Supplementary Online Content

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This supplementary material has been provided by the authors to give readers additional information about their work.

eMethods. Supplementary methods

We included the 19 WMH surveys that administered both the Psychosis and Suicidality Modules STBs (N=33,370). These surveys are distributed across North and South America (Argentina, Colombia, Mexico, Peru, Sao Paulo in Brazil, USA); Africa (Nigeria); the Middle East (Iraq, Lebanon); Asia (Shenzhen in the People's Republic of China); the South Pacific (New Zealand); and Europe (Belgium, France, Germany, Italy, the Netherlands, Portugal, Romania, Spain). The majority of these surveys were based on multi-stage, clustered area probability household sampling designs, the exceptions being Belgium, Germany and Italy, which used municipal resident registries to select respondents (eTable 1 in the Supplement).

In order to focus on the correlates of PEs in those without psychotic disorders, we made the *a priori* decision to exclude individuals who had PEs but who also screened positive for possible schizophrenia/psychosis and manic-depression/mania. Thus, in keeping with previous studies of PEs,[1-4] we excluded respondents who (a) reported *(1) schizophrenia/psychosis* or *(2) manic-depression/mania* in response to the question "*What did the doctor say was causing (this/these) experiences?"*; and (b) those who ever took an antipsychotic medication for these symptoms. This resulted in the exclusion of 146 respondents (0.4% of all respondents), leaving 33,370 respondents for this study.

All WMH interviews were conducted in the homes of respondents by trained lay interviewers. Informed consent was obtained before beginning interviews in all countries. Procedures for obtaining informed consent and protecting individuals (ethical approvals) were approved and monitored for compliance by the institutional review boards of the collaborating organizations in each country. Informed consent was obtained from all participants and approval obtained from local institutional review boards (eTable 2 in the Supplement); more detailed information has been published previously.[5,6]

Standardized interviewer training and quality control procedures were used consistently in the surveys. Full details of these procedures are described elsewhere.[7,8]

Interviews were administered face to face in two parts.[20] Part 1, which assessed a core set of mental disorders, was administered to all respondents. Part 2, which assessed additional mental disorders, STBs, and PEs, was administered to respondents who met lifetime criteria for any Part I disorder, and a random proportion of respondents without any Part 1 disorder.

Part 2 respondents were weighted by the inverse of their probability of selection to adjust for differential sampling, and therefore provide representative data on the target adult general population. Details about sampling methods are available elsewhere.[9] Additional weights were used to adjust for differential probabilities of selection within households, nonresponse, and to match the samples to population socio-demographic distributions.

The WMH surveys administered the WHO Composite International Diagnostic Interview (CIDI),[8] a validated fully-structured diagnostic interview designed to assess the prevalence and correlates of a wide range of mental disorders according to the definitions and criteria of both DSM-IV and ICD-10. Translation, back-translation, and harmonisation protocols were used to adapt the CIDI for use in each participating country.

Mental disorders: The WMH version of the CIDI assessed lifetime history of 21 mental disorders broadly classified into *mood disorders*; *anxiety disorders; behavior disorders*; *eating disorders* and *substance use disorders* (eTable 3c in the Supplement). Full details are given in several WMH publications including two recent papers on PEs.[1,10] Clinical reappraisal studies indicate that lifetime diagnoses based on the CIDI have good concordance with diagnoses based on blinded clinical interviews.[11] In keeping with our previous research, standardised diagnostic hierarchy rules among the disorders assessed were applied where appropriate.[1]

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11. Haro JM, Arbabzadeh-Bouchez S, Brugha TS, et al. Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health surveys. *Int J Methods Psychiatr Res.* 2006;15(4):167-180.

eTable 1. World Mental Health (WMH) sample characteristics by World Bank income categories and sample for psychotic experiences (PEs)

