

1                   **Polygenic prediction of the phenotype, across ancestry, in emerging adulthood**

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8                   RUNNING HEAD: Genome-Phenome Prediction in Emerging Adulthood

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27                   Article word count: 3,540 (excluding title page, abstract, references, figure captions, tables, author contributions,  
28                   and financial disclosures)

29

## Abstract

30 **Background:** Identifying genetic relationships between complex traits in emerging adulthood can provide useful  
31 etiological insights into risk for psychopathology. College-age individuals are under-represented in genomic  
32 analyses thus far, and the majority of work has focused on clinical disorder or cognitive abilities rather than normal-  
33 range behavioral outcomes.

34 **Methods:** This study examined a sample of emerging adults 18-22 years of age (N = 5,947) to construct an atlas of  
35 polygenic risk for 33 traits predicting relevant phenotypic outcomes. Twenty-eight hypotheses were tested based on  
36 the previous literature on samples of European ancestry, and the availability of rich assessment data allowed for  
37 polygenic predictions across 55 psychological and medical phenotypes.

38 **Results:** Polygenic risk for schizophrenia in emerging adults predicted anxiety, depression, nicotine use, trauma,  
39 and family history of psychological disorders. Polygenic risk for neuroticism predicted anxiety, depression, phobia,  
40 panic, neuroticism, and was correlated with polygenic risk for cardiovascular disease.

41 **Conclusions:** These results demonstrate the extensive impact of genetic risk for schizophrenia, neuroticism, and  
42 major depression on a range of health outcomes in early adulthood. Minimal cross-ancestry replication of these  
43 phenomic patterns of polygenic influence underscores the need for more genome-wide association studies of non-  
44 European populations.

45

46 Keywords: phenome; genetic; polygenic; schizophrenia; neuroticism; cardiovascular

47

## Introduction

48 Broad phenotyping can greatly enhance our understanding of the underlying structure of genetic  
49 vulnerability to psychiatric disorders. Thus, genome-wide polygenic risk research is increasingly considering  
50 batteries of clinical phenotypes in “phenome-wide” studies (Bulik-Sullivan *et al.* 2015; Krapohl *et al.* 2015;  
51 Hagenaars *et al.* 2016). One promising approach emerging from the phenome-wide genomic literature uses  
52 published summary statistics from large genome-wide association studies to calculate genome-wide polygenic  
53 scores (GPS) for an array of major disorders and clinically relevant traits. These scores are then used to predict a  
54 number of potentially informative psychiatric, psychological and physical health phenotypes. Along with cross-  
55 disorder genomic research examining the co-heritability of major psychiatric disorders (e.g., LD regression) (Cross-  
56 Disorder Group of the Psychiatric Genomics Consortium, 2013), polygenic phenomic approaches are among the  
57 most promising methods for elucidating the complex overlapping genetic architecture of psychiatric disorders and  
58 discovering unexpected genotype-phenotype associations (Docherty *et al.* 2016). However, previous research has  
59 suffered from a restricted range of phenotypes, and has not included, for instance, GPS of anxiety, eating, and  
60 inflammatory disorders, personality, lipid levels and puberty traits in the prediction of outcome phenotypes (which  
61 have generally focused on cognitive abilities) and has not examined samples between the ages of 17 and 35, the  
62 developmentally critical stage encompassing emerging and young adulthood.

63 This study applied such an approach to GPS (33 total) in a phenotypically extensive genetic study of  
64 emerging adulthood outcomes. Emerging adulthood, a period starting at the age of 18 when adolescents begin to  
65 develop the roles and independence of adulthood, reflects a high-risk age range for the onset of many psychiatric  
66 and substance use disorders, including schizophrenia, affective disorders, anxiety disorders and alcohol and drug use  
67 disorders. Data from the National Comorbidity Survey Replication sample indicate that three quarters of all lifetime  
68 cases of DSM-IV diagnoses start by age 24 (Kessler *et al.* 2005), and WHO's World Mental Health data indicates  
69 that approximately three quarters of lifetime psychiatric disorders begin by the mid-20's (Kessler *et al.* 2007).

