

Mapping the genetic landscape across 14 psychiatric disorders

<https://doi.org/10.1038/s41586-025-09820-3>

Received: 5 December 2024

Accepted: 28 October 2025

Published online: 10 December 2025

Open access



Psychiatric disorders display high levels of comorbidity and genetic overlap^{1,2}, challenging current diagnostic boundaries. For disorders for which diagnostic separation has been most debated, such as schizophrenia and bipolar disorder³, genomic methods have revealed that the majority of genetic signal is shared⁴. While over a hundred pleiotropic loci have been identified by recent cross-disorder analyses⁵, the full scope of shared and disorder-specific genetic influences remains poorly defined. Here we addressed this gap by triangulating across a suite of cutting-edge statistical and functional genomic analyses applied to 14 childhood- and adult-onset psychiatric disorders (1,056,201 cases). Using genetic association data from common variants, we identified and characterized five underlying genomic factors that explained the majority of the genetic variance of the individual disorders (around 66% on average) and were associated with 238 pleiotropic loci. The two factors defined by (1) Schizophrenia and bipolar disorders (SB factor); and (2) major depression, PTSD and anxiety (Internalizing factor) showed high levels of polygenic overlap⁶ and local genetic correlation and very few disorder-specific loci. The genetic signal shared across all 14 disorders was enriched for broad biological processes (for example, transcriptional regulation), while more specific pathways were shared at the level of the individual factors. The shared genetic signal across the SB factor was substantially enriched in genes expressed in excitatory neurons, whereas the Internalizing factor was associated with oligodendrocyte biology. These observations may inform a more neurobiologically valid psychiatric nosology and implicate targets for therapeutic development designed to treat commonly occurring comorbid presentations.

Half of the population will meet criteria for at least one psychiatric disorder during their lifetime⁷, with many meeting criteria for multiple disorders¹. High levels of psychiatric comorbidity complicate efforts to differentiate among psychiatric disorders. These challenges are heightened because psychiatric disorders are defined by signs and symptoms, as the underlying pathophysiologies remain largely unclear. Rapid progress in psychiatric genomics has identified hundreds of associated loci (genetic variants), many of which exhibit pleiotropic (shared) associations across disorders, and revealed high correlations in genetic liability across disorders⁸.

The present analyses represent the third major study from the Psychiatric Genomics Consortium Cross-Disorder working group⁹ (CDG3). Here we examined the shared and unique influences of common genetic variants across 14 psychiatric disorders. Triangulating across multiple, complementary analytic approaches, we dissected the genetic architecture across disorders at the genome-wide, regional, functional and individual genetic variant levels. Our results have implications for refining clinical nosology and repurposing and developing novel treatments.

GWAS data for 14 psychiatric disorders

A summary of the datasets is provided in Extended Data Table 1. Psychiatric disorders were included if described in a psychiatric diagnostic

manual^{10,11} and power was sufficient to interpret genetic correlations⁴. This reflects a major update relative to previous CDG1 (ref. 12) and CDG2 (ref. 5) analyses (average case increase of around 165% above CDG2; Supplementary Fig. 1), with new genome-wide association studies (GWASs) for all eight disorders from CDG2: attention-deficit/hyperactivity disorder (ADHD), anorexia nervosa (AN), autism spectrum disorder (ASD), bipolar disorder (BIP), major depression (MD), obsessive-compulsive disorder (OCD), schizophrenia (SCZ) and Tourette's syndrome (TS)^{13–20}. We added six additional disorders: alcohol-use disorder (AUD)²¹, anxiety disorders (ANX)²², post-traumatic stress disorder (PTSD)²³, nicotine dependence assessed using the Fagerström test for nicotine dependence (NIC)²⁴, opioid-use disorder (OUD)²⁵ and cannabis-use disorder (CUD)²⁶. The three substance-use disorders (SUDs) are novel relative to a more recent cross-disorder analysis²⁷, and sample size increases were significant for previously included disorders (average case increase of around 287%). The sample sizes, and therefore the power of the disorder GWAS, differed (Extended Data Table 1 ($N_{\text{effective}}$)).

Owing to an uneven representation of ancestral groups, the full set of cross-disorder analyses was restricted to GWAS summary statistics from a single genetic ancestry group—European-like (EUR-like)—defined on the basis of genetic similarity to European descent in global reference panels²⁸. We also report bivariate results for MD²⁹ and SCZ³⁰ in East-Asian-like (EAS-like) genetic ancestry groups and AUD³¹, CUD²⁶,

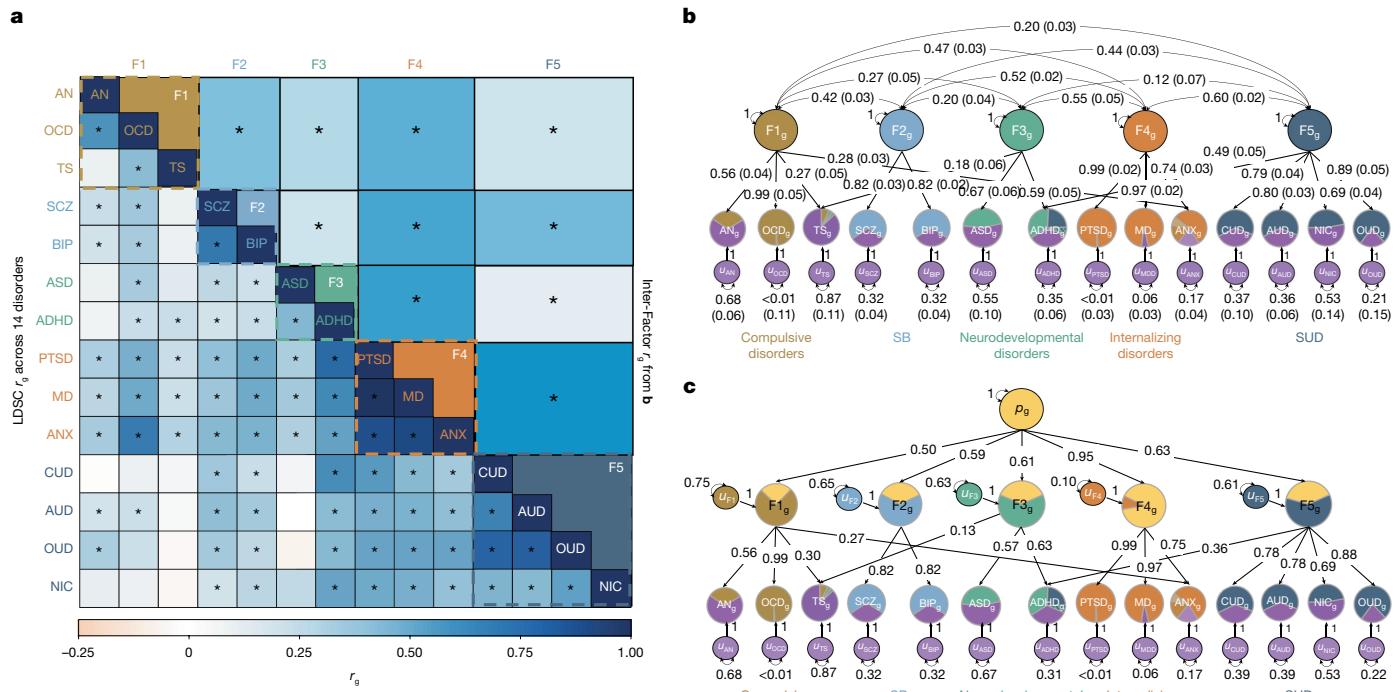


Fig. 1 | Genome-wide structural models. **a**, Heatmap of r_g s across the 14 disorders as estimated using LDSC on the lower diagonal and the correlations among the psychiatric factors as estimated using GenomicSEM above the diagonal. Two-sided P values were derived from the Z -statistics, calculated as the point estimate of the r_g divided by its s.e. Cells depicted with an asterisk reflect values that were significant at a Bonferroni-corrected threshold for multiple comparisons. Exact values are reported in Supplementary Table 1. Disorders that load on the same factor are shown in the same colour. Per the legend at the bottom of the panel, darker blue shading indicates larger, positive r_g s. LDSC estimates were used as the input to genomic SEM to produce the results in **b** and **c**. **b**, Estimates from the five-factor model along with standard

errors in parentheses. Estimates are standardized relative to SNP-based heritabilities, where this is equal to the sum of the squared factor loading (the single-headed arrow(s) from the factor to the disorder) and the residual variance (the values on the double-headed arrows on the single-colour circles with text labels that begin with u). Disorders are shown as pie charts; the proportion of residual variance is shaded in purple and the variance explained by the psychiatric factors is shaded in the colour of the corresponding factor. **c**, Standardized estimates from the p -factor model. The disorders are colour coded as in **b**, and the first-order factors (F1-F5) are also colour coded to show variance explained by the second-order p -factor in yellow.

OUD²⁵ and PTSD²³ in African-like (AFR-like) genetic ancestry groups similarly defined based on reference panels.

Genome-wide genetic correlations

Genetic correlations (r_g s) estimated using linkage disequilibrium (LD) score regression (LDSC)⁴ revealed pervasive genetic overlap across disorders at the genome-wide level, with clusters of disorders demonstrating particularly high genetic overlap in individuals of EUR-like genetic ancestry (Fig. 1; Supplementary Table 1; see Supplementary Figs. 2–4 for consideration of high r_g across PTSD and MD). The LDSC estimates within AFR-like participants were not significant, due to limited power (Supplementary Table 4). The r_g between MD and SCZ in EAS-like participants ($r_g = 0.45$, s.e. = 0.09) was double that observed in EUR-like participants ($r_g = 0.22$, s.e. = 0.04), which has been shown²⁹ to be driven by a single cohort of severe and recurrent MD³².

As the majority of analyses were restricted to participants of EUR-like genetic ancestry, we sought to gauge how generalizable our findings were across ancestral groups. We achieved this using Popcorn³³, which can estimate r_g s for the same trait across ancestral groups. We estimated the genetic impact correlation (ρ_{gi}), which considers different allele frequencies across populations by calculating the correlation between the population-specific, allele-variance-normalized single-nucleotide polymorphism (SNP) effect sizes. The results were underpowered for many comparisons, but included a strong EAS–EUR correlation for SCZ ($\rho_{gi} = 0.85$, s.e. = 0.04), followed by lower correlations between EAS-like and EUR-like for MD ($\rho_{gi} = 0.67$, s.e. = 0.16) and for AFR-like and EUR-like

PTSD ($\rho_{gi} = 0.59$, s.e. = 0.27; Supplementary Table 4). While these results suggest that the findings that follow for EUR-like ancestry groups may generalize better for some disorders (such as SCZ) than for others (for example, PTSD and MD), that conclusion awaits replication in more highly powered analyses.

MiXeR reveals pervasive genetic overlap

Genome-wide r_g s from LDSC indicate shared genetic risk across psychiatric disorders. However, LDSC may underestimate the extent of genetic overlap if shared causal variants reflect a mixture of directionally concordant and discordant associations. We applied bivariate causal mixture modelling (MiXeR) to quantify the degree of genome-wide polygenic overlap reflecting the total number of shared causal variants regardless of magnitude or directionality⁶. Cross-trait analyses were limited to MD, SCZ, BIP, ANX, ADHD, PTSD, AUD and AN, because other disorders were underpowered (Methods; results for univariate MiXeR are reported in Supplementary Table 5 and Extended Data Fig. 1). Supplementary Fig. 5 displays cross-trait MiXeR results for pairwise overlap across four particularly well-powered disorder samples: ADHD, SCZ, BIP and MD (complete results are shown in Supplementary Figs. 6–9 and Supplementary Table 6). There was greater polygenic overlap across psychiatric disorders than suggested by the r_g s from LDSC. Overall, MiXeR results suggested that the shared genetic signal for psychiatric disorders primarily reflects variants with concordant effects across disorders, while differentiation in genetic risk is driven by fewer shared discordant or unique variants.

Genomic SEM identifies five factors

We used genomic structural equation modelling (genomic SEM)^{27,34} in the EUR-like genetic ancestry datasets to model genetic overlap from LDSC across 14 disorders as latent factors representing dimensions of shared genetic risk (Methods). A five-factor model (Supplementary Tables 2 and 3) provided the best fit to the data (comparative fit index (CFI) = 0.971, standard root mean square residual (SRMR) = 0.063). These five latent genomic factors (capitalized throughout, to distinguish them from the psychiatric disorders that define them) (Fig. 1) comprised: F1, a Compulsive disorders factor defined by AN, OCD and, more weakly, TS and ANX; F2, a SB factor defined by SCZ and BIP; F3, a Neurodevelopmental factor defined by ASD, ADHD and, more weakly, TS; F4, an Internalizing disorders factor defined by PTSD, MD and ANX; and F5, a SUD factor defined by OUD, CUD, AUD, NIC and, to a lesser extent, ADHD.

Within this five-factor model, Internalizing disorders and SUD factors displayed the highest interfactor correlation ($r_g = 0.60$; s.e. = 0.02). The median residual genetic variance unexplained by the latent factors was 33.5%, indicating that most genetic risk was shared among disorder subsets. TS displayed the most unique genetic signal, with 87% of its genetic variance unexplained by the factors. The structure of the first four factors was similar to that found by genomic SEM applied to subsets of these disorders in previous work^{5,27}, indicating stability in the underlying factor structure, even as sample sizes and the number of disorders have increased. The newly added SUD traits formed the fifth factor.

Evidence of moderate r_g between factors suggests that a higher-order factor may explain common variance across the correlated factors. Consistent with this observation, a hierarchical model also fit the data well (CFI = 0.959, SRMR = 0.074). We refer to this as the *p*-factor model, which included a higher-order general psychopathology factor defined by the five lower-order psychiatric factors (such as SUD). Internalizing loaded most strongly on *p* (0.95), with the other 4 factors having moderate loadings (0.50–0.63).

As some of the underlying data were obtained using brief, self-reported diagnoses, we performed a sensitivity analysis in which those data were excluded (Supplementary Note 1, Supplementary Tables 7–11 and Supplementary Figs. 10–18). The r_g matrix was largely unchanged; the five-factor model identified in the full sample continued to provide good fit to the data and produced similar point estimates, and downstream GWAS analyses (detailed below) identified similar loci.

Genetic correlations with factors

We estimated r_g s between the five correlated factors, hierarchical *p*-factor and 31 complex traits (Supplementary Table 12) to place shared genetic liability indexed by the factors in a broader clinical context. These factors vary in their use for capturing shared genetic signal; accordingly, we used the Q_{Trait} heterogeneity statistic to assess this use at the genome-wide level. When Q_{Trait} is significant, this indicates a trait's r_g deviates from the factor structure. For example, if trait *X* is negatively correlated with SCZ but unrelated to BIP, Q_{Trait} would probably be significant, suggesting that trait *X* lies outside the shared signal captured by the factor. Significant correlations were defined at a Bonferroni-corrected threshold of $P < 2.68 \times 10^{-4}$, while not significant for Q_{Trait} at this same threshold. This Q_{Trait} exclusion criteria was relaxed for the *p*-factor if that trait was significantly associated with the majority (≥ 3) of the five correlated factors, as this indicates the trait is capturing transdiagnostic associations the *p*-factor is intended to index.

The Internalizing disorders and SUD factors were the only factors associated with household income ($r_{g, Internalizing} = -0.40$, s.e. = 0.02; $r_{g, SUD} = -0.41$, s.e. = 0.03; Fig. 2) and were the most pervasively associated with different cognitive outcomes, including childhood intelligence ($r_{g, Internalizing} = -0.27$, s.e. = 0.05; $r_{g, SUD} = -0.40$, s.e. = 0.07). Only

the SUD factor was associated with adult intelligence ($r_{g, SUD} = -0.40$, s.e. = 0.03) and verbal numerical reasoning ($r_{g, SUD} = -0.41$, s.e. = 0.03). This was compared to more circumscribed cognitive associations for the Compulsive disorders and SB factors, including a large negative correlation with the pairs matching test (potentially indexing memory; $r_{g, Compulsive} = -0.33$, s.e. = 0.03; $r_{g, SB} = -0.34$, s.e. = 0.03). The SB and SUD factors were the only ones associated with risk tolerance ($r_{g, SB} = 0.31$, s.e. = 0.03; $r_{g, SUD} = 0.38$, s.e. = 0.03). The Neurodevelopmental factor was uniquely associated with childhood BMI ($r_{g, Neurodevelopmental} = 0.26$, s.e. = 0.06) and showed high genetic overlap with childhood aggression ($r_{g, Neurodevelopmental} = 0.94$, s.e. = 0.10). As would be expected, the five traits significantly associated with all five correlated factors were also among the top correlations for the *p*-factor, reflecting stress sensitivity ($r_{g, p} = 0.50$, s.e. = 0.02), loneliness ($r_{g, p} = 0.62$, s.e. = 0.02), neuroticism ($r_{g, p} = 0.64$, s.e. = 0.02), self-harm ($r_{g, p} = 0.74$, s.e. = 0.04) and suicide attempts ($r_{g, p} = 0.87$, s.e. = 0.03). The full set of correlations is shown in Supplementary Table 13; comparison across factors is shown in Extended Data Fig. 2; and comparison across traits within each factor is shown in Extended Data Fig. 3.

LAVA finds regional hotspots of overlap

Global estimates of pleiotropy, such as the genome-wide r_g s from LDSC, provide an average of the degree of shared signal across the genome. However, as genetic overlap is unlikely to be constant across genomic regions, we segmented the genome into 1,093 LD-independent regions, and applied local analysis of (co)variant association (LAVA³⁵; Methods) to assess the r_g between disorders within these regions. In addition to capturing heterogeneity in genetic overlap and pinpointing relevant regions, LAVA identifies potential r_g hotspots shared among several disorders, thereby providing further insight into genetic architecture.

We restricted analyses to loci with sufficient SNP-based heritability for the disorders analysed ($P < 4.6 \times 10^{-5} = 0.05/1,093$; Methods). Correcting for the number of bivariate tests performed across all regions and disorder pairs, we detected 458 significant pairwise local r_g s ($P < 2.1 \times 10^{-6} = 0.05/24,273$). The pairs of disorders with the greatest number of local r_g hits were MD and ANX (113 regions), MD and PTSD (88 regions), and BIP and SCZ (40 regions), accounting for over half of all significant local r_g s detected (Fig. 3a). This is consistent with the genome-wide levels of overlap indicated through the LDSC global r_g (Fig. 1), the polygenic overlap estimated with MiXeR (Supplementary Figs. 5–9), and the multivariate genetic structure identified by genomic SEM. Both global and local r_g s tended to be positive, with significant negative r_g s identified in only three instances (Supplementary Fig. 19). This indicates that the genetic risk for one disorder typically increases the risk for another (Supplementary Fig. 20).

We detected 101 regions that contained significant local r_g s between several disorder pairs, which we call r_g hotspots (see Supplementary Tables 14–23 for local r_g s across disorders in the top 10 hotspots). The most pleiotropic of these hotspots was on chromosome 11, which contained 17 positive and significant local r_g s involving 8 of the 14 analysed disorders (Fig. 3b). This region also stands out as the most significantly associated with 8 of these 17 disorder pairs, while ranking in the top 25% of associated loci for 12 of them (Supplementary Fig. 21). Notably, this region contains the *NCAM1–TTC12–ANKK1–DRD2* gene cluster that has been frequently associated with psychiatric phenotypes^{36–39}, and flagged as a likely pleiotropy hotspot for a range of cognitive and behavioural outcomes related to, for example, intelligence, personality, substance use and sleep^{35,40–42}.

Risk loci for psychiatric factors

We used multivariate GWAS within genomic SEM³⁴ to identify SNPs associated with the factors from the five-factor model or the *p*-factor

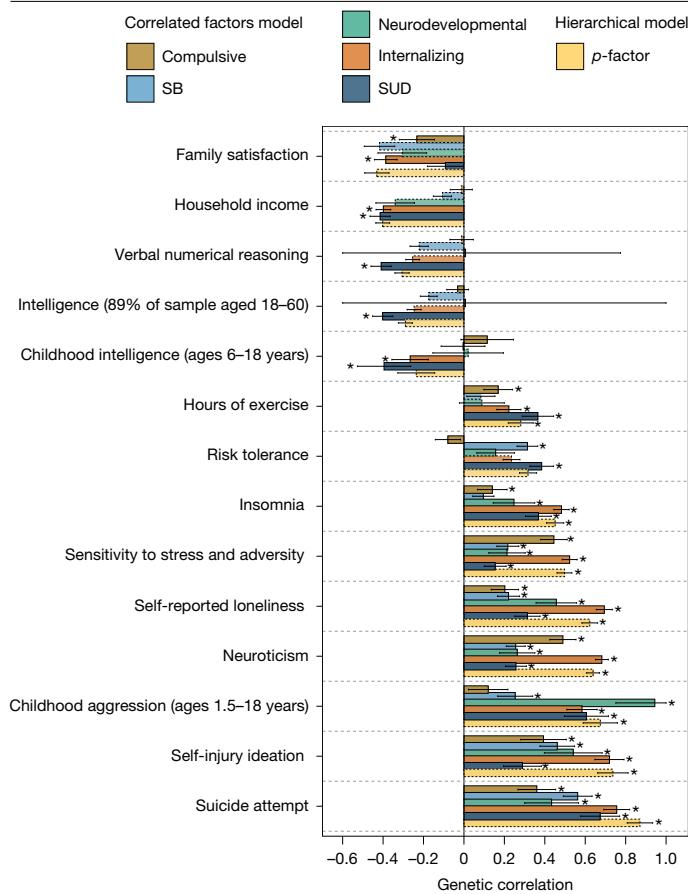


Fig. 2 | External trait genetic correlations for psychiatric factors. Point estimates for the r_g s between 14 external traits and the 5 psychiatric factors from the correlated factors model and the p -factor from the hierarchical model. These traits were selected as they were significantly correlated with at least one factor at >0.35 or <-0.35 . Bars depicted with a dashed outline were significant for the Q_{Trait} heterogeneity statistic, which indicates that the pattern of r_g s for that trait did not fit the factor structure. Bars depicted with an asterisk reflect values that were significant at a Bonferroni-corrected threshold for multiple comparisons, that were also not significant at this same Bonferroni corrected threshold for Q_{Trait} . This is with the exception that the p -factor is depicted with an asterisk even if it is significant for the Q_{Trait} , provided that the same trait was significantly correlated with the majority (at least three) of the five other factors. The two-sided P values used to evaluate significance were derived from the Z -statistics, calculated as the point estimate of the r_g divided by its s.e. Error bars are ± 1.96 s.e., centred around the point estimate of the r_g s. Traits are ordered by the point estimate for the p -factor. The implied sample size for the psychiatric factors was: Compulsive ($\hat{n} = 54,100$), SB ($\hat{n} = 127,202$), Neurodevelopmental ($\hat{n} = 84,760$), Internalizing ($\hat{n} = 1,637,337$), SUD ($\hat{n} = 313,395$) and p -factor ($\hat{n} = 2,168,621$). Sample sizes for the external traits are reported in Supplementary Table 12 and exact P values are reported in Supplementary Table 13.

in the hierarchical model. Similar to the Q_{Trait} metric, we estimated factor-specific Q_{SNP} heterogeneity statistics. This indexes SNPs that deviate strongly from the factor structure, due to either disorder-specific or directionally discordant effects. We defined genomic hits for the factors as those that were significant after Bonferroni correction ($P < 5 \times 10^{-8}/6$ genomic factors) and did not overlap with Q_{SNP} hits for that factor (Methods). Most hits were identified for the SB ($n = 102$) and Internalizing ($n = 150$) factors. After merging overlapping loci across the five correlated factors, 238 unique hits remained, including 27 broadly pleiotropic loci associated with two or more factors. The hierarchical model identified 160 hits for the p -factor (Fig. 4, Supplementary Fig. 22 and Supplementary Tables 24–36), 57 of which were not identified in the five-factor model (295 unique hits across both models). Forty-eight

hits were novel relative to the univariate GWAS, of which 38 have been described in previous GWAS for a broad range of outcomes, and 10 are entirely novel (Supplementary Table 37).

We identified 33 unique hits with significant Q_{SNP} effects across the factors from the five-factor model. By comparison, we identified 117 Q_{SNP} hits from the p -factor model that showed significantly divergent effects across the five, lower-order psychiatric factors (Supplementary Table 36). These p -factor Q_{SNP} hits also included the chromosome 11 LAVA hotspot, where this region was found not to confer transdiagnostic risk due to an absence of signal for the Neurodevelopmental factor. For the SUD factor, highly significant Q_{SNP} hits were driven by variants in the genes involved in biological pathways specific to particular psychoactive substances, including the alcohol dehydrogenase genes (*ADH1A*, *ADH1B* and *ADH1C*) for AUD and the *CHRNA3–CHRNA5–CHRN84* nicotinic receptor subunit gene cluster for NIC. More Q_{SNP} loci for the p -factor model relative to the five-factor model indicates that many shared genetic relationships are better captured by the five factors (Supplementary Figs. 23 and 24).

A genome-wide association study conducted in the Mayo Clinic Biobank revealed that factor hits were associated with multiple psychiatric disorders, especially those that loaded on the factor (Supplementary Table 38 and Supplementary Fig. 25). The Internalizing disorders (Supplementary Fig. 25d) and p -factor (Supplementary Fig. 25f) loci were also associated with a range of medical outcomes (for example, chronic pain and hypertension).

Divergent loci across disorders

In more fine-grained analyses of disorder pairs, case–case GWAS (CC-GWAS)⁴³ was used to identify loci with different allele frequencies across cases of different disorders. Such loci may reflect distinctive genetic effects across disorder pairs. CC-GWAS was applied to 75 disorder pairs, comparing 13 disorders. NIC was excluded because it is a continuous trait, and the pairs ANX–MD, ANX–PTSD and MD–PTSD were excluded because all had an r_g estimate of >0.8 , thereby risking an inflated type I error rate (Methods). The genome-wide significance threshold was defined at 5.5×10^{-10} (that is, $5 \times 10^{-8}/91$ pairwise comparisons). An overview of CC-GWAS input parameters is provided in Supplementary Table 39.

