adverse-life-event-symptom correspondences. As noted by Dr. Levitan, such misattributions seem more likely to occur for amorphous adverse life events, such as the "nothing" adverse life event, than for clearly delineated events with specific onset times (e.g., deaths, romantic breakups, failures, conflicts, scares). Indeed, the "nothing" adverse life event is probably a mixed bag of causes, including both truly endogenous, unperceivable causes (e.g., vascular dysfunction, bioamine dysregulation) and external causes that are difficult to perceive (e.g., changes in the season, diet). Therefore, in agreement with Dr. Levitan, we feel that it is important to remember that participants' causal attributions may have sometimes been incorrect and that this is probably especially the case in dysphoric episodes, for which participants could not determine a cause.

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Dr. Keller's disclosures accompany the original article.

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How "Supportive" Is Internet-Based Supportive Psychotherapy?

TO THE EDITOR: In their article, published in the November 2007 issue of the *Journal*, Brett T. Litz, Ph.D., et al. presented thought-provoking preliminary data on Internet-assisted, cognitive behavioral self-management of posttraumatic stress disorder (PTSD) symptoms (1). In a report that emphasized technology and downplayed human contact, however, it might have been helpful to clarify certain details pertaining to the control intervention. A randomized study is only as credible as its control intervention, which raises conundrums. What exactly is Internet supportive counseling—the control condition—in this trial? Furthermore, how much therapist contact did subjects actually receive?

One imagines that supportive counseling would require affective mirroring and interpersonal warmth. Although the study design included a 2-hour initial meeting between the subject and therapist and allowed "periodic and ad lib study therapist contact via e-mail and telephone" (1, p. 1677), it was not clear how much direct human contact and loving kindness the supportive counseling patients received. Although therapists were "instructed to be empathic and validating" (1, p. 1681), e-mail in particular can obscure affect. The fact that patients read about stress and its management and wrote about "daily nontrauma-related concerns and hassles" (1, p. 1681) does not actually explain how the treatment was supportive. The authors described data on the frequency of Internet sessions but not on the background e-mail and phone contacts. It may have been helpful if they had commented further on how frequent, how long, and how supportive the interpersonal contacts were in each cell.

Training good supportive therapists requires a great deal of work (2). Although the article emphasized the study web site, it omitted any description of the training and prior experience of the therapists involved. Did these same therapists back up both the cognitive and supportive web sites? If so, could this have introduced allegiance bias (3) into the study? Were attempts made to monitor therapist adherence to the respective treatments?

Finally, the authors described their cognitive web site at length, but relatively little about its supportive counterpart was mentioned. What features of the latter make it "supportive"?

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Dr. Litz Replies

TO THE EDITOR: We appreciate Dr. Markowitz's queries pertaining to the role of interpersonal contact in our Internet-based program. He raises a number of questions about our article, which he states "emphasized technology and downplayed human contact." It is important to note that our self-management cognitive behavioral therapy (CBT) *intentionally* reduces the role of human contact with the objective that more people will receive the care they need. The model is germane because many people 1) are reluctant to seek traditional services, 2) live in remote regions where expert care is unavailable, and 3) are unable to access services because the demand exceeds the resources. In an ideal world, there would be no barriers to care, but it is imperative to recognize the sobering reality that most survivors of trauma do not receive evidence-based mental health services (1). Telehealth therapies may be less efficacious because they do not provide intensive human connection and oversight, but there is an unequivocal public health need to overcome barriers to care through alternative methods of therapy delivery.

Dr. Markowitz suggests that a supportive counseling program should provide "interpersonal warmth." Our supportive counseling program followed previous psychotherapy trials by ensuring that it 1) did not contain active CBT skills and 2) involved the same therapist contact time (2). The issue concerning the telephone and e-mail contacts with patients in the respective conditions is an important one, and our analyses indicate that there were no significant differences between patients in the two conditions in terms of the total number or length of phone calls or e-mail messages. It should also be noted that the supportive counseling program resulted in a pre-/posttreatment effect size of 1.1, which is actually larger than most supportive counseling programs offered in traditional therapy formats (3). This suggests that the supportive counseling program was a change agent and provided