Country by income category	Survey[a]	Sample characteristics	Field dates	Age range	Sample size		Response rate[b]
					Part I	PEs sample	
Low and lower middle income countries							
Colombia	NSMH	All urban areas of the country	2003	18-65	4426	722	87.7
Iraq	IMHS	Nationally representative	2006-7	18-96	4332	4329	95.2
Nigeria	NSMHW	21 of the 36 states in the country	2002-3	18-100	6752	1417	79.3
Peru	EMSMP	5 urban areas (approximately 38% of the total national population)	2004-5	18-65	3930	530	90.2
PRC[c] - Shenzhen[d]	Shenzhen	Shenzhen metropolitan area	2006-7	18-88	7132	2468	80.0
Upper-middle income countries							
Brazil - São Paulo	São Paulo Megacity	São Paulo metropolitan area	2005-7	18-93	5037	2922	81.3
Lebanon	LEBANON	Nationally representative	2002-3	18-94	2857	1029	70.0
Mexico	M-NCS	All urban areas of the country	2001-2	18-65	5782	715	76.6
Romania	RMHS	Nationally representative	2005-6	18-96	2357	2357	70.9
High-income countries							
Argentina	AMHES	Nationally representative	2015	18-98	3927	2109	77.3
Belgium	ESEMeD	Nationally representative	2001-2	18-95	2419	319	50.6
France	ESEMeD	Nationally representative	2001-2	18-97	2894	301	45.9
Germany	ESEMeD	Nationally representative	2002-3	18-95	3555	408	57.8
Italy	ESEMeD	Nationally representative	2001-2	18-100	4712	617	71.3
New Zealand[d]	NZMHS	Nationally representative	2003-4	18-98	12790	7263	73.3
Portugal	NMHS	Nationally representative	2008-9	18-81	3849	2053	57.3
Spain	ESEMeD	Nationally representative	2001-2	18-98	5473	1159	78.6
The Netherlands	ESEMeD	Nationally representative	2002-3	18-95	2372	348	56.4
The United States	NCS-R	Nationally representative	2002-3	18-99	9282	2304	70.9
All countries combined					**93878**	**33370**	**72.3**

[a] **NSMH** (The Colombian National Study of Mental Health); **IMHS** (Iraq Mental Health Survey); **NSMHW** (The Nigerian Survey of Mental Health and Wellbeing); **EMSMP** (La Encuesta Mundial de Salud Mental en el Peru); **LEBANON** (Lebanese Evaluation of the Burden of Ailments and Needs of the Nation); **M-NCS** (The Mexico National Comorbidity Survey); **RMHS** (Romania Mental Health Survey); **AMHES** (Argentina Mental Health Epidemiologic Survey; **ESEMeD** (The European Study Of The Epidemiology Of Mental Disorders); **NZMHS** (New Zealand Mental Health Survey); **NMHS** (Portugal National Mental Health Survey); **NCS-R** (The US National Comorbidity Survey Replication).

[b] The response rate is calculated as the ratio of the number of households in which an interview was completed to the number of

households originally sampled, excluding from the denominator households known not to be eligible either because of being vacant at the time of initial contact or because the residents were unable to speak the designated languages of the survey. The weighted average response rate is 72.3%.

[c] People's Republic of China.

[d] For the purposes of cross-national comparisons we limit the sample to those 18+.

eTable 2. Ethics review and informed consent in the World Mental Health Surveys

Country	Type of Organization	IRB/Ethics approval	Type of consent obtained
Argentina	Academic Centre/Institute (School of Medicine, University of Buenos Aires)	Bioethics Committee, School of Medicine, University of Buenos Aires	Written
Belgium	Government Agency	Ethics Committee of the Institute of Public Health (Federal Public Service Health, Food Chain Safety, and Environment)	Verbal
Brazil	Academic Center/Institute; Private For-Profit Company	Research and Ethics Committee of the School of Medicine, University of São Paulo	Written
Colombia	Non-Profit Organization	Ethics Committee for the FES Social Foundation	Verbal
France	Academic Center/Institute	Acta No. 39	Written
Germany	Academic Center/Institute	Ethics Committee of the University of Leipzig	Verbal
Iraq	Government Agencies; World Health Organization	Ethics Scientific Committee of the Ministry of Health of Iraq	Verbal
Italy	Private For-Profit Company	Italian National Institute of Health	Written
Lebanon	Non-Profit Research Institute; Non-Governmental Organization	University of Balamand Faculty of Medicine Institutional Review Board	Verbal
Mexico	Academic Center/Institute	Ethics Committee in Research of the National Institute of Psychiatry Ramon de la Fuente Muñiz	Verbal
New Zealand	Ministry of Health	New Zealand Health Ethics Committees (approval from 14 separate committees)	Written
Nigeria	Government Agency; Academic Center/Institute	University of Ibadan/University College Hospital Joint Ethics Committee	Verbal
Peru	Institute of Health	National Institute of Health Peru	Verbal
PRC Shenzhen	Academic Center/Institute	Ethics Committee of Shenzhen Kangning Hospital	Verbal
Portugal	Academic Center/Institute	Ethics Committee, Faculdade de Ciencias Médicas, Universidade Nova	Verbal
Romania	Academic Center/Institute; Public Organization	Ethic Commission, Scientific Board of National Institute for Research and Development in Health	Verbal
Spain	Academic Center/Institute	Ethical Committees of Sant Joan de Deu Serveis de Salut Menta and of IMIM-Hospital del Mar Medical Research Institute	Written
The Netherlands	Private For-Profit Company; Academic Center/Institute	Ethics Committee of the Netherlands Institute of Mental Health and Addiction	Written

