Archival Report

Cortical Brain Abnormalities in 4474 Individuals With Schizophrenia and 5098 Control Subjects via the Enhancing Neuro Imaging Genetics Through Meta Analysis (ENIGMA) Consortium


SEE COMMENTARY ON PAGE 626
ABSTRACT

BACKGROUND: The profile of cortical neuroanatomical abnormalities in schizophrenia is not fully understood, despite hundreds of published structural brain imaging studies. This study presents the first meta-analysis of cortical thickness and surface area abnormalities in schizophrenia conducted by the ENIGMA (Enhancing Neuro Imaging Genetics through Meta Analysis) Schizophrenia Working Group.

METHODS: The study included data from 4474 individuals with schizophrenia (mean age, 32.3 years; range, 11–78 years; 66% male) and 5098 healthy volunteers (mean age, 32.8 years; range, 10–87 years; 53% male) assessed with standardized methods at 39 centers worldwide.

RESULTS: Compared with healthy volunteers, individuals with schizophrenia have widespread thinner cortex (left/right hemisphere: Cohen’s d = −0.530/−0.516) and smaller surface area (left/right hemisphere: Cohen’s d = −0.251/−0.254), with the largest effect sizes for both in frontal and temporal lobe regions. Regional group differences in cortical thickness remained significant when statistically controlling for global cortical thickness, suggesting regional specificity. In contrast, effects for cortical surface area appear global. Case-control, negative, cortical thickness effect sizes were two to three times larger in individuals receiving antipsychotic medication relative to unmedicated individuals. Negative correlations between age and bilateral temporal pole thickness were stronger in individuals with schizophrenia than in healthy volunteers. Regional cortical thickness showed significant negative correlations with normalized medication dose, symptom severity, and duration of illness and positive correlations with age at onset.

CONCLUSIONS: The findings indicate that the ENIGMA meta-analysis approach can achieve robust findings in clinical neuroscience studies; also, medication effects should be taken into account in future genetic association studies of cortical thickness in schizophrenia.

Keywords: Cortical, Imaging, Meta-analysis, Schizophrenia, Surface area, Thickness

https://doi.org/10.1016/j.biopsych.2018.04.023

Brain structural abnormalities are widely reported in schizophrenia, but there is no published meta-analysis reporting effect sizes for cortical thickness and surface area abnormalities and their relationships to clinical features of the disease. Several hundred studies have reported on cortical thickness and surface area abnormalities in schizophrenia, but it is difficult to meta-analyze published results, as they lack a standard format to ease comparisons and are based on atlas (1) or vertex-wise (2) approaches using a variety of methods (3–9). To address these issues, the Schizophrenia Working Group within the ENIGMA (Enhancing Neuro Imaging Genetics through Meta Analysis; http://enigma.ini.usc.edu) (10–12) consortium brings together schizophrenia researchers from all over the world to jointly conduct large-scale imaging and imaging/genetics meta-analyses using standardized methods.

This meta-analysis focuses on regional cortical thickness and surface area rather than volume, based on evidence that they are influenced by separate sets of genes (13,14). Cortical thickness and surface area abnormalities have been reported in individuals with chronic (1,15–17), short- or medium-duration (18), first-episode (19–24), child-onset (25,26), adolescent-onset (27), and antipsychotic-naive (28–30) schizophrenia; individuals with nonclinical psychotic symptoms (31); and individuals at clinical high risk for psychosis (32–39).

We previously reported effect sizes for deep brain structure volume abnormalities based on 15 samples worldwide, including brain imaging data from 2028 individuals with schizophrenia and 2540 healthy volunteers (40); findings were replicated in an independent cohort using similar methods (41). Here we report Cohen’s d effect sizes comparing regional cortical thickness and surface area between 4474 individuals with schizophrenia and 5098 healthy volunteers, and partial correlation effect sizes with continuous clinical measures based on 39 worldwide samples. Based on prior work, we hypothesized that individuals with schizophrenia, compared with healthy volunteers, show widespread cortical thickness and surface abnormalities that are most prominent in frontal and temporal lobe regions (15) and that show significant associations with age at onset or duration of illness (42), symptom severity (43–48), and antipsychotic medication use (49–51).

