social cognition). We hypothesized that language is related to social functioning, and language is indirectly related to social functioning through negative traits and social cognition.

Participants and Methods: We recruited 42 participants low in schizotypal traits and 44 high in schizotypal traits from undergraduate courses, and 15 FEP individuals were recruited from an early psychosis intervention center. On average, participants were 21.55 (4.39) years old and completed 14 (1.57) years of education. A majority were female (62%) and White (82%). Participants completed the Schizotypal Personality Questionnaire – Brief Revised Updated, which was used to categorize the schizotypy groups and sum negative traits; and measures of language/verbal ability (Similarities, Proverbs Test, semantic fluency, Digit Span), social cognition (Hinting Task, Affect Naming), and examiner-rated (Global functioning [GF]: Social) and performance-based social functioning (Social Skills Performance Assessment; SSPA). We also measured verbal processing speed and COVID-19 distress as covariates. Standardized scores were used for neurocognitive variables, and we used raw scores for most other variables. We utilized hierarchical linear regression models to examine whether specific language/verbal skills accounted for unique variance in examiner-rated and performance-based social functioning. For our exploratory analyses, we created averaged z-scores for language, social cognition, and social functioning and then, employed PROCESS Macro Model 4 to examine whether negative traits or social cognition were significant mediators in two separate mediation models.

Results: Controlling for verbal processing speed and COVID-19 distress, language accounted for a significant portion of variance in SSPA performance, $p = .008$, $\Delta R^2 = .12$. Specifically, better Proverbs Test performance was uniquely associated with better SSPA performance, $\beta = .33$, $p = .002$. Controlling for study covariates, language was unrelated to GF: Social ratings, $p = .31$, $\Delta R^2 = .038$. In exploratory analyses, language was significantly indirectly related to social functioning through social cognition, $\beta = .15$, $SE = .04$, 95% CI [.04, .27], but not through negative traits, $\beta = .08$, $SE = .06$, 95% CI [-.001, .17].

Conclusions: Our findings suggest that executively-mediated language tasks (e.g., Proverbs Test) and social cognition may be beneficial treatment targets for social impairment. Limitations include generalizability of the present findings, small FEP sample, and cross-sectional design. Future work should replicate these findings in longitudinal models.

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Keyword 1: language
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Keyword 3: psychosis
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70 Comparison of MCCB Autocorrelations Between Schizophrenia and Healthy Comparison Populations

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Objective: Deficits in cognitive ability are common among patients with schizophrenia. The MATRICS Consensus Cognitive Battery (MCCB) was designed to assess cognitive ability in studies of patients diagnosed with schizophrenia and has demonstrated high test-retest reliability with minimal practice effects, even in multi-site trials. However, given the motivational challenges associated with schizophrenia, it is unknown whether performance on MCCB tasks affects performance at later stages of testing. The goal of this study was to determine whether there are differences between people with and without schizophrenia in how their performance on individual MCCB tasks influences their performance throughout the battery.

Participants and Methods: The sample comprised 92 total participants including 49 cognitively healthy comparison participants and 43 outpatients diagnosed with schizophrenia. The mean age of participants was 44.2 years (SD = 12.0, range 21-69) and 61% identified as male. The Trail Making Test, Brief Assessment of Cognition in Schizophrenia, Hopkins Verbal Learning Test – Revised, Letter-Number Span,

and Category Fluency from the MCCB were administered in the same order at 2 different sites and studies from 2016-2022. The autocorrelation between t-scores for task scores within each participant was computed and then compared between control and outpatient participants to determine if there are differences between groups. Group mean t-scores for each task were also compared between groups.
Results: We found no significant difference in autocorrelations across MCCB tasks between healthy comparison participants and outpatients. However, mean performance in all tasks was lower for the outpatient group than for the healthy comparison group. None of the tasks used stood out as having significantly lower mean scores than other tasks for either group.
Conclusions: Our findings suggest that performance on individual MCCB tasks do not affect performance throughout the battery differently between the healthy comparison group and outpatients. This suggests that participants with schizophrenia are not particularly reactive to past performance on MCCB tasks. Additionally, this finding further supports use of the MCCB in this population. Further research is needed to determine whether subgroups of patients and/or different batteries of measures show different patterns of reactivity.

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71 Examining the Psychometric Validity of NeuroScreen to Assess Neurocognition in Hospitalized Psychosis Patients in Uganda

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Objective: People with psychotic disorders often experience neurocognitive deficits, such as neurocognitive impairment (NCI), which can negatively affect their daily activities (e.g., performing independent tasks) and recovery. Because of this, the American Psychology Association advocates integrating neurocognitive testing into routine care for people living with psychotic disorders, especially those in their first episode, to inform treatment and improve clinical outcomes. However, in low-and-middle income countries (LMICs), such as Uganda where the current study took place, administering neurocognitive tests in healthcare settings presents numerous challenges. In Uganda there are few resources (e.g., trained clinical staff, and culturally relevant and normed tests) to routinely offer testing in healthcare settings. *NeuroScreen* is a brief, highly automated, tablet-based neurocognitive testing tool that can be administered by all levels of healthcare staff and has been translated into indigenous Ugandan languages. To examine the psychometric properties of *NeuroScreen*, we measured convergent and criterion validity of the *NeuroScreen* tests by comparing performance on them to performance on a traditional battery of neurocognitive tests widely used to assess neurocognition in people with psychotic disorders, the Matric Consensus Cognitive Battery (MCCB).
Participants and Methods: Sixty-five patients admitted into Butabika Mental Referral Hospital in Uganda after experiencing a psychotic episode and forty-seven demographically similar control participants completed two neurocognitive test batteries: the MCCB and *NeuroScreen*. Both batteries include tests measuring the neurocognitive domains of executive functioning, working memory, verbal learning, and processing speed. Prior to completing each battery, patients were medically stabilized and could not exhibit any positive symptoms on the day of testing. On the day of testing, medication dosages were scheduled so