In total, 412 loci showed significantly different effects across the 75 disorder pairs (Supplementary Tables 40 and 41); most (294 out of 412) were in comparisons that included SCZ, possibly reflecting either greater power for the SCZ GWAS or more distinctive biology for this disorder. Owing to overlap among the hits, the 412 loci comprised 109 LD-independent loci (Supplementary Table 42). Five of these were CC-GWAS specific, implying that they were not significantly associated with case–control status in either of the disorders in the respective disorder pair. CC-GWAS also computes a genome-wide genetic distance between the cases of two disorders ($F_{\text{ST,causal}}$), indicating how genetically dissimilar the cases are on average. As expected, these genetic distances were inversely correlated ($r = -0.79$, s.e. = 0.07) with r_g (Supplementary Table 43). In support of the five-factor model, $>99\%$ of the CC-GWAS hits were identified for disorder pairs that loaded on separate factors (Supplementary Tables 44 and 45). Disorders that cluster on the same factor from the five-factor model are, apparently, largely indistinguishable at the level of individual genetic variants.

Functional annotation

Enrichment analyses

To understand biological functions influenced by the risk loci, we prioritized candidate risk genes implicated by the multivariate GWAS loci using expression quantitative trait loci (eQTL)^{44,45} and Hi-C^{44,46} datasets collected from fetal and adult brain samples (Methods and Supplementary Tables 46 and 47). Owing to the limited number of

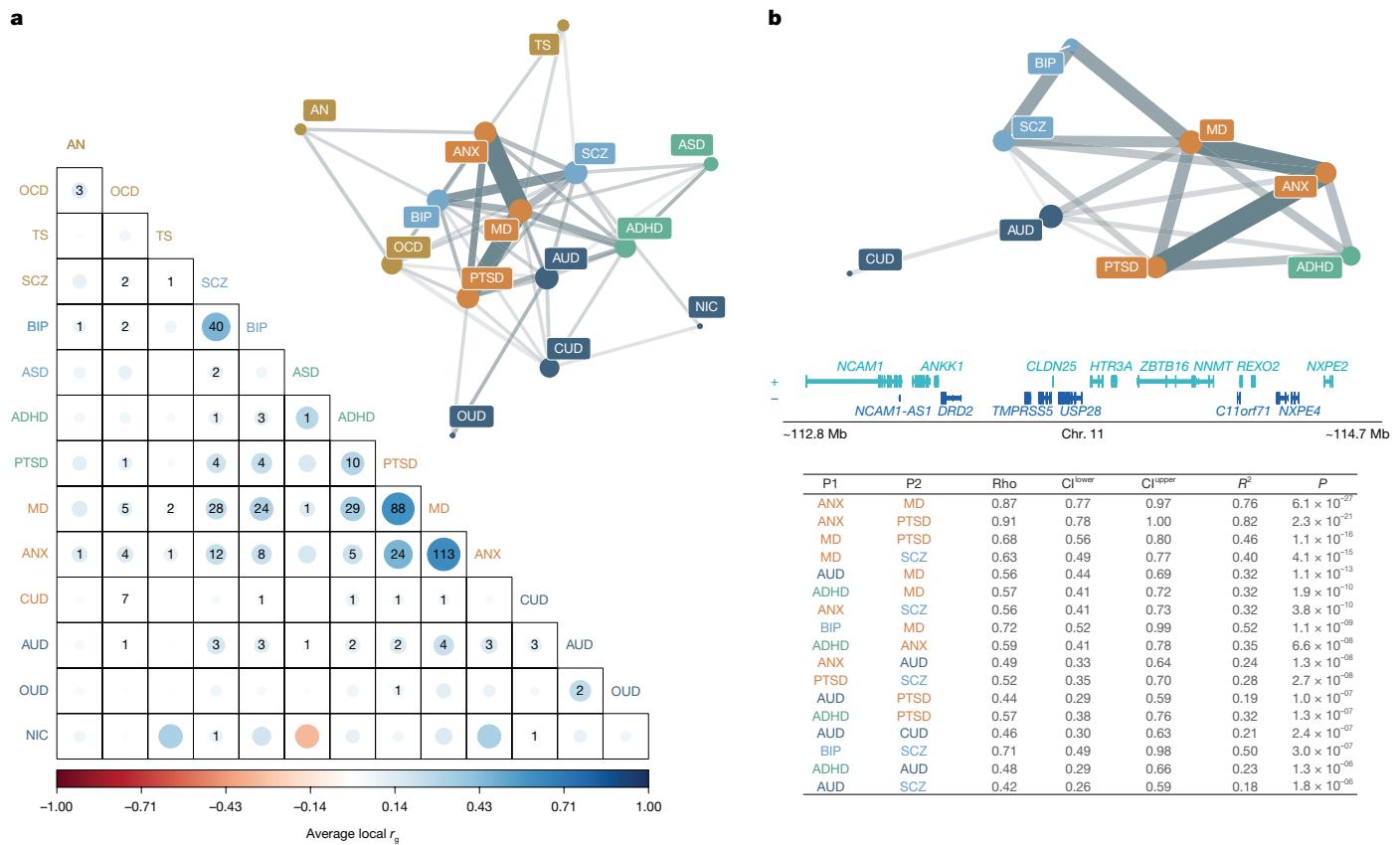


Fig. 3 | Local genetic correlations. **a**, An overview of the average patterns of local r_g s across the genome for all pairs of disorders, shown as a heatmap (below diagonal) and a network plot (above diagonal). The colours of the heatmap represent the average local r_g s across all evaluated loci, with darker red and blue shading indicating more negative and positive r_g , respectively; the dot size reflects the strengths of average associations; and the numbers indicate how many of the local r_g s were significant. These results are mirrored in the network plot, where the width or the edges reflect the number of significant associations, meaning that only disorders with at least one significant local r_g are connected, and the edge opacity reflects the strength of the average local r_g across tested loci. Note that label colours are concordant with the genomic SEM factor

structure from Fig. 1 and, as shown, disorders of similar colours also tend to be proximally located within the network. **b**, The local r_g structure within the top r_g hotspot on chromosome (chr.) 11 (112755447–114742317, GRCh37 reference genome), that is, the region where the greatest number of significant r_g s were found across all disorder pairs. Here, the network plot illustrates all significant r_g s detected in this region, with both edge width and opacity reflecting the strength of the association. The region plot in the middle displays the genes contained within the hotspot, and the table below shows the r_g estimates (Rho), 95% confidence intervals (CI_{lower}, CI_{upper}), variance explained (R^2) and P-values for all significant pairwise local r_g s in this region. Label colours are again concordant with those used for the genomic SEM factor structure in Fig. 1.

variants associated with other factors, analyses were restricted to the *p*-factor, the SB and Internalizing disorders factors and Q_{SNP} for these latter two factors. We first compared the target gene expression along the temporal trajectory of human brain development, finding that genes associated with the three factors were expressed at higher levels than Q_{SNP} target genes across the lifespan, with the largest difference observed at fetal stages and early life (Fig. 5 and Supplementary Fig. 26). This suggests that pleiotropic variants are involved in early, fundamental neurodevelopmental processes. We next examined biological processes using Gene Ontology (GO) enrichment analysis⁴⁷. The target genes of the *p*-factor were primarily enriched in broader biological processes related to gene regulation (Fig. 5). To enhance the specificity of the gene sets, we removed Internalizing disorders and SB target genes that also appeared for the *p*-factor. SB (minus *p*-factor) target genes were enriched in more specific terms related to neuron development. No significant results were identified for the Internalizing disorders factor, probably reflecting the large proportion of target genes overlapping with the *p*-factor. Results from MAGMA⁴⁸ (Supplementary Methods) provided convergent support for the role of early neurodevelopmental processes in transdiagnostic psychiatric risk. Specifically, genetic signal for the five correlated factors and *p*-factor showed enrichment in genes identified from rare variant studies of ASD^{49–51}, neurodevelopmental delay⁴⁹ or both (Supplementary Fig. 27).

Averaged results across expression-weighted cell type enrichment (EWCE)⁵² and MAGMA were used to evaluate enrichment within neuronal cell types in fetal and adult single-cell datasets^{53–57} (Supplementary Tables 48 and 49). Genes associated with the SB factor were significantly enriched in fetal data in interneurons and seven excitatory neuron subtypes, the strongest of which was for excitatory maturing neurons^{53,54} (Fig. 5). The SB factor was also uniquely enriched for deep-layer excitatory neurons in the adult brain⁵⁷. Internalizing disorder genes were enriched within four excitatory neuron subtypes in fetal data⁵³, although the signal was not as strong or pervasive as for the SB factor. In adult data, the Internalizing factor was enriched for medial ganglionic eminence (MGE) interneurons⁵⁶ and different glial cells, specifically oligodendrocytes and Bergmann glia^{56,57}. The *p*-factor was enriched for five excitatory neuron subtypes in fetal data and oligodendrocyte precursor cells in adult data⁵⁶. A significant proportion of these genes is expressed during both fetal and adult stages; cell type enrichment was largely driven by genes that are not expressed in a particular developmental stage (Supplementary Fig. 28). We also tested enrichment for loci specific to MD and SCZ identified from CC-GWAS. MD-specific signal was enriched for cycling and intermediate progenitors in fetal brain. SCZ-specific signal was enriched for endothelial, vascular and upper rhombic lip cells in adult brain (Supplementary Fig. 28).

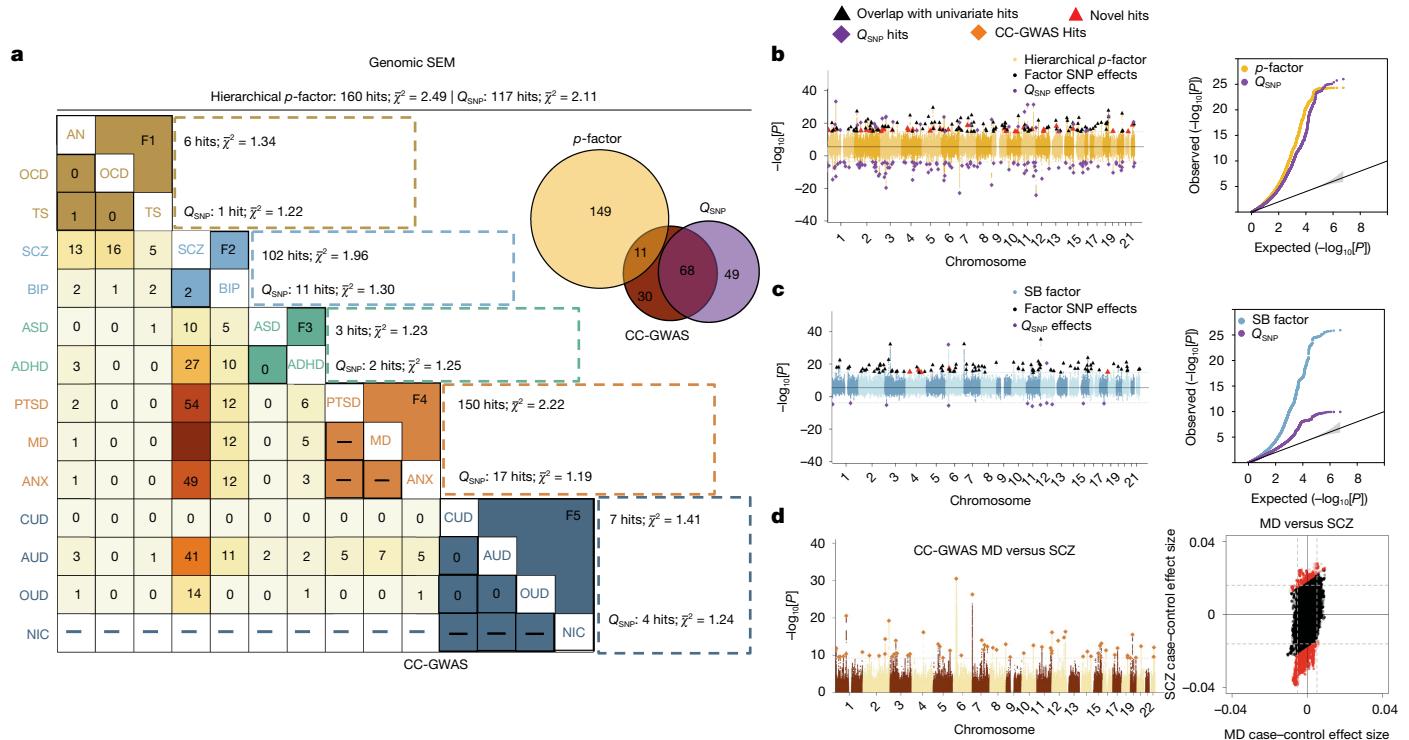


Fig. 4 | Locus-level results. **a**, Heatmap of CC-GWAS loci below the diagonal across pairwise combinations of disorders; the darker orange shading indicates a higher number of CC-GWAS hits. CC-GWAS results are not shown for the Internalizing disorders as their r_g 's were too high, or for nicotine dependence as this is a continuously measured trait. Genomic SEM results (number of hits and mean χ^2 for each factor and factor-specific Q_{SNP} estimate) are reported above the diagonal. Results for the p -factor are shown above the plot along with a Venn diagram of the overlap between p -factor, p -factor Q_{SNP} and overall CC-GWAS hits. The disorders are ordered and coloured according to the genomic SEM factor structure from Fig. 1. **b,c**, The Miami and QQ-plots for the p -factor (**b**) and SBs factors (**c**), respectively. These panels show the results for the $-\log_{10}$ -transformed

two-tailed P values for the factor on the top half of the Miami plot and the \log_{10} -transformed one-tailed P values for Q_{SNP} on the bottom half. Factor hits that were within 100 kb of univariate hits are shown as black triangles, novel hits for the factors that were not within 100 kb of a univariate or Q_{SNP} hit are shown as red triangles and Q_{SNP} hits are shown as purple diamonds. **d**, The two-tailed $-\log_{10}[P]$ in a Manhattan plot for the CC-GWAS comparison across MD and SCZ, which produced the most hits (orange diamonds), as well as the scatterplot of standardized case-control effect sizes of MD (x axis) versus SCZ (y axis), with CC-GWAS significant SNPs labelled in red. For **b–d**, the grey dashed lines indicate the significance threshold, which was defined using Bonferroni correction for multiple comparisons.

Stratified genomic SEM

We used stratified genomic SEM²⁷, a multivariate corollary of partitioned LDSC⁵⁸, to characterize the functional signals captured by the psychiatric factors in the five-factor and p -factor models, estimating enrichment for 162 functional annotations that passed quality control (Methods and Supplementary Table 50). Enrichment of the factor variances in the five-factor or p -factor models reflects groups of genetic variants that index a disproportionate concentration of genetic risk sharing. For the p -factor model, we also examined the enrichment of the residual (unique) variances of the five lower-order factors. Annotations significant for a factor in the p -factor model are therefore likely to capture signal specific to that factor. Enrichment was also calculated for a recent GWAS of height⁵⁹ to evaluate the specificity of the psychiatric findings. We used a Bonferroni-corrected significance threshold of $P < 2.81 \times 10^{-5}$ (Methods). We focus here on results for the better-powered SB, Internalizing and p -factor, and do not discuss annotations that lacked psychiatric specificity, as indicated by significant enrichment for height (for example, evolutionarily conserved annotations).

We identified 34 annotations that were significant for the SB factor in both models and are thereby likely to be specific to the neurobiology of the SB factor. This included the intersection between protein-truncating-variant-intolerant (PI) genes and several neuronal subtypes, including excitatory CA1 and CA3 hippocampal neurons (Extended Data Fig. 4 and Supplementary Table 50). In total, 51 significant annotations were identified for the Internalizing disorders

factor, including PI-oligodendrocyte precursor annotations. We also found strong enrichment for an annotation reflecting neural progenitor biology⁶⁰, further implicating early neurobiological processes in shared psychiatric risk. No annotations remained significant for the Internalizing disorders factor's residual variance (that is, independent of the p -factor), as would be expected given that only 10% of the genetic variance in the Internalizing disorders factor was separate from p . Finally, 64 significant annotations were detected for the p -factor, the strongest of which were fetal male brain H3K4me1 histone mark and PI-GABAergic neuron annotations.

Discussion

Our analyses characterized the landscape of shared and divergent genetic influences of common variants on 14 psychiatric disorders. At the genome-wide level, we confirmed pervasive genetic overlap across 14 clinically distinguished psychiatric disorders, as indicated by large pairwise r_g within the EUR-like genetic ancestry group and even greater overlap when including loci that are shared, but have divergent directional effects. This overlap was parsimoniously captured by five genomic factors (Compulsive, SB, Neurodevelopmental, Internalizing and SUD), which explained the majority of the genetic variance of the individual disorders. We identified 101 regions with correlated effects, including a hotspot on chromosome 11 with associations for 8 disorders. We found that broadly pleiotropic variants are primarily involved in early neurobiological processes, while also identifying different

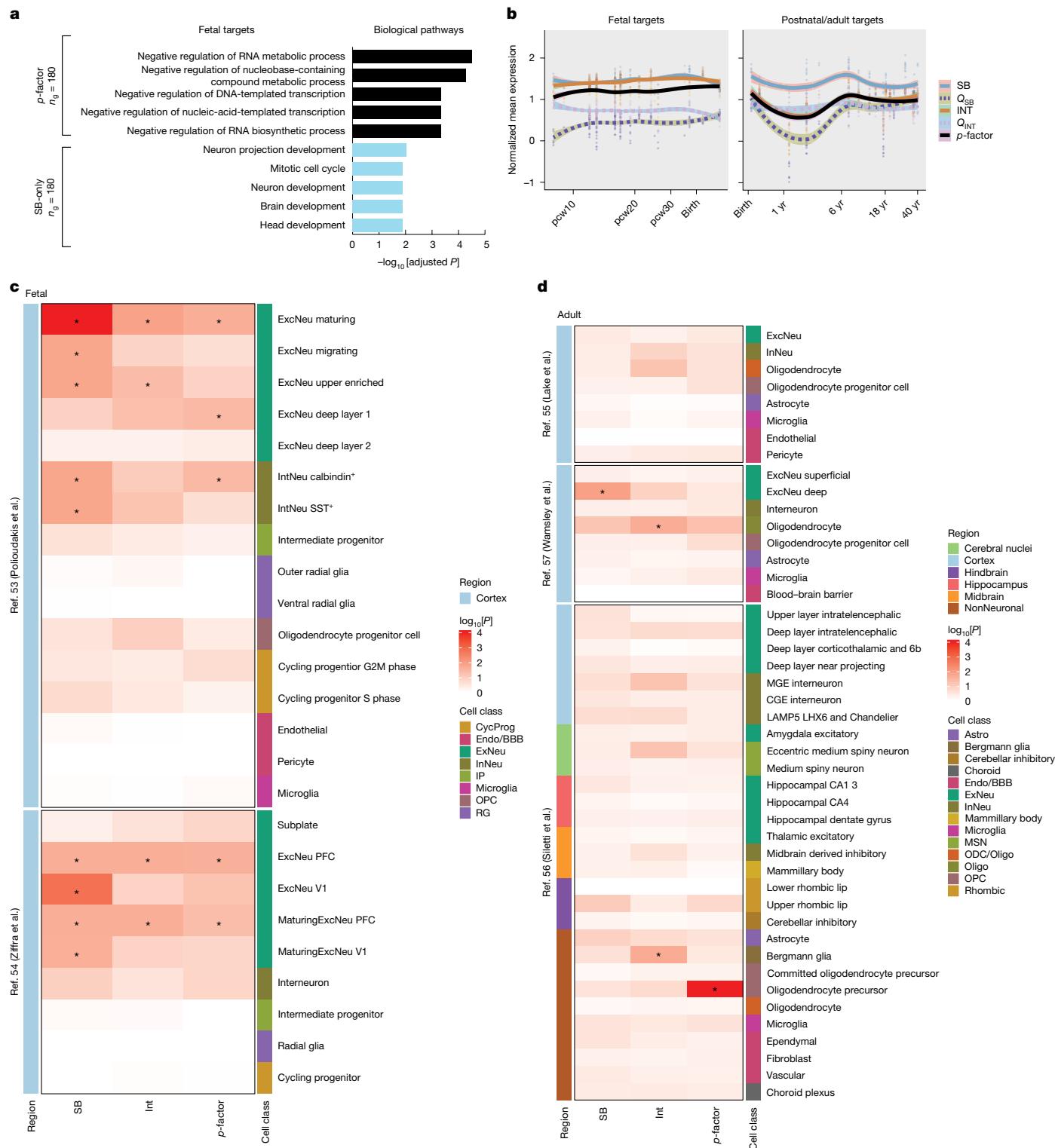


Fig. 5 | Functional annotation of factor variants. **a**, GO enrichment analysis of predicted target genes with transdiagnostic associations (that is, variants associated with the *p*-factor), or those target genes associated with the SB factor that were not overlapping with *p*-factor target genes. Depicted $-\log_{10}$ -transformed *P* values are one-sided, calculated using a χ^2 test; false-discovery rate (FDR) correction was applied for multiple comparisons. **b**, The averaged and normalized expression levels of target genes of the indicated classes along the temporal trajectory of human brain development. Shading around the lines reflects 95% CIs. pcw10, post-conception week 10. **c,d**, Average $\log_{10}[P]$ values across EWCE and MAGMA enrichment for genes associated with the indicated factors in fetal brain cell types using two independent single-cell RNA-sequencing (scRNA-seq) datasets^{33,54} (**c**) or adult brain cell types using three independent

single-nucleus RNA-seq (snRNA-seq) datasets^{55–57} (**d**). The *P* values from EWCE and MAGMA were two-sided and each had an FDR correction applied for multiple comparisons before averaging the two sets of results. EWCE *P* values were empirically derived using a permutation test; MAGMA *P* values were calculated using an *F*-test. Int, Internalizing disorders factor. The implied sample size for the three depicted psychiatric factors was: SB ($\hat{n} = 127,202$), Internalizing ($\hat{n} = 1,637,337$) and *p*-factor ($\hat{n} = 2,168,621$). CycProg, cycling progenitor; Endo/BBB, endothelial/blood brain barrier; ExNeu, excitatory neuron; InNeu, interneurons; IP, intermediate progenitor; OPC, oligodendrocyte progenitor cell; RG, radial glia; Astro, astrocyte; MSN, medium spiny neuron; ODC/Oligo, oligodendrocyte.

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brain cell types that uniquely confer risk to more circumscribed subsets of disorders. At the individual-variant level, we identified 238 loci associated with at least one of the five correlated psychiatric factors, along with 412 loci that distinguished disorders that primarily belong to different factors.

The SB (defined by SCZ and BIP) and Internalizing disorders (defined by major depression, PTSD and anxiety) factors offered a particularly useful way to understand shared risk across sets of disorders. For these factors, a diverse set of methods produced convergent results across genome-wide, regional and locus-level results, indicating that the disorders within these factors are characterized by overlapping genetic signal. A replicated finding across functional methods reflected enrichment for the SB factor in excitatory neuron annotations, including CA1 and CA3 hippocampal neurons, deep-layer neurons from adult data, and maturing, migrating, prefrontal and visual cortex excitatory neurons in fetal data. The Internalizing factor also showed enrichment in excitatory neurons, but was more consistently enriched in different glial cells in adult data, including oligodendrocytes and their precursor cells and Bergmann glia.

At the genome-wide level, the *p*-factor was strongly related to the Internalizing disorders factor and evinced the largest r_g s with external traits reflecting broad clinical characteristics, such as neuroticism, stress sensitivity and loneliness. These results are consistent with conceptualizations of the *p*-factor as reflecting a general tendency towards negative emotionality⁶¹. In support of the *p*-factor, LAVA identified pleiotropic hotspots characterized by widespread local r_g across disorders and multivariate GWAS yielded 160 hits for this factor alone. However, the *p*-factor also had more hits for the Q_{SNP} heterogeneity metric (117) than all five-factors from the correlated factors model (33), indicating that the *p*-factor alone is insufficient for explaining cross-disorder risk. The *p*-factor was largely enriched for broad biological categories, such as gene regulation. These results suggest a conceptual model in which there is a partial, broadly transdiagnostic component of genetic vulnerability to psychiatric disorders that primarily captures Internalizing genetic signals, with subsequent levels of more canalized and neurobiologically meaningful subdomains of psychopathology captured by the five factors.

Our study has several limitations. Analyses were restricted primarily to EUR-like genetic ancestry populations due to the limited availability of GWAS data for other groups and the limitations of methods requiring more genetically homogeneous groups⁶². The sample sizes for GWASs of non-EUR-like populations are still orders of magnitude smaller and not currently powered for more precise cross-ancestry assessments; this emphasizes the need for future research including the generation of additional ancestrally representative data, which will enable well-powered studies and the examination of cross-disorder genetic architecture across regional and cultural differences. Cross-ancestry r_g s should be interpreted in light of findings that show considerably smaller within-disorder, within-ancestry r_g s across cohorts for PTSD ($r_g = 0.73$, s.e. = 0.21)⁶³ and MD ($r_g = 0.76$, s.e. = 0.03)⁶⁴ relative to SCZ ($r_g = 0.95$, s.e. = 0.03)⁶⁵. This suggests that cross-ancestry r_g s for PTSD and MD could drop below 1 for reasons independent of ancestry-specific signal, such as environmental moderation of genetic effects or increased phenotypic heterogeneity. Another limitation reflects potential inflation in r_g estimates by cross-trait assortative mating⁶⁶, diagnostic misclassification⁶⁷ or the use of super-normal controls⁶⁸. However, the high genetic overlap observed among subclusters of psychiatric disorders is unlikely to be explained by cross-trait assortment alone⁶⁹ and current sensitivity analyses using stricter case definitions suggested that impact of diagnostic misclassification was modest. Wide ranges in sample sizes across the univariate psychiatric GWAS used as input should also be considered when evaluating relative levels of significant findings, particularly for locus discovery.

The current investigation into the genetic structure of psychopathology reflects a comprehensive genomic examination of cross-disorder

psychiatric risk. It extends previous cross-disorder psychiatric genetics analyses^{5,27} using updated datasets, new disorders and triangulation across different methodological approaches to produce a robust set of findings⁷⁰. We identified subsets of disorders with particularly high genetic overlap and characterized the biological processes implicated by their shared risk. This evidence should contribute substantially to the ongoing debates regarding diagnostic boundaries between disorders such as BIP and SCZ. Certain pharmacological interventions have proven to be effective across a range of disorders (for example, selective serotonin reuptake inhibitors)⁷¹, indicating that future work could build on our findings to identify new or repurposed therapeutics that target the shared signal captured by the factors. While much remains to be done, cross-disorder genetics continues to fill in critical gaps in our understanding of shared and unique psychiatric risk factors with implications for the future of psychiatric research, therapeutics and nosology.

Online content

Any methods, additional references, Nature Portfolio reporting summaries, source data, extended data, supplementary information, acknowledgements, peer review information; details of author contributions and competing interests; and statements of data and code availability are available at <https://doi.org/10.1038/s41586-025-09820-3>.