METHODS AND MATERIALS

Study Samples

Via the ENIGMA Schizophrenia Working Group, 39 worldwide, cross-sectional study samples totaling 9572 participants, including 4474 individuals with schizophrenia and 5098 healthy volunteers, contributed to the analysis (Tables S1a and S1b and Figure S1 in Supplement 1). Sample-size weighted mean (range) age across samples was 32.3 (21.2–43.6) years for individuals with schizophrenia and 34.5 (21.8–43.9) years for healthy volunteers. Patient and control samples were on average 65% (44–100) and 54% (36–100) male. Weighted mean age at onset and duration of illness across the samples were 23.4 (20.0–35.6) years and 10.5 (6.0–20.2) years. Weighted mean Positive and Negative Syndrome Scale (PANSS) (52) total, negative, and positive scores across the samples were 68.1 (43.0–90.2), 21.9 (10.0–22.9), and 16.4 (10.6–22.6); weighted mean Scale for the Assessment of Negative Symptoms (53) and Scale for the Assessment of Positive Symptoms (54) scores were 20.5 (5.5–33.0) and 19.2
teractions were further explored through within-group anal-

yses and included visual checks of the cortical segmenta-
tions and region-by-region removal of values for segments
ons found to be incorrect (http://enigma.usc.edu/protocols/

Image Acquisition and Processing
All sites processed T1-weighted structural brain scans using
FreeSurfer (9) (http://surfer.nmr.mgh.harvard.edu) and extrac-
ted cortical thickness and surface area for 70 Desikan-Killiany
(DK) atlas regions (55) (34 regions per hemisphere + left and
right hemisphere mean thickness or total surface area)
(Table S3 in Supplement 1). Number of scanners, vendor,
strength, sequence, acquisition parameters, and FreeSurfer
versions are provided in Table S2 in Supplement 1. ENIGMA’s
quality assurance protocol was performed at each site before
analysis and included visual checks of the cortical segmenta-
tions and region-by-region removal of values for segmenta-
tions found to be incorrect (http://enigma.usc.edu/protocols/

Statistical Meta-analyses
Group differences for DK atlas regions within each sample
were examined using univariate linear regression (R linear
model function lm; R Foundation for Statistical Computing,
Vienna, Austria) predicting left and right DK atlas region cortical
thickness or surface area with group (individuals with schizo-

RESULTS
Widespread Thinner Cortex With Regional
Specificity in Schizophrenia
Individuals with schizophrenia, compared with healthy volun-
teers, showed widespread significantly thinner cortex in all DK
atlas regions except the bilateral pericalcarine region (model
A), with effect sizes between Cohen’s $d = -0.536$ (right fusi-
form gyrus) and Cohen’s $d = -0.077$ (left pericalcarine fissure)
and marginal (least square) mean thickness differences be-

Figure 1. Cortical map of regional Cohen’s $d$


effect sizes for schizophrenia subjects’ vs. healthy
volunteers’ cortical thickness contrast statistically
controlling for age and gender (A) and age, gender,
and global cortical thickness (B). Only regions with
$P_{\text{false discovery rate}} < .05$ are depicted in color. In panel
(B), warm colors (yellow-red) reflect regions in which
the effect of schizophrenia is more than the mean
global cortical thinning, and cool colors (green-blue)
reflect regions where the effect of schizophrenia is
less than the mean global thinning compared with
healthy volunteers.
middle, and superior), and left superior frontal gyri; right pars opercularis; and bilateral insula.

In the context of widespread thinner cortex in schizophrenia, we assessed regional specificity of these cortical thickness differences. When controlling for individual differences in global mean cortical thickness, several regions showed significantly thinner cortex (e.g., fusiform, parahippocampal, inferior temporal gyr), whereas other regions showed significantly thicker cortex (e.g., superior parietal cortex, precuneus, paracentral lobule) in individuals with schizophrenia compared with healthy volunteers (model B) (Figures 1B and Figure 2; Table S4b in Supplement 1). These findings suggest regional specificity of thinner cortex in schizophrenia.

**Widespread Smaller Cortical Surface Area Without Regional Specificity in Schizophrenia**

Individuals with schizophrenia, compared with healthy individuals, showed widespread significantly smaller cortical surface area in all DK atlas regions except the bilateral isthmus cingulate region (model A), with effect sizes between Cohen’s $d = 0.254$ (mean right hemisphere) and Cohen’s $d = 0.040$ (right isthmus cingulate) and marginal (least square) mean surface area differences between $-3.39\%$ (left rostral anterior cingulate) and $-0.55\%$ (right isthmus cingulate) (Figure 3A; Table S5a in Supplement 1). The largest effect sizes (Cohen’s $d < -0.20$) were observed for left (Cohen’s $d = -0.251$) and right (Cohen’s $d = -0.254$) hemisphere and bilateral superior frontal, fusiform, inferior and middle temporal, and right precentral gyr.

In the context of widespread smaller cortical surface area in schizophrenia, we assessed regional specificity of these cortical surface area differences. When controlling for individual differences in total cortical surface area, no regions showed significantly smaller surface area, whereas three regions showed significantly larger cortical surface area (bilateral isthmus cingulate, precuneus, and left paracentral) in individuals with schizophrenia compared with healthy volunteers (model B) (Figure 3B; Table S5b in Supplement 1). These findings suggest that smaller cortical surface area is predominantly global in schizophrenia except for the three regions noted, which appear less affected.