United States	Academic Center/Institute	Human Subjects Committees of the Institute for Social Research at the University of Michigan and of Harvard Medical School	Verbal

Abbreviation: PRC, People's Republic of China.

eTable 3. Composite International Diagnostic Interview psychotic experience types in European Study of the Epidemiology of Mental Disorders sites, other sites, and DSM-IV mental disorder categories across sites

A. ESEMed sites (Belgium, France, Germany, Italy, the Netherlands, and Spain)

Item	Type	Description
A. Saw a vision (Visual hallucinations)	**1**	Did you ever see something that wasn't really there that other people could not see? Please do not include any times when you were dreaming or half-asleep or under the influence of alcohol or drugs?
B. Heard voices (Auditory hallucinations)	**2**	Did you ever hear things that other people said did not exist, like strange voices coming from inside your head talking to you or about you, or voices coming out of the air when there was no one around. Please do not include any times when you were dreaming or half-asleep or under the influence of alcohol or drugs?
C. Thought insertion	**3**	Did you ever believe that some mysterious force was inserting many different strange thoughts -- that were definitely not your own thoughts – directly into your head by means of x-rays or laser beams or other methods?
D. Mind control/passivity	**4**	Did you ever feel that your mind had been taken over by strange forces with laser beams or other methods that were making you do things you did not choose to do. Again, do not include times when you were dreaming or under the influence of alcohol or drugs?
E. Ideas of reference	**5**	Did you ever believe that some strange force was trying to communicate directly with you by sending special signs or signals that you could understand but that no one else could understand. Sometimes this happens by special signs coming through the radio or television?
F. Plot to harm/follow	**6**	Did you ever believe that there was an unjust plot going on to harm you or to have people follow you that your family and friends did not believe existed?

ESEMeD = European Study of the Epidemiology of Mental Disorders

B. Non-ESEMed sites (People's Republic of China, Colombia, Lebanon, Mexico, Brazil, Iraq, Nigeria, Peru, Portugal, New Zealand, Romania, United States, and Argentina)

Item	Type	Description
A. Saw a vision (Visual hallucinations)	**1**	Did you ever see something that other people who were there could not see?
	1a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?
B. Hearing voices (Auditory hallucinations)	**2**	Did you ever hear things that other people said did not exist, like strange voices coming from inside your head talking to you or about you, or voices coming out of the air when there was no one around?
	2a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?
C. Thought insertion	**3**	Did you ever believe that some mysterious force was inserting many different strange thoughts -- that were definitely not your own thoughts – directly into your head by means of x-rays or laser beams or other methods?
	3a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?
D. Mind control/passivity	**4**	Did you ever feel that your mind had been taken over by strange forces with laser beams or other methods that were making you do things you did not choose to do?
	4a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?
E. Ideas of reference	**5**	Did you ever believe that some strange force was trying to communicate directly with you by sending special signs or signals that you could understand but that no one else could understand. Sometimes this happens by special signs coming through the radio or television?
	5a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?
F. Plot to harm/follow	**6**	Did you ever believe that there was an unjust plot going on to harm you or to have people follow you that your family and friends did not believe existed?
	6a	Did this every happen when you were not dreaming, not half-asleep, and not under the influence of alcohol or drugs?

Note: For the assessment of psychotic experiences we included items 1a, 2a, 3a, 4a, 5a, and 6a. Similarly for the assessment of hallucinatory experiences we included types 1a and 2a, and for the assessment of delusional experiences we included types 3a, 4a, 5a, and 6a.

C. 21 *DSM-IV* mental disorders across 19 WMH sites

A. Mood disorders	Major depressive disorder
	Bipolar disorder (Bipolar I, II, Subthreshold)
B. Anxiety disorders	Panic disorder
	Generalized anxiety disorder
	Specific phobia
	Social phobia
	Agoraphobia without panic
	Post-traumatic stress disorder
	Separation anxiety disorder (Child)
	Separation anxiety disorder (Adult)
C. Behaviour disorders	Intermittent explosive disorder
	Attention deficit disorder
	Oppositional defiant disorder
	Conduct disorder
D. Eating disorders	Aneroxia nervosa
	Bulimia nervosa
	Binge eating disorder
E. Substance-use disorders	Alcohol abuse
	Alcohol dependence
	Drug abuse
	Drug dependence

eTable 4. Lifetime prevalence of suicidal plans and attempts among those with suicidal ideation