1. Kessler, R. C., Chiu, W. T., Demler, O. & Walters, E. E. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch. Gen. Psychiatry* **62**, 617–627 (2005).
2. Smoller, J. W. et al. Psychiatric genetics and the structure of psychopathology. *Mol. Psychiatry* **24**, 409–420 (2019).
3. Möller, H.-J. Bipolar disorder and schizophrenia: distinct illnesses or a continuum? *J. Clin. Psychiatry* **64**, 23–27 (2003), discussion 28.
4. Bulik-Sullivan, B. B. et al. An atlas of genetic correlations across human diseases and traits. *Nat. Genet.* **47**, 1236–1241 (2015).
5. Lee, P. H. et al. Genomic relationships, novel loci, and pleiotropic mechanisms across eight psychiatric disorders. *Cell* **179**, 1469–1482 (2019).
6. Frei, O. et al. Bivariate causal mixture model quantifies polygenic overlap between complex traits beyond genetic correlation. *Nat. Commun.* **10**, 2417 (2019).
7. Kessler, R. C. et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch. Gen. Psychiatry* **62**, 593–602 (2005).
8. Mallard, T. T., Grotzinger, A. D. & Smoller, J. W. Examining the shared etiology of psychopathology with genome-wide association studies. *Physiol. Rev.* **103**, 1645–1665 (2023).
9. Cross Disorder Analyses Working Group. [PGC pgc.psu.edu/for-researchers/working-groups/cross-disorder-analyses-working-group/](https://pgc.psu.edu/for-researchers/working-groups/cross-disorder-analyses-working-group/) (2008).
10. *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013).
11. *International Classification of Diseases, Eleventh Revision (ICD-11)* (WHO, 2022).
12. Cross-Disorder Group of the Psychiatric Genomics Consortium. Identification of risk loci with shared effects on five major psychiatric disorders: a genome-wide analysis. *Lancet* **381**, 1371–1379 (2013).
13. Mullins, N. et al. Genome-wide association study of more than 40,000 bipolar disorder cases provides new insights into the underlying biology. *Nat. Genet.* **53**, 817–829 (2021).
14. Watson, H. J. et al. Genome-wide association study identifies eight risk loci and implicates metabo-psychiatric origins for anorexia nervosa. *Nat. Genet.* **51**, 1207–1214 (2019).
15. Demontis, D. et al. Genome-wide analyses of ADHD identify 27 risk loci, refine the genetic architecture and implicate several cognitive domains. *Nat. Genet.* **55**, 198–208 (2023).
16. Grove, J. et al. Identification of common genetic risk variants for autism spectrum disorder. *Nat. Genet.* **51**, 431–444 (2019).
17. Trubetskoy, V. et al. Mapping genomic loci implicates genes and synaptic biology in schizophrenia. *Nature* **604**, 502–508 (2022).
18. Yu, D. et al. Interrogating the genetic determinants of Tourette's syndrome and other tic disorders through genome-wide association studies. *Am. J. Psychiatry* **176**, 217–227 (2019).
19. Strom, N. I. et al. Genome-wide association study identifies 30 obsessive-compulsive disorder associated loci. *Nat. Genet.* **57**, 1389–1401 (2025).
20. Major Depressive Disorder Working Group. Trans-ancestry genome-wide study of depression identifies 697 associations implicating cell types and pharmacotherapies. *Cell* **188**, 640–652 (2025).
21. Zhou, H. et al. Genome-wide meta-analysis of problematic alcohol use in 435,563 individuals yields insights into biology and relationships with other traits. *Nat. Neurosci.* **23**, 809–818 (2020).
22. Strom, N. I. et al. Genome-wide association study of major anxiety disorders in 122,341 European-ancestry cases identifies 58 loci and highlights GABAergic signaling. Preprint at medRxiv <https://doi.org/10.1101/2024.07.03.24309466> (2024).

23. Nievergelt, C. M. et al. Genome-wide association analyses identify 95 risk loci and provide insights into the neurobiology of post-traumatic stress disorder. *Nat. Genet.* **56**, 792–808 (2024).

24. Quach, B. C. et al. Expanding the genetic architecture of nicotine dependence and its shared genetics with multiple traits. *Nat. Commun.* **11**, 5562 (2020).

25. Zhou, H. et al. Association of OPRM1 functional coding variant with opioid use disorder. *JAMA Psychiatry* **77**, 1072–1080 (2020).

26. Johnson, E. C. et al. A large-scale genome-wide association study meta-analysis of cannabis use disorder. *Lancet Psychiatry* **7**, 1032–1045 (2020).

27. Grotzinger, A. D. et al. Genetic architecture of 11 major psychiatric disorders at biobehavioral, functional genomic and molecular genetic levels of analysis. *Nat. Genet.* **54**, 548–559 (2022).

28. National Academies of Sciences, Engineering and Medicine. *Using Population Descriptors in Genetics and Genomics Research: A New Framework for an Evolving Field* (National Academies Press, 2023).

29. Giannakopoulou, O. et al. The genetic architecture of depression in individuals of East Asian ancestry. *JAMA Psychiatry* **78**, 1258–1269 (2021).

30. Lam, M. et al. Comparative genetic architectures of schizophrenia in East Asian and European populations. *Nat. Genet.* **51**, 1670–1678 (2019).

31. Walters, R. K. et al. Transancestral GWAS of alcohol dependence reveals common genetic underpinnings with psychiatric disorders. *Nat. Neurosci.* **21**, 1656 (2018).

32. CONVERGE Consortium. Sparse whole-genome sequencing identifies two loci for major depressive disorder. *Nature* **523**, 588–591 (2015).

33. Brown, B. C., Asian Genetic Epidemiology Network Type 2 Diabetes Consortium, Ye, C. J., Price, A. L. & Zaitlen, N. Transethnic genetic-correlation estimates from summary statistics. *Am. J. Hum. Genet.* **99**, 76–88 (2016).

34. Grotzinger, A. D. et al. Genomic structural equation modelling provides insights into the multivariate genetic architecture of complex traits. *Nature Hum. Behav.* **3**, 513 (2019).

35. Werme, J., van der Sluis, S., Posthuma, D. & de Leeuw, C. A. An integrated framework for local genetic correlation analysis. *Nat. Genet.* **54**, 274–282 (2022).

36. Kimbrel, N. A. et al. Identification of novel, replicable genetic risk loci for suicidal thoughts and behaviors among US military veterans. *JAMA Psychiatry* **80**, 135–145 (2023).

37. Mota, N. R. et al. NCAM1-TTC12-ANKK1-DRD2 gene cluster and the clinical and genetic heterogeneity of adults with ADHD. *Am. J. Med. Genet. B* **168**, 433–444 (2015).

38. Bidwell, L. C. et al. NCAM1-TTC12-ANKK1-DRD2 variants and smoking motives as intermediate phenotypes for nicotine dependence. *Psychopharmacology* **232**, 1177–1186 (2015).

39. Yang, B.-Z. et al. Haplotype variants in DRD2, ANKK1, TTC12, and NCAM1 are associated with comorbid alcohol and drug dependence. *Alcohol. Clin. Exp. Res.* **32**, 2117–2127 (2008).

40. Watanabe, K. et al. A global overview of pleiotropy and genetic architecture in complex traits. *Nat. Genet.* **51**, 1339–1348 (2019).

41. Zhang, Y. et al. SUPERGNOVA: local genetic correlation analysis reveals heterogeneous etiologic sharing of complex traits. *Genome Biol.* **22**, 262 (2021).

42. Nagel, M. et al. Meta-analysis of genome-wide association studies for neuroticism in 449,484 individuals identifies novel genetic loci and pathways. *Nat. Genet.* **50**, 920–927 (2018).

43. Peyrot, W. J. & Price, A. L. Identifying loci with different allele frequencies among cases of eight psychiatric disorders using CC-GWAS. *Nat. Genet.* **53**, 445–454 (2021).

44. Wang, D. et al. Comprehensive functional genomic resource and integrative model for the human brain. *Science* **362**, eaat8464 (2018).

45. Walker, R. L. et al. Genetic control of expression and splicing in developing human brain informs disease mechanisms. *Cell* **179**, 750–771 (2019).

46. Won, H. et al. Chromosome conformation elucidates regulatory relationships in developing human brain. *Nature* **538**, 523–527 (2016).

47. Chen, J., Bardes, E. E., Aronow, B. J. & Jegga, A. G. ToppGene Suite for gene list enrichment analysis and candidate gene prioritization. *Nucleic Acids Res.* **37**, W305–W311 (2009).

48. de Leeuw, C. A., Mooij, J. M., Heskes, T. & Posthuma, D. MAGMA: generalized gene-set analysis of GWAS data. *PLoS Comput. Biol.* **11**, e1004219 (2015).

49. Fu, J. M. et al. Rare coding variation provides insight into the genetic architecture and phenotypic context of autism. *Nat. Genet.* **54**, 1320–1331 (2022).

50. Ruzzo, E. K. et al. Inherited and de novo genetic risk for autism impacts shared networks. *Cell* **178**, 850–866 (2019).

51. Satterstrom, F. K. et al. Large-scale exome sequencing study implicates both developmental and functional changes in the neurobiology of autism. *Cell* **180**, 568–584 (2020).

52. Skene, N. G. & Grant, S. G. N. Identification of vulnerable cell types in major brain disorders using single cell transcriptomes and expression weighted cell type enrichment. *Front. Neurosci.* **10**, 16 (2016).

53. Polioudakis, D. et al. A single-cell transcriptomic atlas of human neocortical development during mid-gestation. *Neuron* **103**, 785–801 (2019).

54. Ziffra, R. S. et al. Single-cell epigenomics reveals mechanisms of human cortical development. *Nature* **598**, 205–213 (2021).

55. Lake, B. B. et al. Neuronal subtypes and diversity revealed by single-nucleus RNA sequencing of the human brain. *Science* **352**, 1586–1590 (2016).

56. Siletti, K. et al. Transcriptomic diversity of cell types across the adult human brain. *Science* **382**, eadd7046 (2023).

57. Wamsley, B. et al. Molecular cascades and cell type-specific signatures in ASD revealed by single-cell genomics. *Science* **384**, eadh2602 (2024).

58. Finucane, H. K. et al. Partitioning heritability by functional annotation using genome-wide association summary statistics. *Nat. Genet.* **47**, 1228 (2015).

59. Yengo, L. et al. A saturated map of common genetic variants associated with human height. *Nature* **610**, 704–712 (2022).

60. de la Torre-Ubieta, L. et al. The dynamic landscape of open chromatin during human cortical neurogenesis. *Cell* **172**, 289–304 (2018).

61. Caspi, A. et al. The *p* factor: one general psychopathology factor in the structure of psychiatric disorders? *Clin. Psychol. Sci.* **2**, 119–137 (2014).

62. Peterson, R. E. et al. Genome-wide association studies in ancestrally diverse populations: opportunities, methods, pitfalls, and recommendations. *Cell* **179**, 589–603 (2019).

63. Nievergelt, C. M. et al. International meta-analysis of PTSD genome-wide association studies identifies sex- and ancestry-specific genetic risk loci. *Nat. Commun.* **10**, 1–16 (2019).

64. Wray, N. R. et al. Genome-wide association analyses identify 44 risk variants and refine the genetic architecture of major depression. *Nat. Genet.* **50**, 668 (2018).

65. Pardiñas, A. F. et al. Common schizophrenia alleles are enriched in mutation-intolerant genes and in regions under strong background selection. *Nat. Genet.* **50**, 381–389 (2018).

66. Border, R. et al. Cross-trait assortative mating is widespread and inflates genetic correlation estimates. *Science* **378**, 754–761 (2022).

67. Wray, N. R., Lee, S. H. & Kendler, K. S. Impact of diagnostic misclassification on estimation of genetic correlations using genome-wide genotypes. *Eur. J. Hum. Genet.* **20**, 668–674 (2012).

68. Kendler, K. S., Chatzilakos, C. & Bacanu, S.-A. The impact on estimations of genetic correlations by the use of super-normal, unscreened, and family-history screened controls in genome wide case-control studies. *Genet. Epidemiol.* **44**, 283–289 (2020).

69. Grotzinger, A. D. & Keller, M. C. Potential bias in genetic correlations. *Science* **378**, 709–710 (2022).

70. Munafò, M. R. & Davey Smith, G. Robust research needs many lines of evidence. *Nature* **553**, 399–401 (2018).

71. Vaswani, M., Linda, F. K. & Ramesh, S. Role of selective serotonin reuptake inhibitors in psychiatric disorders: a comprehensive review. *Prog. Neuropsychopharmacol. Biol. Psychiatry* **27**, 85–102 (2003).

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Andrew D. Grotzinger^{1,2,495} , Josefin Werme^{3,495} , Wouter J. Peyrot^{3,4,495} , Oleksandr Frei^{5,6,495} , Christiaan de Leeuw³, Lucy K. Bicks⁷, Qiuyu Guo^{7,8}, Michael P. Margolis^{9,10}, Brandon J. Coombes¹¹, Anthony Batzler¹¹, Vanessa Pazdernik¹¹, Joanna M. Biernacka^{11,12}, Ole A. Andreassen^{6,13}, Verner Anttila^{14,15,16}, Anders D. Børglum^{17,18,19}, Jerome Breen²⁰, Na Cai^{21,22,23,24}, Ditte Demontis^{17,18,19,20}, Howard J. Edenberg^{26,27}, Stephen V. Faraone^{28,29}, Barbara Franke^{30,31,32}, Michael J. Gandal^{33,34}, Joel Gelernter^{35,36}, Alexander S. Hatoum³⁷, John M. Hettema³⁸, Emma C. Johnson³⁷, Katherine G. Jonas³⁹, James A. Knowles^{40,41}, Karestan C. Koenen^{42,43,44}, Adam X. Maihofer^{45,46,47}, Travis T. Mallard^{48,49,50}, Manuel Mattheisen^{18,51,52,53}, Karen S. Mitchell^{54,55}, Benjamin M. Neale^{15,56}, Caroline M. Nievergelt^{45,46,47}, John I. Nurnberger⁵⁷, Kevin S. O'Connell⁶, Roseann E. Peterson³⁹, Elise B. Robinson^{16,59}, Sandra S. Sanchez-Roige^{46,60,61}, Susan L. Santangelo^{62,63}, Jeremiah M. Scharf^{50,64,65,66}, Hreinn Stefansson⁶⁷, Kari Stefansson^{67,68}, Murray B. Stein^{46,69,70}, Nora I. Strom^{51,53,71}, Laura M. Thornton⁷², Elliot M. Tucker-Drob^{73,74,75}, Brad Verhulst³⁸, Irwin D. Waldman⁷⁶, G. Bragi Walters^{67,68}, Naomi R. Wray^{77,78}, Dongmei Yu^{50,66}, Anxiety Disorders Working Group of the Psychiatric Genomics Consortium*, Attention-Deficit/Hyperactivity Disorder (ADHD) Working Group of the Psychiatric Genomics Consortium*, Autism Spectrum Disorders Working Group of the Psychiatric Genomics Consortium*, Bipolar Disorder Working Group of the Psychiatric Genomics Consortium*, Eating Disorders Working Group of the Psychiatric Genomics Consortium*, Major Depressive Disorder Working Group of the Psychiatric Genomics Consortium*, Nicotine Dependence GenOmeS (iNDiGO) Consortium*, Obsessive-Compulsive Disorder and Tourette Syndrome Working Group of the Psychiatric Genomics Consortium*, Post-Traumatic Stress Disorder Working Group of the Psychiatric Genomics Consortium*, Schizophrenia Working Group of the Psychiatric Genomics Consortium*, Substance Use Disorders Working Group of the Psychiatric Genomics Consortium*, Phil H. Lee⁵⁰, Kenneth S. Kendler^{79,80,496} & Jordan W. Smoller^{42,49,50,496}

¹Department of Psychology and Neuroscience, University of Colorado Boulder, Boulder, CO, USA. ²Institute for Behavioral Genetics, University of Colorado Boulder, Boulder, CO, USA.

³Department of Complex Trait Genetics, Center for Neurogenomics and Cognitive Research, Amsterdam Neuroscience, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands.

⁴Department of Psychiatry, Amsterdam UMC, Amsterdam, The Netherlands. ⁵Center for Bioinformatics, Department of Informatics, University of Oslo, Oslo, Norway. ⁶NORMENT Centre, Institute of Clinical Medicine, University of Oslo and Division of Mental Health and Addiction, Oslo University Hospital, Oslo, Norway. ⁷Department of Neurology, David Geffen School of Medicine, University of California, Los Angeles, CA, USA. ⁸Discovery Biomarker, Amgen, Thousand Oaks, CA, USA. ⁹Department of Human Genetics, David Geffen School of Medicine, University of California, Los Angeles, Los Angeles, CA, USA. ¹⁰Department of Psychiatry, David Geffen School of Medicine, University of California, Los Angeles, Los Angeles, CA, USA. ¹¹Department of Quantitative Health Sciences, Mayo Clinic, Rochester, MN, USA. ¹²Department of Psychiatry & Psychology, Mayo Clinic, Rochester, MN, USA. ¹³KG Jebsen

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Centre for Neurodevelopment, University of Oslo, Oslo, Norway. ¹⁴Analytic and Translational Genetics Unit, Massachusetts General Hospital and Harvard Medical School, Boston, MA, USA. ¹⁵Program in Medical and Population Genetics, Broad Institute of MIT and Harvard, Cambridge, MA, USA. ¹⁶Stanley Center for Psychiatric Research, Broad Institute of MIT and Harvard, Cambridge, MA, USA. ¹⁷Center for Genomics and Personalized Medicine, CGPM, Aarhus, Denmark. ¹⁸Department of Biomedicine, Aarhus University, Aarhus, Denmark. ¹⁹The Lundbeck Foundation Initiative for Integrative Psychiatric Research—iPSYCH, Aarhus, Denmark. ²⁰Social Genetic and Developmental Psychiatry Centre, King's College London, London, UK. ²¹Computational Health Centre, Helmholtz Munich, Neuherberg, Germany. ²²Department of Biosystems Science and Engineering, ETH Zurich, Zurich, Switzerland. ²³Department of Medicine, Technical University of Munich, Munich, Germany. ²⁴Helmholtz Pioneer Campus, Helmholtz Munich, Neuherberg, Germany. ²⁵The Novo Nordisk Foundation Center for Genomic Mechanisms of Disease, Broad Institute of MIT and Harvard, Cambridge, MA, USA. ²⁶Department of Biochemistry and Molecular Biology, Indiana University School of Medicine, Indianapolis, IN, USA. ²⁷Department of Medical and Molecular Genetics, Indiana University School of Medicine, Indianapolis, IN, USA. ²⁸Department of Neuroscience and Physiology, Norton College of Medicine, SUNY Upstate Medical University, Syracuse, NY, USA. ²⁹Department of Psychiatry, Norton College of Medicine, SUNY Upstate Medical University, Syracuse, NY, USA. ³⁰Department of Cognitive Neuroscience, Radboud University Medical Center, Nijmegen, The Netherlands. ³¹Department of Human Genetics, Radboud University Medical Center, Nijmegen, The Netherlands. ³²Donders Institute for Brain, Cognition and Behaviour, Radboud University, Nijmegen, The Netherlands. ³³Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, USA. ³⁴Lifespan Brain Institute at Penn Med and the Children's Hospital of Philadelphia, Philadelphia, PA, USA. ³⁵Department of Psychiatry, Yale University School of Medicine, New Haven, CT, USA. ³⁶VA Connecticut Healthcare Center, West Haven, CT, USA. ³⁷Department of Psychiatry, Washington University School of Medicine, St Louis, MO, USA. ³⁸Department of Psychiatry and Behavioral Sciences, Texas A&M University, College Station, TX, USA. ³⁹Department of Psychiatry & Behavioral Health, Stony Brook University, New York, NY, USA. ⁴⁰Department of Genetics, Rutgers University, Piscataway, NJ, USA. ⁴¹Human Genetics Institute of New Jersey (HGINJ), Rutgers University, Piscataway, NJ, USA. ⁴²Broad Institute of MIT and Harvard, Boston, MA, USA. ⁴³Department of Epidemiology, Harvard TH Chan School of Public Health, Boston, MA, USA. ⁴⁴Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA. ⁴⁵Center of Excellence for Stress and Mental Health, Veterans Affairs San Diego Healthcare System, San Diego, CA, USA. ⁴⁶Department of Psychiatry, School of Medicine, University of California San Diego, La Jolla, CA, USA. ⁴⁷Research Service, Veterans Affairs San Diego Healthcare System, San Diego, CA, USA. ⁴⁸Center for Precision Psychiatry, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA. ⁴⁹Department of Psychiatry, Harvard Medical School, Boston, MA, USA. ⁵⁰Psychiatric and Neurodevelopmental Genetics Unit, Center for Genomic Medicine, Massachusetts General Hospital, Boston, MA, USA. ⁵¹Centre for Psychiatry Research, Department of Clinical Neuroscience, Karolinska Institutet & Stockholm Health Care Services, Stockholm, Sweden. ⁵²Department of Community Health and Epidemiology and Faculty of Computer Science, Dalhousie University, Halifax, Nova Scotia, Canada. ⁵³Institute of Psychiatric Phenomics and Genomics (IPPG), University Hospital, LMU Munich, Munich, Germany. ⁵⁴Department of Psychiatry, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA. ⁵⁵National Center for PTSD at VA Boston Healthcare System, Boston, MA, USA. ⁵⁶Analytic and Translational Genetics Unit, Department of Medicine, Massachusetts General Hospital, Boston, MA, USA. ⁵⁷Department of Medical and Molecular Genetics, Department of Psychiatry, Stark Neurosciences Research Institute, Indiana University School of Medicine, Indianapolis, IN, USA. ⁵⁸Department of Psychiatry and Behavioral Sciences, Institute for Genomics in Health, SUNY Downstate Health Sciences University, New York, NY, USA. ⁵⁹Center for Genomic Medicine and Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA. ⁶⁰Department of Medicine, Division of Genetic Medicine, Vanderbilt University, Nashville, TN, USA. ⁶¹Institute for Genomic Medicine, University of California San Diego, San Diego, CA, USA. ⁶²Center for Clinical and Translational Science, Maine Health Institute for Research, Portland, ME, USA. ⁶³Department of Psychiatry, Tufts University School of Medicine, Boston, MA, USA. ⁶⁴Department of Neurology, Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA. ⁶⁵Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA. ⁶⁶Stanley Center for Psychiatric Research, Broad Institute, Cambridge, MA, USA. ⁶⁷Amgen—deCODE Genetics, Reykjavik, Iceland. ⁶⁸Faculty of Medicine, University of Iceland, Reykjavik, Iceland. ⁶⁹Herbert Wertheim School of Public Health and Human Longevity Science, University of California San Diego, La Jolla, CA, USA. ⁷⁰VA San Diego Healthcare System, San Diego, CA, USA. ⁷¹Department of Psychology, Humboldt-Universität zu Berlin, Berlin, Germany. ⁷²Department of Psychiatry, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ⁷³Center on Aging and Population Sciences, University of Texas at Austin, Austin, TX, USA. ⁷⁴Department of Psychology, University of Texas at Austin, Austin, TX, USA. ⁷⁵Population Research Center, University of Texas at Austin, Austin, TX, USA. ⁷⁶Department of Psychology, Emory University, Atlanta, GA, USA. ⁷⁷Department of Psychiatry, University of Oxford, Oxford, UK. ⁷⁸Institute for Molecular Bioscience, University of Queensland, Brisbane, Queensland, Australia. ⁷⁹Virginia Institute for Psychiatric and Behavioral Genetics, Virginia Commonwealth University, Richmond, VA, USA. ⁸⁰Department of Psychiatry, Virginia Commonwealth University, Richmond, VA, USA. ⁴⁹⁵These authors contributed equally: Andrew D. Grotzinger, Josefina Werme, Wouter J. Peyrot, Oleksandr Frei. ⁴⁹⁶These authors jointly supervised this work: Kenneth S. Kendler, Jordan W. Smoller. *Lists of authors and their affiliations appears online. ⁵²e-mail: andrew.grotzinger@colorado.edu; jsmoller@mgb.org

Anxiety Disorders Working Group of the Psychiatric Genomics Consortium

Daniel E. Adkins^{81,82}, Georg W. Alpers⁸³, Helga Ask^{84,85}, Sintia I. Belanger^{86,87}, Ottar Bjerkeset^{88,89}, Sigrid Børte^{90,91,92}, Gerome Breen²⁰, Sandra A. Brown^{93,94}, Enrique Castelao⁹⁵, Hilary Coon^{96,97}, William E. Copeland⁹⁸, Elizabeth C. Corfield^{85,99}, Darina Czamara¹⁰⁰, Jürgen Deckert¹⁰¹, Anna R. Docherty^{79,96,102,103}, Katharina Domschke¹⁰⁴, Ole Kristian Drange^{105,106}, Thalia C. Eley¹⁰⁷, Angelique Erhardt-Lehmann^{101,108}, Andreas J. Forstner^{109,110,111}, Miguel Garcia-Arigbay^{112,113}, Scott D. Gordon¹¹⁴, John M. Hettema¹⁰⁸, Ian B. Hickie¹¹⁵, Iiris Hovatta^{116,117}, Matthew H. Iveson¹¹⁸, James L. Kennedy¹¹⁹, Henrik Larsson^{112,113}, Daniel F. Levey^{120,121}, Christine Lochner¹²², Michelle K. Lupton^{123,124}, Hermine HM Maes¹²⁵, Eduard Maron^{126,127}, Nicholas G. Martin¹¹⁴, Manuel Mattheisen^{18,51,52,53}, Sandra M. Meier¹²⁸, Christiane A. Melzig¹²⁹, Brittany L. Mitchell¹¹⁴, Teemu Palvinainen¹³⁰, Roseann E. Peterson⁹⁸, Giorgio Pistis⁹⁵, Martin Preisig⁹⁵, Börge Schmidt¹³¹, Johannes Schumacher¹⁰⁹, Andrew A. Shabalin^{96,103}, Anne Heidi Skogholt⁹¹, Dan J. Stein¹³², Murray B. Stein^{16,69,70}, Eystein Stordal^{188,133}, Andreas Ströhle¹³⁴, Nora I. Strom^{51,53,71}, Elisa Tasanko^{117,135}, Laurent Thomas^{91,136,137,138}, Henning Tiemeier^{139,140}, Brad Verhulst¹³⁸, Heike Weber¹⁰¹, Bendik S. Winsvold^{90,91,141}, Clement C. Zai^{16,119,142}, Gwyneth Zai^{119,143} & John-Anker Zwart^{90,91,92}