**Group-by-Gender Interactions**

No significant group-by-gender interactions were detected for either cortical thickness or surface area for any of the DK atlas regions (Tables S6 and S7 in Supplement 1).

**Group-by-Age Interactions**

There were significant group-by-age interactions for both left ($p_{\text{FDR}} = .007$) and right ($p_{\text{FDR}} = .01$) temporal pole thickness, with individuals with schizophrenia showing stronger negative correlations with age (left, $r = -.13$, $p_{\text{FDR}} = 1.51E-13$; right, $r = -.12$, $p_{\text{FDR}} = 1.55E-07$) than healthy volunteers (left, $r = -.05$, $p_{\text{FDR}} = .02$; right, $r = -.04$, $p_{\text{FDR}} = .03$). These interactions remained significant even when controlling for global mean cortical thickness (Figure S2 and Tables S8a, S8b, S10, and S11 in Supplement 1). There were no significant group-by-age interactions for cortical surface area for any of the DK atlas regions (Table S9 in Supplement 1).

**Partial Correlations With Age of Onset and Duration of Illness**

Earlier age of onset ($r = .063$, $p_{\text{FDR}} = .03$) and longer duration of illness ($r = -.061$, $p_{\text{FDR}} = .04$) were significantly correlated with thinner right insula cortical thickness (Tables S33 and S34 and Figure S3 in Supplement 1). There were no significant correlations between age of onset or duration of illness and cortical surface area for any of the DK atlas regions (Tables S43 and S44 in Supplement 1).

**Effects of Antipsychotic Medications on Cortical Thickness**

Effect sizes comparing left and right hemisphere cortical thickness from individuals with schizophrenia on no
(unmedicated; left/right, Cohen’s $d = -0.275/-0.278$), second-generation (left/right, Cohen’s $d = -0.536/-0.516$), first-generation (left/right, Cohen’s $d = -0.765/-0.648$), or both second-generation and first-generation (left/right Cohen’s $d = -0.770/-0.704$) antipsychotic medications with healthy volunteers were significant for all but the unmedicated group ($p_{FDR} > .05$) (Figure 4; Tables S12–S15 in Supplement 1).

Groupwise comparisons of left and right hemisphere thickness found nominally significant effects for all medicated versus unmedicated groups (Figure 4; Tables S16–S18 in Supplement 1). Similarly, nominally significant effects were found for first-generation versus second-generation and both second-generation and first-generation versus second-generation medication groups, but not both versus first-generation medication groups (Figure 4; Tables S19–S21 in Supplement 1). No significant regional effects were observed for the last four group contrasts ($p_{FDR} > .05$) (Tables S18–S21 in Supplement 1). For detailed regional effects of antipsychotic medications on cortical thickness and surface area, see Results SR1 in Supplement 1.

### Partial Correlations With Medication Dose

Higher chlorpromazine dose equivalents were significantly correlated with thinner cortex in almost all the DK atlas regions except bilateral entorhinal and pericalcarine cortex; bilateral lingual and transverse temporal gyri; left postcentral, cuneus, and parahippocampal gyri; caudal anterior cingulate cortex; right superior parietal and rostral anterior cingulate cortex; and right frontal pole (Figure S6A and Table S32 in Supplement 1). The correlations were significant for both left ($r = -.126$) and right ($r = -.126$) hemisphere thickness and were strongest (partial $r < -.10$) for left ($r = -.166$) and right ($r = -.148$) superior frontal, left ($r = -.113$) and right ($r = -.108$) middle temporal, left ($r = -.112$) and right ($r = -.106$) superior temporal, right inferior temporal ($r = -.113$), right pars triangularis of inferior frontal ($r = -.113$), left ($r = -.102$) and right ($r = -.108$) caudal middle frontal, and left supramarginal ($r = -.103$) gyri.

![Figure 4](Image)

**Figure 4.** Cohen’s $d$ effect sizes (A) and least square mean percent difference (B) for schizophrenia subjects vs. healthy volunteers contrasts in global cortical thickness statistically controlling for age and gender by medication group and hemisphere. Nominal one-tailed $p$ values for left and right hemisphere thickness group comparisons statistically controlling for age and gender were as follows: second-generation vs. unmedicated (left, $p < .05$; right, $p < .06$); first-generation vs. unmedicated (left, $p < .01$; right, $p < .002$); both first-generation and second-generation vs. unmedicated (left, $p < .02$; right, $p < .05$); first-generation vs. second-generation (left, $p < .03$; right, $p < .03$); both first-generation and second-generation vs. second-generation (left, $p < .02$; right, $p < .05$); both first-generation and second-generation vs. first-generation (left, $p = .50$; right, $p = .48$) (Tables S16–S21 in Supplement 1).
Importantly, post hoc analysis showed that higher chlorpromazine dose equivalents were significantly correlated with thinner cortex even when controlling for negative symptom severity (Table S41 and Figure S7 in Supplement 1). There were no detectable correlations between chlorpromazine dose equivalents and cortical surface area for any of the DK atlas regions (Table S42 in Supplement 1).