	Plans			Planned attempts			Unplanned attempts		
	n[a]	%[b]	SE	n[a]	%[b]	SE	n[a]	%[b]	SE
STB prevalence	2000	**33.6**	0.9	1142	**55.5**	1.5	629	**17.0**	0.9
(Denominator N)[c]		(5106)			(2000)			(3106)	
PE status (in those with ideation)									
No PE	1583	**32.7**	0.9	884	**53.6**	1.6	504	**16.6**	0.9
(Denominator N)[c]		(4165)			(1583)			(2582)	
Any PE	417	**37.9**	2.1	258	**63.1**	3.1	125	**18.9**	2.2
(Denominator N)[c]		(941)			(417)			(524)	
Number of PEs (in those with ideation and PEs)									
Exactly 1 PE type	236	**36.0**	2.4	139	**59.8**	4.3	80	**18.6**	2.7
(Denominator N)[c]		(571)			(236)			(335)	
Exactly 2 PE types	111	**36.2**	4.0	65	**59.5**	6.6	33	**20.0**	4.6
(Denominator N)[c]		(247)			(111)			(136)	
3 or more PE types	70	**50.1**	6.6	54	**79.0**	5.8	12	**17.8**	7.1
(Denominator N)[c]		(123)			(70)			(53)	
PE annualized frequency metric[b] (in those with ideation and PEs)									
≤ 0.3 episodes/year	183	**37.3**	3.1	115	**66.3**	4.5	52	**16.1**	3.2
(Denominator N)[c]		(425)			(183)			(242)	
> 0.3 episodes/year	234	**38.5**	2.8	143	**60.4**	4.4	73	**21.4**	3.1
(Denominator N)[c]		(516)			(234)			(282)	

STB, Suicidal thoughts and behaviors; PE, Psychotic experiences

[a]Numerators refer to the number of individuals with each suicidal outcome.

[b]Estimates are based on weighted data.

[c]Denominators refer to the number of individuals in the conditional sample among those with ideation, those with ideation with a plan and those with ideation without a plan

[b]Annualized PE (Frequency of PE per year)=(Frequency of PE occurrences)/((age at interview - age of onset of PE + 1))

eTable 5. Associations between psychotic experiences and subsequent onset of suicide plans and attempts among those with suicidal ideation

	Plan				Planned attempt				Unplanned attempt			
	Basic demographic adjustment[a]		Adjusted for antecedent mental disorders[b]		Basic demographic adjustment[a]		Adjusted for antecedent mental disorders[b]		Basic demographic adjustment[a]		Adjusted for antecedent mental disorders[b]	
	OR	(95% CI)	**OR**	(95% CI)	**OR**	(95% CI)	**OR**	(95% CI)	**OR**	(95% CI)	**OR**	**(95% CI)**
PE status												
Any PE	**1.0**	(0.8-1.3)	**1.0**	(0.8-1.3)	**1.0**	(0.7-1.5)	**1.0**	(0.7-1.5)	**0.7**	(0.5-1.1)	**0.7**	(0.4-1.1)
Number of PEs												
Exactly 1 PE type	**0.9**	(0.6-1.2)	**0.9**	(0.6-1.2)	**0.8**	(0.5-1.3)	**0.8**	(0.5-1.4)	**0.8**	(0.4-1.4)	**0.7**	(0.4-1.3)
Exactly 2 PE types	**0.9**	(0.6-1.4)	**1.0**	(0.7-1.4)	**1.0**	(0.5-2.0)	**1.0**	(0.5-2.0)	**0.8**	(0.4-1.6)	**0.7**	(0.3-1.7)
3 or more PE types	**1.8**	(1.0-3.3)	**1.6**	(0.8-3.2)	**1.8**	(0.8-4.3)	**1.9**	(0.8-4.5)	**0.5**	(0.2-1.4)	**0.5**	(0.2-1.3)
Joint significance of the 3 number-of-PE type measures	**$\chi^2_3 = 4.5$, P = 0.214**		**$\chi^2_3 = 3.0$, P = 0.397**		**$\chi^2_3 = 2.9$, P = 0.409**		**$\chi^2_3 = 3.0$, P = 0.385**		**$\chi^2_3 = 2.7$, P = 0.448**		**$\chi^2_3 = 3.3$, P = 0.346**	
Difference in the ORs of the 3 number-of-PE type measures	**$\chi^2_2 = 4.5$, P = 0.106**		**$\chi^2_2 = 2.9$, P = 0.230**		**$\chi^2_2 = 2.9$, P = 0.236**		**$\chi^2_2 = 3.0$, P = 0.221**		**$\chi^2_2 = 0.4$, P = 0.808**		**$\chi^2_2 = 0.6$, P = 0.754**	
Test for linear trend	**$\chi^2_1 = 4.1$*, P = 0.043**		**$\chi^2_1 = 3.3$, P = 0.069**		**$\chi^2_1 = 3.4$, P = 0.064**		**$\chi^2_1 = 5.0$*, P = 0.025**		**$\chi^2_1 = 1.0$, P = 0.326**		**$\chi^2_1 = 0.0$, P = 0.868**	
PE frequency metric												
> 0.3 episodes/year	**1.1**	(0.8-1.5)	**1.1**	(0.8-1.5)	**0.7**	(0.5-1.2)	**0.7**	(0.4-1.2)	**0.9**	(0.5-1.6)	**0.8**	(0.4-1.5)