⁸¹Department of Sociology, University of Utah, Salt Lake City, UT, USA. ⁸²Graduate Program in Statistics, University of Utah, Salt Lake City, UT, USA. ⁸³Department of Psychology, School of Social Sciences, University of Mannheim, Mannheim, Germany. ⁸⁴PROMENTA research center, University of Oslo, Oslo, Norway. ⁸⁵PsychGen Centre for Genetic Epidemiology and Mental Health, Norwegian Institute of Public Health, Oslo, Norway. ⁸⁶Department of Morphology and Genetics, Universidade Federal de São Paulo, São Paulo, Brazil. ⁸⁷Laboratory of Integrative Neuroscience, Universidade Federal de São Paulo, São Paulo, Brazil. ⁸⁸Department of Mental Health, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway. ⁸⁹Faculty of Nursing and Health Sciences, Nord University, Levanger, Norway. ⁹⁰Department of Research and Innovation, Division of Clinical Neuroscience, Oslo University Hospital, Oslo, Norway. ⁹¹HUNT Center for Molecular and Clinical Epidemiology, Department of Public Health and Nursing, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway. ⁹²Institute of Clinical Medicine, University of Oslo, Oslo, Norway. ⁹³Department of Psychiatry, University of California San Diego, La Jolla, CA, USA. ⁹⁴Department of Psychology, University of California San Diego, La Jolla, CA, USA. ⁹⁵Department of Psychiatry, Lausanne University Hospital and University of Lausanne, Lausanne, Switzerland. ⁹⁶Department of Psychiatry, University of Utah School of Medicine, Salt Lake City, UT, USA. ⁹⁷Huntsman Mental Health Institute, University of Utah School of Medicine, Salt Lake City, UT, USA. ⁹⁸Department of Psychiatry, University of Vermont, Burlington, VT, USA. ⁹⁹Nic Waals Institute, Lovisenberg Diaconal Hospital, Oslo, Norway. ¹⁰⁰Max-Planck-Institute of Psychiatry, Department Genes and Environment, Munich, Germany. ¹⁰¹Department of Psychiatry, Psychosomatics and Psychotherapy, University of Würzburg, Würzburg, Germany. ¹⁰²Center for Genomic Medicine, Salt Lake City, UT, USA. ¹⁰³Huntsman Mental Health Institute, Salt Lake City, UT, USA. ¹⁰⁴Department of Psychiatry and Psychotherapy, Medical Center, Faculty of Medicine, University of Freiburg, Freiburg, Germany. ¹⁰⁵Department of Psychiatry, Sørlandet Hospital, Kristiansand/Arendal, Norway. ¹⁰⁶NORMENT Centre, Division of Mental Health and Addiction, Oslo University Hospital, Oslo, Norway. ¹⁰⁷Social, Genetic & Developmental Psychiatry Centre, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK. ¹⁰⁸Max-Planck-Institute for Psychiatry, Munich, Germany. ¹⁰⁹Centre for Human Genetics, University of Marburg, Marburg, Germany. ¹¹⁰Institute of Human Genetics, University of Bonn, School of Medicine & University Hospital Bonn, Bonn, Germany. ¹¹¹Institute of Neuroscience and Medicine (INM-1), Research Center Jülich, Jülich, Germany. ¹¹²Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden. ¹¹³School of Medical Sciences, Örebro University, Faculty of Medicine and Health, Örebro, Sweden. ¹¹⁴Mental Health and Neuroscience Research Program, QIMR Berghofer Medical Research Institute, Brisbane, Queensland, Australia. ¹¹⁵Brain and Mind Centre, The University of Sydney Australia, Sydney, New South Wales, Australia. ¹¹⁶Department of Psychology and Logopedics, University of Helsinki and Helsinki University Central Hospital, Helsinki, Finland. ¹¹⁷SleepWell Research Program, Faculty of Medicine, University of Helsinki, Helsinki, Finland. ¹¹⁸Centre for Clinical Brain Sciences, The University of Edinburgh, Edinburgh, UK. ¹¹⁹Department of Psychiatry, Institute of Medical Science, University of Toronto, Toronto, Ontario, Canada. ¹²⁰Division of Human Genetics, Department of Psychiatry, Yale University School of Medicine, New Haven, CT, USA. ¹²¹Veterans Affairs Connecticut Healthcare Center, West Haven, CT, USA. ¹²²SA MRC Unit on Risk and Resilience in Mental Disorders, Department of Psychiatry, Stellenbosch University, Stellenbosch, South Africa. ¹²³QIMR Berghofer Medical Research Institute, Brisbane, Queensland, Australia. ¹²⁴School of Biomedical Sciences, Faculty of Health, Queensland University of Technology, Brisbane, Queensland, Australia. ¹²⁵Virginia Institute for Psychiatric and Behavioral Genetics, Department of Human and Molecular Genetics, Virginia Commonwealth University, Richmond, VA, USA. ¹²⁶Department of Psychiatry, University of Tartu, Tartu, Estonia. ¹²⁷Faculty of Medicine, Department of Medicine, Centre for Neuropsychopharmacology, Division of Brain Sciences, Imperial College London, London, UK. ¹²⁸Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada. ¹²⁹Department of Clinical Psychology, Experimental Psychopathology and Psychotherapy, University of Marburg, Marburg, Germany. ¹³⁰Institute for Molecular Medicine Finland (FIMM), University of Helsinki, Helsinki, Finland. ¹³¹Institute for Medical Informatics, Biometry and Epidemiology, University Hospital Essen, University Duisburg-Essen, Essen, Germany. ¹³²SAMRC Unit on Risk & Resilience in Mental Disorders, Department of Psychiatry & Neuroscience Institute, University of Cape Town, Cape Town, South Africa. ¹³³Department of Psychiatry, Hospital Namsos, Nord-Trøndelag Health Trust, Namsos, Norway. ¹³⁴Department of Psychiatry and Psychotherapy, Charité Campus Mitte, Charité-Universitätsmedizin Berlin, Berlin, Germany. ¹³⁵Department of Psychology, Faculty of Medicine, University of Helsinki, Helsinki, Finland. ¹³⁶BioCore—Bioinformatics Core Facility, Norwegian University of Science and Technology, Trondheim, Norway. ¹³⁷Clinic of Laboratory Medicine, St. Olav's Hospital, Trondheim University Hospital, Trondheim, Norway. ¹³⁸Department of Clinical and Molecular Medicine, Norwegian University of Science and Technology, Trondheim, Norway. ¹³⁹Department of Child and Adolescent Psychiatry, Erasmus University Medical Center,

Rotterdam, The Netherlands. ¹⁴⁰Department of Social and Behavioral Sciences, Harvard T.H. Chan School of Medicine, Boston, MA, USA. ¹⁴¹Department of Neurology, Oslo University Hospital, Oslo, Norway. ¹⁴²Tanenbaum Centre for Pharmacogenetics, Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Toronto, Ontario, Canada. ¹⁴³Neurogenetics Section, Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Toronto, Ontario, Canada.

Attention-Deficit/Hyperactivity Disorder (ADHD) Working Group of the Psychiatric Genomics Consortium

Silvia Alemany^{144,145,146,147}, Clayton HD Bau^{148,149}, Sintia I. Belanger^{86,87}, Dorret I. Boomsma^{150,151}, Rosa Bosch^{152,153}, Isabell Brikkell^{18,112,154}, Christie L. Burton¹⁵⁵, Miquel Casas^{153,156,157}, Elizabeth C. Corfield^{85,99}, Bru Cormand^{158,159,160}, Jennifer Crosbie^{119,155}, Ditte Demontis^{17,18,19,25}, Alysa E. Doyle^{49,161}, Josephine Elia¹⁶⁷, Stephen V. Faraone^{28,29}, Barbara Franke^{30,31,32}, Miguel Garcia-Arigbay^{112,113}, Joseph T. Glassner^{163,164}, Eugenio H. Grevel^{148,165}, Jan Haavik^{166,167}, Alexandra Hovdahl¹⁶⁵, Ziarah Hawi¹⁶⁸, Anke Hinney^{169,170}, Daniel P. Howrigan^{16,56}, Marieke Klein^{31,32}, Henry R. Kranzler^{171,172}, Jonna Kuntsi¹⁰⁷, Kate Langley¹⁷³, Henrik Larsson^{112,113}, Klaus-Peter Lesch^{174,175}, Calwing Liao^{16,56}, Sandra K. Loo¹⁷⁶, Hermine HM Maes¹²⁵, James J. McGough^{176,177}, Sarah E. Medland^{114,178,179}, Nina R. Mota^{31,32}, Benjamin M. Neale^{16,56}, Michael C. O'Donovan¹⁸⁰, Roseann E. Peterson⁵⁸, Danielle Posthuma^{181,182}, Josep Antoni Ramos-Quiroga^{152,153,154}, Andreas Reif^{185,186}, Marta Ribasés^{144,145,146,147}, Diego L. Rovaris^{187,188}, Russell J. Schachar^{119,155}, Stephen W. Scherer^{169,190}, Yingjie Shi^{31,32}, María Soler Artigas^{144,145,146,147}, Edmund JS Sonuga-Barke^{191,192,193}, Hreinn Stefansson⁶⁷, Kari Stefansson^{67,68}, Hans-Christoph Steinhausen¹⁹⁴, Ludger Tebartz van Elst¹⁰⁴, Martin Testi¹⁹⁵, G. Bragi Walters^{67,68}, Raymond K. Walters^{16,56}, Stephanie H. Witt¹⁹⁶ & Yanli Zhang-James¹⁹⁷

¹⁴⁴Biomedical Network Research Centre on Mental Health (CIBERSAM), Instituto de Salud Carlos III, Madrid, Spain. ¹⁴⁵Department of Genetics, Microbiology and Statistics, Faculty of Biology, Universitat de Barcelona, Barcelona, Spain. ¹⁴⁶Department of Mental Health, Hospital Universitari Vall d'Hebron, Barcelona, Spain. ¹⁴⁷Psychiatric Genetics Unit, Group of Psychiatry, Mental Health and Addiction, Vall d'Hebron Research Institute (VHIR), Universitat Autònoma de Barcelona, Barcelona, Spain. ¹⁴⁸ADHD and Developmental Psychiatry Programs, Hospital de Clínicas de Porto Alegre, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil. ¹⁴⁹Department of Genetics, Instituto de Biociências, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil. ¹⁵⁰Department of Biological Psychology, Vrije Universiteit, Amsterdam, The Netherlands. ¹⁵¹Netherlands Twin Register, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. ¹⁵²Biomedical Network Research Centre on Mental Health (CIBERSAM), Barcelona, Spain. ¹⁵³SJD MIND Schools Program, Hospital Sant Joan de Déu, Institut de Recerca Sant Joan de Déu, Esplugues de Llobregat, Spain. ¹⁵⁴Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway. ¹⁵⁵Program in Neurosciences and Mental Health, Hospital for Sick Children, Toronto, Ontario, Canada. ¹⁵⁶Department of Psychiatry and Legal Medicine, Universitat Autònoma de Barcelona, Barcelona, Spain. ¹⁵⁷Fundació Privada d'Investigació Sant Pau (FISP), Barcelona, Spain. ¹⁵⁸Department of Genetics, Microbiology, and Statistics, Faculty of Biology, University of Barcelona, Barcelona, Spain. ¹⁵⁹Biomedical Network Research Centre on Rare Diseases (CIBERER), Instituto de Salud Carlos III, Madrid, Spain. ¹⁶⁰Institute of Biomedicine of the University of Barcelona (IBUB), Barcelona, Spain. ¹⁶¹Center for Genomic Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA. ¹⁶²Department of Pediatrics, Nemours Children's Health Delaware, Sidney Kimmel School of Medicine, Philadelphia, PA, USA. ¹⁶³Center for Applied Genomics, The Children's Hospital of Philadelphia, Philadelphia, PA, USA. ¹⁶⁴Department of Pediatrics, University of Pennsylvania, Philadelphia, PA, USA. ¹⁶⁵Department of Psychiatry and Legal Medicine, Faculty of Medicine, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil. ¹⁶⁶Department of Biomedicine, University of Bergen, Bergen, Norway. ¹⁶⁷Division of Psychiatry, Haukeland University Hospital, Bergen, Norway. ¹⁶⁸Turner Institute for Brain and Mental Health, School of Psychological Sciences, Monash University, Melbourne, Victoria, Australia. ¹⁶⁹Center for Translational Neuro- and Behavioral Sciences, University Hospital Essen, University of Duisburg-Essen, Essen, Germany. ¹⁷⁰Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, University Hospital Essen, University of Duisburg-Essen, Duisburg, Germany. ¹⁷¹Department of Psychiatry, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA. ¹⁷²Mental Illness Research, Education and Clinical Center, Crescenz VAMC, Philadelphia, PA, USA. ¹⁷³Institute of Neuroscience and Physiology, University of Gothenburg, Gothenburg, Sweden. ¹⁷⁴Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, University Hospital Wuerzburg, Wuerzburg, Germany. ¹⁷⁵Department of Psychiatry and Neuropsychology, School for Mental Health and Neuroscience, Maastricht University Medical Center, Maastricht, The Netherlands. ¹⁷⁶UCLA Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles, CA, USA. ¹⁷⁷David Geffen School of Medicine at UCLA, Los Angeles, CA, USA. ¹⁷⁸School of Psychology and Counselling, Queensland University of Technology, Brisbane, Queensland, Australia. ¹⁷⁹School of Psychology, University of Queensland, Brisbane, Queensland, Australia. ¹⁸⁰Centre for Neuropsychiatric Genetics and Genomics, School of Medicine, Cardiff University, Cardiff, UK. ¹⁸¹Department of Complex Trait Genetics, Vrije Universiteit Amsterdam, Amsterdam, The Netherlands. ¹⁸²Department of Child and Adolescent Psychiatry, Vrije Universiteit Medical Centre, Amsterdam, The Netherlands. ¹⁸³Department of Mental Health, Vall Hebron University Hospital, Barcelona, Spain. ¹⁸⁴Group of Psychiatry, Mental Health and Addictions, Vall Hebron Research Institute, Barcelona, Spain. ¹⁸⁵Fraunhofer Institute for Translational Medicine and Pharmacology ITMP, Frankfurt am Main, Germany. ¹⁸⁶Psychosomatic Medicine and Psychotherapy, Department of Psychiatry, University Hospital, Goethe University Frankfurt, Frankfurt, Germany. ¹⁸⁷Department of Physiology and Biophysics, Instituto de Ciencias Biomedicas Universidade de São Paulo, São Paulo, Brazil. ¹⁸⁸Laboratory of Physiological Genomics of Mental Health (PhysioGen Lab), Institute of Biomedical Sciences, University of São Paulo, São Paulo, Brazil. ¹⁸⁹Department of Molecular Genetics and McLaughlin Centre, University of Toronto, Toronto, Ontario, Canada. ¹⁹⁰The Centre for Applied Genomics and Department of Genetics and Genome Biology, The Hospital for Sick Children, Toronto, Ontario, Canada. ¹⁹¹Institute of Psychiatry, Psychology and Neuroscience,

Article

King's College London, London, UK. ¹⁹²School of Medicine, Aarhus University, Aarhus, Denmark. ¹⁹³School of Psychology, University of Hong Kong, Hong Kong, China. ¹⁹⁴Department of Child and Adolescent Psychiatry, University of Zurich, Zurich, Switzerland. ¹⁹⁵Department of Mental Health and Suicide, Norwegian Institute of Mental Health, Oslo, Norway. ¹⁹⁶Central Institute of Mental Health, Medical Faculty Mannheim, Heidelberg University, Mannheim, Germany. ¹⁹⁷Department of Psychiatry and Behavioral Sciences, State University of New York Upstate Medical University, Syracuse, NY, USA.

Autism Spectrum Disorders Working Group of the Psychiatric Genomics Consortium

Anders D. Børglum^{17,18,19}, Edwin H. Cook¹⁹⁸, Elizabeth C. Corfield^{85,99}, Jakob Grove^{18,19,199,200}, Alexandra Havdahl⁸⁵, Susan S. Kuo^{161,201}, Joseph Piven^{202,203}, Danielle Posthuma^{181,182}, Elise B. Robinson^{16,59}, Stephan J. Sanders^{204,205,206}, Susan L. Santangelo^{62,63}, Stephen W. Scherer^{189,190}, Ludger Tebartz van Elst¹⁰⁴, Mohammed Uddin^{207,208}, Jacob AS Vorstman^{189,209}, Varun Warrier²¹⁰ & Lauren A. Weiss²¹¹

¹⁹⁸University of Illinois, Chicago, IL, USA. ¹⁹⁹Bioinformatics Research Centre, Aarhus University, Aarhus, Denmark. ²⁰⁰Center for Genomics and Personalized Medicine, Aarhus, Denmark. ²⁰¹Broad Institute of MIT and Harvard, Cambridge, MA, USA. ²⁰²Carolina Institute for Developmental Disabilities, Carrboro, NC, USA. ²⁰³University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ²⁰⁴Department of Psychiatry and Behavioral Sciences, UCSF Weill Institute for Neurosciences, University of California, San Francisco, CA, USA. ²⁰⁵Institute of Developmental and Regenerative Medicine, Department of Paediatrics, University of Oxford, Oxford, UK. ²⁰⁶New York Genome Center, New York, NY, USA. ²⁰⁷Center for Applied and Translational Genomics (CATG), MBRU, Dubai Health, Dubai, UAE. ²⁰⁸GenomeArc, Mississauga, Ontario, Canada. ²⁰⁹Department of Psychiatry and Program in Genetics and Genome Biology, The Hospital for Sick Children, Toronto, Ontario, Canada. ²¹⁰Departments of Psychiatry and Psychology, University of Cambridge, Cambridge, UK. ²¹¹Institute for Human Genetics, Department of Psychiatry and Behavioral Science, Weill Institute for Neurosciences, University of California San Francisco, San Francisco, CA, USA.

Bipolar Disorder Working Group of the Psychiatric Genomics Consortium

Martin Alda^{128,212}, Silvia Alemany^{144,145,146,147}, Lars Alfredsson²¹³, Till F. M. Andlauer²¹⁴, Ole A. Andreassen^{6,13}, Nicholas Bass²¹⁵, Anthony J. Batzler¹¹, Bernhard T. Baume^{216,217}, Eva C. Beins¹⁰, Joanna M. Biernacka^{11,2}, Tim B. Bigdeli^{218,219}, Rosa Bosch^{152,153}, Gerome Breen²⁰, Miquel Casas^{153,156,157}, Sven Cichon^{111,220,221,222}, Jonathan RI Coleman^{107,223}, Brandon J. Coombes¹, Alfredo B. Cuellar-Barboza^{224,225}, Udo Dannowski²²⁶, Friederike S. David^{110,227}, Andreas J. Forstner^{109,110,111}, Josef Frank²²⁸, Janice M. Fullerton^{229,230}, Fernando S. Goes²³¹, Scott D. Gordon¹¹⁴, Maria Grigoriou-Serbanescu^{232,233}, Jakob Grove^{18,19,199,201}, Per Hoffmann¹⁰, James A. Knowles^{40,41}, Kristi Krebs²³⁵, Mikael Landén^{112,173}, Phil H. Lee⁵⁰, James L. Kennedy¹¹⁹, James A. Knowles^{40,41}, Kristi Krebs²³⁵, Mikael Landén^{112,173}, Phil H. Lee⁵⁰, Cathryn M. Lewis¹⁰⁷, Qingqin S. Li²³⁶, Calwing Liao^{16,56}, Penelope A. Lind^{114,124}, Christine Lochner¹²², Jurjen J. Luykx^{175,237,238}, Mirko Manchia^{239,240,241}, Nicholas G. Martin¹¹⁴, Morten Mattingdal^{106,242}, Andrew M. McIntosh²⁴³, Andrew McQuillin²¹⁵, Sarah E. Medland^{114,178,179}, Sandra M. Meier¹²⁸, Anna Meloni²⁴⁴, Lili Milani²³⁵, Brittany L. Mitchell¹¹⁴, Philip B. Mitchell²⁴⁵, Derek W. Morris²⁴⁶, Niamh Mullins^{247,248,249}, Woojae Myung^{250,251}, John I. Nurnberger Jr²⁵², Kevin S. O'Connell⁶, Michael C. O'Donovan¹⁸⁰, Roel A. Ophoff²⁵³, Michael J. Owen¹⁸⁰, George P. Patrinos^{254,255,256,257}, Claudia Pisani²⁴⁴, Danielle Posthuma^{181,182}, James J. Prisciandaro²⁵⁸, Josep Antoni Ramos-Quiroga^{152,183,184}, Andreas Reif^{195,196}, Eva Z. Reiningshaus²⁵⁹, Marta Ribasés^{144,145,146,147}, John P. Rice²⁶⁰, Marcella Rietschel²²⁸, Eva C. Schulte^{53,110,234,261,262,263,264}, Alessandro Serretti^{265,266}, Lea Sirignano²²⁸, María Soler Artigas^{144,145,146,147}, Jordan W. Smoller^{42,49,50,496}, Alessia Squassina^{128,244}, Dan J. Stein¹³², Fabiana Streit²²⁸, Jana Strohmaier²²⁸, Martin Tesli¹⁹⁵, Tracey van der Veen^{215,267}, Marqués P. Vawter²⁶⁸, John B. Vincent^{269,270,271,272}, Stephanie H. Witt¹⁹⁶, Peter P. Zandi²³¹ & Lea Zillitch²²⁸

²¹²National Institute of Mental Health, Klecany, Czech Republic. ²¹³Institute of Environmental Medicine, Karolinska Institutet, Stockholm, Sweden. ²¹⁴Department of Neurology, Klinikum rechts der Isar, School of Medicine, Technical University of Munich, Munich, Germany. ²¹⁵Division of Psychiatry, University College London, London, UK. ²¹⁶Department of Psychiatry, University of Melbourne, Melbourne, Victoria, Australia. ²¹⁷Department of Psychiatry, University of Münster, Münster, Germany. ²¹⁸Department of Psychiatry and Behavioral Sciences, Institute for Genomics in Health, Department of Epidemiology and Biostatistics, State University of New York Downstate Health Sciences University, New York, NY, USA. ²¹⁹Department of Veterans Affairs (VA) New York Harbor Healthcare System, New York, NY, USA. ²²⁰Department of Biomedicine, University of Basel, Basel, Switzerland. ²²¹Institute of Medical Genetics and Pathology, University Hospital Basel, Basel, Switzerland. ²²²Institute of Neuroscience and Medicine (INM-1), Research Center Juelich, Juelich, Germany. ²²³NIHR Maudsley Biomedical Research Centre, South London and Maudsley NHS Trust, London, UK. ²²⁴Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN, USA. ²²⁵Department of Psychiatry, Universidad Autónoma de Nuevo Leon, Monterrey, Mexico. ²²⁶Institute for Translational Psychiatry, University of Münster, Münster, Germany. ²²⁷Department of Psychiatry and Psychotherapy, University of Marburg, Marburg, Germany. ²²⁸Department of Genetic Epidemiology in Psychiatry, Central Institute of Mental Health, Medical Faculty Mannheim, Heidelberg University, Mannheim, Germany. ²²⁹Neuroscience Research Australia, Randwick, New South Wales, Australia. ²³⁰University of New South Wales, Faculty of Medicine, School of Biomedical Science, Kensington, New South Wales, Australia. ²³¹Department of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine, Baltimore, MD, USA. ²³²Biometric Psychiatric Genetics Research Unit, Alexandru Obregia Clinical Psychiatric Hospital, Bucharest, Romania. ²³³Psychiatric Genetics Research Unit, Alexandru Obregia Clinical Psychiatric Hospital, Bucharest, Romania. ²³⁴Department of Psychiatry and Psychotherapy, LMU University Hospital, LMU Munich, Munich, Germany. ²³⁵Estonian Genome Center, Institute of Genomics, University of Tartu, Tartu, Estonia. ²³⁶Janssen Research and

Development, Titusville, NJ, USA. ²³⁷Department of Psychiatry, Amsterdam University Medical Center, Amsterdam, The Netherlands. ²³⁸GGZ inGeest Mental Health Care, Amsterdam, The Netherlands. ²³⁹Department of Medical Science and Public Health, University of Cagliari, Cagliari, Italy. ²⁴⁰Department of Pharmacology, Dalhousie University, Halifax, Nova Scotia, Canada. ²⁴¹Unit of Psychiatry, Department of Medical Sciences and Public Health, University of Cagliari, Cagliari, Italy. ²⁴²Department of Medical Research, Baerum Hospital, Vestre Viken Hospital Trust, Rud, Norway. ²⁴³Centre for Clinical Brain Sciences, University of Edinburgh, Edinburgh, UK. ²⁴⁴Section of Neuroscience and Clinical Pharmacology, Department of Biomedical Sciences, University of Cagliari, Cagliari, Italy. ²⁴⁵Discipline of Psychiatry and Mental Health, School of Medicine and Health, University of New South Wales, Sydney, New South Wales, Australia. ²⁴⁶Centre for Neuroimaging, Cognition and Genomics (NICOG), University of Galway, Galway, Ireland. ²⁴⁷Charles Bronfman Institute for Personalized Medicine, Icahn School of Medicine at Mount Sinai, New York, NY, USA. ²⁴⁸Department of Genetics and Genomic Sciences, Icahn School of Medicine at Mount Sinai, New York, NY, USA.

²⁴⁹Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY, USA. ²⁵⁰Department of Neuropsychiatry, Seoul National University Bundang Hospital, Seoul, South Korea. ²⁵¹Department of Psychiatry, Seoul National University College of Medicine, Seoul, South Korea. ²⁵²Department of Psychiatry, Department of Medical and Molecular Genetics, Stark Neurosciences Research Institute, Indiana University School of Medicine, Indianapolis, IN, USA. ²⁵³Center for Neurobehavioral Genetics, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine, University of California Los Angeles, Los Angeles, CA, USA. ²⁵⁴Clinical Bioinformatics Unit, Department of Pathology, Faculty of Medicine and Health Sciences, Erasmus MC, Rotterdam, The Netherlands. ²⁵⁵Department of Genetics and Genomics, United Arab Emirates University, College of Medicine and Health Sciences, Abu Dhabi, UAE. ²⁵⁶Zayed Center for Health Sciences, United Arab Emirates University, Abu Dhabi, UAE. ²⁵⁷Department of Pharmacy, University of Patras School of Health Sciences, Patras, Greece. ²⁵⁸Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, USA. ²⁵⁹Division of Psychiatry and Psychotherapeutic Medicine, Medical University of Graz, Graz, Austria. ²⁶⁰Department of Psychiatry, Washington University in Saint Louis, St Louis, MO, USA. ²⁶¹Department of Psychiatry and Psychotherapy, University of Bonn, School of Medicine & University Hospital Bonn, Bonn, Germany. ²⁶²Department of Psychiatry, University Hospital, Faculty of Medicine, University of Bonn, Bonn, Germany. ²⁶³German Center for Mental Health (DZPG) partner site Munich-Augsburg, Munich, Germany. ²⁶⁴Institute of Psychiatric Phenomics and Genomics (IPPG), LMU University Hospital, LMU Munich, Munich, Germany. ²⁶⁵Department of Medicine and Surgery, Kore University of Enna, Enna, Italy. ²⁶⁶Oasi Research Institute—IRCCS, Troina, Italy. ²⁶⁷Human Genetics Branch, Intramural Research Program, National Institute of Mental Health, NIH, US Department of HHS, Bethesda, MD, USA. ²⁶⁸Department of Psychiatry and Human Behavior, School of Medicine, University of California, Irvine, CA, USA. ²⁶⁹Brain Molecular Science, Centre for Addiction & Mental Health, Toronto, Ontario, Canada.