**Partial Correlations With Symptom Severity Scores**

Higher PANSS total and positive symptom severity scores were significantly correlated with regional thinner cortex (Figure S6B, Table S35, Figure S6C, and Table S36 in Supplement 1), whereas higher PANSS negative symptom scores were significantly correlated with widespread thinner cortex in left \( (r = -0.085) \) and right \( (r = -0.089) \) hemispheres (Figure S6C and Table S37 in Supplement 1; see Results SR2 in Supplement 1 for details). PANSS total, positive, and negative symptom severity scores were not significantly correlated with regional cortical surface area for any of the DK atlas regions (Tables S45-S47 in Supplement 1).

**DISCUSSION**

The main findings of this study are that individuals with schizophrenia, compared with healthy volunteers, show the following: 1) widespread thinner cortex \( (left/right, \text{Cohen’s } d = -0.530\sim-0.516) \); 2) widespread smaller cortical surface area, about half the size of the effect observed for cortical thickness \( (left/right \text{Cohen’s } d = -0.251\sim-0.254) \); 3) the largest effect sizes in frontal and temporal lobe regions for both measures, with regional specificity for cortical thickness, but not cortical surface area (based on the analyses controlling for global thickness and surface area); 4) approximately two times larger negative cortical thickness effect size when on second-generation antipsychotic medications \( (left/right, \text{Cohen’s } d = -0.536\sim-0.516) \) and approximately three times larger cortical thickness effect size when on first-generation \( (left/right, \text{Cohen’s } d = -0.765\sim-0.648) \) or both first-generation and second-generation \( (left/right, \text{Cohen’s } d = -0.770\sim-0.704) \) antipsychotic medications relative to unmedicated individuals with schizophrenia \( (left/right, \text{Cohen’s } d = -0.275\sim-0.278) \); and 5) a stronger negative correlation between age and bilateral temporal pole cortical thickness \( (left, r = -.13 \text{ vs. } r = -.05; \text{right, } r = -.12 \text{ vs. } r = -.04) \). With regard to partial correlations with clinical variables, 6) earlier age at onset and longer duration of illness were associated with thinner insula cortex; 7) standardized medication dose (chlorpromazine dose equivalents) and 8) negative symptom severity were associated with widespread thinner cortex; and 9) total and 10) positive symptom severity were associated with regional thinner cortex. Most observed correlations were small \( (r < .2) \). Moreover, despite the high power to detect small effects, medication use and other clinical variables were not significantly associated with cortical surface area.

These findings are consistent with the interpretation that the thinner cortex observed in individuals with schizophrenia shows regional specificity and is associated with the disease \( (28\sim30) \), its severity \( (43\sim48) \), and antipsychotic medication treatment \( (49\sim51) \), with a larger effect for first-generation compared with second-generation antipsychotic medications \( (16,58\sim60) \). We cannot fully exclude the possibility that observed medication effects on cortical thickness are partially due to group differences in age or duration of illness \( (61) \), which also show patterns of increase across the groups. However, such an interpretation is rendered unlikely by the facts that 1) age was statistically controlled for in the medication type analyses; 2) duration of illness, which is highly collinear with age, showed effects above and beyond age only on right insula thickness; 3) there was only a group-by-age interaction on temporal pole thickness (while medication effects were widespread); and 4) meta-regressions showed no effects of age or duration of illness on group contrast effect sizes (see Results SR1 in Supplement 1). Furthermore, dissociating medication effects from other potentially confounding variables requires well-powered, first-episode longitudinal studies, preferably with random assignment to first-generation or second-generation antipsychotics. Two longitudinal imaging studies that randomly assigned individuals to medication treatments found significant gray matter reductions for haloperidol but not olanzapine \( (58,62) \); these findings are consistent with our meta-analysis and with reported medication effects on cortical thickness in rodents \( (63) \).

