external social factors (such as direct-to-consumer advertising) might have had in forming positive medication expectations.

Huneke & Baldwin raise the point that our participants' medication expectations, which predicted placebo response, may have been formed, at least in part, by the consent process and initial exposure to the study environment. Participants consented and had their introduction to study personnel prior to rating their expectations of improvement. Although we do not know to what extent medication expectations might have been influenced by this initial exposure, a significant effect is unlikely. Participants rated the degree to which they expected that treatment in general, and medication in particular, would be helpful in relieving their depression. If participants' initial exposure to the study milieu shaped expectations, it would be expected to influence both medication and general treatment expectations. Yet, only participants' ratings of medication expectations predicted response to placebo. The selective relationship between medication, but not general, treatment expectations and placebo outcome suggests the influence of a process outside of the study milieu.

We agree with Huneke & Baldwin that it would be instructive to learn more about participants' previous experiences with antidepressant treatment and how this might affect current medication expectations, as well as the likelihood of placebo response. In this regard, we recently examined the potential role of prior antidepressant treatment and placebo treatment response in these same participants.[1] Self-report data collected from a subset of participants from the parent study revealed that previous experience with antidepressant medication was significantly associated with poorer response to placebo. Interestingly, among those who had received prior antidepressant treatment, their self-report of response to prior treatment was not significantly related to expectations in the current trial or to placebo outcome. This finding suggests that antidepressant-experienced participants may show classic conditioning effects, consistent with our previously reported findings.[2] The finding that prior antidepressant exposure, regardless of response, predicts placebo outcome is worthy of future study.

1 Hunter AM, Cook IA, Tartter M, Sharma SK, Disse GD, Leuchter AF. Antidepressant treatment history and drug–placebo separation in a placebo-controlled trial in major depressive disorder. *Psychopharmacology (Berl)* 2015; **232**: 3833–40.

2 Hunter AM, Cook IA, Abrams M, Leuchter AF. Neurophysiologic effects of repeated exposure to antidepressant medication: are brain functional changes during antidepressant administration influenced by learning processes? *Med Hypotheses* 2013; **81**: 1004–11.

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Methodological considerations in determining the effects of films with suicidal content

We read carefully the article by Till *et al*,[1] which focuses on a laboratory experiment to determine the effect of films with suicidal content. This important issue has been largely unexplored in terms of research bringing to bear on practice. The study is well conceptualised and the scales and questionnaires used are highly suitable, especially in terms of internal consistency and targeting study population. However, we would still like to highlight a few limitations of the study.

1 The unpredictable nature of suicide in participants with no or low suicidality is of major concern, especially for ethical reasons.

2 Either obtaining a detail clinical history (medical and psychiatric) and mental state examination by mental health professionals or using a screening instrument like the Composite International Diagnostic Interview[2] prior to the laboratory experiment would have helped in ruling out other psychiatric disorders as a part of exclusion criteria and would have served the purpose adequately.

3 The possibility of unreliable responses among participants with ongoing psychotic illnesses like schizophrenia in all the scales cannot be ruled out completely.

4 The Erlanger Depression Scale[3] consists of 9 statements on a printed form with 5 possible answers ranging from 'accurate' to 'not true', and has been wrongly described as having 8 items rated on a scale from 0 (completely wrong) to 4 (exactly right).

5 The Reasons for Living Scale,[4] which has 72 items, has been wrongly described as having 48 items. It is only in the revised scale that 24 out of 72 items were dropped because of ambiguous factor loading.

6 Reason for excluding other subscales of the World Assumptions Scale[5] like 'justice', 'benevolence of people', 'randomness' and 'self-worth' is not mentioned.

7 Other factors like camera positioning,[6] audio quality, lighting, and special effects studied for stimulating cue-induced craving in substance use disorders, have a qualitative role in predicting outcome and not only how the film ends.