²⁷⁰Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Toronto, Ontario, Canada. ²⁷¹Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada. ²⁷²Institute of Medical Sciences, University of Toronto, Toronto, Ontario, Canada.

Eating Disorders Working Group of the Psychiatric Genomics Consortium

Roger A. Adan^{273,274}, Lars Alfredsson²¹³, Helga Ask^{84,85}, Andreas Birgegård¹¹², Gerome Breen²⁰, Cynthia M. Bulik^{72,112,275}, Jonathan RI Coleman^{107,223}, Christian Dina²⁷⁶, Monika Dmitrzak-Weglarcz²⁷⁷, Elisa Docampo^{278,279}, Karin M. Egberts¹⁷⁴, Fernando Fernandez-Andrade^{280,281,282,283}, Katrin E. Giel^{284,285,286}, Scott D. Gordon¹¹⁴, Philip Gorwood²⁸⁷, Alexandra Havdahl⁸⁵, Anke Hinney^{169,170}, Christopher Hübel^{107,288}, James I. Hudson²⁶⁹, Susana Jimenez-Murcia^{280,281,282,283}, Jennifer Jordan^{290,291}, Gursharan K. Kalsi^{107,223}, Jaakkko Kaprio¹³⁰, Leila Karhunen²⁹², Martien J. H. Kas^{273,293}, James L. Kennedy¹¹⁹, Martin A. Kennedy²⁹⁴, Mikael Landén^{112,173}, Janne T. Larsen²⁸⁸, Qingqin S. Li²³⁶, Lisa R. Lilenfeld²⁹⁵, Jurjen J. Luykx^{175,237,238}, Nicholas G. Martin¹¹⁴, Sarah E. Medland^{114,178,179}, Alessio Maria Monteleone²⁹⁶, Karen S. Mitchell^{54,55}, Melissa A. Munn-Chernoff²⁹⁷, Benedetta Nacmias^{298,299}, Roel A. Ophoff²⁵³, Liselotte V. Petersen²⁸⁸, Dalila Pinto³⁰⁰, Anu Raevuori^{301,302}, Nicolas Ramoz²⁸⁷, Valdo Ricca³⁰³, Marion E. Roberts³⁰⁴, Filip Rybakowski³⁰⁵, Ulrike H. Schmidt³⁰⁶, Alexandra Schosser^{307,308}, Sandro Sorbi^{298,299}, Michael A. Strober³⁰⁹, Laura M. Thornton⁷², Hunna J. Watson^{310,311,312} & Stephan Zipfel^{313,314,315}

²⁷³Department of Translational Neuroscience, UMC Utrecht, Utrecht, The Netherlands.

²⁷⁴Rintveld Eating disorder clinic, Altrecht GGZ, Zeist, The Netherlands. ²⁷⁵Department of Nutrition, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ²⁷⁶l'institut du thorax, INSERM, CNRS, Nantes Université, Nantes, France. ²⁷⁷Department of Psychiatric Genetics, Department of Psychiatry, University of Medical Sciences, Poznan, Poland.

²⁷⁸Department of Human Genetics, University Hospital of Liège, Liège, Belgium.

²⁷⁹Rheumatology Department, University Hospital of Liège, Liège, Belgium. ²⁸⁰Ciber Physiopathology of Obesity and Nutrition (CIBERObn), Instituto de Salud Carlos III, Madrid, Spain. ²⁸¹Department of Clinical Psychology, University Hospital of Bellvitge-IDIBELL, Barcelona, Spain. ²⁸²Department of Clinical Sciences, School of Medicine and Health Sciences, University of Barcelona, Barcelona, Spain. ²⁸³Psychoneurobiology of Eating and Addictive Behaviors Group, Neuroscience Program, Bellvitge Biomedical Research Institute (IDIBELL), L'Hospitalet de Llobregat, Barcelona, Spain. ²⁸⁴Center for Excellence in Eating Disorders Tübingen (KOMET), Tübingen, Germany. ²⁸⁵German Center for Mental Health (DZPG), Tübingen, Germany. ²⁸⁶Department of Psychosomatic Medicine & Psychotherapy, Medical University Hospital Tübingen, Tübingen, Germany. ²⁸⁷Université Paris Cité, Institute of Psychiatry and Neuroscience of Paris (INSERM U1266), Paris, France. ²⁸⁸National Centre for Register-based Research, Aarhus University, Aarhus, Denmark. ²⁸⁹Department of Psychiatry, McLean Hospital, Harvard Medical School, Boston, MA, USA. ²⁹⁰Department of Psychological Medicine, University of Otago, Christchurch, New Zealand. ²⁹¹Te Whatu Ora—Waitaito (Health New Zealand), Christchurch, New Zealand. ²⁹²Institute of Public Health and Clinical Nutrition, University of Eastern Finland, Kuopio, Finland. ²⁹³Groningen Institute for Evolutionary Life Sciences, University of Groningen, Groningen, The Netherlands. ²⁹⁴Department of Pathology

and Biomedical Science, University of Otago, Christchurch, New Zealand. ²⁹⁵Department of Clinical Psychology, College of Professional Psychology, The Chicago School, Washington, DC, USA. ²⁹⁶Department of Psychiatry, University of Campania L. Vanvitelli, Naples, Italy. ²⁹⁷Department of Community, Family, and Addiction Sciences, Texas Tech University, Lubbock, TX, USA. ²⁹⁸Department of Neuroscience, Psychology, Drug Research and Child Health University of Florence, Florence, Italy. ²⁹⁹IRCCS Fondazione Don Carlo Gnocchi, Florence, Italy. ³⁰⁰Department of Psychiatry, Genetics and Genomic Sciences, Icahn School of Medicine at Mount Sinai, New York, NY, USA. ³⁰¹Department of Psychiatry, Division of Adolescent Psychiatry, Helsinki University Hospital, Helsinki, Finland. ³⁰²Faculty of Medicine, Clinicum, University of Helsinki, Helsinki, Finland. ³⁰³Department of Health Science, University of Florence, Firenze, Italy. ³⁰⁴Department of General Practice & Primary Healthcare, Faculty of Medical & Health Sciences, University of Auckland, Auckland, New Zealand. ³⁰⁵Department of Adult Psychiatry, University of Medical Sciences, Poznan, Poland. ³⁰⁶Department of Psychological Medicine, Centre for Research in Eating and Weight Disorders, King's College London, London, UK. ³⁰⁷Department of Psychiatry and Psychotherapy, Medical University Vienna, Vienna, Austria. ³⁰⁸Faculty of Medicine, Sigmund Freud University Vienna, Vienna, Austria. ³⁰⁹Department of Psychiatry and Biobehavioral Science, Semel Institute for Neuroscience & Human Behavior, David Geffen School of Medicine, University of California Los Angeles, Los Angeles, CA, USA. ³¹⁰Department of Psychiatry, School of Medicine, The University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ³¹¹Discipline of Psychology, School of Population Health, Curtin University, Perth, Western Australia, Australia. ³¹²Division of Paediatrics, School of Medicine, The University of Western Australia, Perth, Western Australia, Australia. ³¹³Centre of Excellence for Eating Disorders Tuebingen Germany (KOMET), Tuebingen, Germany. ³¹⁴Department of Psychosomatic Medicine and Psychotherapy, University Medical Hospital Tuebingen, Tuebingen, Germany. ³¹⁵German Centre for Mental Health (DZG) Tuebingen, Tuebingen, Germany.

Major Depressive Disorder Working Group of the Psychiatric Genomics Consortium

Mark J. Adams²⁴³, Till F. M. Andlauer²¹⁴, Helga Ask^{84,85}, Bernhard T. Baune^{216,217}, Sintia I. Belanger^{86,87}, Michael E. Benros^{316,317}, Tim B. Bigdeli^{218,219}, Ottar Bjerkeset^{88,89}, Dorret I. Boomsma^{150,151}, Jerome Breen²⁰, Rodrigo A. Bressan³¹⁸, Enda M. Byrne³¹⁹, Na Cai^{21,22,23,24}, Carolina M. Carvalho^{37,320}, Enrique Castelao⁹⁵, Boris Chaumette^{287,321}, Sven Cichon^{111,220,221,222}, Jonathan RI Coleman^{107,223}, Lucia Colodro-Conde¹⁷⁹, Hilary Coon^{96,97}, William E. Copeland⁹⁸, Elizabeth C. Corfield^{85,99}, Darina Czamara¹⁰⁰, Udo Dannowski²²⁶, Eske M. Derk¹¹⁴, Anna R. Doherty^{79,96,102,103}, Katharina Domschke¹⁰⁴, Erin C. Dunn^{49,161}, Chiara Fabbri³²², Giuseppe Fanelli^{31,322}, Jerome C. Foo²²⁸, Andreas J. Forstner^{109,110,111}, Josef Frank²²⁸, Ary Gadelha³¹⁸, Zachary F. Gerring^{114,124}, Fernando S. Goes²³¹, Scott D. Gordon¹¹⁴, Hans J. Grabe³²³, Jakob Grove^{18,19,199,200}, Jan Haavik^{166,167}, Andrew C. Heath³²⁴, Matthew H. Iveson¹¹⁸, James A. Knowles^{40,41}, Jaakko Kaprio¹³⁰, James L. Kennedy¹¹⁹, James A. Knowles^{40,41}, Henry R. Kranzler^{171,172}, Kristi Krebs²³⁵, Mikael Landén^{112,173}, Kelli Lehto²³⁹, Daniel F. Leyte^{120,121}, Douglas F. Levinson³²⁵, Kathryn M. Lewis¹⁰⁷, Glyn Lewis²¹⁵, Qingqin S. Li²³⁶, Penelope A. Lind^{14,124}, Jurjen J. Luykx^{175,237,238}, Hermine HM Maes¹²⁵, Eduard Maron^{126,127}, Nicholas G. Martin¹¹⁴, Andrew M. McIntosh²⁴³, Sarah E. Medland^{114,178,179}, Lili Milani²³⁵, Brittany L. Mitchell¹¹⁴, Woojae Myung^{250,251}, Michael C. O'Donovan¹⁸⁰, Vanessa K. Ota^{96,97}, Michael J. Owen¹⁸⁰, Teemu Palvinainen¹³⁰, Pedro M. Pan⁸⁷, Peristera Paschou³²⁶, Roseann E. Peterson⁵⁸, Giorgio Pistic⁹⁵, Danielle Posthuma^{161,182}, James B. Potash²³¹, Martin Preisig⁹⁵, Andreas Reif^{185,186}, John P. Rice³⁶⁰, Marcella Rietschel²²⁸, Brien P. Riley³²⁷, Giovanni A. Salum^{328,329,330,331}, Marcos L. Santoro^{87,322}, Eva C. Schulte^{53,110,234,261,262,263,264}, Alessandro Serretti^{265,266}, Andrey A. Shabalina^{96,103}, Jordan W. Smoller^{42,49,50,496}, Lea Sirignano²²⁶, Dan J. Stein¹³², Murray B. Stein^{46,69,70}, Fabian Streit²²⁸, Jana Strohmaier²²⁸, Martin Tesli⁹⁵, Jackson G. Thor^{114,124}, Henning Tiemeier^{139,140}, Sandra Van der Auwera³²³, Bradley T. Webb^{79,333}, Stephanie H. Witt¹⁹⁶ & Naomi R. Wray^{77,78}

³¹⁶Copenhagen Research Centre for Biological and Precision Psychiatry, Mental Health Centre Copenhagen, Copenhagen University Hospital, Copenhagen, Denmark. ³¹⁷Department of Clinical Medicine, University of Copenhagen, Copenhagen, Denmark. ³¹⁸Department of Psychiatry, Universidade Federal de Sao Paulo, Sao Paulo, Brazil. ³¹⁹Child Health Research Centre, The University of Queensland, Brisbane, Queensland, Australia. ³²⁰Department of Psychiatry and Medical Psychology, Universidade Federal de São Paulo (UNIFESP), São Paulo, Brazil. ³²¹Department of Psychiatry, McGill University, Montreal, Quebec, Canada. ³²²Department of Biomedical and Neuromotor Sciences, University of Bologna, Bologna, Italy. ³²³Department of Psychiatry and Psychotherapy, University Medicine Greifswald, Greifswald, Germany. ³²⁴Department of Psychiatry, Washington University, St Louis, MO, USA. ³²⁵Department of Psychiatry, Stanford University, Stanford, CA, USA. ³²⁶Department of Biological Sciences, Purdue University, West Lafayette, IN, USA. ³²⁷Departments of Psychiatry and Human & Molecular Genetics, Virginia Commonwealth University, Richmond, VA, USA. ³²⁸Child Mind Institute, New York, NY, USA. ³²⁹Department of Psychiatry, Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil. ³³⁰Hospital de Clínicas de Porto Alegre, Porto Alegre, Brazil. ³³¹National Institute of Developmental Psychiatry, São Paulo, Brazil. ³³²Department of Biochemistry, Universidade Federal de São Paulo, São Paulo, Brazil. ³³³GenOmics and Translational Research Center, RTI International, Durham, NC, USA.

Nicotine Dependence GenOmics (iNDiGO) Consortium

Timothy B. Baker³³⁴, Dorret I. Boomsma^{150,151}, Danielle M. Dick^{335,336}, Dmitriy Drichel³³⁷, Lindsay A. Farver³³⁸, Nathan C. Gaddis³³³, Dana B. Hancock³³⁹, John E. Hokanson³⁴⁰, Jouke-Jan Hottenga¹⁵⁰, Eric O. Johnson^{333,341}, Jaakko Kaprio¹³⁰, Henry R. Kranzler^{171,172}, Pamela A. Madden³²⁴, Mary L. Marazita¹³⁰, Jesse A. Marks³³³, Daniel W. McNeil³⁴³, Michael Nethnagel³⁴⁴, Teemu Palvinainen¹³⁰, Bryan C. Quach³³³, Marcella Rietschel²²⁸, Nancy L. Saccone^{345,346}, Nancy YA Sey³⁴⁷, Richard Sherva^{338,348}, Scott Vrieze³⁴⁹, Alex Waldrop³⁵⁰, Georg Winterer³⁵¹, Kendra Young³⁴⁰ & Stephanie Zellers^{130,349}

³³⁴Department of Medicine, University of Wisconsin School of Medicine and Public Health, Madison, WI, USA. ³³⁵Department of Psychiatry, Robert Wood Johnson Medical School, Rutgers—The State University of New Jersey, New Brunswick, NJ, USA. ³³⁶Department of Psychiatry, Rutgers Robert Wood Johnson School of Medicine, Rutgers University, Piscataway, NJ, USA. ³³⁷Drichel Analytics, Bonn, Germany. ³³⁸Department of Medicine (Biomedical Genetics), Boston University School of Medicine, Boston, MA, USA. ³³⁹RTI International, Research Triangle Park, NC, USA. ³⁴⁰Department of Epidemiology, University of Colorado Anschutz Medical Campus, Aurora, CO, USA. ³⁴¹Fellow Program, RTI International, Durham, NC, USA. ³⁴²Center for Craniofacial and Dental Genetics, Department of Oral and Craniofacial Sciences, School of Dental Medicine, University of Pittsburgh, Pittsburgh, PA, USA. ³⁴³Department of Community Dentistry and Behavioral Science, University of Florida, Gainesville, FL, USA. ³⁴⁴Cologne Center for Genomics, University of Cologne, Cologne, Germany. ³⁴⁵Department of Genetics, Washington University School of Medicine, St Louis, MO, USA. ³⁴⁶Division of Biostatistics, Washington University School of Medicine, St Louis, MO, USA. ³⁴⁷National Human Genome Research Institute, National Institutes of Health, Bethesda, MD, USA. ³⁴⁸Biomedical Genetics, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA. ³⁴⁹Department of Psychology, University of Minnesota Twin Cities, Minneapolis, MN, USA. ³⁵⁰Biobot Analytics, Cambridge, MA, USA. ³⁵¹PI Pharmaimage Biomarker Solutions, Cambridge, MA, USA.

Obsessive-Compulsive Disorder and Tourette Syndrome Working Group of the Psychiatric Genomics Consortium

Silvia Alemany^{144,145,146,147}, Helga Ask^{84,85}, Cathy L. Barr^{155,352,353}, Csaba Barta³⁵⁴, Katharina Bey³⁵⁵, Oscar J. Bienvenu²³¹, Julia Boberg³⁵⁶, Rosa Bosch^{152,153}, Christie L. Burton¹⁵⁵, Jonas Bybjerg-Grauholm^{19,357}, Enda M. Byrne³¹, Adrian Camarena³⁵⁸, Beatriz Camarena³⁵⁹, Miquel Casas^{163,156,157}, Danielle C. Cath^{360,361}, Edwin H. Cook¹⁹⁸, Jennifer Crosbie^{119,155}, James J. Crowley³⁶², Eske M. Derk¹¹⁴, Andrea Dietrich^{363,364}, Katharina Domschke¹⁰⁴, Peter Falkai^{108,231}, Thomas V. Fernandez³⁶⁵, Daniel A. Geller³⁶, Zachary F. Gerring^{114,124}, Fernando S. Goes²³¹, Hans J. Grabe³²³, Marco A. Grados²³¹, Erica L. Greenberg⁶⁵, Jakob Grove^{18,19,199,200}, Edna Grünblatt^{366,367,368}, Jan Haavik^{166,167}, Kristen Hagen^{369,370,371}, Gregory L. Hanna³⁷², Bjarne Hansen^{369,373}, Gary A. Heiman^{374,375}, Pieter J. Hoekstra^{363,364}, David M. Houghard^{19,357}, James A. Knowles^{40,41}, Jaakko Kaprio¹³⁰, Norbert Kathmann⁷¹, Julia Klawohn^{71,376}, Gerd Kvale^{167,377}, Nuria Lanzagorta³⁷⁸, Stephanie Le Hellard³⁷⁹, Daniel F. Levey^{20,121}, Christine Lochner¹²², Jurjen J. Luykx^{175,237,238}, Fabio Macciardi³⁸⁰, Brion S. Maher³⁸¹, Irene A. Malaty³⁸², David Mataix-Cols^{356,383}, Carol A. Mathews^{384,385}, Manuel Mattheisen^{18,51,52,53}, Nicole CR McLaughlin^{386,387}, Euripedes C. Miguel³⁸⁸, Kirsten R. Müller-Vahl³⁸⁹, Humberto Nicolini^{378,390}, Erika L. Nurmi^{391,392}, Michael S. Okun³⁸², Peristera Paschou³²³, Danielle Posthuma^{181,182}, Raquel Rabionet^{145,393,394,395}, Alfredo Ramirez^{396,397,398,399,400}, Joses Antoni Ramos-Quiroga^{152,183,184}, Marta Ribas^{144,145,146,147}, Renata Rizzo⁴⁰¹, Cristina Rodriguez-Fonterra⁴⁰², Paul Sandor¹¹⁹, Jeremiah M. Scharf^{50,64,65,66}, Elles de Schipper³⁵⁶, Harvey S. Singer⁴⁰³, Maria Soler Artigas^{144,145,146,147}, Dan J. Stein¹³², Murray B. Stein^{46,69,70}, Eric A. Storch⁴⁰⁴, Nora I. Strom^{51,53,71}, Jackson G. Thorp^{114,124}, Jeremy Veenstra-VanderWeele^{405,406}, Michael Wagner^{355,397,400}, Christopher P. Walker^{374,375}, Dongmei Yu^{50,66} & Gwyneth Zai^{119,143}

³⁵²Departments of Psychiatry and Physiology, University of Toronto, Toronto, Ontario, Canada. ³⁵³Division of Experimental and Translational Neuroscience, Krembil Research Institute, University Health Network, Toronto, Ontario, Canada. ³⁵⁴Department of Molecular Biology, Semmelweis University, Budapest, Hungary. ³⁵⁵Department of Psychiatry and Psychotherapy, University Hospital Bonn, Bonn, Germany. ³⁵⁶Centre for Psychiatry Research, Department of Clinical Neuroscience, Karolinska Institutet & Stockholm Health Care Services, Region Stockholm, Stockholm, Sweden. ³⁵⁷Department for Congenital Disorders, Statens Serum Institut, Copenhagen, Denmark. ³⁵⁸Duke University Hospital, Department of Surgery, Durham, NC, USA. ³⁵⁹Department of Pharmacogenetics, Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Mexico City, Mexico. ³⁶⁰Department of Psychiatry, UMCG & RUG, Groningen, The Netherlands. ³⁶¹GGZ Drenthe, Assen, The Netherlands. ³⁶²Department of Genetics, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ³⁶³Accare Child Study Center, Groningen, The Netherlands. ³⁶⁴University of Groningen, University Medical Center Groningen, Department of Child and Adolescent Psychiatry, Groningen, The Netherlands. ³⁶⁵Child Study Center and Department of Psychiatry, Yale School of Medicine, New Haven, CT, USA. ³⁶⁶Department of Child and Adolescent Psychiatry and Psychotherapy, Psychiatric University Hospital Zurich, University of Zurich, Zurich, Switzerland. ³⁶⁷Neuroscience Center Zurich, University of Zurich and the ETH Zurich, Zurich, Switzerland. ³⁶⁸Zurich Center for Integrative Human Physiology, University of Zurich, Zurich, Switzerland. ³⁶⁹Bergen Center for Brain Plasticity (BCBP), Haukeland University Hospital, Bergen, Norway. ³⁷⁰Department of Psychiatry, Helse Møre and Romsdal Hospital Trust, Molde, Norway. ³⁷¹Norwegian University for Science and Technology, Trondheim, Norway. ³⁷²Department of Psychiatry, University of Michigan, Ann Arbor, MI, USA. ³⁷³Centre for Crisis Psychology, University of Bergen, Bergen, Norway. ³⁷⁴Department of Genetics and the Human Genetics Institute of New Jersey, Rutgers University, New Brunswick, NJ, USA. ³⁷⁵Rutgers University, Piscataway, NJ, USA. ³⁷⁶Department of Medicine, MSB Medical School Berlin, Berlin, Germany. ³⁷⁷Department of Clinical Psychology, University of Bergen, Bergen, Norway. ³⁷⁸Carracci Medical Group, Mexico City, Mexico. ³⁷⁹Department of Clinical Science, University of Bergen, Bergen, Norway. ³⁸⁰Department of Psychiatry, University of California, Irvine, Irvine, CA, USA. ³⁸¹Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA. ³⁸²Department of Neurology, Norman Fixel Institute for Neurological Diseases, Gainesville, FL, USA. ³⁸³Department of Clinical Sciences, Lund University, Lund, Sweden. ³⁸⁴Department of Psychiatry and Genetics Institute, University of Florida, Gainesville, FL, USA. ³⁸⁵UF Center for OCD, Anxiety and Related Disorders, Gainesville, FL, USA. ³⁸⁶Alpert Medical School of Brown University, Providence, RI, USA. ³⁸⁷Butler Hospital, Providence, RI, USA. ³⁸⁸Faculdade de Medicina, Universidade de São Paulo, São Paulo, Brazil. ³⁸⁹Department of Psychiatry, Social Psychiatry and Psychotherapy, Hannover Medical School, Hannover, Germany. ³⁹⁰Laboratory of Genomics of Psychiatric and Neurodegenerative Diseases, National Institute of Genomic Medicine (INMEGEN), Mexico City, Mexico. ³⁹¹Department of Mental Health, Greater Los Angeles VA Healthcare, Los Angeles, CA, USA. ³⁹²Department of Psychiatry and

Article

Biobehavioral Sciences, University of California at Los Angeles, Los Angeles, CA, USA. ³⁹³Centro de Investigación Biomédica en Red de Enfermedades Raras (CIBERER), ISCIII, Madrid, Spain. ³⁹⁴Institut de Biomedicina de la Universitat de Barcelona (IBUB), Barcelona, Spain. ³⁹⁵Institut de Recerca Sant Joan de Déu (IRSJD), Barcelona, Spain. ³⁹⁶Cologne Excellence Cluster for Stress Responses in Ageing-Associated Diseases (CECAD), University of Cologne, Cologne, Germany. ³⁹⁷Department of Neurodegenerative Diseases and Geriatric Psychiatry, University Hospital Bonn, Bonn, Germany. ³⁹⁸Department of Psychiatry, Glenn Biggs Institute for Alzheimer's and Neurodegenerative Diseases, San Antonio, TX, USA. ³⁹⁹Department of Psychiatry and Psychotherapy, Division of Neurogenetics and Molecular Psychiatry, Medical Faculty, University of Cologne, Cologne, Germany. ⁴⁰⁰German Center for Neurodegenerative Diseases (DZNE), Bonn, Germany. ⁴⁰¹Department of Clinical and experimental Medicine, Child and Adolescent Neuropsychiatry, Catania University, Catania, Italy. ⁴⁰²Genomics and Bioinformatics, Center for Research in Molecular Medicine and Chronic Diseases (CIMUS), University of Santiago de Compostela, Compostela, Spain. ⁴⁰³Department of Neurology and the Kennedy Krieger Institute, Johns Hopkins University School of Medicine, Baltimore, MD, USA. ⁴⁰⁴Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, TX, USA. ⁴⁰⁵Departments of Psychiatry and Pediatrics, Columbia University, New York, NY, USA. ⁴⁰⁶New York State Psychiatric Institute, New York, NY, USA.