None of the other potential confounding variables, including gender distribution, age at onset, medication dose, global symptoms, negative symptoms, or positive symptoms, showed a pattern consistent with the observed medication effects. These variables are therefore unlikely to explain the differences in cortical thickness effect sizes across the antipsychotic medication groups on their own, although more complex interactions could exist. In contrast to thinner cortex, smaller cortical surface area in individuals with schizophrenia appears to be a more global phenomenon associated with the disease, but not with its severity or its treatment. It is possible that more focal cortical surface area effects are obfuscated through the averaging of measurements within DK atlas regions; vertexwise analyses may have higher power for detecting and localizing such effects.

This study found significant group-by-age interactions on cortical thickness in the bilateral temporal pole regions only, with a stronger negative correlation between age and cortical thickness in individuals with schizophrenia than in healthy volunteers. In addition, this study found that earlier age at onset and longer duration of illness were associated with thinner cortical thickness in the insula only. These findings corroborate reported longitudinal findings of lower cortical volumes at illness onset as well as progressive volume decline in the temporal pole and insula in individuals with schizophrenia \( (64,65) \) and individuals at ultra-high risk for psychosis \( (66) \). Given our results, these volume declines may reflect cortical thinning rather than cortical surface area reduction. While our findings may suggest that there are few differential effects of age on cortical thickness between individuals with schizophrenia and healthy volunteers, we must keep in mind that age effects on thickness across a large age range are nonlinear \( (67) \) and that this meta-analysis combines linear age effects across multiple independent cross-sectional cohorts of various ages. Longitudinal studies are better poised to address the question of differential effects of age and duration of illness on cortical thickness in schizophrenia, and some have observed steeper rates of cortical thinning in multiple regions.
in individuals with schizophrenia and their non-ill co-twins (61). ENIGMA Schizophrenia Working Group members are actively working on pooling longitudinal studies for a meta-analysis to further address these questions.

Taken together, these findings may suggest that cortical surface area developmental trajectories in psychosis may be predominantly influenced by early neurodevelopmental, perhaps predominantly genetic, factors. In contrast, cortical thickness, in addition to likely being influenced by different genes (13,14), may be more plastic and also influenced by additional environmental and neurodegenerative factors (e.g., treatment, cannabis use, age) (68).

This study found significant widespread associations between standardized medication doses (chlorpromazine equivalents) and cortical thickness but not cortical surface area. This finding is consistent with and extends a prior meta-regression analysis, which reported that higher medication doses are associated with smaller gray matter volume (51). Given our results, the association with volume is likely due to cortical thickness rather than surface area. The finding is also consistent with the larger effect sizes for individuals with schizophrenia who were on antipsychotic medications compared with individuals who were not. An alternative interpretation may be that more severely ill patients receive higher doses of medication given the observed significant associations between symptom severity and regional cortical thickness. However, consistent with medication dose effects on cortical thickness, we found that significant associations between chlorpromazine dose equivalent and cortical thickness were still observed in post hoc partial correlation analyses that statistically controlled for negative symptom severity. In this analysis, we opted to control for negative rather than positive symptom severity, as negative symptoms tend to be less influenced by medication dose than positive symptoms.

We caution that the likelihood that antipsychotic medications are associated with thinner cortex in individuals with schizophrenia should by no means be interpreted as a contraindication for their use in treating patients with severe mental illnesses, including schizophrenia. In fact, a recent study found that medication treatment was associated with thinner cortex and better behavioral performance on a cognitive control task (26% higher d’-context score) (24). Most importantly, antipsychotic medications tend to successfully treat severely debilitating psychotic symptoms, reduce relapse risk following a first-episode break (69), and reduce suicide risk (70). As such, they play a critical role in the treatment of psychosis.

Similar published meta-analyses in bipolar disorder and major depressive disorder, with the same study design and analytical methods, found thinner bilateral frontal, temporal, and parietal lobe cortex in individuals with bipolar disorder with evidence for divergent effects of medication treatments (71) and thinner regional cortex in adults with major depressive disorder and smaller total and regional cortical surface area in adolescents with major depressive disorder (72). Together, these very-large-scale studies suggest both similarities and differences in cortical abnormalities observed among these three major psychiatric illnesses.

To our knowledge, this is the first meta-analysis of cortical thickness and surface area abnormalities in schizophrenia. Only one other schizophrenia study has provided a comprehensive listing of Cohen’s d’ effect sizes for regional cortical thickness abnormalities comparing individuals with schizophrenia, non-ill first-degree relatives, and healthy volunteers (1).

