Schizophrenia is more often than not a chronic relapsing illness and unfortunately, it is one of the top 10 most disabling conditions in the World Health Organization’s Global Burden of Disease.\(^1\) Schizophrenia is further complicated by multiple comorbidities—both physical and psychiatric. Common physical comorbidities include cardiovascular disorders and metabolic disturbances such as lipid-cholesterol abnormalities, lung disease, and heightened risk for some cancers. These added disease burdens are not chance occurrences and reflect shared genetic risks, environmental and social determinants, sedentary lifestyle, and potentially also antipsychotic drug-host interactions—all in some admixture over the course of illness.\(^2,3\) Psychiatric and addiction comorbidities are equally common and no less problematic than the physical comorbidities. Psychiatric comorbidities include depression, anxiety, suicidality, and obsessive-compulsions. More than one-half of people with schizophrenia become depressed and 4 of 100 people with schizophrenia end their lives by suicide.\(^4\)

Substance comorbidities include abuse and misuse of cigarettes, alcohol, illicit drugs, recreational cannabis, and most often issues with polysubstance abuse. As the genetics of schizophrenia and other conditions slowly become clearer, there is evidence of overlap in genetic liability for psychosis, addictions, and more selectively, smoking. Earlier notions of drug and alcohol use as (merely) expressions of self-medication have evolved into more complex formulations that encompass genetic risk, neurological determinants of craving and addictive behaviors, and pharmacologic modulations of anhedonia and other negative symptoms of schizophrenia. Moreover, some illicit drugs appear to be de facto causes for schizophrenia. In one recent study of the evolution of substance-induced psychosis, 47% of people went on to develop either schizophrenia or bipolar disorder.\(^5\) And, of course, this patient group is notoriously noncompliant with medications; therefore, further undermining treatment outcomes.\(^6,7\)

Accordingly, this issue of *Psychiatric Annals* is both timely and informative for clinicians. In the article, “The NIMH Research Domain Criteria Initiative and Comorbidity in Schizophrenia: Research Implications,” Dr. Jean-Pierre Lindenmayer sets the stage for research on comorbidity in schizophrenia with an overview of the framework of comorbidities in schizophrenia in the context of the federal research priorities. In the second article, “Obsessive-Compulsive Schizophrenia: Clinical and Conceptual Perspective,” Dr. Michael Hwang, Dr. Ashvin Sood, Burhan Riaz, and Dr. Michael Poyurovsky tease out the clinical overlap and potentially synergistic risk for schizophrenia and comorbid obsessive-compulsive disorders (OCD). The review on OCD is nicely complemented with the article “Comorbid Obsessive-Compulsive Symptoms in Schizophrenia: Neurocognitive Profile” by Drs. Won-Gyo Shin, Junhee Lee, Tae Young Lee, Danielle S. Himelfarb, and Jun Soo Kwon, which highlights the interaction between cognitive dysfunction and the OCD comorbidity in schizophrenia. The final article, “Comorbid Schizophrenia and Panic Anxiety: Panic Psychosis Revisited,” by Dr. Jeffrey P. Kahn, Tatiane Bombassaro,
and Dr. Andre B. Veras provides a thoughtful synthesis of current knowledge of the nosology and treatment of anxiety disorders that are comorbid in schizophrenia.

Collectively, these articles cover most of our present-day understanding of common comorbidities in schizophrenia. We appreciate the opportunity to bring together these experts in a single issue of the journal.

REFERENCES