Similarly, in 22q11DS there is a steeper decline in verbal IQ associated with the emergence of psychotic disorders.^{46,54} Divergence of intellectual trajectories between those who subsequently develop a psychotic disorder and those who do not is distinguishable from age 11 years onward.⁵⁴

In schizophrenia, there are well-documented deficits in specific domains including verbal memory, executive functions and social cognition.^{51,55} Comparable patterns of impairments evident in clinical high-risk populations,^{56,57} and family members of patients,^{58,59} implicate these as potential endophenotypes. Similar impairments in executive function, social cognition, non-verbal memory, working memory and visual-spatial function in 22q11DS,^{24,45-47,60-62} suggest possible sharing of underlying neural networks.

Historically, studies of brain and behavior in 22q11DS have involved relatively small samples, with convergent findings emerging. Recognizing that multicenter samples are necessary

to generate large datasets, enabling integration of genomic and phenotypic data, investigators with complementary expertise who had established an international collaborative effort to study 22q11DS came together to form the IBBC.

THE INTERNATIONAL 22q11.2 BRAIN BEHAVIOR CONSORTIUM (IBBC)

OBJECTIVES

The IBBC established several aims to harmonize existing cohorts of 22q11DS participants with both phenotypic data and DNA available to perform next-generation sequencing and other genome-wide genomic analyses: 1) to examine the neuropsychiatric and neurocognitive-behavioral phenotypes associated with schizophrenia spectrum disorders in 22q11DS; 2) to generate and analyze genome-wide data for >300 adults with 22q11DS, about half with schizophrenia and half, aged 25 years and older with no psychotic illness, and use the same strategy for at-risk youths with 22q11DS; 3) to develop and pilot commonly used measures to optimize assessment of neuropsychiatric and cognitive-behavioral phenotypes in 22q11DS as a platform for future prospective longitudinal studies; 4) to build coordinated resources in the public domain for the international scientific community. The genetic analyses involve genome-wide data from WGS and high-resolution microarrays, with the goal of identifying genetic pathways that may influence the expression of schizophrenia and related phenotypes.

ORGANIZATIONAL STRUCTURE

The IBBC includes multiple international phenotyping sites, contributing DNA samples and phenotypic data, and genomic sites (Table 1). The phenotyping working group provides neuropsychiatric and neurobehavioral expertise and the genomic working group the genetic

analytic approach. An executive committee (EC) is comprised of 13 representatives from the working groups, including 9 members who lead the four phenotyping groups. The EC communicates regularly by conference calls and in-person meetings to implement research plans, communicate with NIMH, disseminate information to collaborative sites, arrange general meetings, oversee the development and quality of the database and the website, and review proposals for ancillary studies and publications.

SAMPLE AND ELIGIBILITY CRITERIA

For inclusion in the study, the IBBC took advantage of available cohorts of well-characterized individuals with 22q11DS where DNA samples exist. Initial steps in the IBBC study involve extensive quality control. These include reviewing the phenotypic data, verifying the presence of a typical 22q11.2 deletion (Figure 1), and determining relatedness between and ancestry of participants with high-quality DNA samples. Table 2 details the sample characteristics.

PHENOTYPIC PROCEDURES

Psychiatric Assessment

Harmonization of existing clinical psychiatric data for the IBBC has involved two main phases. To enable dichotomous “case-control” categorization, the presence of schizophrenia (or related psychotic illness), or the absence of any psychotic illness in subjects assessed at age 25 years or older, is established for all subjects. Complementary methods enable the study of at-risk youths with 22q11DS.

Schizophrenia spectrum disorders. Across sites, a semi-structured diagnostic interview,^{63,64} with collateral information and medical records, provided details on clinical presentation and longitudinal history for establishing a DSM-IV diagnosis of schizophrenia,

schizoaffective disorder, or related psychotic disorders such as delusional disorder or psychotic disorder not otherwise specified. After extensive discussion, the few cases with a psychotic mood disorder were excluded from initial analyses. For phenotypic harmonization, two investigators with clinical expertise independently reviewed standardized clinical summaries (average 2-3 subjects/site). There was full consensus among the two reviewers and the diagnosis provided by the sites for case-control classification. Individuals of any age who met diagnostic criteria for a major psychotic disorder, predominantly schizophrenia, were included as “cases”.

Non-psychotic adults. Participants ≥ 25 years-old at the time of assessment, with no evidence for a psychotic disorder or psychotic mood disorder (i.e., bipolar disorder or major depression with psychosis), were classified as “non-psychotic,” as they were likely to be through the major risk period for developing psychosis. Consequently, individuals <25 years at the time of the last assessment without a psychotic disorder nor subthreshold psychotic symptoms are labeled as “putative controls.” This categorization does not exclude the possibility of other neuropsychiatric conditions that are common in 22q11DS (e.g., anxiety, ADHD).²²

Subthreshold psychosis youths. The majority of existing participants in the IBBC cohort are young, thus not yet through the risk period for developing schizophrenia when assessed (Table 2). Subthreshold psychosis is systematically assessed by applying established diagnostic interviews and scales.⁶⁵⁻⁶⁷ Investigators with expertise in child and adolescent psychiatry reached a best estimate “subthreshold psychosis” designation based on review of a standard clinical summary provided across sites (on average 3 subjects/site). Subthreshold psychosis is applied when positive psychotic symptoms are persistently reported, but severity and impact on function do not justify a formal diagnosis of a psychotic disorder. Most sites provided quantification of subthreshold symptom severity, based on structured interview data (Structured Interview for

Prodromal Syndromes, SIPS;⁶⁶ or Comprehensive Assessment of At-Risk Mental States, CAARMS⁶⁷). Because many youths who have not yet passed through the risk period for the development of psychotic illness have been followed longitudinally at IBBC sites, data available on quantitative cognitive phenotypes relevant to schizophrenia risk, including decline in verbal abilities in individuals,⁵⁴ will also be used for genomic analyses.

Cognitive assessments

Standardized IQ scores, available for many subjects across sites, provide measures of general cognitive ability, verbal abilities, nonverbal abilities, and selected executive functions. Using both cross-sectionally and longitudinally obtained standardized IQ scores allowed definition of an average cognitive trajectory for 22q11DS individuals, on which individual trajectories can be plotted to identify deviations from what is expected in this population. This approach has enabled generation of a quantitative measure of IQ decline as a phenotype of interest for genetic analyses.^{46,54} To enhance commonality across other neurocognitive variables, several considerations were applied: representation across at least five IBBC sites, and comparability of neurocognitive test versions, administration procedures, and scoring. This will allow the application of standard procedures to create composite measures for the domains of executive function, social cognition and verbal learning. These domains were initially prioritized given their relevance of these domains to schizophrenia vulnerability.^{51,56-59} Also, the majority of sites used comparable measures within these domains.

GENOMIC APPROACH

The IBBC genomic approach to identify variants that may contribute to expression of schizophrenia and related conditions in the 22q11DS population is outlined in Figure 2. The

approach envisions testing four genetic models. One model is that variants on the haploid (single copy) 22q11.2 deletion region segment are enriched in those with psychotic illness and related conditions. The other three models will test for enrichment of genome-wide variants outside this 22q11.2 region: in common sequence variants (i.e., single nucleotide polymorphisms (SNPs), in a traditional genome-wide association study (GWAS) paradigm), in rare sequence variants, and in rare structural variants.

To test these models the IBBC plans to use both existing and new genotypic data. Indeed, a major focus of the IBBC is to generate WGS data for this valuable cohort. In comparison to whole exome sequencing, WGS permits more complete analysis of sequence and structural variation including coding and non-coding regions of the genome, while not suffering from capture and coverage biases.⁶⁷ The rapid drop in price increased feasibility, and thus the bulk of the grant funding has supported the generation of WGS data for >80% of subjects in the IBBC 22q11DS cohort (estimated n=1,576, before quality control measures, Figure 2). DNA samples were submitted for WGS (average depth 30X) using two platforms: for the first ~100 samples the Illumina HiSeq 2000,⁶⁸ and thereafter the Illumina HiSeq X Ten. Initially, participants with schizophrenia ('cases'), or with no psychotic disorder and age ≥ 25 years ('controls'), were prioritized.