Post-Traumatic Stress Disorder Working Group of the Psychiatric Genomics Consortium

Søren B. Andersen⁴⁰⁷, Helga Ask^{84,85}, Sintia I. Belanger^{86,87}, Laura J. Bierut³²⁴, Jerome Breen²⁰, Rodrigo A. Bressan³¹⁸, Sandra A. Brown^{93,94}, Carolina M. Carvalho^{87,320}, Chia-Yen Chen⁴⁰⁸, Jonathan RI Coleman^{107,223}, Lucia Colodro-Conde¹⁷⁹, Nikolaos P. Daskalakis^{16,289}, Jürgen Deckert¹⁰¹, Seth G. Disner^{409,410}, Anna R. Docherty^{96,78,102,103}, Norah C. Feeny⁴¹¹, Ary Gadelha³¹⁸, Scott D. Gordon¹¹⁴, Lana R. Grasser⁴¹², Magali Haas⁴¹³, Kelly M. Harrington^{54,414}, Victor M. Hesselbrock⁴¹⁵, Mohammed H. Ibrahim⁴¹⁶, Seyma Katrinli⁴¹⁷, James L. Kennedy¹¹⁹, Nathan A. Kimble^{418,419,420}, Karestan C. Koenen^{42,43,44}, Kristi Krebs³³⁵, Kelli Lehto²³³, Daniel F. Levey^{120,121}, Jurjen J. Luykx^{175,237,238}, Adam X. Maihofner^{45,46,47}, Jessica L. Maples-Keller⁴²¹, Sarah E. Medland^{114,178,179}, Jacqueline L. Meyers⁴²², Janitta L. Montalvo-Ortiz^{423,424}, Charles P. Morris¹²⁴, Caroline M. Nievergelt^{45,46,47}, Vanessa K. Ota^{36,87}, Pedro M. Pan⁸⁷, Robert H. Pietrzak⁴²³, Renato Polimanti⁴²⁴, Richard J. Rosenblum⁴²⁵, Barbara O. Rothbaum⁴²¹, Bart PF Rutten^{16,175}, Nancy L. Saccone^{345,346}, Giovanni A. Salum^{328,329,330,331}, Marcos L. Santoro^{87,332}, Soraya Seedat¹²⁶, Andrey A. Shabalin^{96,103}, Alicia K. Smith^{417,421,427}, Dan J. Stein¹³², Murray B. Stein^{46,69,70}, Ralph E. Tarter⁴²⁸, Clement C. Zai^{16,119,142} & Gwyneth Zai^{119,143}

⁴⁰⁷Imaging Future Aps, Tåstrup, Denmark. ⁴⁰⁸Biogen, Cambridge, MA, USA. ⁴⁰⁹Department of Psychiatry and Behavioral Sciences, University of Minnesota Medical School, Boston, MA, USA. ⁴¹⁰Minneapolis VA Health Care System, Boston, MA, USA. ⁴¹¹Case Western Reserve University, Boston, MA, USA. ⁴¹²Department of Psychiatry and Behavioral Neurosciences, Wayne State University School of Medicine, Boston, MA, USA. ⁴¹³Cohen Veterans Bioscience, Boston, MA, USA. ⁴¹⁴Million Veteran Program (MVP) Coordinating Center, VA Boston Healthcare System, Boston, MA, USA. ⁴¹⁵Department of Psychiatry, University of Connecticut School of Medicine, Farmington, CT, USA. ⁴¹⁶Department of Psychology, Eberhard Karls Universität Tübingen, Tübingen, Germany. ⁴¹⁷Department of Gynecology and Obstetrics, Emory University, Atlanta, GA, USA. ⁴¹⁸Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine, Durham, NC, USA. ⁴¹⁹Durham Veterans Affairs (VA) Health Care System, Durham, NC, USA. ⁴²⁰VA Mid-Atlantic Mental Illness Research, Education and Clinical Center, Durham, NC, USA. ⁴²¹Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, GA, USA. ⁴²²Department of Psychiatry, State University of New York Downstate Medical Center, New York, NY, USA. ⁴²³Connecticut VA Healthcare Center, Orange, CT, USA. ⁴²⁴Department of Psychiatry, Yale School of Medicine, New Haven, CT, USA. ⁴²⁵Department of Psychological & Brain Sciences, Indiana University, Bloomington, IN, USA. ⁴²⁶South African Medical Research Council Genomics of Brain Disorders Research Unit, Department of Psychiatry, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa. ⁴²⁷Department of Human Genetics, Emory University, Atlanta, GA, USA. ⁴²⁸Department of Pharmaceutical Sciences, University of Pittsburgh, Pittsburgh, PA, USA.

Schizophrenia Working Group of the Psychiatric Genomics Consortium

Muhammad Ayub⁴²⁹, Nicholas Bass²¹⁶, Bernhard T. Baune^{216,217}, Sintia I. Belanger^{86,87}, Tim B. Bigdeli^{218,219}, Rodrigo A. Bressan³¹⁸, Dominique Campion^{430,431}, Boris Chaumette^{287,321}, Sven Cichon^{111,220,221,222}, David Cohen^{432,433,434}, Angel Consoli^{432,443}, Marta Di Forti¹⁰⁷, Johan G. Eriksson^{435,436}, Olga YU Fedorenko^{437,438}, Josef Frank²²⁸, Robert Freedman⁴³⁹, Janice M. Fullerton^{229,230}, Ary Gadelha³¹⁸, Raul R. Gainetdinov^{440,441}, Marianna Giannitelli^{143,433}, Ina Giegling⁴⁴², Stephen J. Glatt^{197,381}, Stephanie Godard⁴⁴³, Jakob Grove^{18,19,199,200}, Olivier Guillen^{430,431,444}, Annette M. Hartmann¹⁴⁵, Svetlana A. Ivanova^{437,446}, Katherine G. Jonas³⁹, James A. Knowles^{40,41}, Kenneth S. Kendler^{79,80,496}, James L. Kennedy¹¹⁹, Alexander O. Kibitov^{447,448}, James A. Knowles^{40,41}, Bettina Konte¹⁴⁵, Claudine Laurent-Levinson^{432,433}, Phil H. Lee⁵⁰, Anastasia Levchenko⁴⁴⁹, Douglas F. Levinson³²⁵, Qingqin S. Li²³⁶, Jurjen J. Luykx^{175,237,238}, Brion S. Maher³⁹¹, Morten Mattingdal^{106,242}, Andrew McQuillin²¹⁵, Sandra M. Meier¹²⁸, Robin Murray⁴⁵⁰, Merete Nordentoft^{317,451}, Cristiano Noto³¹⁸, Michael C. O'Donovan¹⁸⁰, Roel A. Ophoff⁴²⁹, Vanessa K. Ota^{36,87}, Michael J. Owen¹⁸⁰, Danielle Posthuma^{181,182}, Diego Quattrone¹⁰⁷, Marcella Rietschel²²⁹, Brien P. Riley³²⁷, Dan Rujescu⁴⁴⁵, Bart PF Rutten^{16,175}, Safaaker Delye⁴⁵², Marcos L. Santoro^{87,332}, Silbily G. Schwab^{453,454}, Alessandro Serretti^{265,266}, Jordan W. Smoller^{42,49,50,499}, Fabian Streit²²⁸, Jana Strohmaier²²⁸, Florence Thibaut^{455,456}, Marquis P. Vawter²⁶⁸, James TR Walters¹⁸⁰, Bradley T. Webb^{79,333}, Thomas Werge^{317,457}, Dieter B. Wildenauer⁴⁵⁸, Stephanie H. Witt¹⁹⁶ & Clement C. Zai^{16,119,142}

⁴²⁹Mental Health Neuroscience Research Department, Division of Psychiatry, UCL, London, UK. ⁴³⁰Centre Hospitalier du Rouvray, Rouen, France. ⁴³¹INSERM U1245, Rouen, France. ⁴³²Centre de Référence des Maladies Rares à Expression Psychiatrique, Department of Child and Adolescent Psychiatry, AP-HP Sorbonne Université, Hôpital Universitaire de la Pitié-Salpêtrière, Paris, France. ⁴³³Faculté de Médecine Sorbonne Université, Groupe de Recherche Clinique n°15 - Troubles Psychiatriques et Développement (PSYDEV), Department of Child and Adolescent Psychiatry, Hôpital Universitaire de la Pitié-Salpêtrière, Paris, France. ⁴³⁴Institut des Systèmes Intelligents et de Robotique (ISIR), CNRS UMR7222, Sorbonne Université, Campus Pierre et Marie Curie, Faculté des Sciences et Ingénierie, Paris, France. ⁴³⁵Department of General Practice and Primary Health Care, University of Helsinki, Helsinki, Finland. ⁴³⁶Department of Obstetrics and Gynecology, National University of Singapore, Singapore, Singapore. ⁴³⁷Mental Health Research Institute, Tomsk National Research Medical Center, Tomsk, Russia. ⁴³⁸School of Non-Destructive Testing, Tomsk Polytechnic University, Tomsk, Russia. ⁴³⁹Department of Psychiatry, University of Colorado Denver School of Medicine, Aurora, CO, USA. ⁴⁴⁰Institute of Translational Biomedicine, Saint Petersburg State University, St Petersburg, Russia. ⁴⁴¹Saint Petersburg University Hospital, Saint Petersburg State University, St Petersburg, Russia. ⁴⁴²Comprehensive Center for Clinical Neurosciences and Mental Health (C3NMH), Medical University of Vienna, Vienna, Austria. ⁴⁴³Departments of Psychiatry and Human and Molecular Genetics, INSERM, Institut de Myologie, Hôpital de la Pitié-Salpêtrière, Paris, France. ⁴⁴⁴UFR Santé, Université de Rouen Normandie, Rouen, France. ⁴⁴⁵Department of Psychiatry and Psychotherapy, Comprehensive Center for Clinical Neurosciences and Mental Health (C3NMH), Medical University of Vienna, Vienna, Austria. ⁴⁴⁶Psychiatry, Addictology and Psychotherapy Department, Siberian State Medical University, Tomsk, Russia. ⁴⁴⁷Department of Psychiatric Genomics, Bekhterev National Medical Research Center for Psychiatry and Neurology, St Petersburg, Russia. ⁴⁴⁸Valdman Institute of Pharmacology, First St. Petersburg Pavlov State Medical University, St Petersburg, Russia. ⁴⁴⁹Saint Petersburg State University, St Petersburg, Russia. ⁴⁵⁰Department of Psychosis Studies, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK. ⁴⁵¹Mental Health Services in the Capital Region of Denmark, Mental Health Center Copenhagen, University of Copenhagen, Copenhagen, Denmark. ⁴⁵²Génethon, Evry, France. ⁴⁵³Faculty of Science, Medicine and Health, School of Chemistry and Molecular Bioscience, University of Wollongong, Wollongong, New South Wales, Australia. ⁴⁵⁴Illawarra Health and Medical Research Institute, Wollongong, New South Wales, Australia. ⁴⁵⁵INSERM U1266, Institut de Psychiatrie et de Neurosciences, Paris, France. ⁴⁵⁶Université de Paris, Faculté de Médecine, Hôpital Cochin-Tarnier, Paris, France. ⁴⁵⁷Institute of Biological Psychiatry, Mental Health Services, Copenhagen University Hospital, Copenhagen, Denmark. ⁴⁵⁸School of Psychiatry and Clinical Neurosciences, The University of Western Australia, Perth, Western Australia, Australia.

Substance Use Disorders Working Group of the Psychiatric Genomics Consortium

Daniel E. Adkins^{81,82}, Arpana Agrawal³²⁴, Silvia Alemany^{144,145,146,147}, David AA Baranger⁴⁵⁹, Anthony J. Batzler¹¹, Joanna M. Biernacka^{11,12}, Laura J. Bierut³²⁴, Tim B. Bigdeli^{218,219}, Jason D. Boardman⁴⁶⁰, Joseph M. Boden^{93,290}, Ryan Bogdan⁴⁵⁹, Sandra A. Brown^{93,94}, Karhleen K. Bucholz³²⁴, Doo-Sup Choi^{461,462}, Sarah MC Colbert²⁴⁸, Brandon J. Coombes¹¹, William E. Copeland⁴⁹⁸, Joseph D. Deak^{424,463}, Marta Di Forti¹⁰⁷, Nancy Diazgranados⁴⁶⁴, Danielle M. Dick^{335,336}, Anna R. Docherty^{79,96,102,103}, Howard J. Edenberg^{26,27}, Alexis C. Edwards⁴⁶⁵, Jerome C. Foo²²⁸, Josef Frank²²⁸, Raul R. Gainetdinov^{440,441}, Joel Gelernter^{35,36}, Ina Giegling⁴⁴², Alison M. Goate²⁴⁸, David Goldman⁴⁶⁶, Laura M. Hack^{467,468}, Dana B. Hancock³³⁹, Kathleen Mullan Harris⁴⁶⁹, Annette M. Hartmann¹⁴⁵, Sarah M. Hartz³²⁴, Alexander S. Hatoum³⁷, Caroline Hayward⁴⁷⁰, Andrew C. Heath³²⁴, John K. Hewitt⁴⁷¹, Per Hoffmann¹⁰, Christian J. Hopfer⁴³³, Daniel P. Howrigan^{16,59}, Emma C. Johnson³⁷, Eric O. Johnson^{333,341}, Jaakko Kaprio¹³⁰, Victor M. Karpyak²²⁴, Martin A. Kennedy²⁹⁴, Alexander O. Kibitov^{447,448}, Bettina Konte¹⁴⁵, Henry R. Kranzler^{171,172}, Kenneth S. Krauter⁴⁷², Evgeny M. Krupitsky^{448,473}, Samuel Kuperman⁴⁷⁴, Jari Lahti^{116,475}, Marius Lahti-Pulkkinen^{116,476,477}, Dongbing Lai⁴⁷⁸, Anastasia Levchenko⁴⁴⁹, Daniel F. Lever^{120,121}, Penelope A. Lind^{114,124}, Jurjen J. Luykx^{175,237,238}, Pamela A. Madden³²⁴, Hermine H. Maes²⁶⁵, Brion S. Maher³⁸¹, Nicholas G. Martin¹⁴, Sarah E. Medland^{114,178,179}, Jacqueline L. Meyers⁴²², Alex P. Miller³²⁴, Janitta L. Montalvo-Ortiz^{423,424}, John I. Nurnberger Jr²⁵², Abraham A. Palmer^{93,479}, Rohn H. Palmer^{480,481,482}, Teemu Palvinainen¹³⁰, John F. Pearson⁴⁸³, Roseann E. Peterson⁵⁸, Renato Polimanti⁴²⁴, Bernice Porjesz⁴⁸⁴, Ulrich W. Preuss^{485,486}, James J. Prisciandaro²⁵⁹, Diego Quattrone¹⁰⁷, Josep Antoni Ramos-Quiroga^{152,183,184}, Marta Ribasés^{144,145,146,147}, John P. Rice²⁶⁰, Brien P. Riley³²⁷, Daniel M. Rosenblum⁴⁸⁷, Richard J. Rosenblum⁴²⁵, Dan Rujescu⁴⁴⁵, Nancy L. Saccone^{345,346}, Sandra S. Sanchez-Roige^{46,60,61}, Norbert Scherbaum⁴⁸⁸, Andrey A. Shabalin^{96,103}, Richard Sherva^{338,341}, María Soler Artigas^{144,145,146,147}, Fabian Streit²²⁸, Ralph E. Tarter⁴²⁸, Michael Vanyukov⁴⁸⁹, Tamara L. Wall⁹³, Raymond K. Walters^{16,56}, Bradley T. Webb^{79,333}, Robbee Wedow^{478,490}, Stanley H. Weiss¹⁸⁷, Leah Wetherill⁴⁷⁸, Stephanie H. Witt¹⁹⁶, Norbert Wodarz⁴⁹¹, Stephanie Zellers^{130,349}, Haitao Zhang⁴⁹², Hongyu Zhao⁴⁹³, Hang Zhou^{121,242,494}, Peter Zill²³⁴ & Lea Zillich²²⁸

⁴⁵⁹Department of Psychological & Brain Sciences, Washington University, St Louis, MO, USA. ⁴⁶⁰Institute of Behavioral Science and Department of Sociology, University of Colorado, Boulder, CO, USA. ⁴⁶¹Department of Molecular Pharmacology and Experimental Therapeutics, Mayo Clinic College of Medicine and Science, New York, NY, USA. ⁴⁶²Department of Psychiatry and Psychology, Mayo Clinic College of Medicine and Science, New York, NY, USA. ⁴⁶³Department of Psychiatry, Veterans Affairs Connecticut Healthcare Center, West Haven, CT, USA. ⁴⁶⁴Office of the Clinical Director, NIAAA, NIH, Bethesda, MD, USA. ⁴⁶⁵Department of Psychiatry, Virginia Commonwealth University School of Medicine, Virginia Institute for Psychiatric and Behavioral Genetics, Richmond, VA, USA. ⁴⁶⁶Office of the Clinical Director and Lab of Neurogenetics, NIAAA, NIH, Rockville, MD, USA. ⁴⁶⁷Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, CA, USA. ⁴⁶⁸Sierra-Pacific Mental Illness Research, Education and Clinical Center (MIRECC), Veterans Affairs Palo Alto Health Care System, Palo Alto, CA, USA. ⁴⁶⁹Department of Sociology and the Carolina Population Center, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA. ⁴⁷⁰MRC Human Genetics Unit, IGC, University of Edinburgh, Edinburgh, UK. ⁴⁷¹Institute for

Behavioral Genetics, University of Colorado Boulder, Boulder, CO, USA. ⁴⁷²Department of Molecular, Cellular, and Developmental Biology, University of Colorado, Boulder, CO, USA. ⁴⁷³Department of Addictions, Bekhterev National Medical Research Center for Psychiatry and Neurology, Edinburgh, UK. ⁴⁷⁴Department of Psychiatry, University of Iowa Carver College of Medicine, Edinburgh, UK. ⁴⁷⁵Folkhälsan Research Center, Helsinki, Finland. ⁴⁷⁶Centre for Cardiovascular Science, University of Edinburgh, Edinburgh, UK. ⁴⁷⁷Population Health Unit, Finnish Institute for Health and Welfare, Helsinki and Oulu, Finland. ⁴⁷⁸Department of Medical & Molecular Genetics, Indiana University, Indianapolis, IN, USA. ⁴⁷⁹Institute for Genomic Medicine, University of California San Diego, La Jolla, CA, USA. ⁴⁸⁰Department of Psychology, Emory University, Atlanta, GA, USA. ⁴⁸¹The Jackson Laboratory, Bar Harbor, ME, USA. ⁴⁸²Providence VA Medical Center, Providence, RI, USA. ⁴⁸³Department of Medicine, University of Otago, Christchurch, New Zealand. ⁴⁸⁴Department of Psychiatry, State University of New York Downstate Health Science University, New York, NY, USA. ⁴⁸⁵Department of Psychiatry,

Psychotherapie und Psychosomatik, Martin-Luther University Halle-Wittenberg, Newark, NJ, USA. ⁴⁸⁶RKH Ludwigsburg, Psychiatrie, Psychotherapie und Psychosomatische Medizin, Newark, NJ, USA. ⁴⁸⁷Department of Medicine, Rutgers New Jersey Medical School, Newark, NJ, USA. ⁴⁸⁸Department of Psychiatry and Psychotherapy, LVR-University Hospital Essen, University of Duisburg-Essen, Duisburg-Essen, Germany. ⁴⁸⁹Departments of Pharmaceutical Sciences, Psychiatry, and Human Genetics, University of Pittsburgh, Pittsburgh, PA, USA. ⁴⁹⁰Department of Sociology, Purdue University, Regensburg, Germany. ⁴⁹¹Department of Psychiatry and Psychotherapy, Center of Addiction Medicine, University Hospital Regensburg at the Bezirksklinikum, Regensburg, Germany. ⁴⁹²Epidemiology and Biometry Branch, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Bethesda, MD, USA. ⁴⁹³Department of Biostatistics, Yale School of Public Health, New Haven, CT, USA. ⁴⁹⁴Section of Biomedical Informatics and Data Science, Yale School of Medicine, New Haven, CT, USA.

Methods

Quality control of summary statistics

A standard set of quality-control filters was applied to all univariate GWAS summary statistics before conducting cross-disorder analyses. Any additional quality-control filters applied by a method are noted in its corresponding section below. These quality-control filters included removing strand ambiguous SNPs, restricting to SNPs with an imputation score (INFO) > 0.6 and with a minor allele frequency $> 1\%$ when this information was available in the GWAS data. We also restricted analyses to SNPs with an SNP-specific sum of the effective sample that is $> 50\%$ of the total sum of the effective sample or, when this SNP-specific information was not available, to SNPs for which $> 50\%$ of the cohorts contributed information, as indexed by the direction column in the GWAS summary statistics. The MHC region was excluded from all summary statistics before the analysis. Base pair location is given in genome build GRCh37/hg19 throughout the Article and its Supplementary Information.

Genomic SEM

Genome-wide models. All GWAS summary statistics were run through the munge function before running the multivariable version of LDSC used as input to genomic SEM⁷. The munge function aligns GWAS effects to the same reference allele and restricts to HapMap3 SNPs and SNPs with INFO > 0.9 . LDSC was estimated using these munged summary statistics, applying a liability threshold model for all case-control psychiatric disorders (that is, all disorders except for the NIC outcome, which reflects a GWAS of the continuous Fagerström test for nicotine dependence²⁴). For comparability, population prevalence was chosen to match what was used in the corresponding manuscript that introduced the GWAS of each trait. The ascertainment correction was performed using the sum of effective sample sizes across contributing cohorts for each disorder⁷². We note that, for CUD²⁶, we used the recently described formula⁷² for estimating the sum of effective sample size directly from the GWAS data. This is because, in this instance, we found that the implied sum of effective sample size was much smaller than the value computed from the reported sample sizes, which is probably attributable to the complex familial structure in the included deCODE sample.

The two primary estimates from multivariable LDSC are the genetic covariance matrix and the corresponding sampling covariance matrix. The genetic covariance matrix contains SNP-based heritabilities on the diagonal and the co-heritabilities (genetic covariances) across every pairwise combination of included disorders on the off-diagonal. The sampling covariance matrix contains squared standard errors (sampling variances) on the diagonal, which allows genomic SEM to appropriately account for differences in the precision of GWAS estimates for disorders with unequal power. The off-diagonal contains sampling dependencies, which will arise in the presence of sample overlap across GWAS phenotypes. As these sampling dependencies are estimated directly from the data, summary statistics can be included with varying and unknown levels of sample overlap. We note that study overlap between disorders is not expected to affect the findings, as study overlap affects only the covariance of error terms of the GWASs resulting in increased intercepts of cross-trait LDSC with no expected impact on the estimates of r_g ^{4,43}. To guard against model overfitting, an exploratory factor analysis (EFA) was performed on even chromosomes and used to inform the fitting of an confirmatory factor analysis (CFA) in odd chromosomes. The EFA was performed using the factanal R package for 2–5 factors using both promax (correlated) and varimax (orthogonal) rotations. Disorders were specified to load on a factor in the CFA when the standardized EFA loadings were > 0.3 , with disorders allowed to cross-load (for example, TS on the Compulsive and Neurodevelopmental factors) if this was the case for multiple factors. Models specified based on varimax EFA results still allowed for interfactor correlations,

as allowing only subsets of disorders to load on each factor will induce genetic overlap. A common-factor model was also modelled to test a single-latent-factor model predicting all 14 disorders. We did not evaluate models with more than five factors as these caused issues with model convergence. Results revealed that a five-factor model specified based on the promax EFA results (Supplementary Table 3) fit the data best in odd chromosomes (CFI = 0.973, SRMR = 0.073; Supplementary Table 2). This model also fit the data well in all autosomes, and was subsequently carried forward for all analyses, along with the *p*-factor model described in the main text. Considering the high r_g across PTSD and MD, we also evaluated a model (in odd autosomes) that estimated the residual genetic covariance across these two disorders; however, we found that this did not significantly improve model fit (model χ^2 difference = 2.86, $P = 0.094$).

Stratified genomic SEM. Stratified genomic SEM proceeds in two stages²⁷. In stage 1, the *s_ldsc* function in genomic SEM, a multivariable implementation of stratified LDSC (S-LDSC)⁵⁸, was used to estimate the stratified genetic covariance and sampling covariance matrices within each functional annotation. We specifically used the zero-order estimates for these analyses. In stage 2, the *enrich* function was used to estimate the enrichment of the factor variances and residual genetic variances unique to the indicators. This is achieved by first estimating the model in the genome-wide annotation including all SNPs. The factor loadings from these genome-wide estimates are then fixed and the (residual) variances of the factors and disorders are freely estimated within each annotation. These reflect the within-annotation estimates for each variance component that are scaled to be comparable to the genome-wide estimates. This cumulative set of results is used to calculate the enrichment ratio of ratios. The numerator reflects the ratio of the estimate of the factor variance within an annotation over the genome-wide estimate. The denominator is the ratio of SNPs in the annotation over the total number of SNPs examined. Enrichment estimates greater than the null of 1 are therefore observed when an annotation explains a disproportionate level of genetic variance relative to the annotation's size.

Functional annotations used to estimate the stratified matrices were obtained from a variety of data resources. This included: (1) the baseline annotations from the 1000 Genomes Phase 3 BaselineLD (v.2.2)⁷³ from the S-LDSC developers⁵⁸; (2) tissue-specific gene expression annotation files created using data from GTEx⁷⁴ and DEPICT⁷⁵; (3) tissue-specific histone marks from the Roadmap Epigenetics project⁷⁶; (4) annotations that we created²⁷ from data in GTEx⁷⁴ and the Genome Aggregate Database (gnomAD)⁷⁷ that index protein-truncating-variant-intolerant (PI) genes, genes expressed in different types of brain cells in the human hippocampus and prefrontal cortex, and their intersection; (5) 11 neuronal cell type annotations defined by peaks from single-cell assay for transposase accessibility by sequencing (scATAC-seq) in the human forebrain⁵⁴; (6) an annotation defined by peaks from ATAC-seq data with greater accessibility in neural progenitor enriched regions encompassing the ventricular, subventricular and intermediate zones (GZ) over neuron enriched regions within the subplate, marginal zone and cortical plate (CP; GZ > CP), and a second CP > GZ annotation reflecting the converse⁶⁰; and (7) a fetal and an adult annotations defined by eQTLs identified using high-throughput RNA-seq⁴⁵. We excluded 22 annotations that produced stratified genetic covariance matrices that were highly non-positive definite to examine a total of 162 annotations. We corrected for multiple testing by using a strict Bonferroni correction for the 162 annotations analysed that passed quality control across the 11 factors examined (the factors from the five-factor factor model and the *p*-factor and residuals of the five factors from the *p*-factor model) of $P < 2.81 \times 10^{-5}$.