1 Till B, Strauss M, Sonneck G, Niederkrotenthaler T. Determining the effects of films with suicidal content: a laboratory experiment. *Br J Psychiatry* 2015; **207**: 72–8.

2 Kessler RC, Ustün TB. The World Mental Health (WMH) Survey Initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *Int J Meth Psychiatr Res* 2004; **13**: 93–121.

3 Lehrl S, Gallwitz A. *Erlanger Depression Scale (EDS)* [in German]. Vless, 1983.

4 Linehan MM, Goodstein JL, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking of killing yourself: the Reasons for Living Inventory. *J Consult Clin Psychol* 1983; **51**: 276–86.

5 Janoff-Bulman R. Assumptive worlds and the stress of traumatic events: applications of the schema construct. *Soc Cogn* 1989; **7**: 113–36.

6 Brody AL, Mandelkern MA, Lee G, Smith E, Sadeghi M, Saxena S, et al. Attenuation of cue-induced cigarette craving and anterior cingulate cortex activation in bupropion-treated smokers: a preliminary study. *Psychiatry Res* 2004; **130**: 269–81.

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Authors' reply: Regarding the questionnaires discussed by Drs Jha & Kumar, we want to clarify some statements regarding some of the measures of our study. As they correctly pointed out, the Erlanger Depression Scale[1] consists of 9 items, but only 8 of these items are used to calculate the score for depression, and the first item of the scale is a 'warm-up' item used for introduction to the scale. Further, the 48-item scale by Linehan and colleagues[2] is commonly referred to as the Reasons for Living Inventory,[3-5] even though earlier versions of this scale may exist.

We agree that factors other than the outcome of the suicidal crisis portrayed in the films (e.g. camera positioning, audio quality, lighting, special effects) might have determined the impact

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of the movies on the audiences, and this was discussed in our paper. Further studies are necessary to determine the effect of movies that do not differ with regard to characteristics other than the crisis outcome.

Regarding the screening process, ethical considerations and the safety of participants are of course a main priority. Therefore, we excluded individuals with high depression or suicidality scores from participation in the study and offered psychological counselling to them and to all participants after the screening, to help them cope with any distress they may have experienced due to exposure to the films or answering questions on suicidality. The screening process was approved by the Ethics Committee of the Medical University of Vienna and the Vienna General Hospital (study protocol 942/2011, date 24/11/2011). Of note, there is no evidence of general harmful effects of answering questions on suicidality among depressed patients[6] or the general population. Obtaining a detailed clinical history or examining the mental state with screening instruments such as the Composite International Diagnostic Interview,[7] as suggested by Jah & Kumar, would have further increased the participants' time spent on completing questionnaires, which may have resulted in negative consequences on participation. It is also important to note that suicidal ideation scores among study participants with baseline suicidality above the median who watched the suicide film were still considerably lower after the film screening than suicidal ideation scores of individuals with a history of suicidal ideation or parasuicide in previous studies (e.g. Linehan *et al*[2]). We also checked for incoherent responses during the screening process in order to identify potentially unreliable responses. There were no contradictory or inconsistent responses in the questionnaires, and there were no indicators of psychotic illnesses among the participants during briefing and debriefing of the study, which were both conducted by a psychologist (B.T.).

1 Lehrl S, Gallwitz A. *Erlanger Depression Scale (EDS)* [in German]. Vless, 1983.

2 Linehan MM, Goodstein JL, Nielsen SL, Chiles JA. Reasons for staying alive when you are thinking of killing yourself: the Reasons for Living Inventory. *J Consult Clin Psychol* 1983; **51**: 276–86.

3 Brown GK. *A Review of Suicide Assessment Measures for Intervention Research with Adults and Older Adults*. National Institute of Mental Health, 2004.

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7 Kessler RC, Ustün TB. The World Mental Health (WMH) Survey Initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *Int J Meth Psychiatr Res* 2004; **13**: 93–121.

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