Mapping and variant calling of SNVs (including SNPs) includes use of novel software tools (PEMapper/PECaller) developed at Emory.⁶⁹ Cleaned and annotated (reference genome assembly GRCh38) sequence data are placed into Variant Call Format (VCF) and annotated using ANNOVAR,⁷⁰ enabling standard analytic approaches to be applied, including variant classes (i.e., exonic, intronic), rarity, and functional effects.⁷¹⁻⁷³ Annotation of SNVs from coding regions uses standard pipelines and bioinformatic filters for functional impact.^{15,74-78} Similarly,

variants from non-coding regions are annotated using the most up-to-date methods available in this evolving area of genomic study.^{15,74}

WGS data allow detection of small structural variants beyond the resolution of microarray data. Calling of structural variants across the size spectrum from WGS data requires a combination of complementary methods. The analytic strategy for the IBBC includes interrogating read depth data, and discordant pair/split read data needed to call both balanced (inversions and translocations) and unbalanced (CNV) variants.⁷⁹⁻⁸² CNV calls will provide a comprehensive genome-wide structural map for each subject, ready for further computational analyses.

Complementing the WGS approach, the study takes advantage of existing data from Affymetrix 6.0 microarrays (Figure 2) available for many participating 22q11DS subjects from previous studies of cardiac phenotypes,^{83,84} with comparable array data generated for remaining subjects. Arrays provide both SNP data for use in genome-wide association study (GWAS) analyses and calculation of schizophrenia polygenic scores,⁸⁵ and for genome-wide studies of structural variants (CNV) in addition to the 22q11.2 deletion.^{86,87} These common sequence and rare and common structural variant data also serve an important role in quality control, e.g., for comparison with variants identified by WGS.

The potential power of the proposed IBBC genomic approach and the enhanced effect sizes in 22q11DS are supported by the results to date reported in the Early Findings section below for additional rare structural variants.⁸⁷ For genome-wide rare sequence variants, published power calculations in a proof-of-principle study using a WGS method to assess patients with 22q11DS with and without schizophrenia are available for gene-set burden

tests.¹⁵ For $n=100$ subjects per group, power for plausible functional gene-sets was >0.90 for various types of coding sequence variants, with Cohen's d effect size estimates of, e.g., 1.90, 0.88, and 0.55, based on the nine genomes investigated.¹⁵ With respect to aggregate common variants, there were also promising though non-significant results reported for the schizophrenia polygenic risk score in this study.¹⁵ Estimates for detecting individual common variants with relative risk of 2 to 3 using a typical GWAS genome-wide significance threshold (5×10^{-8}) show power >0.80 in the IBBC cohort (sample sizes as in Table 2) but, as expected, very low power for individual rare variants.

Variants in the 22q11.2 deletion region that increase likelihood of expressing schizophrenia and related phenotypes

Individuals with 22q11DS have just a single copy of the genes within the 22q11.2 deletion region, a region of the genome well known for its complexity, partly due to the multiple low copy repeats (LCR22s) flanking and within this region (Figure 1).¹⁹⁻²¹ Comprehensive analysis of genotype-phenotype associations in 22q11DS mandates special expertise and consideration of this region. The IBBC study thus involves initial analysis of the haploid allele on the intact chromosome 22 separately from WGS data from the rest of the genome (Figure 2).^{88,89} To call hemizygous single nucleotide variants (SNVs), PEGcaller is rerun for this region in a haploid mode. 22q11.2 deletion region variants are then annotated and analyzed as for variants from other regions, but with special consideration of the hemizyosity and its potential effects on phenotype.¹³ Detailed annotation and investigation of the complex architecture of the LCR22s,⁸⁹⁻⁹¹ and analysis of breakpoints and corresponding 22q11.2 deletion extent, including for rare nested 22q11.2 deletions, provide further unique data. These will allow regional and haplotype-based analyses of the deleted or non-deleted allele, effects related to coding and non-coding

sequence variants within and flanking the 22q11.2 deletion region, and the potential for identifying hotspots for meiotic chromosomal rearrangements. Collectively, these data will enable the development of a morbid/benign variation map of the entire 22q11.2 region for testing with phenotypic expression.⁸⁸

Genome-wide variants that increase likelihood of expressing schizophrenia and related phenotypes

Planned analyses of SNV data include logistic-regression modelling to compare allele frequencies between the 22q11DS schizophrenia and no psychotic illness groups, accounting for covariates such as sex, ethnicity, genotyping platform, and read length. Statistical significance is established via permutation. These sequence-based variant analyses will proceed in a logical fashion, using standard genome-wide approaches. These will include GWAS for common variants of >5% minor allele frequency (MAF), gene-based analyses for other SNPs (1-5% MAF), and modified Sequence Kernel Association Test (SKAT) or other burden tests for rare SNVs with <1% MAF.⁹¹ Rare coding and non-coding variants will be grouped by type (e.g., missense, lincRNAs) and prioritized using factors such as functional scores (e.g., CADD) and conservation.^{15,76} Inspection of expected variant frequencies using public databases (e.g., ExAC, gnomAD) will be important.⁷⁵ Both individual variants and groups of variants at the gene or pathway (e.g., functional gene-set) level will be tested, using such aggregate-type tests as polygenic risk scores (for common variants) and burden tests (for rare variants).^{15,92} Notably, a test like SKAT can detect genes or pathways that contain causal variants that act in different directions on phenotypes (e.g., some variants may increase risk, while others decrease risk). Also, as noted above, there is some published evidence for the utility of functional gene-set based burden analyses for rare functional variants and for polygenic risk scores in 22q11DS.^{15,87}

For the rapidly evolving area of analyzing non-coding variants, including intragenic enhancers distal to coding sequence, the most up-to-date resources and functional-based variant scoring methods available will be used, appropriate to common or rare variant analyses.^{15,71}

To test the generalizability of individual and aggregate rare and common, coding and non-coding, top hits will be evaluated in available general population schizophrenia samples.⁸⁵ Other resources will also be used to prioritize the schizophrenia-related variants identified in 22q11DS, including in silico analyses of potential function (including regulatory function) using animal model data and human tissue expression data.¹⁶ To adjust for multiple testing while avoiding overcorrection in analyses that involve inherently correlated data (e.g. testing two pathways that may have genetic overlap), various methods may be applied, e.g., using permutation or other standard methods (e.g., Benjamini-Hochberg False Discovery Rate).^{15,74} To appreciate the overall genomic architecture of schizophrenia in 22q11DS will require eventual integration of all genomic variant findings with the phenotypic data, and other downstream analyses to investigate potential disease mechanism and function¹⁶ using actual animal models, tissue expression profiles, and spatiotemporal expression profiles during brain development (Figure 2).

Alternative phenotype approach

Initial analyses prioritize comparisons between participants with 22q11DS and schizophrenia and those with no psychotic disorder over age 25 years (Table 2).⁸⁷ Other analyses involving data from youths where numbers are far greater (Table 2) will test whether various definitions of subthreshold psychosis and related phenotypes, including IQ decline,⁵⁴ produce similar genetic findings. Thus, all of the analyses described above will also be performed using alternative schizophrenia-related phenotypes. Notably, the vast majority of the 22q11DS sample with WGS

results from this cross-sectional IBBC study comprises youths with their years of greatest risk for psychotic illness ahead of them.

EARLY FINDINGS

The IBBC has provided an unprecedented large sample, establishing a database for 22q11DS with common phenotypes that enable data integration. Initial published findings illustrate the promise of this consortium. In the largest study of psychiatric disorders in 22q11DS (n=1,402; ages 6–68 years) using validated diagnostic instruments, psychotic disorders were present in 41% of adults over age 25 years. Autism spectrum disorders and ADHD in children and adolescents, and anxiety disorders across all age ranges, were also prevalent with sex differences in ADHD and anxiety disorders similar to those reported in the general population.²²

To evaluate the relationship between psychosis and cognitive functioning, clinical assessment and IQ measures were examined longitudinally in 411 participants with 22q11DS.⁵⁴ Across the sample, mild decline in IQ, especially in the verbal domain, was noted with increasing age.⁵³ However, in youth who developed psychotic illness, this decline was significantly steeper, similar to observations in schizophrenia in the general population.⁹⁴

In another recent Consortium-based paper, individuals with 22q11DS (n=692) were assessed for subthreshold psychotic symptoms. Nearly one-third of the participants met criteria for positive subthreshold psychotic symptoms and almost a quarter met criteria for negative/disorganized subthreshold symptoms. Adolescents (aged 13–17 years) showed the highest rates of subthreshold psychotic symptoms. Cognitive deficits were associated with subthreshold psychosis.⁹⁵

To investigate the role of additional rare genome-wide CNVs in expression of schizophrenia in 22q11DS,⁸⁷ high quality genome-wide CNV from the available microarrays were annotated using stringent methods and adjudicated for rarity using independent control microarray data as in previous studies.^{12,86,96-101} Compared to participants aged 25 years and older with no psychotic illness, the schizophrenia group was significantly enriched for genome-wide rare CNVs that implicated known and novel schizophrenia risk genes and loci.⁸⁷ Evidence of interactions at a network level of these genes with 22q11.2 deletion region genes is consistent with the threshold-lowering effect of the deletion, highlighting the importance of an integrated genome-wide approach.⁹²

A novel data mining strategy that integrates biological information from gene association, gene network, and disease/trait phenotypes has been developed to help prioritize potential schizophrenia risk genes and networks.⁹³ This method is to be applied in the IBBC WGS analyses. Other upcoming IBBC publications include findings on novel structural polymorphisms that predispose to chromosome 22q11.2 rearrangements, and analysis of the extent to which schizophrenia polygenic risk score predicts outcome in 22q11DS.