The major strength of the study is its large sample size, which provides sufficient power to detect even small effects (e.g., symptom associations). Weaknesses include the following: 1) the group of unmedicated individuals with schizophrenia does not distinguish never-medicated from unmedicated at time of scan, leaving effect sizes for medication-naive subjects to be determined; 2) despite the large total sample size, many regional thickness differences between medication subgroups did not survive multiple comparison correction; 3) this study does not examine possible group differences in brain lateralization, though such analyses will be reported on separately; and 4) the analysis of chlorpromazine equivalents did not dissociate first-generation and second-generation antipsychotic medications, which may have dissociable effects on cortical thickness (51,72). Finally, while this meta-analysis is unique in that it standardized image analysis methods across sites, any meta-analysis, including this one, is limited by sources of variation inherent to the analysis of retrospectively collected samples that cannot be fully controlled for. Sample differences include the use of different scanners and different assessments or processes to arrive at diagnosis, age at onset, duration of illness, medication dose and adherence, etc. Meta-analyses control for these differences by summing within-site effects across sites, providing generalized mean effect sizes. Similar to other meta-analyses, this meta-analysis does not control for all variance in assessments that can lower power to detect effects.

Taken together, the findings from this meta-analysis suggest that thinner cortex in schizophrenia shows regional specificity and is affected by the illness, its severity, and treatments with antipsychotic medications, whereas smaller cortical surface area is mainly influenced by widespread effects of the illness possibly mainly influenced by developmental processes. In the context of ENIGMA, these findings suggest that schizophrenia genetic association studies employing cortical thickness as a quantitative trait may need to control for medication effects, whereas studies that employ cortical surface area as a quantitative trait may not need to control for medication effects.

ACKNOWLEDGMENTS AND DISCLOSURES
The ENIGMA project is in part supported by the National Institute of Biomedical Imaging and Bioengineering of the National Institutes of Health (Grant No. U54EB020403). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. Acknowledgments for the various participating data contributors are listed in Supplement 1.

Author contributions are as follows: protocol design, quality testing, and meta-analysis, TGMvE, EW, DPH, LS, and WJ; data collection, processing, analysis, and funding, TGMvE, EW, DPH, LS, WJ, DCG, GDP, NY, MF, RH, NO, HY, JRB, VPC, IA, BAM, WC, SMCoz, HEHP, RSK, RAD, NEMH, OAA, AMD, NTD, TPG, CBH, UKH, KNJ, TVL, IM, LTW, LG, BK, AR, DZ, VDC, BC-F, RR-S, MJG, VIC, SCA, JF, VLC, JMFu, MUG, FAH, AJ, RKL, CL, BJM, PTM, CP, YQ, PER, GC, US, RJt, SG, PHT, CSS, RSW, TWW, DWt, EIM, EH, PK, LMB, REG, RCG, TDS, DHW, ABel, GGB, JMFo, FM, DHM, DSO, SGP, AP, JV, KOL, SM, FY, YT, STan, ZW, FF, JC, HK, STang, HG, PW, DW, HJB, SE, RFW, MDK, JMS, SRS, LDH, LK, MWM, TVa, DJV, FA, NB, PD, MI, FP.
Meta-analysis of Cortical Brain Abnormalities in Schizophrenia

GS, PJM, EP-C, JR, RSa, AC, GD, SKe, CDW, EWD, DR, ANV, SCI, PD, RM, TRM, ASi, SB, LE, FHa, AR-R, RSm, KIA, LW, EGJ, SKo, IECs, ABeBo, ABo, ADG, EN, ARM, JSMk, JSK, J-YY, DYM, CM, IL, AST, TA, VKk, HF-B, LF, GFB, PGPb, MHS, MVZ, CH, ASk, FS, DT, SPH, AMm, HCW, SML, CK, VO-K, MSi, FMH, DJS, HST, AU, JU, CL-D, DD, AM, JIF, BAG, NJ, PMT, and JAT; manuscript preparation, TGMVe, JAT, and PMT. All authors contributed edits and approved the contents of the manuscript.

TGMVe has had a research contract with Otsuka Pharmaceutical. AP has served as a consultant for Boehringer Ingelheim. The remaining authors report no biomedial financial interests or potential conflicts of interest.