70 The University Student Survey (called “Spit for Science”, or S4S) was developed to identify risk factors for  
71 onset of mental health disorders with large-scale assessment of genetic, environmental, and developmental  
72 influences. Discovery summary statistics from 33 genome-wide association studies (GWAS) were used to derive  
73 GPSs in this large sample of young adults (N = 5,947) across a range of psychiatric, psychological, and physical  
74 health traits (Table S1 in online supplementary materials). Expanding on previous research, twenty-eight hypotheses

75 of genetic prediction were tested based on selected studies in past literature. Further, the availability of rich clinical  
76 assessment data allowed for the calculation of polygenic predictions across a greater number of outcomes than has  
77 ever been studied previously, many of which were completely novel in phenomic studies. These included 55  
78 psychiatric, psychological and medical phenotypes (listed in Table S2 in the online supplementary material).

79 Moreover, the GPS metrics were powerful enough to examine relationships across subsamples of different  
80 ancestries. While GWAS approaches require tens of thousands of individuals to locate “hits,” continuous polygenic  
81 scores require far smaller samples for adequate power. This sample was suitably diverse in ancestry to map the GPS-  
82 phenotype in young adults of European ancestry (EUR, N=3,016) and then to replicate these findings across non-  
83 European ancestry groups including of African origin (AFR, N=1,339), native American origin (AMR, N=581), and  
84 East Asian (EAS, N=557), and South Asian origin (SAS, N=454). Separate association matrices were created for the  
85 empirically categorized AFR, AMR, EAS, and SAS samples and are provided here and in the supplemental figures  
86 available online.

87 We can learn much from the study of emerging adults over and above adolescent samples, as early  
88 behavioral patterns that may precede adult psychopathology can be studied, and new hypotheses about critical  
89 exposures and environmental risk factors can emerge. The results presented here reflect a polygenic modeling  
90 framework in a large young adult sample, and provides evidence that the integration of phenotypic and genotypic  
91 data will be useful in the prediction of negative health outcomes in emerging adults.

92

### 93 **Methods**

#### 94 **Sample Ascertainment and Phenotyping**

95 Phenome-wide behavioral data (N=7,592) were drawn from young adults from the first three cohorts in  
96 S4S, samples drawn from a large urban university in the Mid-Atlantic United States, which included 5,947 unrelated  
97 individuals with genome-wide genotypes (Dick *et al.* 2014). The S4S sample does not overlap with any of the  
98 discovery GWAS samples used in these analyses. Details of participant ascertainment have been published  
99 elsewhere (Dick *et al.* 2014) but briefly, emerging adults ages 18-22 were recruited across multiple cohorts, for a  
100 campus-wide study of genetic and environmental factors contributing to alcohol and substance use. The protocol  
101 was approved by the university Institutional Review Board, and carried out in accordance with the provisions of the  
102 World Medical Association Declaration of Helsinki. Participants were 61.1% female with a mean age of 18.59 at

103 first assessment. Representativeness of this sample is strong and has been reported elsewhere (Dick *et al.* 2014).  
104 Assignment to ancestry group was empirically based on greatest similarity to 1000 Genomes Phase 3 super-  
105 populations. The present analyses included 55 traits from the domains of psychopathology, personality, health  
106 factors, and educational achievement (Table S2 in the online supplementary materials). All analyses included age,  
107 sex, and 10 ancestry principal components as covariates. Variables assessed at multiple occasions or in multiple  
108 cohorts were adjusted for number of assessments and cohort group. Sample sizes for each of the phenotypic  
109 measures are also provided in Table S2.