LIMITATIONS AND FUTURE DIRECTIONS

The IBBC has capitalized on existing global collaborations in an effort to assemble the largest sample available of a highly informative neurogenetic syndrome. The consortium includes retrospective data. While carefully assessed, the IBBC data do not have the depth and scope that prospective studies can attain. Importantly, prospective studies can use the same standardized validated and efficient measures for deep phenotyping. Such future studies could use novel tools, such as computerized assessment, which can be administered in multisite large scale studies across a broad age range, and have been validated in 22q11DS. To investigate the possible

contribution of environmental non-genetic factors to schizophrenia will require recontacting subjects or collection of new data. Prospective longitudinal studies would help address these limitations and enhance the contributions to the field. Although the current work of the IBBC is focused on schizophrenia, the dataset and findings might also be of interest to researchers working in other areas, such as anxiety in neurodevelopmental disorders and cognitive development in young people with intellectual disabilities.

The genomic efforts were also built on the expertise of established investigators and the promise of WGS to help delineate the genomic architecture of human disease. Nevertheless, other molecular approaches may well be needed to fully understand the changes wrought by a 22q11.2 deletion, including risk for schizophrenia and the variable expression of 22q11DS in general. The potential roles of transcriptional regulation, post-translational modification, and other yet to be identified mechanisms will be important to pursue with emerging technologies. These investigations are likely to need expanded sample sizes. This would also be the case for the current study which is underpowered, despite the large sample amassed, for lower effect size individual variants or variant groups, and for analyses of interaction effects.

With advances in technology and reduction in costs, future studies can also consider informative replication samples and the best methods to address hypotheses generated in the field, particularly those that focus on relevant genotype-phenotype associations. Novel strategies to identify potential protective factors, and develop possible preventive and therapeutic interventions, are also promising future directions.

CONCLUSION

The IBBC has demonstrated the feasibility and utility of large-scale collaborations to examine an informative rare CNV that can contribute to advancing the mechanistic understanding of

schizophrenia spectrum disorders. The rich phenotypic dataset amassed for individuals with 22q11DS and schizophrenia spectrum disorders, compared to those without psychotic features, as well as at-risk youth is unprecedented and buttresses the generalizability to schizophrenia and clinical risk for the disorder in the general population. Integration with the broad genomic approach, combining whole genome sequencing, genome-wide microarray technologies and novel emerging technologies can contribute to advancing the pathogenesis of schizophrenia and ultimately to targeted preventive and therapeutic efforts. Likely outcomes include identifying genetic modifiers from both the intact 22q11.2 region alleles and genome-wide⁸⁷ that will not only address the key goal of delineating schizophrenia vulnerability but could also inform other important aspects of expression in this syndrome and beyond. The implications for other molecular models, for understanding development, and for neuropsychiatric research in general are potentially profound.

CONFLICT OF INTEREST

Donna McDonald-McGinn has given lectures on 22q11DS for Natera; Celso Arango has been a consultant to or has received honoraria or grants from Abbot, AMGEN, AstraZeneca, CIBERSAM, Dainippon Sumitomo Pharma, Fundación Alicia Koplowitz, Forum, Instituto de Salud Carlos III, Gedeon Richter, Janssen Cilag, Lundbeck, Ministerio de Ciencia e Innovación, Ministerio de Sanidad, Ministerio de Economía y Competitividad, Mutua Madrileña, Otsuka, Pfizer, Roche, Servier, Shire, Schering Plough, Sunovio and Takeda. David Fraguas has been a consultant and/or advisor to or has received honoraria from AstraZeneca, Bristol-Myers Squibb, Eisai, Janssen, Lundbeck, Otsuka, and Ministerio de Ciencia e Innovación, Ministerio de Sanidad, Ministerio de Economía.

The other authors declare no conflict of interest.

ACKNOWLEDGMENTS

The IBBC is supported by the National Institute of Mental health grants USA U01MH101719, U01MH0101720, CAN+: U01MH0101723, EUA: U01MH101722, EUB: U01MH101724; Additional support includes: NIH R01MH087626 (REG), R01MH087636 (BSE, DMM-M), R01MH085953 (CEB), Simons Foundation Explorer Award (CEB), RO1MH064824 (WRK), P01HD070454 (BEM, BSE, DMM-M), R01MH107018 (TJS), NIH U54 HD079125 MIND Institute Intellectual and Developmental Disabilities Research Center (TJS), the Emory Integrated Genomics Core (EIGC), which is subsidized by the Emory University School of Medicine and is one of the Emory Integrated Core Facilities, National Center for Advancing Translational Sciences of the National Institutes of Health under Award Number UL1TR000454, RW Woodruff Fund (JFC, OYO), the Canadian Institutes of Health Research (ASB, EWCC, MOP-74631, MOP-97800; ASB, MOP-111238), the Canada Research Chairs in Schizophrenia Genetics and Genomic Disorders (ASB), Brain Canada Mental Health Training Award (NJB), Baily Thomas Charitable Trust (2315/1) (MvdB), The Waterloo Foundation (WF918-1234) (MvdB), Wellcome Trust ISSF grant (MvdB), A Medical Research Council (UK) Centre grant G0800509 (MO), CIBERSAM (CA), the Binational Science Foundation, grant number 2011378 (DG), FONDECYT-Chile #1130392 and 1171014 (GMR), Wellcome Trust 110222/Z/15/Z (MN), The FWO grant G.0E11.17N (JRV), the Brain and Behavior Research Foundation 22597 (AW), the Swiss National Science Foundation (324730_144260) (SE), the EU IMI initiative EU AIMS (DM), the Brain and Behavior Research Foundation (JV), the Brain and Behavior Research Foundation 21278 (MA), the NHMRC 1072593 (AL).

We thank the research teams across the international sites and the individuals and family members who have enabled the establishment of the Consortium and have contributed to advancing the understanding and treatment of 22q11DS.

Table 1. IBBC Sites, Roles and Samples

IBBC Site (by Group)	Samples Submitted per Site
Toronto*^	155
Australia	28
Santiago	73
Total by group CAN+	256
 	
Leuven*^	125
Geneva	119
Maastricht	95
Marseilles	25
Tel Aviv	103
Utrecht*	151
Total by Group EUA	618
 	
Cardiff*	122
Dublin	64
London	22
Madrid	34
Mallorca	27
Rome	89
Total by Group EUB	358
 	
Albert Einstein NY⁺	NA
CHOP-Penn*^	335
Duke	70
Emory*^	29
SUNY	101
UCLA	81
UC Davis	69
Total by Group USA	685
 	
Total Samples Submitted¹	1,917

IBBC –International 22q11.2 Brain Behavior Consortium

*-Indicates Group Organizing Site; ^ -Indicates both Phenomic and Genomic Site; +-Indicates Genomic only site; NA –Not applicable

¹Total samples submitted will be greater than the number of those with usable genomic and phenotypic data, after extensive data cleaning.

Table 2. Demographic and genotypic characteristics of the 22q11DS IBBC sample with typical 22q11.2 deletions (c February 15, 2017)¹

	Main diagnostic groups (n=582)				At risk group (n=1,034)		Total (n=1,616)	
	Psychotic illness² (n=292)		No psychotic illness at age ≥25 y (n=290)					
	n	%	n	%	n	%	n	%
Females	143	49.0	177	61.0	513	49.6	833	51.6
Youths (< age 21 y)	97	33.2	-	-	915	88.5	1012	62.6
European ethnicity	241	86.7	258	91.5	809	78.2	1308	80.9
A to D 22q11.2 deletion	268	91.8	263	90.7	953	92.2	1484	91.8
WGS data available	271	92.8	275	94.8	918	88.8	1464	90.6
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mean age	29.3	13.0	35.6	9.8	14.4	4.5	20.9	11.8
Age at onset	22.3	8.9	-	-	-	-	-	-

¹All numbers are best estimates for subjects with typical 22q11.2 deletions, subject to data checking and cleaning; individuals (total n=301 of 1,917) without available 22q11.2 deletion data as yet, and a small number (<20) with atypical 22q11.2 deletions, are not included (see text for details).

²The psychotic illness designation comprises schizophrenia (66.1%), schizoaffective or psychotic disorder not otherwise specified (25.3%), or other psychotic spectrum disorders (8.6%), but excludes a small number of subjects with psychotic mood disorders.