PE, Psychotic experience; STB, Suicidal thoughts and behaviors; OR, Odds ratio; CI, Confidence interval

*Significant at the .05 level, 2-sided test

[a]PE (any PE, number of PE type, and PE frequency metric) was used as a predictor of STB outcomes in separate discrete-time survival models. These models control for age-cohorts, sex, person-year dummies and country.

[b]These models additionally control for 21 other temporally-ordered mental disorders.

eTable 6. Associations between lifetime psychotic experiences and subsequent onset of suicide ideation, plans, and attempts in those with and without lifetime mental disorders

	Ideation				Plan				Attempt			
	With mental disorder[a]		Without mental disorder[b]		With mental disorder[a]		Without mental disorder[b]		With mental disorder[a]		Without mental disorder[b]	
	OR	(95% C.I)	OR	(95% C.I)	OR	(95% C.I)	OR	(95% C.I)	OR	(95% C.I)	OR	(95% C.I)
PE status												
Any PE	**2.1***	(1.8-2.5)	**3.5***	(2.3-5.3)	**2.2***	(1.8-2.8)	**4.6***	(2.4-8.8)	**2.1***	(1.6-2.7)	**4.1***	(1.7-10.0)
Number of PEs												
Exactly 1 PE type	**1.7***	(1.4-2.1)	**3.3***	(2.0-5.3)	**1.8***	(1.4-2.4)	**3.2***	(1.6-6.3)	**1.6***	(1.2-2.2)	**3.0**	(0.9-10.0)
Exactly 2 PE types	**2.5***	(1.9-3.4)	**3.5***	(1.7-7.5)	**2.3***	(1.6-3.3)	**4.5***	(1.0-20.1)	**2.2***	(1.4-3.5)	**3.4**	(0.9-12.3)
3 or more PE types	**4.2***	(3.0-6.0)	**8.1***	(1.8-36.8)	**5.1***	(3.3-8.0)	**33.8***	(7.9-145.2)	**5.2***	(3.2-8.5)	**29.3***	(5.6-153.9)
Joint significance of the 3 number-of-PE type measures	**X^2_3 = 126.5*, P <.001**		**X^2_3 = 37.1*, P <.001**		**X^2_3 = 83.3*, P <.001**		**X^2_3 = 34.4*, P <.001**		**X^2_3 = 61.0*, P <.001**		**X^2_3 = 20.8*, P <.001**	
Difference in the ORs of the 3 number-of-PE type measures	**X^2_2 = 20.5*, P = 0.001**		**X^2_2 = 1.3, P = 0.519**		**X^2_2 = 15.6*, P = 0.001**		**X^2_2 = 9.0*, P = 0.011**		**X^2_2 = 16.5*, P < .001**		**X^2_2 = 5.7, P = 0.058**	
Test for linear trend	**X^2_1 = 15.6*, P = 0.001**		**X^2_1 = 0.9, P = 0.349**		**X^2_1 = 9.1*, P = 0.003**		**X^2_1 = 7.4*, P = 0.006**		**X^2_1 = 13.2*, P <.001**		**X^2_1 = 6.6*, P = 0.010**	
PE frequency metric												
> 0.3 episodes	**2.4***	(1.9-3.0)	**4.0***	(2.4-6.5)	**2.3***	(1.7-3.1)	**8.3***	(4.0-17.0)	**2.1***	(1.5-2.8)	**3.2***	(1.2-8.0)

OR, Odds ratio; CI, Confidence interval

[a]PE (any PE, number of PE type, and PE frequency metric) was used as a predictor of STB outcomes in separate discrete-time survival models in those with any lifetime mental disorder. These models control for age-cohorts, gender, person-year dummies and country.

[b]PE (any PE, number of PE type, and PE frequency metric) was used as a predictor of STB outcomes in separate discrete-time survival models in those without any lifetime mental disorder. These models also control for age-cohorts, gender, person-year dummies and country.