### 110 **Genetic Risk Scoring**

111 DNA collection, calling, and imputation is detailed elsewhere (Dick *et al.* 2014). We processed genotypes  
112 using standard quality control procedures followed by imputation of SNPs using the 1000 Genomes Project  
113 reference panel. After imputation and quality control, we included approximately 2.3 million variants into the  
114 polygenic scoring analyses. A GPS for each discovery phenotype was calculated using the summary statistics we  
115 obtained from 33 GWAS (Table S1 in the online supplementary materials). Python-based LDpred (Vilhjálmsson *et*  
116 *al.* 2015) was used for these analyses because of its ability to account for linkage disequilibrium (LD) structure  
117 (Krapohl *et al.* 2015) using our own large EUR test sample, and its use of all genetic variants (instead of specified p-  
118 value threshold for inclusion of the genetic variants in the GPS). LDpred allows for the modeling of LD based on  
119 LD in the discovery sample to weight the relative contributions of syntenic variants to the outcome phenotype.  
120 LDpred uses postulated proportions of causal variants in the genome as Bayesian prior probabilities for GPS  
121 calculations, and we tested a range of different priors (proportions of 0.3, 0.1, 0.03, 0.01, 0.003, and 0.001), as well  
122 as the model of infinite variants of infinitesimally small effect (Fisher, 1919) to construct scores.

### 123 **Phenotype Prediction**

124 A flowchart depicting the GPS-phenome cross-ancestry prediction and GPS-GPS correlation procedure is presented  
125 in Figure 1. Regressions were run using R to compare full (GPS, ten ancestry principal components, age, sex,  
126 cohort, and number of measurements when applicable) and restricted models where GPS was removed. Prior to the  
127 global analyses, a set of *a priori* hypotheses, gathered from previous research, were tested (Table 1). We elected to  
128 generate several hypotheses prior to analysis, because some literature was available to support previous evidence of  
129 relationships between GPS and outcome. We elected to forgo experimental binning (into quantiles, for example) in  
130 order to minimize the number of exploratory analyses beyond regressions of GPS on the phenotypes. Multiple

131 testing was corrected for using a False Discovery Rate (FDR) of 5% (Benjamini & Hochberg, 1995) within each  
132 ancestry group using the *p.adjust* function in R; the FDR is appropriate for an analysis designed to evaluate the  
133 pattern of relationships between many constructs because it treats each combination of discovery phenotype,  
134 outcome, and LDpred prior level as an independent test, despite the presence of positive dependency between many  
135 of these tests. It should be noted that this multiple testing correction did not account for previously established  
136 associations or for the correlations observed in our sample, between multiple prior levels tested in the same  
137 discovery phenotypes. This was an added attempt to filter out potentially spurious results.

138 **Cross-Disorder GPS Partial Correlations and GPS-GPS Replication Hypotheses Across Ancestry**

139 In addition to testing the GPSs prediction of the phenotypes, GPSs were also examined for correlations  
140 with each other in all ethnicities. These provide different results than genetic correlation estimates, but are intended  
141 to demonstrate that GPS scores are not independent, and that variance attributable to a particular discovery  
142 phenotype may be partially shared with another. This sharing may be due to common genetic factors between  
143 phenotypes, possible sample overlap, and error variance. GPS correlations have been previously reported in EUR,  
144 but this analysis added phenotypes such as cardiovascular and triglyceride factors. Correlation coefficients, *p*-values,  
145 and *q*-values (after correcting the *p*-values for the FDR of 5%) were derived for GPS partial correlations using R and  
146 adjusting for the ancestry principal components. We chose to use partial correlations in order to standardize the  
147 weights across phenotype and provide more direct comparisons of statistics for plotting purposes. Based on the  
148 cross-disorder psychiatric genomics findings to date (Bulik-Sullivan *et al.* 2015), we expected significant GPS  
149 associations between schizophrenia (SZ) and bipolar disorder (BP), SZ and autism (AUT), SZ and major depressive  
150 disorder (MDD), BP and MDD, and AUT and attention deficit hyperactivity disorder (ADHD) across each of the  
151 ancestry groups (see Table 2).

152

153 **Results**

154 **Genetic Profile Score-Phenotype Prediction**

155 ***A Priori* Replication Analyses**

156 We evaluated previous cross-phenotype predictions based on recent work—for example, that age at  
157 menarche had an inverse association with obesity/body mass index (Bulik-Sullivan *et al.* 2015). We tested several  
158 hypotheses in the European group, in order to maximize sample size without introducing potential population

159 stratification. The multiple testing correction procedure we chose (FDR) was suitable for these analyses, given the  
160 positive dependency between many of the tests, allowing us to correct uniformly for the total number of tests while  
161 still keeping type I error rate relatively controlled. Of the 28 predictions tested, 22 showed effects in the expected  
162 direction ( $p=0.002$ , one-tailed sign test), and 7 were significant after stringent multiple-testing correction. Two  
163 previous notable null associations, MDD GPS predicting Grade Point Average (GPA), and Type 2 Diabetes GPS  
164 predicting GPA, were also null in our sample. Full results are presented in Table 1, including additional associations  
165 with the listed GPS phenotypes.