Figure legends

Figure 1. The 22q11.2 region. Cytogenetic representation of chromosome 22 showing the short (p) and long (q) arms with the centromere, which functions to separate both arms. Chromosome 22 is an acrocentric chromosome, as indicated by the two horizontal lines in the p arm. The 22q11.2 deletion occurs on the long arm of one of the two chromosomes, depicted by dashed lines in the 22q11.2 band. The position of the two low copy repeats (LCRs) on 22q11.2 (LCR22A and LCR22D), which flank the typical 3-Mb deletion, LCR22B and LCR22C and genes (protein-coding and selected non-protein-coding) within the 22q11.2 deletion region, as well as the three typical 22q11.2 deletions that include LCR22A and two nested 22q11.2 deletions that do not include LCR22A (all indicated by blue bars below), are depicted in the inset.¹³

Figure 2. Genomics flow diagram.

The figure provides an overview of the ongoing and planned genomics analyses in the IBBC study, beginning with genomic DNA samples available from subjects with 22q11DS from participating international centers. Samples were sent to one laboratory (Albert Einstein College of Medicine, NY) that serves as a central clearinghouse, and provides a unique IBBC identification number to enable linking of genotypic and phenotypic data. Data primarily from studies that pre-dated the IBBC are indicated on a cyan background. The mauve and yellow backgrounds indicate data generated from the IBBC study from WGS and microarray data, respectively. Dotted lines indicate the work flow for microarray data. These provided data for initial analyses, and available for comparison with WGS data, albeit at lower resolution. Red font indicates analyses using the phenotypic data available for subjects with 22q11DS from participating international centers. Main analyses involve comparisons of subjects with 22q11DS

and schizophrenia vs. those with no psychotic illness at age 25 years and older. See text for details.

¹Quality control measures applied to both WGS and microarray data include checking for duplicate and related samples, for sex and ethnicity using phenotypic data to help detect sample mix-ups, and for 22q11.2 deletion size (assisted by available multiplex ligation dependent probe amplification (MLPA) data and heat-map data generated from microarrays). Additional quality control measures, following transfer of raw WGS data (fastq files) generated at HudsonAlpha Genome Sequencing Center (Huntsville, AL) to the Human Genetics Computational Cluster (Emory U), include checking for mixing of samples, level of genetic variation, base transition to transversion ratios, too many variants in particular regions, and variants that departed from Hardy–Weinberg equilibrium at $p < 10^{-4}$.

²The intact haploid 22q11.2 allele requires special computational considerations, thus is analyzed separately from data from the rest of the genome.^{82,83}

³Annotation of structural variation from WGS data is a pioneering area of genomics. Availability of CNV data from standard microarrays in this study will be valuable for comparison purposes.⁷⁴⁻⁷⁷

⁴Integrated analysis using all variant data, common and rare, sequence and structural, will provide an overview of the genomic architecture of schizophrenia in 22q11DS. Validation studies, e.g., polymerase chain reaction for SNV, quantitative polymerase chain reaction for SV, will proceed according to results.

CNV = copy number variation; LOF = loss of function; SNP = single nucleotide polymorphisms
(common sequence variants); SNVs = single nucleotide variants; SV = structural variants; WGS
= whole genome sequencing

Figure 1 - Chromosome 22 ideogram with inset indicating low copy repeats and genes within the 22q11.2 region

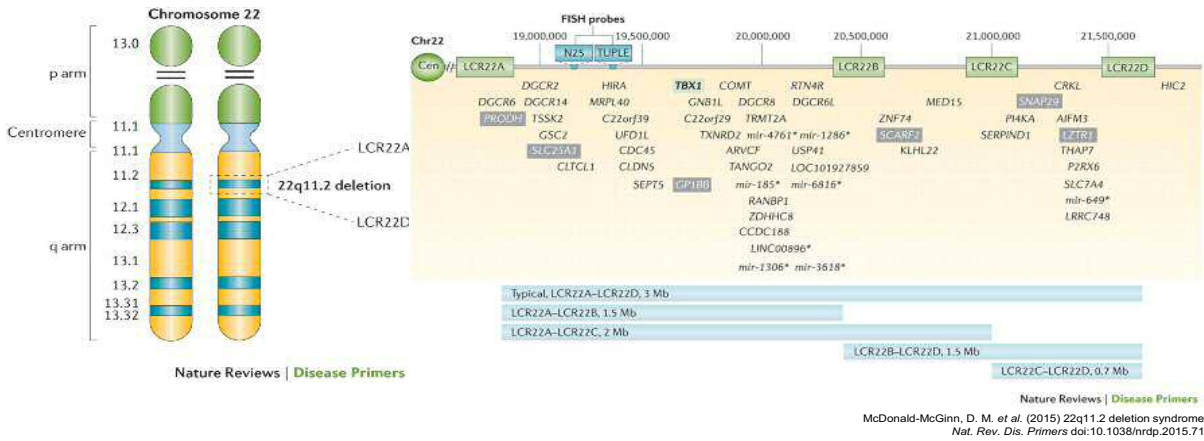
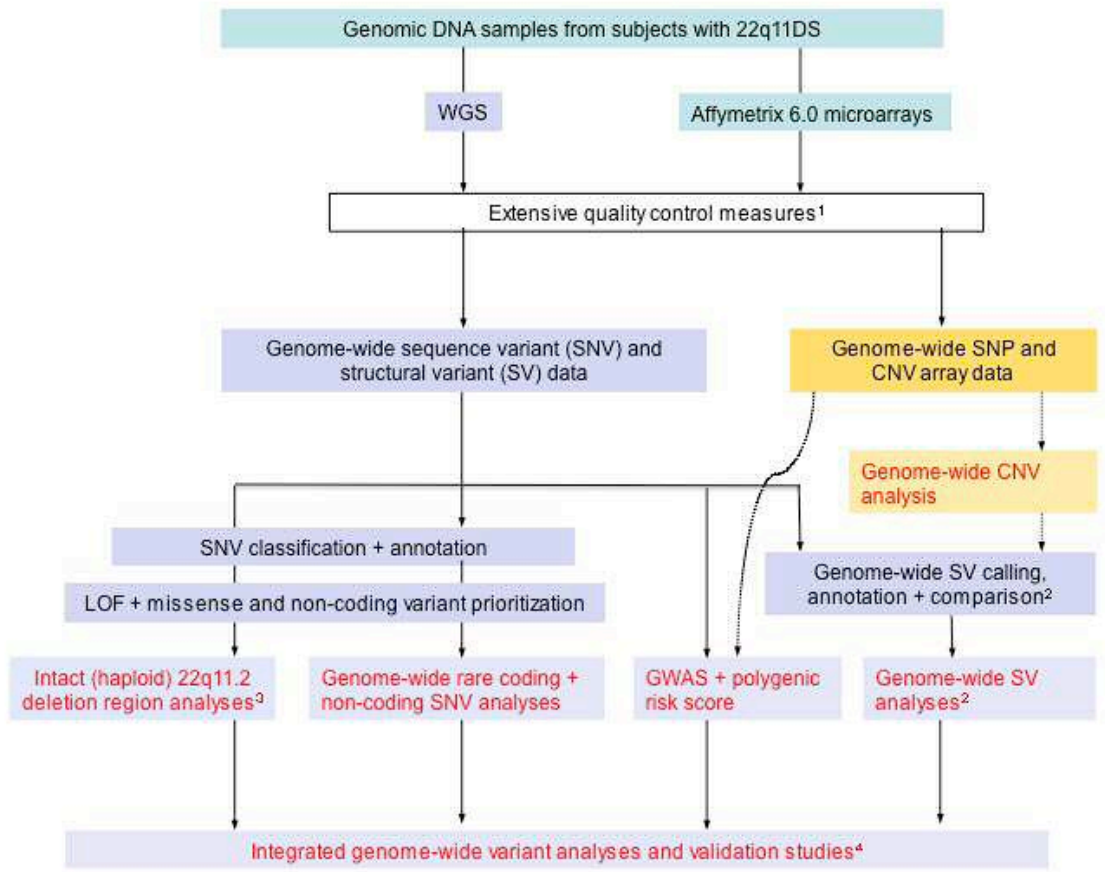