ARTICLE INFORMATION
From the Department of Psychiatry and Human Behavior (TGMVe, FM, SGP, AP), University of California, Irvine, Irvine, California; Imaging Genetics and Neuroinformatics Lab (EW, JAT), Department of Psychology (WJ), Georgia State University, Atlanta, Georgia; Imaging Genetics Center (DPH, CDW, AM, JIF, NJ, PMT), Mark and Mary Stevens Neuroimaging & Informatics Institute, Keck School of Medicine of the University of Southern California, Los Angeles, California; Brain Imaging Research Center (DR, ADG), University of California, San Diego; Center for Translational Imaging and Precision Medicine (AMD), San Diego; Departments of Neurosciences (AMD), Radiology (AMD), Psychiatry (AMD, GGB), and Cognitive Science (AMD), University of California, San Diego, La Jolla; Department of Psychiatry (DCG, GDP, NY), Yale University, New Haven; Olin Neuropsychiatric Research Center (DCG, GDP, NY), Institute of Living, Hartford Hospital, Hartford, Connecticut; Department of Psychiatry, University of New Mexico (JRB, VPC, VDC); Mind Research Network (VPC, VDC, HJB, MDK, JMSH, ARM, JSMt, JAT), Albuquerque, New Mexico; Department of Psychiatry (BAM, KOL, SRS), University of New Mexico; Minneapolis VA Health Care System (SRs), Minneapolis, Minnesota; Semel Institute for Neurosciences and Human Behavior (RAO) and Department of Psychiatry & Biobehavioral Sciences (SM), University of California, Los Angeles, Los Angeles, California; Maryland Psychiatric Research Center (EH, PK), University of Maryland School of Medicine, Baltimore, Maryland; Department of Psychiatry (LMB, REG, RCG, TDS, Dhw), University of Pennsylvania, Philadelphia, Pennsylvania; Department of Psychiatry (ABel), University of North Carolina at Chapel Hill, Chapel Hill; Brain Imaging and Analysis Center (ABel, Jv), Duke University Medical Center, Durham, North Carolina; Department of Psychiatry, Weill Institute for Neurosciences, University of California, San Francisco (JMFo, DHM); San Francisco Veterans Affairs Medical Center (JMFo, DHM), San Francisco, California; Department of Psychiatry (DSo, HJB), University of Iowa; Advanced Biomedical Informatics Group, LLC (HJB), Iowa City, Iowa; Social Neuroimaging Laboratory (RPlw), Athinoulia A. Martinos Center for Biomedical Imaging (Se), Charlestown; Psychiatric Neuroimaging Research Program (RPM), and Department of Psychiatry (RPlw), Massachusetts General Hospital; Harvard Medical School; Department of Psychiatry (SkE), Beth Israel Deaconess Medical Center, Harvard Medical School; Psychiatry Neuroimaging Laboratory (SkE), Brigham and Women’s Hospital, Harvard Medical School, Boston, Massachusetts; Beth K. and Stuart C. Yudofsky Division of Neuropsychiatry (GS), Menninger Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, Houston, Texas; Departments of Psychiatry and Behavioral Sciences (KIA, LW) and Radiology (LW), Northwestern University Feinberg School of Medicine; Department of Biomedical Engineering (BAG), Illinois Institute of Technology, Chicago, Illinois; Oxygen (LS), The National Centre of Excellence in Youth Mental Health; Centre for Youth Mental Health (LS), Neuropsychiatry Centre (Vlc, Cp), and Florey Institute of Neuroscience and Mental Health (CP), University of Melbourne; Department of Psychiatry, Monash University (VjC); Murdoch Children’s Research Institute (Msie), Melbourne, Victoria; School of Biomedical Sciences and Pharmacy (RJs, MJC, PAT), Priority Research Centre for Health Behaviour (FAH), School of Medicine and Public Health (FAH), School of Psychology (PTM), Priority Research Centre for Brain & Mental Health (Cl, Us, Pat, Per, Gc), and Grow Up Well (Us), University of Newcastle; Hunter Medical Research Institute (Cl, FaH, Us, Rs, MJC, Pat); Hunter New England Local Health District (Cl), Newesota School of Psychiatry (VjC, MJG, RkL, YQ, Csw, Tww) and School of Medical Sciences (JMFu), University of New South Wales, New South Wales; Neuroscience Research Australia (JMFu, MJC, RkL, YQ, Csw, Tww), Sydney, New South Wales; Queensland Brain Institute (BjM) and Queensland Centre for Mental Health Research (BjM), Discipline of Psychiatry, School of Medicine, University of Queensland (ScA), Brisbane, Queensland; School of Psychiatry and Clinical Neurosciences, University of Western Australia (Aj), Perth, Western Australia, Australia; Department of Psychiatry and Neurosciences (LS), Uv University Medical Center; Department of Psychiatry (Ldh, Lk, Mrm), Academic Medical Center, University of Amsterdam; Department of Psychiatry (DjV), Vrije Universiteit