166 Phenome-Wide Prediction

167 We also performed hypothesis-free analyses across all 33 GPS and 55 S4S phenotypes to explore  
168 potentially novel associations. Multiple prior proportions of causal variants in the genome were tested, as detailed in  
169 Methods. Figure 2 presents notable results for GPS prediction of phenotypes in the European group for the prior  
170 proportion of 0.3 (that is, an initial assumption that 30% of the genome is associated with the GPS phenotype). The  
171 0.3 prior level showed stronger prediction in past work (Krapohl *et al.* 2015), and corresponds to a plausible  
172 assumption about the genetic architecture of many complex traits, due to instances of increasing sample size of  
173 GWAS proportionally increasing numbers of associated loci. In this group and prior proportion level, out of 1,815  
174 associations 35 were between  $q < 0.16$  and  $q > 0.05$  (0.16 being the P-value threshold corresponding to Akaike  
175 Information Criterion (Akaike, 1974)), 11 between  $q < 0.05$  and  $q > 0.01$ , and 26  $q < 0.01$ . An additional 53  
176 associations showed at least suggestive significance at other prior levels. A heatmap of analyses at can be found in  
177 Figure 2 (EUR; and for replications in all ancestries, Figures S1-S4 available in the online supplementary materials).  
178 Each plot presents significant associations as well as the direction of effect. Because of the uniform correction for  
179 multiple testing, we included of interest  $q < 0.16$  associations, which would be significant with more traditional  
180 correction methods accounting for previously established associations.

181 Notable results included SZ GPS significantly predicting nicotine use, depression and anxiety symptoms,  
182 and family history of depression, anxiety, alcohol use disorder, and drug use. In addition, GPS for neuroticism (N)  
183 predicted a number of relevant psychiatric phenotypes, including neuroticism, depression and anxiety symptoms.

184 **Genetic Profile Score Prediction of the Phenome Across Non-European Ancestries**

185 As noted earlier, most discovery GWAS have used European samples, and while there is good evidence for  
186 cross-ancestral replication for some traits, the generalizability of many of these relationships across ancestry is not

187 known. The diverse ancestry groups within S4S allowed cross-ancestral replication, and the use of continuous GPS  
188 metrics made the sample sizes available powerful enough to examine these hypotheses. A small proportion of the  
189 strongest predictors observed in the EUR were replicated across the other ancestries, with a broadly similar pattern  
190 of results across all ancestry groups only for “basic” traits such as height and BMI. While some outcome phenotypes  
191 were strongly predicted by GPS, a few outcome phenotypes, including physical activity, lifetime history of panic  
192 attack, age at first sexual intercourse, and bulimia nervosa were not predicted by any GPS in any ancestry group. In  
193 addition, some expected associations (e.g., PRS for nicotine use predicting smoking behaviors) while in the expected  
194 direction, were not significant in this sample.

195 Most associations of SZ GPS with outcome traits observed in EUR did not reach significance in other  
196 ancestry samples. In addition, some novel associations were observed in other ancestries. For example, lifetime  
197 smoking GPS was positively associated with number of alcoholic drinks per day in AMR. Neuroticism GPS was  
198 positively associated with stressful life events, trauma (interpersonal and general), and PTSD in SAS. These patterns  
199 of effects are based on EUR GWAS summary statistics, and must be replicated using AMR and SAS GWAS  
200 summary statistics in the future. However, they suggest potential pleiotropic effects relevant to outcomes in these  
201 populations.