Figure 2



References

1. CNV and Schizophrenia Working Groups of the Psychiatric Genomics Consortium. Contribution of copy number variants to schizophrenia from a genome-wide study of 41,321 subjects. *Nat Genet* 2017; **49**: 27-35.
2. Walsh T, McClellan JM, McCarthy SE, Addington AM, Pierce SB, Cooper GM *et al*. Rare structural variants disrupt multiple genes in neurodevelopmental pathways in schizophrenia. *Science* 2008; **320**: 539-543.
3. International Schizophrenia Consortium. Rare chromosomal deletions and duplications increase risk of schizophrenia. *Nature* 2008; **455**: 237-241.
4. Bassett AS, Scherer SW, Brzustowicz LM. Copy number variations in schizophrenia: critical review and new perspectives on concepts of genetics and disease. *Am J Psychiatry* 2010; **167**: 899-914.
5. Shprintzen RJ, Goldberg R, Golding-Kushner KJ, Marion RW. Late-onset psychosis in the velo-cardio-facial syndrome. *Am J Med Genet* 1992; **42**: 141-142.
6. Chow EW, Bassett AS, Weksberg R. Velo-cardio-facial syndrome and psychotic disorders: implications for psychiatric genetics. *Am J Med Genet A* 1994; **54**: 107-112.
7. Karayiorgou M, Morris MA, Morrow B, Shprintzen RJ, Goldberg R, Borrow J *et al*. Schizophrenia susceptibility associated with interstitial deletions of chromosome 22q11. *Proc Natl Acad Sci U S A* 1995; **92**: 7612-7616.
8. Gothelf D, Frisch A, Munitz H, Rockah R, Aviram A, Mozes T *et al*. Velocardiofacial manifestations and microdeletions in schizophrenic inpatients. *Am J Med Genet A* 1997; **72**: 455-461.
9. Bassett AS, Hodgkinson K, Chow EW, Correia S, Scutt LE, Weksberg R. 22q11 deletion syndrome in adults with schizophrenia. *Am J Med Genet* 1998; **81**: 328-337.
10. Bassett AS, Chow EW. 22q11 deletion syndrome: a genetic subtype of schizophrenia. *Biol Psychiatry* 1999; **46**: 882-891.
11. Murphy KC, Jones LA, Owen MJ. High rates of schizophrenia in adults with velo-cardio-facial syndrome. *Arch Gen Psychiatry* 1999; **56**: 940-945.
12. Costain G, Lionel AC, Merico D, Forsythe P, Russell K, Lowther C *et al*. Pathogenic rare copy number variants in community-based schizophrenia suggest a potential role for clinical microarrays. *Hum Mol Genet* 2013; **22**: 4485-4501.
13. McDonald-McGinn DM, Sullivan KE, Marino B, Philip N, Swillen A, Vorstman JAS *et al*. 22q11.2 deletion syndrome. *Nat Rev Dis Prim* 2015; **1**: 15071.
14. Insel TR. Rethinking schizophrenia. *Nature* 2010; **468**: 187-193.
15. Merico D, Zarrei M, Costain G, Ogura L, Alipanahi B, Gazzellone MJ *et al*. Whole-genome sequencing suggests schizophrenia risk mechanisms in humans with 22q11.2 deletion syndrome. *G3 (Bethesda)* 2015; **5**: 2453-2461.
16. Meechan DW, Maynard TM, Tucker ES, Fernandez A, Karpinski BA, Rothblat LA *et al*. Modeling a model: Mouse genetics, 22q11.2 Deletion Syndrome, and disorders of cortical circuit development. *Prog Neurobiol* 2015; **130**: 1-28.
17. Puech A, Saint-Jore B, Funke B, Gilbert DJ, Sirotkin H, Copeland NG *et al*. Comparative mapping of the human 22q11 chromosomal region and the orthologous region in mice reveals complex changes in gene organization. *Proc Natl Acad Sci U S A* 1997; **94**: 14608-14613.

18. Guna A, Butcher NJ, Bassett AS. Comparative mapping of the 22q11.2 deletion region and the potential of simple model organisms. *J Neurodev Disord* 2015; **7**: 18.
19. Shaikh TH, Kurahashi H, Saitta SC, O'Hare AM, Hu P, Roe BA *et al.* Chromosome 22-specific low copy repeats and the 22q11.2 deletion syndrome: genomic organization and deletion endpoint analysis. *Hum Mol Genet* 2000; **9**: 489-501.
20. Edelman L, Pandita RK, Spiteri E, Funke B, Goldberg R, Palanisamy N *et al.* A common molecular basis for rearrangement disorders on chromosome 22q11. *Hum Mol Genet* 1999; **8**: 1157-1167.
21. Edelman L, Pandita RK, Morrow BE. Low-copy repeats mediate the common 3-Mb deletion in patients with velo-cardio-facial syndrome. *Am J Hum Genet* 1999; **64**: 1076-1086.
22. Schneider M, Debbané M, Bassett AS, Chow EWC, Fung WLA, Van den Bree MBM *et al.* Psychiatric disorders from childhood to adulthood in 22q11.2 deletion syndrome: results from the International Consortium on Brain and Behavior in 22q11.2 deletion syndrome. *Am J Psychiat* 2014; **171**: 627-639.
23. Green T, Gothelf D, Glaser B, Debbané M, Frisch A, Kotler M *et al.* Psychiatric disorders and intellectual functioning throughout development in velocardiofacial (22q11.2 deletion) syndrome. *J Am Acad Child Adolesc Psychiatry* 2009; **48**: 1060-1068.
24. Gur RE, Yi JJ, McDonald-McGinn DM, Tang SX, Calkins ME, Whinna D *et al.* Neurocognitive development in 22q11.2 deletion syndrome: comparison with youth having developmental delay and medical comorbidities. *Mol Psychiatry* 2014; **19**: 1205-1211.
25. Tang SX, Yi JJ, Calkins ME, Whinna DA, Kohler CG, Souders MC *et al.* Psychiatric disorders in 22q11.2 deletion syndrome are prevalent but undertreated. *Psychol Med* 2014; **44**: 1267-1277.
26. Niarchou M, Martin J, Thapar A, Owen MJ, van den Bree MB. The clinical presentation of attention deficit-hyperactivity disorder (ADHD) in children with 22q11.2 deletion syndrome. *Am J Med Genet B Neuropsychiatr Genet* 2015; **168**: 730-738.
27. Morgan VA, Leonard H, Bourke J, Jablensky A. Intellectual disability co-occurring with schizophrenia and other psychiatric illness: population-based study. *Br J Psychiatry* 2008; **193**: 364-372.
28. Karayiorgou M, Simon TJ, Gogos JA. 22q11.2 microdeletions: linking DNA structural variation to brain dysfunction and schizophrenia. *Nat Rev Neurosci* 2010; **11**: 402-416.
29. Jonas RK, Montojo CA, Bearden CE. The 22q11.2 deletion syndrome as a window into complex neuropsychiatric disorders over the lifespan. *Biol Psychiatry* 2014; **75**: 351-360.
30. Hiroi N, Takahashi T, Hishimoto A, Izumi T, Boku S, Hiramoto T. Copy number variation at 22q11.2: from rare variants to common mechanisms of developmental neuropsychiatric disorders. *Mol Psychiatry* 2013; **18**: 1153-1165.
31. Tamura M, Mukai J, Gordon JA, Gogos JA. Developmental inhibition of Gsk3 rescues behavioral and neurophysiological deficits in a mouse model of schizophrenia predisposition. *Neuron* 2016; **89**: 1100-1109.
32. Hamm JP, Peterka DS, Gogos JA, Yuste R. Altered Cortical Ensembles in Mouse Models of Schizophrenia. *Neuron* 2017; **94**: 153-167.
33. Bassett AS, Chow EW, Husted J, Weksberg R, Caluseriu O, Webb GD *et al.* Clinical features of 78 adults with 22q11 deletion syndrome. *Am J Med Genet A* 2005; **138**: 307-313.