Medical Center, Amsterdam; Department of Child and Adolescent Psychiatry/Psychology (NemVh), Erasmus Medical Centre, Rotterdam; Departments of Neuroscience (IecS), University Medical Center Groningen, Rijks Universiteit Groningen, Groningen; Department of Psychiatry and Brain Center Rudolf Magnus (Wc, SMCsAz, HEPH, NemVh, RSk, RAO, Sko), University Medical Center Utrecht, Utrecht; Department of Psychiatry & Psychology (TvA), Maastricht University, Maastricht, The Netherlands; Division of Cerebral Integration (MF), National Institute for Physiological Sciences, Okazaki, Aichi; Molecular Research Center for Children’s Mental Development (Rhh), Undergraduate School of Child Development, Osaka University; Department of Psychiatry (Rh, Hy), Osaka University Graduate School of Medicine, Suita, Osaka; Department of Neuropsychiatry (No), Graduate School of Medicine, University of Tokyo, Bunkyo-ku, Tokyo, Japan; Institute of Clinical Medicine (IA, Oaa, NTD, Tpg, Cbh, UkH, KnJ, IM, Egj, Norwegia Centre for Mental Disorders Research (Norment), K.G. Jebsen Centre for Psychosis Research, and Department of Psychology (Lw), University of Oslo; Division of Mental Health and Addiction (Oaa, UkH, Tvl, IM, LtW), Norment. K.G. Jebsen Centre for Psychosis Research, Oslo University Hospital; Department of Psychiatric Research (IA, KnJ, Tgp), Diakonhjemmet Hospital, Oslo, Norway; Centre for Psychiatry Research (HF-B, LF), Department of Clinical Neuroscience (IA, JR, Egj), Karolinska Institutet; Stockholm Health Services (HF-B, LF), Stockholm County Council, Stockholm, Sweden; Section for Experimental Psychopathology and Neuroimaging (Og, BK, Ar, Dz), Department of General Psychiatry, Heidelberg University Hospital, Heidelberg; Center for Translational Research in Systems Neuroscience and Psychiatry (Og, BK, Ar, Dz), Department of Psychiatry, Georg August University; Department of Psychiatry (Dz), University Medical Center Göttingen, Göttingen; Division of Psychological and Social Medicine and Developmental Neurosciences (Se, Rpfw), Faculty of Medicine, Technische Universität Dresden, Dresden; Department of Psychiatry, Psychosomatic Medicine and Psychotherapy (Og, Vc-K, MsU), University Hospital Frankfurt, Goethe University Frankfurt, Frankfurt, Germany; Department of Psychiatry (BC-F, RR-S, DT-G), University Hospital Marqués de Valdecilla, School of Medicine; Neuroimaging Unit (DT-G), Technological facilities, Valdecilla Biomedical Research Institute, Marqués de Valdecilla Research Institute (IDIVAl), University of Cantabria; Centro Investigación Biomedica en Red de Salud Mental (BC-F, RR-S, DT-G), Santander; Fundación para la Investigación y Docencia Maria Augustas Giménez (FidMAG), Germanes Hospitalaries Research Foundation (FmL, Ep-C, RsA, JpR), Centro de Investigación Biomedica en Red de Salud Mental (Pjm, Ep-C, RsA, JpR), Barcelona, Spain; Centre for Neuroimaging & Cognitive Genomics (DwM, GD, DMC, CM), Clinical Neuroimaging Laboratory, National Centre for Biomedical Engineering (NCBES) Galway Neuroscience Centre, College of Medicine Nursing and Health Sciences, School of Psychology (DwM, GD), and Department of Biochemistry (DwM, GD), National University of Ireland Galway, Galway; Neuropsychiatric Genetics Research Group (DwM, AC, GD), Department of Psychiatry and Trinity College Institute of Neuroscience, Trinity College, Dublin, Ireland; Psychiatry Research Center (Fy, YT, StAn, ZW, Ff, Jc), Beijing Huiyongguan Hospital, Beijing; Chongqing Three Gorges Central Hospital (Hx, StAnG), Chongqing; Zhuhai Psychiatry Hospital (Hg, Pw), Henan Province, Zhuhai; Luoyang Fifth People’s Hospital (DwM), Henan Province, Luoyang; China; Laboratory of Neuropsychiatry (Pai, Nb, PR, Mi, Fp, Gs), Department of Clinical and Behavioral Neurology, IRCCS Santa Lucia Foundation; Centro Fermi (Fa, Fp), Museo Storico della Fisica e Centro Studi e Ricerche “Enrico Fermi”; Dipartimento di Neuroscienze, Salute Mentale e Organi di Senso (Nesmos) (Pdr), Faculty of Medicine and Psychology, and Department of Neurology and Psychiatry (Pdr), Sapienza University of Rome, Rome; School of Clinical Medicine, Neuroscience and Sense Organs (AbE), University of Bari “Aldo Moro,” Bari; Istituto Di Ricovero e Cura a Carattere Scientifico Casa Sollievo della Sofferenza (AbO, ADg), San Giovanni Rotondo, Italy; Centre for Biological Psychiatry November 1, 2018; 84:644–654 www.sobp.org/journal 651
Meta-analysis of Cortical Brain Abnormalities in Schizophrenia

REFERENCES

Meta-analysis of Cortical Brain Abnormalities in Schizophrenia