## 202 **GPS-GPS Correlations**

### 203 A Priori Hypothesis Testing and Global Cross-Disorder Genetic Profile Analyses

204 *A priori* hypotheses (described in the Methods and listed in Table 2) of relationships between GPS scores  
205 were tested at a prior proportion level of 0.3. Figure 3 presents the results for GPS-GPS partial correlations at a GPS  
206  $p = 0.3$ , and these results are presented because some phenotypes studied here (e.g., Neuroticism) were not included  
207 in previous analyses. Notable unexpected correlations were observed, including significant positive correlations of  
208 neuroticism GPS with GPSs for triglycerides and coronary artery disease. These associations also serve as evidence  
209 of non-independence across traits in this sample. Finally, Figures S5-S8 (available in the online supplementary  
210 materials) present these same correlations across the four non-EUR ancestry groups. There is some overlap between  
211 the discovery samples for neuroticism and triglycerides, but no overlapping studies were included in the neuroticism  
212 and the coronary artery disease discovery samples. Therefore, the correlation of neuroticism and coronary artery  
213 disease is especially likely to reflect underlying genetic correlation between neuroticism and artery disease. Despite

214 overlap in the discovery samples for the neuroticism and triglycerides polygenic scores, validation using LD score  
215 regression supported the existence of a genetic relationship between them ( $r_G = 0.53$ ;  $SE = 0.04$ ;  $p = 1.5 \times 10^{-36}$ ).

216

217 **Discussion**

218 The findings here present a wide-ranging and nuanced picture of major dimensions of vulnerability to  
219 psychopathology at a genetic level. This study includes substantial sample sizes of emerging adults, uses outcome  
220 measures (with novel phenotypes in phenomic analyses; see Table S2 in the online supplement for details of  
221 assessment scales), includes a wide range of discovery GWAS, and is powerful enough to draw preliminary  
222 conclusions about several ancestries. Because this study does not look for “hits” in the traditional GWAS sense and  
223 instead uses continuous GPS metrics, sample sizes provide adequate power across all separate ancestries in this  
224 study.

225 Importantly, results reflect EUR relationships between anxiety, depressive, and schizophrenia-spectrum  
226 disorders that are largely consistent with current conceptualizations of diagnostic classification, and confirm the  
227 important involvement of a network of medical and risk phenotypes in genetic predisposition to these disorders.  
228 Informative genetic associations between medical and clinical phenotypes exist despite the relative dearth of  
229 individual loci of genome-wide significance.

230 We can learn a lot from the study of emerging adults relative to younger, adolescent samples, as more  
231 targeted theories about critical exposures and environmental risk factors can emerge. For example, GPS for SZ  
232 predicted anxiety, depression, nicotine use, experiences of interpersonal trauma, and family history of mental health  
233 problems. Importantly, these results expand on recent evidence that genetic risk for SZ can successfully predict  
234 diverse risk phenotypes such as anxiety and negative symptoms (Kendler *et al.* 1996; Fanous *et al.* 2001; Docherty  
235 & Sponheim, 2008; Docherty & Sponheim, 2014; Docherty *et al.* 2015; Jones *et al.* 2016; Kendler, 2016), and  
236 demonstrate important links between SZ genetic risk and health factors in early adulthood. Significant association of  
237 GPS with easily measured, specific risk factors (e.g., nicotine use, family history, trauma) indicates that GPS could  
238 be useful in predicting psychopathology, particularly in conjunction with environmental moderators.

239 The incorporation of personality traits such as neuroticism was also quite informative. For example,  
240 neuroticism GPS significantly predicted a broad network of general anxiety, phobia, panic, neuroticism, and  
241 depression phenotypes in EUR, as well as multiple health-related GPSs. This is consistent with previous biometrical

242 and genomic research reporting significant relationships of neuroticism with MDD (Kendler & Myers, 2010;  
243 Genetics of Personality Consortium *et al.* 2015; Docherty *et al.* 2016), and preliminary findings from the  
244 UKBiobank suggesting a genetic overlap of neuroticism with cardiovascular health (Gale *et al.* 2016). Conversely,  
245 GPS for extraversion predicted fewer depressive symptoms, fewer anxiety symptoms, and less family history of  
246 mental health problems, though these associations did not remain significant after multiple testing correction.  
247 Associations pertaining to GPS for well-being in this sample are forthcoming from our research group.