34. Murphy KC. Schizophrenia and velo-cardio-facial syndrome. *Lancet* 2002; **359**: 426-430.
35. Bassett AS, Chow EW, AbdelMalik P, Gheorghiu M, Husted J, Weksberg R. The schizophrenia phenotype in 22q11 deletion syndrome. *Am J Psychiat* 2003; **160**: 1580-1586.
36. Butcher N, Fung W, Fitzpatrick L, Guna A, Andrade D, Lang A *et al*. Response to clozapine in a clinically identifiable subtype of schizophrenia. *Br J Psychiat* 2015; **206**: 484-491.
37. Dori N, Green T, Weizman A, Gothelf D. The effectiveness and safety of antipsychotic and antidepressant medications in individuals with 22q11.2 deletion syndrome. *J Child Adolesc Psychopharmacol* 2017; **27**: 83-90.
38. Cannon TD, Cadenhead K, Cornblatt B, Woods SW, Addington J, Walker E *et al*. Prediction of psychosis in youth at high clinical risk: a multisite longitudinal study in North America. *Arch Gen Psychiatry* 2008; **65**: 28-37.
39. Fusar-Poli P, Rutigliano G, Stahl D, Schmidt A, Ramella-Cravaro V, Hitesh S *et al*. Deconstructing pretest risk enrichment to optimize prediction of psychosis in individuals at clinical high risk. *JAMA Psychiatry* 2016; **73**: 1260-1267.
40. Kelleher I, Connor D, Clarke MC, Devlin N, Harley M, Cannon M. Prevalence of psychotic symptoms in childhood and adolescence: a systematic review and meta-analysis of population-based studies. *Psychol Med* 2012; **42**: 1857-1863.
41. Calkins ME, Moore TM, Merikangas KR, Burstein M, Satterthwaite TD, Bilker WB *et al*. The psychosis spectrum in a young U.S. community sample: findings from the Philadelphia Neurodevelopmental Cohort. *World Psychiatry* 2014; **13**: 296-305.
42. Seidman LJ, Shapiro DI, Stone WS, Woodberry KA, Ronzio A, Cornblatt BA *et al*. Association of neurocognition with transition to psychosis: baseline functioning in the second phase of the North American prodrome longitudinal study. *JAMA Psychiatry* 2016; **73**: 1239-1248.
43. Gur RC, Calkins ME, Satterthwaite TD, Ruparel K, Bilker WB, Moore TM *et al*. Neurocognitive growth charting in psychosis spectrum youths. *JAMA Psychiatry* 2014; **71**: 366-374.
44. Satterthwaite TD, Vandekar SN, Wolf DH, Bassett DS, Ruparel K, Shehzad Z *et al*. Connectome-wide network analysis of youth with psychosis-spectrum symptoms. *Mol Psychiatry* 2015; **20**: 1508-1515.
45. Hooper SR, Curtiss K, Schoch K, Keshavan MS, Allen A, Shashi V. A longitudinal examination of the psychoeducational, neurocognitive, and psychiatric functioning in children with 22q11.2 deletion syndrome. *Res Dev Disabil* 2013; **34**: 1758-1769.
46. Duijff SN, Klaassen PW, Swanenburg de Veye HF, Beemer FA, Sinnema G, Vorstman JA. Cognitive and behavioral trajectories in 22q11DS from childhood into adolescence: a prospective 6-year follow-up study. *Res Dev Disabil* 2013; **34**: 2937-2945.
47. Antshel KM, Fremont W, Ramanathan S, Kates WR. Predicting cognition and psychosis in young adults with 22q11.2 deletion syndrome. *Schizophr Bull* 2016; e-pub ahead of print 25 October 2016; doi: 10.1093/schbul/sbw135.
48. Tang SX, Yi JJ, Moore TM, Calkins ME, Kohler CG, Whinna DA *et al*. Subthreshold psychotic symptoms in 22q11.2 deletion syndrome. *J Am Acad Child Adolesc Psychiatry* 2014; **53**: 991-1000.e1002.
49. Armando M, Girardi P, Vicari S, Menghini D, Digilio MC, Pontillo M *et al*. Adolescents at ultra-high risk for psychosis with and without 22q11 deletion syndrome: a comparison

- of prodromal psychotic symptoms and general functioning. *Schizophr Res* 2012; **139**: 151-156.
50. Gothelf D, Schneider M, Green T, Debbane M, Frisch A, Glaser B *et al*. Risk factors and the evolution of psychosis in 22q11.2 deletion syndrome: a longitudinal 2-site study. *J Am Acad Child Adolesc Psychiatry* 2013; **52**: 1192-1203.
 51. Kahn RS, Keefe RS. Schizophrenia is a cognitive illness: time for a change in focus. *JAMA Psychiatry* 2013; **70**: 1107-1112.
 52. Meier MH, Caspi A, Reichenberg A, Keefe RS, Fisher HL, Harrington H *et al*. Neuropsychological decline in schizophrenia from the premorbid to the postonset period: evidence from a population-representative longitudinal study. *Am J Psychiatry* 2014; **171**: 91-101.
 53. Cannon M, Caspi A, Moffitt TE, Harrington H, Taylor A, Murray RM *et al*. Evidence for early-childhood, pan-developmental impairment specific to schizophreniform disorder: results from a longitudinal birth cohort. *Arch Gen Psychiatry* 2002; **59**: 449-456.
 54. Vorstman JA, Breetvelt E, Duijff SN, Jalbrzikowski M, Vogels A, Swillen A *et al*. Cognitive decline preceding the onset of psychosis in patients with 22q11.2 deletion syndrome. *JAMA Psychiatry* 2015; **72**: 377-385.
 55. Zai G, Robbins TW, Sahakian BJ, Kennedy JL. A review of molecular genetic studies of neurocognitive deficits in schizophrenia. *Neurosci Biobehav Rev* 2017; **72**: 50-67.
 56. Fusar-Poli P, Borgwardt S, Bechdolf A, Addington J, Riecher-Rossler A, Schultze-Lutter F *et al*. The psychosis high-risk state: a comprehensive state-of-the-art review. *JAMA Psychiatry* 2012; **70**: 1-14.
 57. Carrion RE, McLaughlin D, Auther AM, Olsen R, Correll CU, Cornblatt BA. The impact of psychosis on the course of cognition: a prospective, nested case-control study in individuals at clinical high-risk for psychosis. *Psychol Med* 2015; **45**: 3341-3354.
 58. Gur RC, Braff DL, Calkins ME, Dobie DJ, Freedman R, Green MF *et al*. Neurocognitive performance in family-based and case-control studies of schizophrenia. *Schizophr Res* 2015; **163**: 17-23.
 59. Gur RE, Nimgaonkar VL, Almasry L, Calkins ME, Ragland JD, Pogue-Geile MF *et al*. Neurocognitive endophenotypes in a multiplex multigenerational family study of schizophrenia. *Am J Psychiatry* 2007; **164**: 813-819.
 60. Duijff SN, Klaassen PW, de Veye HF, Beemer FA, Sinnema G, Vorstman JA. Cognitive development in children with 22q11.2 deletion syndrome. *Br J Psychiatry* 2012; **200**: 462-468.
 61. De Smedt B, Devriendt K, Fryns JP, Vogels A, Gewillig M, Swillen A. Intellectual abilities in a large sample of children with velo-cardio-facial syndrome: an update. *J Intellect Disabil Res* 2007; **51**: 666-670.
 62. Chow EW, Watson M, Young DA, Bassett AS. Neurocognitive profile in 22q11 deletion syndrome and schizophrenia. *Schizophr Res* 2006; **87**: 270-278.
 63. Miller TJ, McGlashan TH, Rosen JL, Cadenhead K, Cannon T, Ventura J *et al*. Prodromal assessment with the structured interview for prodromal syndromes and the scale of prodromal symptoms: predictive validity, interrater reliability, and training to reliability. *Schizophr Bull* 2003; **29**: 703-715.
 64. First MB, Spitzer RL, Gibbon M *et al*. Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition. New York: Biometrics Research, New York State Psychiatric Institute, 2002.

65. Kaufman J, Birmaher B, Brent D, Rao U, Flynn C, Moreci P *et al.* 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* 1997; **36**: 980–988.
66. Miller TJ, McGlashan TH, Rosen JL, Somjee L, Markovich PJ, Stein K *et al.* Prospective diagnosis of the initial prodrome for schizophrenia based on the Structured Interview for Prodromal Syndromes: preliminary evidence of interrater reliability and predictive validity. *Am J Psychiatry* 2002; **159**: 863-865.
67. McGorry PD, Singh B. Schizophrenia: risk and possibility. Handbook of studies on preventive psychiatry, Burrows G. Elsevier, Amsterdam 1995; 491-514.
68. Meienberg J, Bruggmann R, Oexle K, Matyas G. Clinical sequencing: is WGS the better WES? *Hum Genet* 2016; **135**: 359-362.
69. Johnston HR, Chopra P, Wingo TS, Patel V, International Consortium on Brain and Behavior in 22q11.2 Deletion Syndrome, Epstein MP *et al.* PEMapper and PECaller provide a simplified approach to whole-genome sequencing. *Proc Natl Acad Sci U S A* 2017; **114**: E1923-E1932.
70. Wang K, Li M, Hakonarson H. ANNOVAR: functional annotation of genetic variants from high-throughput sequencing data. *Nucleic Acids Res* 2010; **38**: e164.
71. Genomes Project C, Auton A, Brooks LD, Durbin RM, Garrison EP, Kang HM *et al.* A global reference for human genetic variation. *Nature* 2015; **526**: 68-74.
72. Tennessen JA, Bigham AW, O'Connor TD, Fu W, Kenny EE, Gravel S *et al.* Evolution and functional impact of rare coding variation from deep sequencing of human exomes. *Science* 2012; **337**: 64-69.
73. Pollard KS, Hubisz MJ, Rosenbloom KR, Siepel A. Detection of nonneutral substitution rates on mammalian phylogenies. *Genome Res* 2010; **20**: 110-121.
74. Yuen RK, Thiruvahindrapuram B, Merico D, Walker S, Tammimies K, Hoang N *et al.* Whole-genome sequencing of quartet families with autism spectrum disorder. *Nat Med* 2015; **21**: 185-191.
75. Karczewski KJ, Weisburd B, Thomas B, Solomonson M, Ruderfer DM, Kavanagh D *et al.* The ExAC browser: displaying reference data information from over 60 000 exomes. *Nucleic Acids Res* 2017; **45**: D840-D845.
76. Kircher M, Witten DM, Jain P, O'Roak BJ, Cooper GM, Shendure J. A general framework for estimating the relative pathogenicity of human genetic variants. *Nat Genet* 2014; **46**: 310-315.
77. Adzhubei IA, Schmidt S, Peshkin L, Ramensky VE, Gerasimova A, Bork P *et al.* A method and server for predicting damaging missense mutations. *Nat Methods* 2010; **7**: 248-249.
78. Gene Ontology C, Blake JA, Dolan M, Drabkin H, Hill DP, Li N *et al.* Gene ontology annotations and resources. *Nucleic Acids Res* 2013; **41**: D530-D535.
79. Zhu M, Need AC, Han Y, Ge D, Maia JM, Zhu Q *et al.* Using ERDS to infer copy-number variants in high-coverage genomes. *Am J Hum Genet* 2012; **91**: 408-421.
80. Abyzov A, Urban AE, Snyder M, Gerstein M. CNVnator: an approach to discover, genotype, and characterize typical and atypical CNVs from family and population genome sequencing. *Genome Res* 2011; **21**: 974-984.