Multivariate GWAS. The *sumstats* function in genomic SEM was used to align SNP effects across traits to the same reference allele and

standardize the effects and their corresponding s.e. values relative to the total variance in the predicted phenotype. The s.e. values were additionally corrected for uncontrolled confounds by taking the product of s.e. values and the LDSC univariate intercept when this value was >1 . After removing 136 SNPs that produced highly non-positive definite matrices when combined with the genetic covariance matrix, the final listwise deleted set consisted of 2,795,800 SNPs present across all 14 disorders. The userGWAS function was used to estimate the multivariate GWAS for SNP effects on the five factors from the five-factor model and the *p*-factor. We used a significance threshold of $P < 8.33 \times 10^{-9}$, reflecting the standard genome-wide threshold of 5×10^{-8} with a Bonferroni correction for the six factors. As a quality-control check, we confirmed that the attenuation ratio³² was near 0 for all factors (Supplementary Table 17), suggesting that the factor signal is not due to uncontrolled confounds (such as population stratification).

The Q_{SNP} heterogeneity metric is a χ^2 -distributed test statistic produced through a nested-model comparison of a common pathway model, in which the SNP predicts a latent factor, to an independent pathways model, where the SNP directly predicts the factor indicators. Factor-specific Q_{SNP} estimates for the five-factor model were estimated using five independent pathways models that consisted of the SNP predicting both the indicators for one factor and the remaining four factors. For the *p*-factor model, the SNP predicted the five, first-order factors to obtain Q_{SNP} estimates for the second-order, *p*-factor.

Cross-ancestry analyses

We applied the cross-ancestry Popcorn³³ method to estimate genetic impact correlation (ρ_{gi} metric) across EUR-like, EAS-like and AFR-like genetic ancestry groups. Six disorders were included in the analysis, including EAS-like summary statistics for MD and SCZ and AFR-like summary statistics for OUD, AUD, PTSD and CUD. The reference panel for the EAS dataset was based on 504 individuals from EAS population of the 1000 Genomes Phase3 data⁷⁸. For AFR-like genetic ancestry, we performed the Popcorn analysis using three alternative references from 1000 Genomes Phase3 data: (1) the African Ancestry in the southwest United States subgroup ($n = 61$); (2) the African population ($n = 661$); and (3) a reference panel created to capture the admixed ancestral background of some AFR-like individuals reflecting the combination across the EUR-like and AFR-like sample ($n = 1,164$). Cross-ancestry results and within-ancestry LDSC results for the AFR-like and EAS-like populations are reported in Supplementary Table 4. We acknowledge that using LDSC with admixed ancestry may violate its assumptions; thus, our results for AFR-like ancestry should be interpreted with caution. With this in mind, we performed LDSC for AFR-like datasets using two different LD reference panels for AFR-like ancestry or admixed American ancestry from Pan UK Biobank to assess their impact on results (Supplementary Table 4). The results in Extended Data Table 1 report liability-scale heritabilities for AFR-like datasets using the admixed LD scores, as these produced more sensible results.

MiXeR

MiXeR (v.1.3) was applied using the procedure outlined in the original publication⁶. We performed additional simulations to evaluate appropriate threshold for inclusion of a GWAS study in cross-trait MiXeR analysis. In previous simulations, we demonstrated that MiXeR cannot produce reliable estimates for analyses using low-powered input⁷⁹. Specifically, as statistical power increases, the Akaike information criterion (AIC) differences indicate that MiXeR-modelled estimates become increasingly more distinguishable from the minimum and maximum overlap, corresponding to the increasing precision of MiXeR estimates. This demonstrates that AIC differences are sensitive to the input power of the summary statistics and can be used to support the reliability of MiXeR estimates. On the basis of these previous simulations, psychiatric disorders were brought forward for cross-trait MiXeR analysis when the product of N_{Eff} and MiXeR h_{SNP}^2 estimates were

$>12,000$, where this cut point reflects the product of $N_{Eff} \geq 100,000$ and $h_{SNP}^2 \geq 0.12$. As a result, we excluded OUD, TS, NIC, OCD, ASD and CUD. As AN was very close to this threshold and had a high AIC in univariate analysis, it was brought forward for cross-trait analyses along with the seven remaining psychiatric disorders. For the NIC summary statistics, we excluded two loci defined as a 2 Mb window around either the *CHRNA3-CHRNA5-CHRN4* gene cluster or the *CHRNA4* gene, which is known to have such a large effect on the phenotype that it would skew results. We note that, for PTSD, ANX and MD, the r_g s were so high that there was little room for additional overlap beyond correlation, given MiXeR's modelling assumptions. Specifically, the range in size of the putative shared component is too small to allow for an accurate model fit in this situation, as demonstrated by the range on the respective *x* axes (Supplementary Fig. 7). There is also a considerable uncertainty of polygenicity estimates for PTSD and ANX. Thus, cross-trait MiXeR results for PTSD, ANX and MD should be interpreted with caution.

LAVA

Local r_g analyses were conducted using LAVA v.0.1.0³⁵. To avoid evaluating local r_g s in regions in which there is a low amount of genetic signal (which could lead to unstable or uninterpretable estimates) for all phenotype pairs and loci separately, we used the univariate test in LAVA as a filtering step, computing bivariate local r_g s only in loci where both analysed phenotypes have a h_{SNP}^2 significant at $P < 4.6 \times 10^{-5} = 0.05/1,093$ (where 1,093 represents the total number of analysed loci). Given this filtering step, we performed 24,273 local r_g tests across all loci and phenotype pairs, resulting in a Bonferroni corrected *P* value threshold of $P < 2.1 \times 10^{-6} = 0.05/24,273$ for the bivariate, local r_g analyses.

Genomic loci used for the regional r_g analyses were defined by segmenting the genome into approximately equal-sized, semi-independent blocks using the LAVA partitioning algorithm (<https://github.com/cadelleeuw/lava-partitioning>). This algorithm works by iteratively splitting the chromosomes into smaller chunks, creating break points at regions where the LD between SNPs is the lowest (see the program manual for more details). To achieve a balance between block size and correlations between adjacent blocks, we ran the algorithm with the default parameters, changing only the minimum size requirement (in the number of SNPs) to 5,000, based on the 1,000 genomes data. Sample overlap was accounted for by obtaining the estimated intercepts from bivariate LDSC and providing these to LAVA.

CC-GWAS

CC-GWAS⁴³ was applied to identify loci with different allele frequencies across cases of different disorders, contrasting cases one disorder pair at a time. CC-GWAS is based on estimating a weighted difference of the CC-GWAS results of the disorders considered, thereby avoiding the necessity to match cases across disorders at individual level. CC-GWAS combines two components. The first component (CC-GWAS_{OLS}) optimizes power and protects against type I error rate at null-null SNPs (SNPs that affect neither of both disorders), based on analytical expectations of genetic differences between cases and controls of both diseases. The second component (CC-GWAS_{Exact}) controls type I error rate at 'stress test' SNPs (SNPs affecting both disorders resulting in no allele frequency difference across cases of both disorders). A SNP is significantly associated with case-case status when the *P* value of the OLS component reaches genome-wide significance and when the *P* value of the exact-component is $<10^{-4}$ (there is an upper bound on the number of stress test SNPs as these are causal SNPs). Importantly, CC-GWAS also filters false-positive associations that may arise due to (subtle) differential tagging of a stress test SNP in the respective CC-GWAS, which are present even in within-ancestry analysis⁴³. CC-GWAS excludes analyses of any disorder pair with an $r_g > 0.8$ because these have a small genetic distance between cases with increased risk of type-I error at stress test SNPs.

Locus definition and cross-locus overlap

The same locus definition (also referred to as a hit in the main text) was used for CC-GWAS and genomic SEM. Significant loci were identified using the clumping functionality in PLINK v.1.9 with an r^2 threshold of 0.1 and a 3,000 kb window. Physically proximal loci (including when comparing loci both within and across factors from genomic SEM and for CC-GWAS and univariate GWAS results), were additionally collapsed into a single locus when the locus windows were within 100 kb of one another on either side. For the univariate results, we use the same locus definition applied to the complete GWAS summary statistics for each disorder (that is, without our quality-control filters applied), along with a more liberal genome-wide significance threshold of $P < 5 \times 10^{-8}$ without a Bonferroni correction. These more liberal quality-control and significance thresholds were used for univariate loci to benchmark whether genomic SEM and CC-GWAS loci could be considered strictly novel. The 1000 Genomes Phase 3 reference files⁷⁸ were used for LD pruning for each respective genetic ancestry group (that is, EUR-like, EAS-like, AFR-like).

Functional annotation

To predict the target genes of the variants (Supplementary Fig. 17), we first expanded the variants by including any variants within the LD block ($r^2 > 0.6$) based on the EUR population using LDProxy from the LDlink R package⁸⁰. We began by curating the genes of which the promoters (± 500 bp from the transcription start site) or exons overlap with the variants of interest. Conversely, to map target genes that are not near the variants, we first filtered the variants for those localized in either human fetal brain open-chromatin regions⁶⁰ or human adult brain H3K27ac ChIP-seq regions⁴⁴, both of which indicate enhancer activity, but during different stages of brain development. Next, we assigned target genes to each filtered variant using eQTL^{44,45} or HiC loops^{44,46} generated from samples from the corresponding stages. We also assigned variants present in promoter or exonic regions to the corresponding genes (Supplementary Fig. 17). Finally, we filtered all of the target genes for those expressed (RNA-seq count > 0) in the corresponding tissues. In this way, we obtained 715 and 572 target genes in fetal and adult brains, respectively (Supplementary Tables 40 and 41). Notably, there is a prominent overlap between the two sets of genes, which is a result of the shared, positional mapping of genes to promoters or exons (Supplementary Fig. 17). Both the fetal and adult target genes were enriched in GO terms related to neuron or brain development, suggesting the biological relevance of the genetic variants.

To plot the temporal expression trends of the predicted target genes, we used gene expression datasets from the BrainSpan. We plotted the averaged gene expression (reads per million kb) of the selected genes over all samples collected from the cortex at the available stages of development, then generated a smoothed curve with the loess method. We performed GO enrichment analysis using the ToppGene suite³⁶. We filtered the enriched terms by containing at least 10% of the input list of genes, then displayed up to top 5 terms by adjusted P values under the indicated category.

EWCE⁵² was used to assess the cell type enrichment of target genes for the variants using a size-biased averaging method. This method uses single-cell datasets to compute the average expression of a set of genes (in this case, genes assigned to variants for each factor) and compares this to the average expression levels for 100,000 permuted gene lists of the same size that are randomly sampled from a background set of genes. Annotations were taken from publicly available datasets^{53–57}, but simplified to provide cell-type-level instead of cluster-level enrichments. For example, several upper-layer clusters in the dataset of ref. 57 were combined into ‘ExcNeu superficial’ and so on. For the ref. 56 dataset, EWCE objects were processed for each brain region separately. This included the hippocampal formation,

cortex, cerebral nuclei (dissections including basal nuclei, amygdala complex, basal forebrain, claustrum), midbrain (including tissues from thalamic complex, hypothalamus, and midbrain) and hindbrain (including tissues from spinal cord, pons, myelencephalon and cerebellum) and non-neuronal cells across regions. For superclusters that were present in multiple regions, enrichment was tested only for regions with the highest abundance of that supercluster (for example, MGE interneuron supercluster is most abundant in cortex, so this cell type was dropped from enrichment analyses in the midbrain) to prevent excess multiple comparisons. P values were FDR-corrected based on the number of cell types \times gene lists within brain region and dataset.

MAGMA gene-set enrichment analyses were performed using the MAGMA.Celltyping package in R⁸¹. Rather than considering only the top associated genes, as done in EWCE, MAGMA relies on the genome-wide signals to competitively evaluate enrichment through linear regression⁴⁸. We used the European subset of the 1000 Genomes⁷⁸ as LD reference data, and mapped SNPs to genes based on their genomic location (GRCh37/hg19). To allow the inclusion of nearby regulatory variants, we considered all SNPs within a 35 kb upstream and 10 kb downstream window of the gene transcription region. As signed effect-size estimates are not available for the Q_{SNP} results, these analyses were restricted to the factors. The FDR corrected P values from MAGMA and EWCE were averaged together to produce the results reported in the main text (but see Supplementary Tables 48 and 49 for P values from the individual methods).

Reporting summary

Further information on research design is available in the Nature Portfolio Reporting Summary linked to this article.

Data availability

The data supporting the findings of this study are all publicly available or can be requested for access. Specific download links for various datasets are directly below. Psychiatric disorder GWAS summary statistics for data from the PGC can be downloaded or requested online (<https://www.med.unc.edu/pgc/download-results/>). Links to the LD scores and reference panel data for GenomicSEM analyses can be found at GitHub (<https://github.com/GenomicSEM/GenomicSEM/wiki>). Links to the BaselineLD v.2.2 annotations can be found online (<https://data.broadinstitute.org/alkesgroup/LDSCORE>). Gene expression datasets from Brainspan can be found online (<https://brainspan.org/static/download.html>). Multivariate GWAS summary statistics for the latent psychiatric factors in GenomicSEM, including the sensitivity GWAS results, are available online (<https://www.med.unc.edu/pgc/download-results/>).

Code availability

Genomic SEM analyses were implemented using publicly available code (v.0.5.0, <https://github.com/GenomicSEM/GenomicSEM>). Factanal was conducted using publicly available code within the stats R package (v.3.6.2, <https://www.rdocumentation.org/packages/stats/versions/3.6.2>). MiXeR was conducted using publicly available code (v.1.3; <https://github.com/precimed/mixer>). LAVA was conducted using publicly available code (v.0.1.0, <https://github.com/josefin-werme/LAVA>). CC-GWAS was conducted using publicly available code (v.0.1.0, <https://github.com/wouterpeyrot/CCGWAS>). LDlink was conducted using publicly available code (v.1.4.0, <https://cran.r-project.org/web/packages/LDlinkR/vignettes/LDlinkR.html>). ToppGene suite was conducted using publicly available code (v.0.1.0, <https://toppgene.cchmc.org/>). EWCE was conducted using publicly available code (v.1.16.0, <https://nathanskene.github.io/EWCE/>). MAGMA was conducted using publicly available code (v.2.0.15, https://neurogenomics.github.io/MAGMA_Celltyping/index.html).

72. Grotzinger, A. D., de la Fuente, J., Privé, F., Nivard, M. G. & Tucker-Drob, E. M. Pervasive downward bias in estimates of liability-scale heritability in GWAS meta-analysis: a simple solution. *Biol. Psychiatry* <https://doi.org/10.1016/j.biopsych.2022.05.029> (2022).

73. Hujoo, M. L. A., Gazal, S., Hormozdiari, F., van de Geijn, B. & Price, A. L. Disease heritability enrichment of regulatory elements is concentrated in elements with ancient sequence age and conserved function across species. *Am. J. Hum. Genet.* **104**, 611–624 (2019).

74. The GTEx Consortium et al. The Genotype-Tissue Expression (GTEx) pilot analysis: multitissue gene regulation in humans. *Science* **348**, 648–660 (2015).

75. Pers, T. H. et al. Biological interpretation of genome-wide association studies using predicted gene functions. *Nat. Commun.* **6**, 5890 (2015).

76. Kundaje, A. et al. Integrative analysis of 111 reference human epigenomes. *Nature* **518**, 317–330 (2015).

77. Karczewski, K. J. et al. The mutational constraint spectrum quantified from variation in 141,456 humans. *Nature* **581**, 434–443 (2020).

78. 1000 Genomes Project Consortium A global reference for human genetic variation. *Nature* **526**, 68–74 (2015).

79. Hindley, G. et al. Charting the landscape of genetic overlap between mental disorders and related traits beyond genetic correlation. *Am. J. Psychiatry* **179**, 833–843 (2022).

80. Myers, T. A., Chanock, S. J. & Machiela, M. J. LDlinkR: an R package for rapidly calculating linkage disequilibrium statistics in diverse populations. *Front. Genet.* **11**, 157 (2020).

81. Skene, N. G. et al. Genetic identification of brain cell types underlying schizophrenia. *Nat. Genet.* **50**, 825–833 (2018).

Research Council of Norway (RCN) 334920 (K.S.O.); U54GM115516 (S.L.S.); R01MH124847 (J.M.H.); R01DA054869 (H.J.E.); R01MH106595 (A.X.M.); R01MH106595 (K.C.K., C.M.N. and M.B.S.); R01MH124847 (C.M.N.); R01MH112904, R01MH123775, U24MH068457, R01MH104964 and R01MH123451 (J.A.K.); R01MH119243 and R01GM148494 (P.H.L.); R01MH120219, R01AG073593, P30AG066614 and P2CHD042849 (E.M.T.-D.); R01MH121924 (B.J.C., A.B., V.P. and J.M.B.); R01MH123922 and R01MH121521 (M.J.G.); R01MH124851 (B.F.); R01MH136149 and R01120170 (L.M.T.); R21MH123908 and K08MH122673 (K.G.J.); the Novo Nordisk Foundation (NNF200CC0065561, NNF21SA0072102), the Lundbeck Foundation (R344-2020-1060), the European Union's Horizon 2020 research and innovation program under grant agreement no. 965381 (TIMESPAN) (D.D.); R01NS102371, R01NS105746 and R01MH124851 (J.M.S.); U01MH125050 (CIHR) and PJT-180339 (M.M.); NIHR Biomedical Research Centre (IS-BRC-1215-20018) (G.B.); K01DA051759 (E.C.J.); AA030083 (A.S.H.); and R01MH125938, R01MH137208, P50AA022537 and The Brain & Behavior Research Foundation NARSAD grant 28632P&S Fund (R.E.P.).

Acknowledgements We acknowledge the work of the members of individual Psychiatric Genomics Consortium working groups, the iNDiGO consortium and the MVP who contributed summary statistics to these analyses. GWAS summary statistics for the MVP used in this study were obtained from the database of Genotypes and Phenotypes (dbGaP) under accession number phs001672.v9.p1.c1 under approved project 30159. We thank the MVP staff, researchers and volunteers, who have contributed to MVP, and especially participants who previously served their country in the military and now agreed to enrol in the study (<https://www.research.va.gov/mvp/>). This work was made possible by the contributions of the many investigators who comprise these working groups and the numerous grants from governmental and charitable bodies, as well as philanthropic donation. We acknowledge the Mayo Clinic Biobank (MCB) research team, as well as the patient participants who consented to participate in this research program; the Mayo Clinic Center for Individualized Medicine for support of the MCB, and Regeneron Genetics Center for providing genetic data for MCB participants for the analysis. In particular, we thank the research participants worldwide who shared their life experiences and biological samples to make work like this possible. The PGC has been supported by the following grants: MH085508, MH085513, MH085518, MH085520, MH094411, MH094421, MH094432, MH096296, MH109499, MH109501, MH109514, MH109528, MH109532, MH109536, MH109539, MH124871, MH124851, MH124839, MH124847, MH124873, MH124875 and DA054869. Specific investigators were supported by the following grants: R01MH120219 and R01AG073593 (A.D.G.); European Union Horizon 2020 grant agreement 964874 (RealMent) (J.W.); The Amsterdam Cohort Hub, which is part of the Sector Plan 'Accelerating Health' of the Dutch Ministry of Education, Culture and Science (W.J.P.); Autism Speaks Postdoctoral Fellowship (Q.G.); DP1DAO54394 and T32IR5226 (S.S.S.-R.); ERC-2018-ADG 834057 (C.d.L.); European Union Horizon grant agreement 965381, U01AR076092, R01MH116037, 1R01NS128535, R01MH131685, 1R01MH130899, U01MH135970 and Supernus (S.V.F.); F30MH135712 (M.P.M.); K08MH135343 (T.T.M.); Lundbeck Foundation (R102-A9118, R155-2014-1724, and R248-2017-2003), NIH/NIMH (R01MH124851-01) and EU's Horizon Europe program under grant agreement no. 101057385 (R2D2-MH) (A.D.B.); R01MH124839-02.

Author contributions Note that the lists of working group members are organized alphabetically by last name. We also highlight that these lists are not exhaustive with respect to the members of the working groups; rather, they reflect individual members of the working groups who approved the contents of this Article. A.D.G., J.W., W.J.P. and O.F. conducted the primary analyses presented in the paper for GenomicSEM, LAVA, CC-GWAS and MiXeR, respectively. L.K.B., Q.G., M.P.M. and J.W. ran the functional follow-up analyses. O.F. and R.E.P. ran and provided feedback on cross-ancestry and diverse ancestry genome-wide analyses. B.J.C., A.B., V.P. and J.M.B. conducted the phenotype-wide association study analyses. C.d.L., E.M.T.-D. and P.H.L. provided additional feedback on the analyses and included data. A.D.G., J.W., W.J.P., O.F., K.S.K. and J.W.S. wrote the initial draft of the manuscript. K.S.K. and J.W.S. jointly supervised the research. All of the named authors provided iterative feedback on the manuscript, including O.A.A., V.A., A.D.B., G.B., N.C., D.D., H.J.E., S.V.F., B.F., M.J.G., J.G., A.S.H., J.M.H., E.C.J., T.T.M., M.M., K.S.M., B.M.N., C.M.N., J.I.N., K.S.O., E.B.R., S.S.S.-R., S.L.S., J.M.S., H.S., K.S., M.B.S., N.I.S., L.M.T., B.V., I.D.W., G.B.W., N.R.W. and D.Y. All of the collaborators within the listed working group banners approved the contents of the manuscript.

Competing interests J.W.S. is a member of the scientific advisory board of Sensorium Therapeutics (with stock options) and has received grant support from Biogen. K.G.J. is a consultant for Allia Health. A.D.B. has received a speaker fee from Lundbeck. In the past year, S.V.F. received income, potential income, travel expenses continuing education support and/or research support from Aardvark, Aardwolf, AIMH, Akili, Attentiv, Axsome, Genomind, Ironshore, Johnson & Johnson/Kenvue, Kanjo, KernPharm/Corium, Noven, Otsuka, Sky Therapeutics, Sandoz, Supernus, Tris and Vallon. With his institution, S.V.F. has US patent US20130217707 A1 for the use of sodium-hydrogen exchange inhibitors in the treatment of ADHD. S.V.F. also receives royalties from books published by Guilford Press (*Straight Talk about Your Child's Mental Health*), Oxford University Press (*Schizophrenia: The Facts*) and Elsevier (*ADHD: Non-Pharmacologic Interventions*) and is program director of www.ADHEvidence.org and www.ADHDinAdults.com. The other authors declare no competing interests.

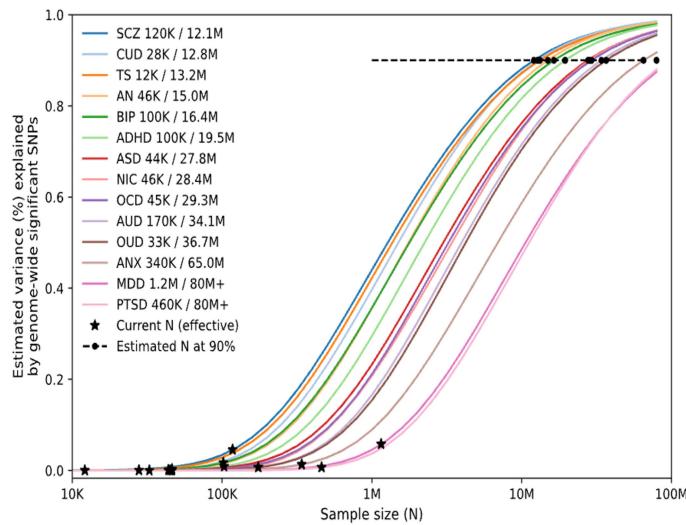
Additional information

Supplementary information The online version contains supplementary material available at <https://doi.org/10.1038/s41586-025-09820-3>.

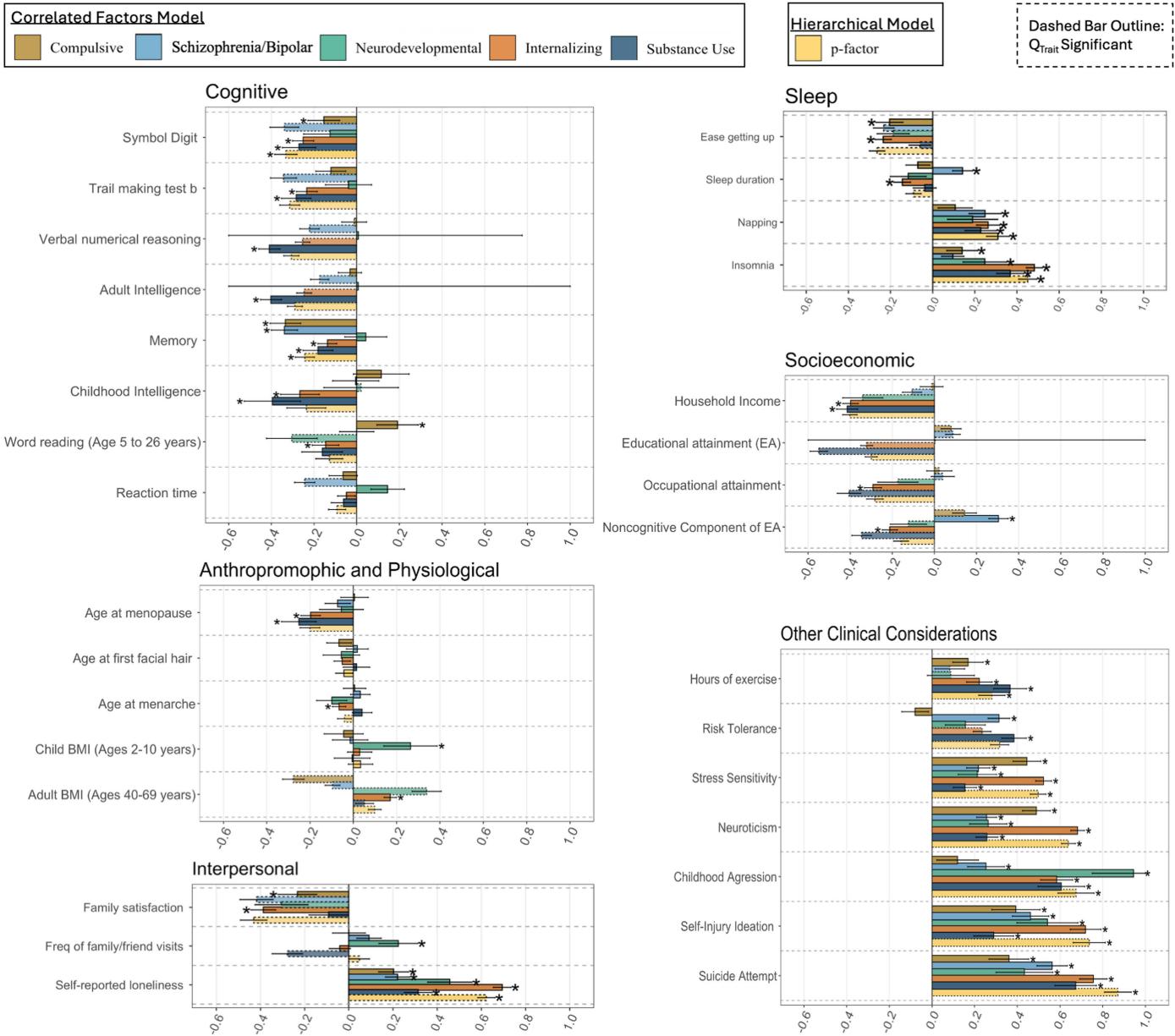
Correspondence and requests for materials should be addressed to Andrew D. Grotzinger or Jordan W. Smoller.