248 Notable unexpected GPS-GPS results included positive correlations of neuroticism GPS with GPSs for  
249 coronary artery disease, which is likely to reflect underlying genetic correlation, as well as with triglycerides. This is  
250 the first study we know of to document significant positive genetic associations between neuroticism and cardiac  
251 health, despite the high public health cost of neuroticism being well-documented (Cuijpers *et al.* 2010;  
252 cardiovascular risk and association with psychiatric phenotypes like neuroticism may be of special interest to public  
253 health efforts). Most of the GPS-GPS *a priori* relationships chosen for replication testing were represented in the  
254 same direction across all ancestry groups, corroborating previous efforts to map relationships between genetic risk  
255 profiles.

256 The abundance of significant relationships between intuitive combinations of GPSs and related outcomes is  
257 reassuring considering the many factors that could attenuate the statistical link between them. Association between a  
258 GPS and an outcome not only reflects correlation between the phenotype in the original ('discovery') GWAS that  
259 produced the statistics used to compute the GPS and the outcome phenotype, but is also related to a number of other  
260 factors. The link is limited by how accurately the GWAS measured the initial phenotype, how similar the discovery  
261 and test samples are (in age, ancestry composition, proportions of each sex, etc.), how well the test phenotype is  
262 measured by the data collection instrument, and how well it can incorporate indirect pathways from the genetic  
263 architectures to either phenotype.

264 For example, physical activity increases HDL levels (Kokkinos & Fernhall, 1999), so those who had higher  
265 HDL levels in the discovery GWAS (Teslovich *et al.* 2010) were likely a mix of those with innately high levels,  
266 those who engaged in higher levels of physical activity, and those with both traits. Therefore, HDL GPS perhaps  
267 indexes some propensity to engage in HDL-promoting behaviors, in addition to HDL metabolic variation such as a  
268 slower rate of HDL catabolism, which is thought to be the most common genetically determined mechanism  
269 of increased HDL levels in humans (Rader, 2006). The portion of the HDL GPS due to fitness behaviors may

270 explain some of the polygenic association with the test phenotypes of BMI and weight. Of note, while the HDL GPS  
271 did not significantly predict the physical activity phenotype in S4S, the direction of effect was positive, and that  
272 particular phenotype had one of the smallest sample sizes, at 433 EUR individuals, and therefore lower power than  
273 others.

274 Using EUR GWAS summary statistics produced differential relationships of GPS with outcomes across  
275 ancestry, with few effects replicating across ancestry groups. This could be due to decreased power to detect effects  
276 given the smaller sample sizes of the other ancestry groups. However, within each ancestry group, new significant  
277 effects across GPS and outcome measures were observed as well. These effects suggest ancestry-specific summary  
278 statistics, or those with larger samples, may reveal differences in the pattern of relationships between phenotypes in  
279 different groups. Results underscore a need for more GWAS of non-EUR ancestry samples.

280 There are a number of limitations to be aware of when interpreting these results. The synthesis of  
281 information from so many sources compounds any methodological and psychometric issues present in the original  
282 studies, so there is probable bias in multiple levels of the analysis that is difficult to measure. It is unclear how  
283 generalizable our results are to the general population. However, we might assume that bias in the college sample  
284 would cause less robust associations with psychopathology, and that effects might be more pronounced in the  
285 general population. In order to maintain proximity with real outcomes, we did not transform our phenotypic  
286 variables to increase normality, but standardized the continuous variables computed from the participant responses  
287 to maintain comparable ranges of measurement. However, none of the phenotypes in which we found significant  
288 results evidenced high skew or kurtosis, so it is unlikely that significant effects were due to non-normal phenotype  
289 distributions. While LDpred performs adequately across ancestry groups, the accuracy in non-European ancestry  
290 groups is attenuated to the degree that multiple causal variants fall in regions where LD patterns differ across  
291 ancestry. In addition, a recent pre-print (Martin *et al.* 2016) shows biased predictions in several different populations  
292 using GPS for phenotypes that are also used in this paper (for example, Type 2 diabetes and SZ). Finally, we  
293 observed some differential effects across priors in our analyses. Until these effects are replicated at a given prior, or  
294 there is justified precedent in the literature, we are unable to choose one ideal prior.