81. Ye K, Schulz MH, Long Q, Apweiler R, Ning Z. Pindel: a pattern growth approach to detect break points of large deletions and medium sized insertions from paired-end short reads. *Bioinformatics* 2009; **25**: 2865-2871.
82. Wang J, Mullighan CG, Easton J, Roberts S, Heatley SL, Ma J *et al.* CREST maps somatic structural variation in cancer genomes with base-pair resolution. *Nat Methods* 2011; **8**: 652-654.
83. Mlynarski EE, Sheridan MB, Xie M, Guo T, Racedo SE, McDonald-McGinn DM *et al.* Copy-number variation of the glucose transporter gene SLC2A3 and congenital heart defects in the 22q11.2 deletion syndrome. *Am J Hum Genet* 2015; **96**: 753-764.
84. Mlynarski EE, Xie M, Taylor D, Sheridan MB, Guo T, Racedo SE *et al.* Rare copy number variants and congenital heart defects in the 22q11.2 deletion syndrome. *Hum Genet* 2016; **135**: 273-285.
85. Schizophrenia Working Group of the PGC. Biological insights from 108 schizophrenia-associated genetic loci. *Nature* 2014; **511**: 421-427.
86. Bassett AS, Marshall CR, Lionel AC, Chow EW, Scherer SW. Copy number variations and risk for schizophrenia in 22q11.2 deletion syndrome. *Hum Mol Genet* 2008; **17**: 4045-4053.
87. Bassett AS, Lowther C, Merico D, Costain G, Chow EWC, Van Amelsvoort T *et al.* Rare genome-wide copy number variation affects expression of schizophrenia in 22q11.2 deletion syndrome. *Am J Psychiatry* DOI: 10.1176/appi.ajp.2017.16121417.
88. Hestand MS, Nowakowska BA, Vergaelen E, Van Houdt J, Dehaspe L, Suhl JA *et al.* A catalog of hemizygous variation in 127 22q11 deletion patients. *Hum Genome Var* 2016; **3**: 15065.
89. Guo X, Delio M, Haque N, Castellanos R, Hestand MS, Vermeesch JR *et al.* Variant discovery and breakpoint region prediction for studying the human 22q11.2 deletion using BAC clone and whole genome sequencing analysis. *Hum Mol Genet* 2016; **25**: 3754-3767.
90. Bailey JA, Yavor AM, Viggiano L, Misceo D, Horvath JE, Archidiacono N *et al.* Human-specific duplication and mosaic transcripts: the recent paralogous structure of chromosome 22. *Am J Hum Genet* 2002; **70**: 83-100.
91. Babcock M, Pavlicek A, Spiteri E, Kashork CD, Ioshikhes I, Shaffer LG *et al.* Shuffling of genes within low-copy repeats on 22q11 (LCR22) by Alu-mediated recombination events during evolution. *Genome Res* 2003; **13**: 2519-2532.
92. Lee S, Emond MJ, Bamshad MJ, Barnes KC, Rieder MJ, Nickerson DA *et al.* Optimal unified approach for rare-variant association testing with application to small-sample case-control whole-exome sequencing studies. *Am J Hum Genet* 2012; **91**: 224-237.
93. Lin JR, Cai Y, Zhang Q, Zhang W, Nogales-Cadenas R, Zhang ZD. Integrated post-GWAS analysis sheds new light on the disease mechanisms of schizophrenia. *Genetics* 2016; **204**: 1587-1600.
94. Dickson H, Laurens KR, Cullen AE, Hodgins S. Meta-analyses of cognitive and motor function in youth aged 16 years and younger who subsequently develop schizophrenia. *Psychol Med* 2012; **42**: 743-755.
95. Weisman O, Guri Y, Gur RE, McDonald-McGinn DM, Calkins MET, S. Subthreshold psychosis in 22q11.2 deletion syndrom: multi-site naturalistic study. *Schizophr Bull* (in press) 2017.

96. Lionel AC, Crosbie J, Barbosa N, Goodale T, Thiruvahindrapuram B, Rickaby J *et al.* Rare copy number variation discovery and cross-disorder comparisons identify risk genes for ADHD. *Sci Transl Med* 2011; **3**: 95ra75.
97. Scherer SW, Lee C, Birney E, Altshuler DM, Eichler EE, Carter NP *et al.* Challenges and standards in integrating surveys of structural variation. *Nat Genet* 2007; **39**: S7-S15.
98. Korn JM, Kuruvilla FG, McCarroll SA, Wysoker A, Nemesh J, Cawley S *et al.* Integrated genotype calling and association analysis of SNPs, common copy number polymorphisms and rare CNVs. *Nat Genet* 2008; **40**: 1253-1260.
99. Pinto D, Pagnamenta AT, Klei L, Anney R, Merico D, Regan R *et al.* Functional impact of global rare copy number variation in autism spectrum disorders. *Nature* 2010; **466**: 368-372.
100. Silversides CK, Lionel AC, Costain G, Merico D, Migita O, Liu B *et al.* Rare copy number variations in adults with tetralogy of Fallot implicate novel risk gene pathways. *PLoS Genetics* 2012; **8**: e1002843.
101. Marshall CR, Noor A, Vincent JB, Lionel AC, Feuk L, Skaug J *et al.* Structural variation of chromosomes in autism spectrum disorder. *Am J Hum Genet* 2008; **82**: 477-488.

The International 22q11.2 Deletion Syndrome Brain Behavior Consortium Additional Members

Last Name	First Name	Site	Institution	City, Country	Email
Antshel	Kevin	SUNY	Syracuse University	Syracuse, USA	kmantshe@syr.edu
Arango*	Celso	Madrid	Hospital General Universitario Gregorio Marañón, Universidad Complutense and CIBERSAM	Madrid, Spain	carango@hggm.es
Armando*	Marco	Rome	Ospedale Bambino Gesù	Rome, Italy	Marco.armando@etat.ge.ch
Boot	Erik	Toronto	Toronto General Hospital, the University of Toronto and University Medical Center Utrecht	Toronto, Canada and Utrecht, the Netherlands	erik.boot@uhn.ca
Bravo-Sanchez	Marta	Madrid	Hospital General Universitario Gregorio Marañón	Madrid, Spain	marta.bravo@salud.madrid.org
Breetvelt	Elemi	Utrecht	Department of Psychiatry, Brain Center Rudolf Magnus, University Medical Center Utrecht	Utrecht, the Netherlands	E.J.Breetvelt@umcutrecht.nl
Busa	Tiffany	Marseille	Aix-Marseille University	Marseille, France	tiffany.busa@ap-hm.fr
Butcher	Nancy	Toronto	Center for Addiction and Mental Health, the University of Toronto and the Children's Hospital of Philadelphia	Toronto, Canada and Philadelphia, USA	nancy.j.butcher@gmail.com
Calkins	Monica	Penn	Perelman School of Medicine University of Pennsylvania	Philadelphia, USA	mcalkins@mail.med.upenn.edu
Campbell*	Linda	Australia	University of New Castle	Newcastle, Australia	linda.e.campbell@newcastle.edu.au
Carmel	Miri	Tel Aviv	Tel Aviv University and Felsenstein Medical Research Center	Tel Aviv, Israel	mcarmel@post.tau.ac.il
Crowley	T. Blaine	CHOP	The Children's Hospital of Philadelphia	Philadelphia, USA	crowleyt@email.chop.edu
Cubells	Joseph	Emory	Emory University	Atlanta, USA	jcubell@emory.edu
Cutler	David	Emory	Emory University	Atlanta, USA	cutler.davidj@gmail.com
Demaerel	Wolfram	Leuven	Katholieke University, Leuven	Leuven, Belgium	wolfram.demaerel@med.kuleuven.be
Di Fabio	Fabio	Rome	Sapienza University of Rome	Rome, Italy	fabiodifa@gmail.com
Digilio	Maria Cristina	Rome	Ospedale Bambino Gesù	Rome, Italy	Mcristina.digilio@opbg.net