Peer review information *Nature* thanks Karoline Kuchenbaecker and the other, anonymous, reviewer(s) for their contribution to the peer review of this work. Peer reviewer reports are available.

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Extended Data Fig. 1 | Univariate MiXeR Results. Power curves estimating the sample size of a GWAS study are needed to saturate the yield of genome-wide significant loci. The legend shows the current effective sample size of today's GWAS, followed by the projected effective sample size needed for the GWAS yield to saturate.

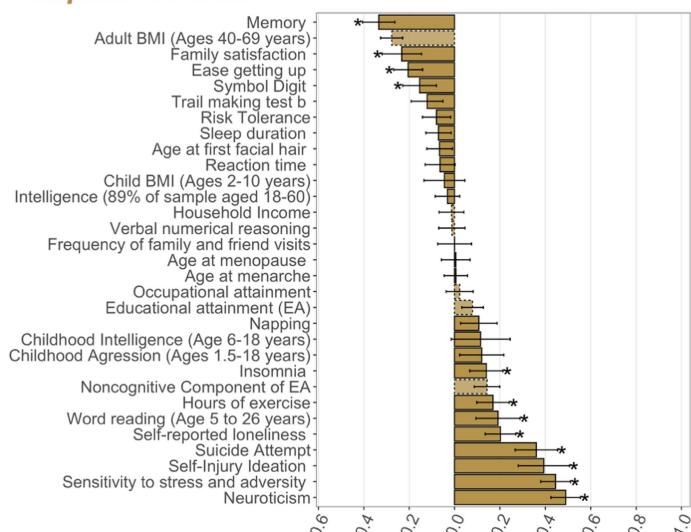


Extended Data Fig. 2 | External trait genetic correlations: Comparison across psychiatric factors. Bar graphs depict genetic correlations with the 31 complex traits for the five psychiatric factors from the correlated factors model and the second-order, *p*-factor from the hierarchical model. Panels are separated by the different groupings of traits (e.g., cognitive; socioeconomic). Bars depicted with a dashed outline were significant at a Bonferroni-corrected threshold for the Q_{Trait} heterogeneity metric that flags traits whose patterns of genetic correlations from LDSC do not conform to those implied by the factor model. Error bars are $\pm 1.96 SE$ that are centred around the point estimate of the genetic correlations. Bar depicted with a * reflect values that were significant at a Bonferroni corrected threshold for multiple comparisons, that were also not significant at this same

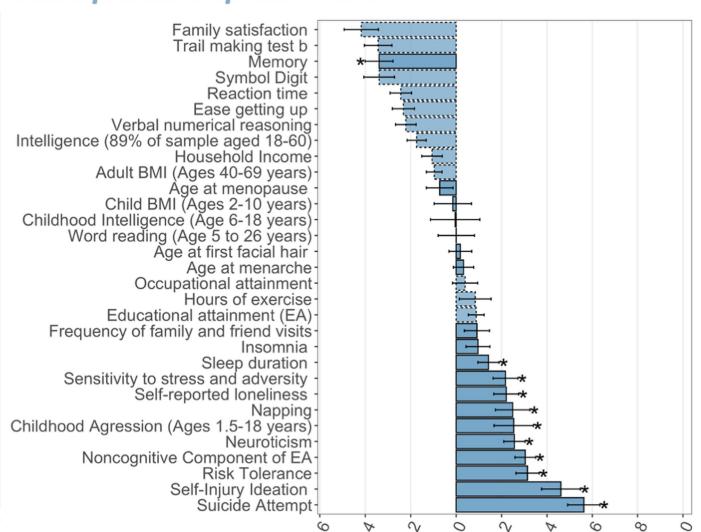
Bonferroni corrected threshold for Q_{Trait} . This is with exception of the *p*-factor, which is depicted with a '*' even if it is significant for the Q_{Trait} , as long as that same trait was significantly correlated with the majority (at least three) of the five other factors. The two-sided *P*-values used to evaluate significance were derived from the *Z*-statistics, calculated as the point estimate of the genetic correlation divided by its standard error. Correlations are ordered according to the point estimate for the *p*-factor. The implied sample size for the psychiatric factors was: Compulsive ($\hat{n} = 54,100$); Schizophrenia/Bipolar ($\hat{n} = 127,202$); Neurodevelopmental ($\hat{n} = 84,760$); Internalizing ($\hat{n} = 1,637,337$); Substance Use ($\hat{n} = 313,395$); *p*-factor ($\hat{n} = 2,168,621$). See Suppl. Table 12 for sample sizes for the external traits and Suppl. Table 13 for exact *P*-values.

Article

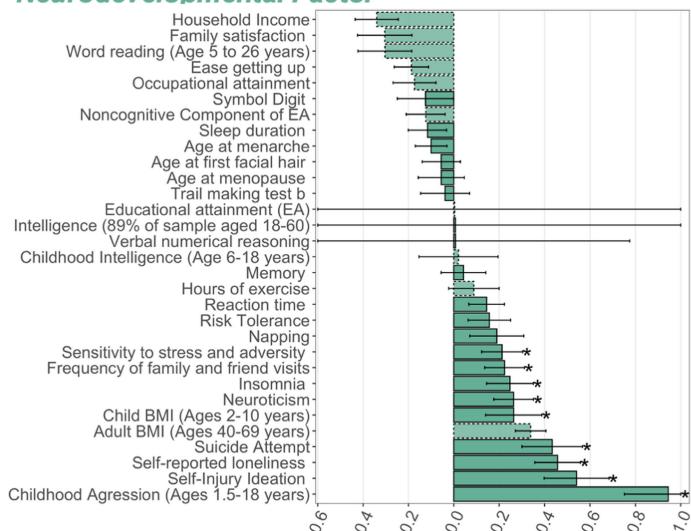
Compulsive Factor



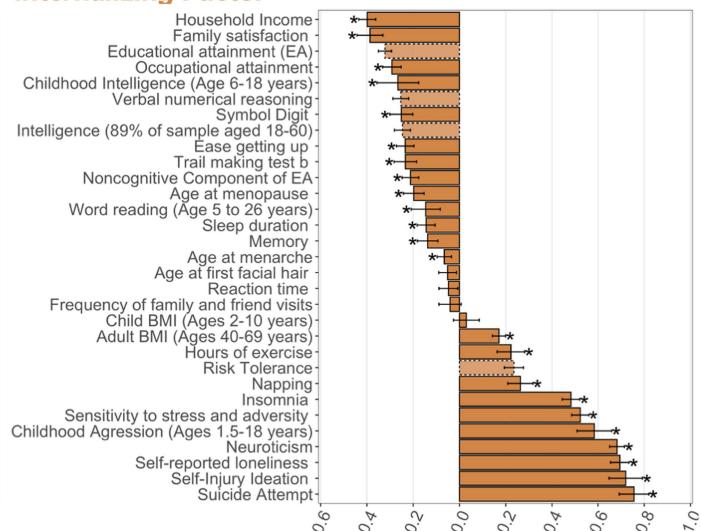
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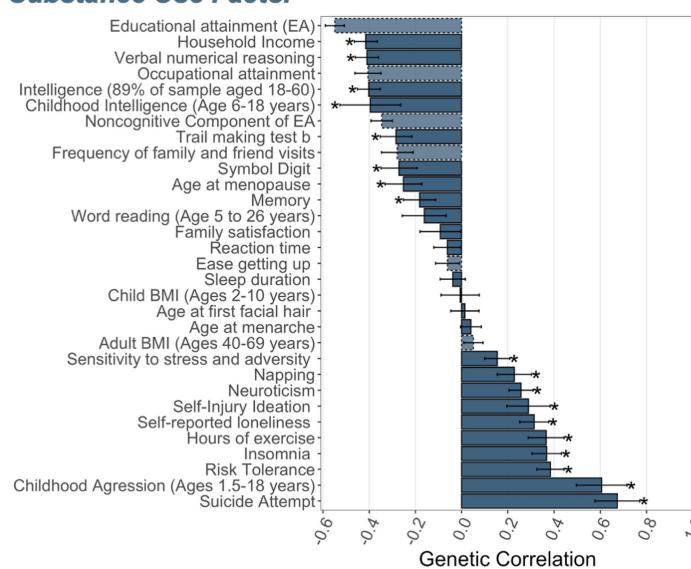
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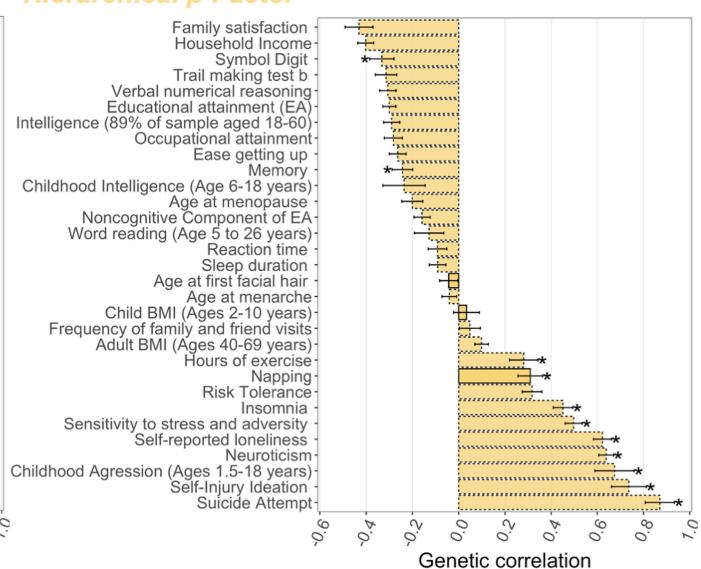
Internalizing Factor



Substance Use Factor

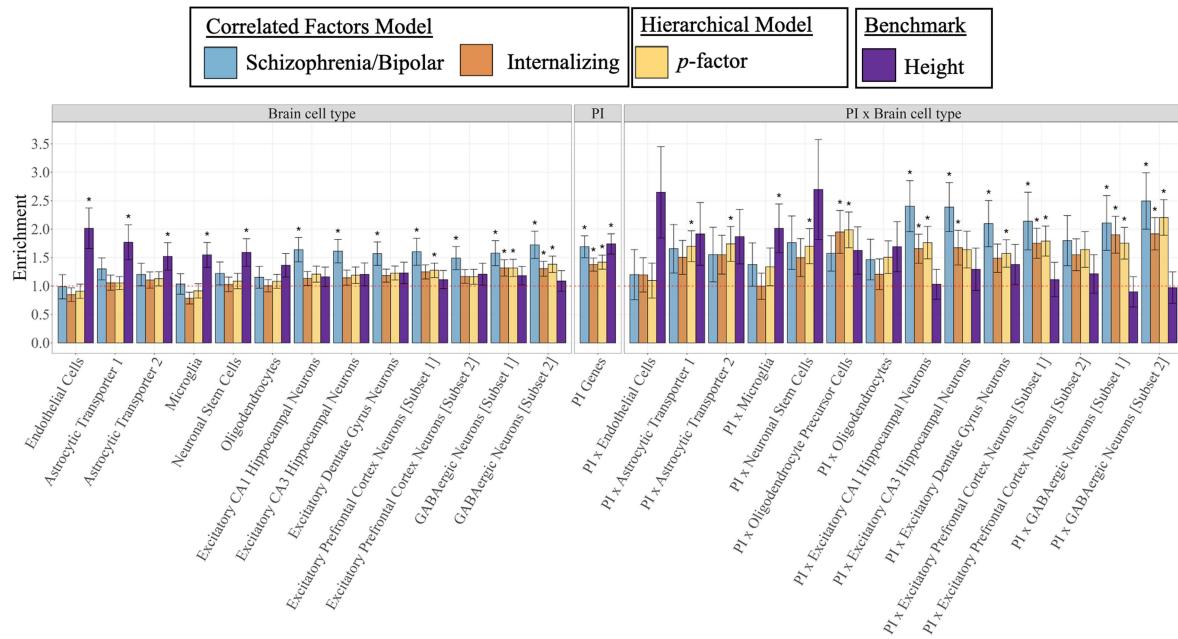


Hierarchical p-Factor



Extended Data Fig. 3 | External trait genetic correlations: Comparison within factors. Bar graphs depict genetic correlations with the 31 complex traits that are ordered by magnitude within each factor for the five psychiatric factors from the correlated factors model and the second-order, *p*-factor from the hierarchical model. Bars depicted with a dashed outline for the Q_{Trait} heterogeneity metric. Bar depicted with a * reflect values that were significant at a Bonferroni corrected threshold for multiple comparisons, that were also not significant at this same Bonferroni corrected threshold for Q_{Trait} . This is with exception of the *p*-factor, which is depicted with a ** even if it is significant for the Q_{Trait} , as long as that same trait was significantly correlated with the majority

(at least three) of the five other factors. The two-sided *P*-values used to evaluate significance were derived from the *Z*-statistics, calculated as the point estimate of the genetic correlation divided by its standard error. Error bars are $\pm 1.96 SE$ that are centred around the point estimate of the genetic correlations. The implied sample size for the psychiatric factors was: Compulsive ($\hat{n} = 54,100$); Schizophrenia/Bipolar ($\hat{n} = 127,202$); Neurodevelopmental ($\hat{n} = 84,760$); Internalizing ($\hat{n} = 1,637,337$); Substance Use ($\hat{n} = 313,395$); *p*-factor ($\hat{n} = 2,168,621$). See Suppl. Table 12 for sample sizes for the external traits and Suppl. Table 13 for exact *P*-values.



Extended Data Fig. 4 | Stratified Genomic SEM results. Bar graph depicts the enrichment results for different brain cell types, protein-truncating variant intolerant (PI) genes, and the intersection across PI genes and brain cell types. Results are shown only for the SB, Internalizing, and *p*-factor due to the limited signal for the other factors. Enrichment for height is depicted in purple to benchmark results and evaluate specificity in signal for the psychiatric factors relative to another human complex trait. Error bars are $\pm 1.96 SE$ that are centred around the enrichment point estimate. Enrichment estimates that

were significant at a strict Bonferroni corrected threshold for multiple comparisons are shown with a *. The one-sided *P*-values used to evaluate significance were derived from the *Z*-statistics, calculated as the enrichment point estimate divided by its standard error. Exact *P*-values are reported in Suppl. Table 50. The implied sample size for the psychiatric factors was: Compulsive ($\hat{n} = 54,100$); Schizophrenia/Bipolar ($\hat{n} = 127,202$); Neurodevelopmental ($\hat{n} = 84,760$); Internalizing ($\hat{n} = 1,637,337$); Substance Use ($\hat{n} = 313,395$); *p*-factor ($\hat{n} = 2,168,621$).

Extended Data Table 1 | Summary of Psychiatric Disorder Datasets

Psychiatric Disorders	Sample Size			Lifetime Prevalence	Liability Scale Heritability	GWAS loci
	Cases	Controls	<i>N</i> _{effective}			
European (EUR)-Like Genetic Ancestry						
<i>Tourette's Syndrome</i>	4,819	9,488	12,140	0.8%	.22 (.03)	1
<i>Schizophrenia</i>	53,386	77,258	117,498	1.0%	.22 (.01)	177
<i>Cannabis Use Disorder</i>	14,808	343,726	26,789	4.8%	.19 (.02)	2
<i>Bipolar Disorder</i>	41,917	371,549	101,963	2.0%	.19 (.01)	58
<i>Attention-Deficit/Hyperactivity Disorder</i>	38,691	186,843	99,252	5%	.18 (.01)	27
<i>Anorexia Nervosa</i>	16,992	55,525	46,322	0.9%	.16 (.01)	8
<i>Obsessive Compulsive Disorder</i>	14,688	656,901	32,706	2.5%	.16 (.01)	1
<i>Alcohol Use Disorder</i>	57,564	256,399	179,186	15.9%	.12 (.01)	25
<i>Autism Spectrum Disorder</i>	18,381	27,969	43,778	1.2%	.12 (.01)	3
<i>Anxiety Disorders</i>	117,401	699,243	329,323	2.0%	.11 (.01)	47
<i>Nicotine Dependence</i>	46,213	-	-	.09 (.01)	2	
<i>Major Depression</i>	412,305	1,588,397	1,105,086	15.0%	.06 (.01)	230
<i>Opioid Use Disorder</i>	10,544	72,163	45,543	1.0%	.06 (.01)	1
<i>Post-traumatic Stress Disorder</i>	141,479	1,113,329	451,034	12.5%	.05 (.01)	25
African-Like Genetic Ancestry						
<i>Alcohol Use Disorder</i>	3,335	2,945	4,053	15.9%	.22 (.09)	1
<i>Cannabis Use Disorder</i>	3,848	5,897	9,044	4.8%	.10 (.03)	0
<i>Post-traumatic Stress Disorder</i>	11,560	39,474	32,940	12.5%	.03 (.01)	0
<i>Opioid Use Disorder</i>	5,212	26,876	15,935	1.0%	.01 (.02)	0
East Asian (EAS)-Like Genetic Ancestry						
<i>Schizophrenia</i>	22,778	35,362	11,532	1.0%	.69 (.04)	19
<i>Major Depression</i>	13,893	155,912	42,011	15%	.05 (.01)	1

The table is ordered with respect to the liability scale heritabilities (within each genetic ancestry). The *N*_{effective} column reports the sum of effective sample sizes across contributing cohorts. Nicotine dependence includes a single value for the sample size columns as this was the one continuous measure, defined using the Fagerström Test for Nicotine Dependence. The reported population prevalences were taken from the corresponding univariate publication when possible and were used for liability scale conversions (possible scale = 0–100%). The numbers in parentheses in the liability scale heritability column reflect the corresponding standard errors. The GWAS loci column reports the number of independent significant hits. A genome-wide significance threshold of $P < 5 \times 10^{-8}$ was employed to correct for multiple statistical comparisons, and significance was evaluated using two-sided *P* values obtained from Z-statistics, which reflected the estimated univariate GWAS beta over its estimated standard error. Results are shown for: Tourette's Syndrome¹⁸, Schizophrenia^{17,30}, Cannabis Use Disorder²⁶, Bipolar Disorder¹³, Attention-Deficit/Hyperactivity Disorder¹⁵, Anorexia Nervosa¹⁴, Obsessive Compulsive Disorder¹⁹, Alcohol Use Disorder^{21,31}, Autism Spectrum Disorder¹⁶, Anxiety Disorders²², Nicotine Dependence²⁴, Major Depression^{20,29}, Opioid Use Disorder²⁵, and Post-traumatic Stress Disorder²³.

Reporting Summary

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Statistics

For all statistical analyses, confirm that the following items are present in the figure legend, table legend, main text, or Methods section.

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- The exact sample size (n) for each experimental group/condition, given as a discrete number and unit of measurement
- A statement on whether measurements were taken from distinct samples or whether the same sample was measured repeatedly
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Only common tests should be described solely by name; describe more complex techniques in the Methods section.
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- For null hypothesis testing, the test statistic (e.g. F , t , r) with confidence intervals, effect sizes, degrees of freedom and P value noted
Give P values as exact values whenever suitable.
- For Bayesian analysis, information on the choice of priors and Markov chain Monte Carlo settings
- For hierarchical and complex designs, identification of the appropriate level for tests and full reporting of outcomes
- Estimates of effect sizes (e.g. Cohen's d , Pearson's r), indicating how they were calculated

Our web collection on [statistics for biologists](#) contains articles on many of the points above.

Software and code

Policy information about [availability of computer code](#)

Data collection	No software was used for data collection.
Data analysis	<p>Genomic SEM analyses were implemented using the publicly available code here for v0.5.0: https://github.com/GenomicSEM/GenomicSEM</p> <p>Factanal was conducted using publicly available code here within the stats R package for v3.6.2: https://www.rdocumentation.org/packages/stats/versions/3.6.2</p> <p>MiXeR was conducted using publicly available code here for v1.3: https://github.com/precimed/mixer</p> <p>LAVA was conducted using publicly available code here for v0.1.0: https://github.com/josefin-werme/LAVA</p> <p>CC-GWAS was conducted using publicly available code here for v0.1.0: https://github.com/wouterpeyrot/CCGWAS</p> <p>LDlink was conducted using publicly available code here for v1.4.0: https://cran.r-project.org/web/packages/LDlinkR/vignettes/LDlinkR.html</p> <p>ToppGene suite was conducted using publicly available code here for v0.1.0: https://toppgene.cchmc.org/</p> <p>EWCE was conducted using publicly available code here for v.1.16.0: https://nathanskene.github.io/EWCE/</p> <p>MAGMA was conducted using publicly available code here for v.2.0.15: https://neurogenomics.github.io/MAGMA_Celldtyping/index.html</p>

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Policy information about [availability of data](#)

All manuscripts must include a [data availability statement](#). This statement should provide the following information, where applicable:

- Accession codes, unique identifiers, or web links for publicly available datasets
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Psychiatric disorder GWAS summary statistics for data from the PGC can be downloaded or requested here:

<https://www.med.unc.edu/pgc/download-results/>

Links to the LD-scores and reference panel data for GenomicSEM analyses can be found here: <https://github.com/GenomicSEM/GenomicSEM/wiki>

Links to the BaselineLD v2.2 annotations can be found here:

<https://data.broadinstitute.org/alkesgroup/LDScore>

Gene expression datasets from Brainspan can be found here:

<https://brainspan.org/static/download.html>

Multivariate GWAS summary statistics for the latent psychiatric factors in GenomicSEM, including the sensitivity GWAS results, are available at:

<https://www.med.unc.edu/pgc/download-results/>

Research involving human participants, their data, or biological material

Policy information about studies with [human participants or human data](#). See also policy information about [sex, gender \(identity/presentation\), and sexual orientation](#) and [race, ethnicity and racism](#).

Reporting on sex and gender

Biological sex (as determined by the sex chromosomes) was used as a covariate in the original GWAS analyses for all included traits. All included GWAS summary statistics included both male and female subjects, with the exact split across males and females provided in the original papers describing this univariate GWAS data.

Reporting on race, ethnicity, or other socially relevant groupings

This study includes GWAS summary statistics for genetic ancestry groups that can be approximately described, based on genetic similarity to global reference panels, as reflecting European-like, East Asian-like, and African/African American-like genetic ancestries. The sample sizes are separately reported for each of these genetic ancestry groups in Extended Data Table 1.

Population characteristics

In order to achieve adequate power for GWAS analyses, the psychiatric disorders that are used as the primary data input in this paper include data from multiple cohorts, each with different population characteristics. The supplementary materials of the corresponding univariate GWAS papers include information on the different cohorts that went into their analyses. Our current manuscript reports sample sizes (case/control) and diagnosis for each disorder.

Recruitment

As described directly above, this study was not involved in recruitment of study participants. Rather, the individual cohorts that made-up the univariate GWAS for psychiatric disorders employed different recruitment strategies. This recruitment strategies ranged from volunteer basis, population-level surveys, and convenience sampling from hospital settings. As no single recruitment strategy was used for a psychiatric disorder this should ideally reduce bias induced by any one form of recruitment.

Ethics oversight

Primary data collection was not conducted for this study. As the data was used was already collected and deidentified, ethics oversight was not applicable.

Note that full information on the approval of the study protocol must also be provided in the manuscript.

Field-specific reporting

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For a reference copy of the document with all sections, see nature.com/documents/nr-reporting-summary-flat.pdf

Life sciences study design

All studies must disclose on these points even when the disclosure is negative.

Sample size

The current study reflects the largest and most comprehensive cross-disorder psychiatric genetic analysis to-date. This study makes use of the largest psychiatric disorder GWAS currently available. Sample sizes for each of the included 14 disorders are provided in Table 1 of the main text.

Data exclusions

We employed strict quality control of the GWAS summary statistics prior to running analyses. These QC filters included removing strand ambiguous SNPs, restricting to SNPs with an imputation score (INFO) > 0.6 and with a minor allele frequency (MAF) > 1% when this information was available in the GWAS summary stats. Finally, we restrict to SNPs with a SNP-specific sum of the effective sample that is >

50% of the total sum of the effective sample or, when this SNP-specific information was not available, to SNPs for which > 50% of the cohorts contributed information, as indexed by the direction column in the GWAS summary stats. The MHC region was excluded from all summary statistics prior to the analysis.

Replication

We examined how genetic correlations in European-like genetic ancestry individuals compared to results from East Asian-like and African/African American-like genetic ancestry individuals. The genetic correlation (r_g) between major depression and schizophrenia in East Asian-like participants ($r_g = 0.45$; $SE = 0.09$) was double that observed in European-like participants ($r_g = 0.22$; $SE = 0.04$), though this discrepancy was previously shown to be driven by a single cohort of severe and recurrent major depression. Genetic correlations across disorders using African-like genetic ancestry GWAS did not produce any significant results due to lower power reflective of smaller participants sample sizes in these GWAS. Genetic correlations across genetic ancestry groups within a disorder were generally underpowered, but included a strong East Asian-like and European-like genetic correlation for schizophrenia.

Functional analyses using MAGMA, Expression-Weighted Cell Type Enrichment, and Stratified Genomic SEM replicated certain key findings, including the enrichment of excitatory neuron pathways for the Schizophrenia/Bipolar factor and oligodendrocyte biology for the Internalizing factor.

We also evaluated replication of results when utilizing more strictly ascertained samples of psychiatric cases. We find that the general pattern of results replicates for this ascertainment sensitivity analysis, with similar patterns of genetic correlations across disorders, multivariate genetic architecture, and genetic variants associated with the psychiatric factors.

Randomization

As this is a study of genetic risk for psychiatric disorders, and not a study of treatment effects as might be evaluated in a randomized control trial, randomization is not relevant as a study consideration. This is because participants cannot be randomized by the experimenter to have a psychiatric disorder or not.

Blinding

Blinding does not apply to this type of study design as the study participants are not randomly assigned to have a psychiatric disorder or not. In addition, there is no bias that can be introduced by the scientists running the genetic association analyses being aware of their psychiatric case status.

Reporting for specific materials, systems and methods

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