295 Overall, this broader picture of genetic vulnerability has important implications for how we study risk and  
296 resilience in emerging adulthood. While the variance explained by any of these GPSs is small, (for instance, the  
297 largest  $R^2$  for predicting the height phenotype was 0.055, from the height GPS at a prior level of 1) they provide

298 easily accessible information to guide future prediction, prevention, and intervention efforts to improve health and  
299 quality of life outcomes. Future longitudinal and intervention research could elaborate on this atlas to examine the  
300 predictive validity and prevention utility of many of the phenotypes here, such as neuroticism, family history,  
301 trauma, and nicotine use. This research also suggests that future polygenic work would benefit from GPSs based on  
302 non-European ancestry groups when such summary statistics are available. Phenome-wide research utilizing deeper  
303 phenotyping methods will likely further enhance results, and thus future prediction of positive and negative health  
304 outcomes.

305 Finally, the relationships outlined here provide implicit suggestions for studies of the causal structure of the  
306 GPS phenotypes themselves. The genetic architecture of most of the traits and disorders in the atlas display  
307 substantial overlap; a significant portion of genetic variation involved in the etiology of these constructs does not  
308 selectively contribute to risk for one phenotype as we know it, but rather has effects that act on some axis of liability  
309 that increases the likelihood of many phenotypes. Analyzing multiple related phenotypes in a holistic fashion allows  
310 elucidation of the individual patterns of genetic and environmental factors that may explain causal mechanisms—  
311 which risk factors they share, and which are unique to one phenotype, thus serving to refine our nosological theories.  
312 Any epidemiological analysis is limited if the construct under study is not a uniform disease entity, but as  
313 characterization of constructs improves, the power to find their correlates does as well. The better we ask the  
314 questions, the more useful the answers become, for both clinical and scientific purposes.

315

**Author Contributions**

316 A. R. Docherty, A. Moscati, and K. S. Kendler developed the study concept. A. Moscati, J. E. Savage, J. E.  
317 Salvatore, and M. Cooke contributed to psychometric analyses and data collection. D. Dick and K. S. Kendler  
318 oversaw data collection. A. Moscati and A. R. Docherty performed the data analysis and interpretation under the  
319 supervision of B. T. Webb, S. A. Bacanu, D. E. Adkins, F. Aliev, A. C. Edwards, and B. P. Riley. A. R. Docherty  
320 and A. Moscati drafted the manuscript, and K. Kendler, A. C. Edwards, J. E. Savage, J. E., Salvatore, M. Cooke, B.  
321 T. Webb, S. A. Bacanu, D. E. Adkins, A. Moore, R. Peterson, and D. Dick provided edits. All authors approved the  
322 final version of the manuscript for submission.

323

### **Acknowledgements**

324 We would like to thank the participants and the many VCU faculty, students, and staff who contributed to the design

325 and implementation of this project.

326

**Financial Disclosures**

327 All authors declare no conflict of interest with respect to the authorship or publication of this article. Data collection  
328 for the study was funded by R37AA011408, P20AA107828, K02AA018755, and P50AA022537 from the National  
329 Institute on Alcohol Abuse and Alcoholism, by Virginia Commonwealth University, and by UL1RR031990 from  
330 the National Center for Research Resources and National Institutes of Health Roadmap for Medical Research. A.  
331 Docherty was funded by K01MH109765 from the National Institute of Mental Health, and by a Brain & Behavior  
332 Research Foundation (formerly NARSAD) Young Investigator Award. A. Moscati, A. Moore were supported by  
333 institutional training grant T32MH20030. J. Salvatore was supported by F32AA22269 and K01AA024152. M.  
334 Cooke received support from UL1TR000058 from the National Institutes of Health National Center for Advancing  
335 Translational Science. A. Edwards was supported by K01AA021399.

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338

**Declaration of Interest**

339 Authors report no conflicts of interest.

340

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