The International 22q11.2 Deletion Syndrome Brain Behavior Consortium Additional Members

Duijff	Sasja	Utrecht	Department of Psychiatry, Brain Center Rudolf Magnus, University Medical Center Utrecht	Utrecht, the Netherlands	s.duijff@umcutrecht.nl
Eliez*	Stephan	Geneva	University of Geneva	Geneva, Switzerland	Stephan.eliez@etat.ge.ch
Epstein	Michael	Emory	Emory University	Atlanta, USA	mpepste@emory.edu
Evers	Rens	Maastricht	Maastricht University	Maastricht, the Netherlands	rensevers@home.nl
Fernandez Garcia-Moya	Luis	Madrid	Instituto de Genética Médica y Molecular, Hospital Universitario La Paz	Madrid, Spain	lfernandezg@salud.madrid.org
Fiksinski	Ania	Utrecht	Department of Psychiatry, Brain Center Rudolf Magnus, University Medical Center Utrecht	Utrecht, the Netherlands	a.m.fiksinski@umcutrecht.nl
Fraguas	David	Madrid	Hospital General Universitario Gregorio Marañón and CIBERSAM	Madrid, Spain	davidfraguas@gmail.com
Fremont	Wanda	SUNY	SUNY Upstate Medical University	Syracuse, USA	fremontw@upstate.edu
Fritsch	Rosemarie	Chile	Universidad de Chile	Santiago, Chile	
Garcia-Minaur	Sixto	Madrid	Instituto de Genética Médica y Molecular, Hospital Universitario La Paz	Madrid, Spain	sixto.garciamin@gmail.com
Golden	Aaron	Einstein	Albert Einstein College of Medicine and National University of Ireland, Galway	New York, USA and Galway, Ireland	aaron.golden@nuigalway.ie
Gothelf*	Doron	Tel Aviv	Tel Aviv University and Sheba Medical Center	Tel Aviv, Israel	gothelf@post.tau.ac.il
Guo	Tingwei	Einstein	Albert Einstein College of Medicine	New York, USA	Tingwei.guo@einstein.yu.edu
Gur	Ruben	Penn	Perelman School of Medicine University of Pennsylvania	Philadelphia, USA	gur@upenn.edu
Heine-Suner*	Damian	Mallorca	Hospital Son Espases	Palma, Spain	damian.heine@ssib.es
Hestand	Matthew	Leuven	Katholieke University, Leuven	Leuven, Belgium	matthew.hestand@kuleuven.be
Hooper	Stephen	Duke	Duke University and the University of North Carolina at Chapel Hill	Durham, USA and Chapel Hill, USA	stephen_hooper@med.unc.edu

The International 22q11.2 Deletion Syndrome Brain Behavior Consortium Additional Members

Medical Center					
Johnston	Richard		Emory University	Atlanta, USA	henry.johnston@gmail.com
Kates*	Wendy	SUNY	SUNY Upstate Medical University	Syracuse, USA	katesw@upstate.edu
Kushan	Leila	UCLA	University of California Los Angeles	Los Angeles, USA	lkushan@mednet.ucla.edu
Laorden-Nieto	Alejandra	Madrid	Hospital General Universitario Gregorio Marañón	Madrid, Spain	ale.teresalaorden@gmail.com
Maeder	Johanna	Geneva	University of Geneva	Geneva, Switzerland	Johanna.Maeder@unige.ch
Marino	Bruno	Rome	Ospedale Bambino Gesù and La Sapienza University	Rome, Italy	Bruno.marino@uniroma1.it
Marshall	Christian	Toronto	The Hospital for Sick Children	Toronto, Canada	crm@sickkids.ca
McCabe	Kathryn	Australia	University of New Castle	Newcastle, Australia	kathryn.mccabe@sydney.edu.au
McGinn	Daniel E.	CHOP	Davidson College	Davidson, NC, USA	mcginn.daniel@comcast.edu
Michaelovosky	Elena	Tel Aviv	Tel Aviv University and Felsenstein Medical Research Center	Tel Aviv, Israel	michaelo@post.tau.ac.il
Morey Cañellas*	Jaume	Palma	Fundador del Institut Balear de Salut Mental de la Infància i l'Adolescència IBSMIA Hospital Universitari Son Espases	Palma, Spain	jaume.morey@ssib.es
Moss	Edward	CHOP	The Children's Hospital of Philadelphia	Philadelphia, USA	kidbrains@gmail.com
Moss	Hayley	Cardiff	Cardiff University	Cardiff, Wales	mosshm@cardiff.ac.uk
Mulle	Jennifer	Emory	Emory University	Atlanta, USA	jmulle@emory.edu
Murphy	Declan	London	King's College London	London, England	declan.murphy@kcl.ac.uk
Murphy*	Kieran	Dublin	Royal College of Surgeons Ireland	Dublin, Ireland	kmurphy@rcsi.ie
Murphy*	Clodagh	London	King's College London	London, England	clodagh.m.murphy@kcl.ac.uk
Niarchou	Maria	Cardiff	Cardiff University	Cardiff, Wales	niarchoum@cardiff.ac.uk
Ornstein	Claudia	Chile	Universidad de Chile	Santiago, Chile	
Philip*	Nicole	Marseille	Aix-Marseille University	Marseilles, France	nicole.philip@ap-hm.fr
Repetto*	Gabriela	Chile	Universidad del Desarrollo	Santiago, Chile	gretto@udd.cl
Schneider*	Maude	Geneva	University of Geneva	Geneva, Switzerland	maude.schneider@unige.ch

The International 22q11.2 Deletion Syndrome Brain Behavior Consortium Additional Members

Shashi*	Vandana	Duke	Duke University	Durham, USA	vandana.shashi@duke.edu
Simon*	Tony	UC Davis	University of California	Sacramento, USA	tjsimon@ucdavis.edu
Tang	Sunny	Penn	Perelman School of Medicine University of Pennsylvania	Philadelphia, USA	suntang@mail.med.upenn.edu
Tassone	Flora	UC Davis	University of California	Sacramento, USA	ftassone@ucdavis.edu
Unolt	Marta	Rome	Ospedale Bambino Gesù and La Sapienza University	Rome, Italy	Unolt.marta@gmail.com
Van Amelsvoort*	Therese	Maastricht	Maastricht University	Maastricht, the Netherlands	t.vanamelsvoort@maastrichtuniversity.nl
van Duin	Esther	Maastricht	Maastricht University	Maastricht, the Netherlands	eda.vanduin@maastrichtuniversity.nl
Vergaelen	Elfi	Leuven	Katholieke University, Leuven	Leuven, Belgium	elfi.vergaelen@uzleuven.be
Vicari	Stefano	Rome	Ospedale Bambino Gesù	Rome, Italy	stefano.vicari@opbg.net
Vingerhoets	Claudia	Maastricht	Maastricht University	Maastricht, the Netherlands	claudia.vingerhoets@maastrichtuniversity.nl
Weinberger	Ronnie	Tel Aviv	Tel Aviv University and Sheba Medical Center	Tel Aviv, Israel	ronnie.wein@gmail.com
Weisman	Omri	Tel Aviv	Tel Aviv University and Sheba Medical Center	Tel Aviv, Israel	omriwei@yahoo.com
Weizman	Abraham	Tel Aviv	Tel Aviv University and Felsenstein Medical Research Center	Tel Aviv, Israel	weizmana@gmail.com
Zackai	Elaine	CHOP	The Children's Hospital of Philadelphia	Philadelphia, USA	zackai@email.chop.edu
Zhang	Zhengdong	Einstein	Albert Einstein College of Medicine	New York, USA	zhengdong.zhang@einstein.yu.edu
Zwick	Michael	Emory	Emory University	Atlanta, USA	mzwick@emory.edu

* Site team leader