Supplementary Table 1: Videoconferencing and internet-delivered treatments for obsessive-compulsive disorder

Ref.	Videoconferencing treatment	Internet-based treatments
High and low-intensity treatments[1-5]	High-intensity VC treatments are similar to in-person ERP/CBT in the amount of clinician contact, the structure of ERP, and the length of the exposure sessions. High-intensity treatments are delivered live and synchronously.	Low-intensity treatments such as clinician-or self-guided ICBT have lower levels of clinical contact than VC-delivered or in-person ERP/CBT. Low-intensity treatments are not delivered synchronously.
Primary purpose of treatment[1-5]	VC-delivered ERP/CBT is designed to be as efficacious as in-person treatment and is meant to increase access for patients from remote locations. While it may save on costs and clinical resources, this is not the primary consideration.	ICBT is primarily used for wider dissemination of evidence-based ERP/CBT. ICBT is also designed to save on clinician resources and costs of treatment.
Evidence-base[3-5, 6, 7]	The evidence for the efficacy of VC treatments is relatively limited and consists of fewer RCTs than ICBT for OCD.	The number of RCTs and meta-analyses on clinician-guided and self-guided ICBT interventions is more than those for VC- delivered ERP/CBT.
Comparison with in-person ERP/CBT[3, 9-11]	VC- delivered ERP/CBT resembles in-person ERP more closely than any other digital intervention. The core ERP components, synchronous interaction, intensity of treatment, and amount of clinician contact are almost the same.	ICBT includes the core ERP components but varies greatly in terms of synchronicity, intensity of treatment, and amount of clinician contact. Clinician-guided ICBT may resemble VC treatments, whereas self-guided treatments are quite different.
Clinician contact[2, 3, 5, 6, 12]	There is usually a strong correlation between the extent of clinical involvement, treatment efficacy, and	The amount of clinician involvement varies from sufficient contact for clinician-guided ICBT to minimal or no

	treatment engagement.VC treatments have the highest amount of therapist contact. However, it is not clear whether this leads to a difference in outcomes between VC and internet-based treatments.	contact in self-guided treatments. Although all treatments are efficacious, clinician-guided ICBT may lead to better outcomes. However, the effect of clinician-guidance may be small.
Efficacy[1, 3, 5 10, 13]	Most of the evidence suggests that both VC and internet-based treatments are equally efficacious. There is some evidence that the effect of VC treatments on symptom-reduction could be larger than ICBT.	There is some evidence that ICBT, particularly self-guided treatments may be less suitable for severe OCD, but this evidence is limited and inconsistent. ICBT is also suitable for those patients who prefer more autonomy and greater involvement in their treatment.
Access to the patient's natural environment[8, 9, 13-15]	Access to the patient's home environment is only possible with VC treatment. Apart from providing an insight about the patient's living conditions, home-based treatment facilitates ERP and may lead to greater generalization of gains to real-life contexts.	Access to the patient's home or other natural environments is not a requirement for ICBT.
Greater family involvement[8, 13, 16]	VC- delivered ERP/CBT allows greater family involvement in the treatment, which can improve its efficacy.	No family involvement in ICBT.
Flexibility and adaptability[8, 13, 17]	VC- delivered ERP/CBT is more and adaptable to a wide range of situations that trigger OC symptoms. It offers greater opportunities to intensify treatment if required. This might improve treatment alliance and	ICBT, particularly self-guided treatments are more rigid and have less capacity to deal with unexpected problems. This may lead to greater dropouts.

	engagement.	
Cost-effectiveness[3, 6, 18-20]	There is some evidence that VC treatment is more cost-effective than in-person CBT, but this has not been examined adequately.	There is more robust evidence that low-intensity treatments such as ICBT including self-guided treatments are cost-saving compared to in-person ERP/CBT.

CBT: Cognitive behavioural therapy; ERP: Exposure and response prevention treatment; ICBT: Internet-based cognitive behavioural therapy; OCD: Obsessive compulsive disorder; RCTs: Randomized-controlled trials; VC: Videoconferencing.

REFERENCES

1. **Lovell K**, Bee P. Optimising treatment resources for OCD: a review of the evidence base for technology-enhanced delivery. *J Ment Health* 2011; **20**: 525-542 [PMID: 22126631 DOI: 10.3109/09638237.2011.608745]
2. **Newman MG**, Szkodny LE, Llera SJ, Przeworski A. A review of technology-assisted self-help and minimal contact therapies for anxiety and depression: is human contact necessary for therapeutic efficacy? *Clin Psychol Rev* 2011; **31**: 89-103 [PMID: 21130939 DOI: 10.1016/j.cpr.2010.09.008]
3. **Wootton BM**. Remote cognitive-behavior therapy for obsessive-compulsive symptoms: A meta-analysis. *Clin Psychol Rev* 2016; **43**: 103-113 [PMID: 26494179 DOI: 10.1016/j.cpr.2015.10.001]
4. **Hoppen LM**, Kuck N, Bürkner PC, Karin E, Wootton BM, Buhlmann U. Low intensity technology-delivered cognitive behavioral therapy for obsessive-compulsive disorder: a meta-analysis. *BMC Psychiatry* 2021; **21**: 322 [PMID: 34193113 DOI: 10.1186/s12888-021-03272-5]
5. **Salazar de Pablo G**, Pascual-Sánchez A, Panchal U, Clark B, Krebs G. Efficacy of remotely-delivered cognitive behavioural therapy for obsessive-compulsive disorder: An updated meta-analysis of randomised controlled trials. *J Affect Disord* 2023; **322**: 289-299 [PMID: 36395988 DOI: 10.1016/j.jad.2022.11.007]

6. **Pearcy CP**, Anderson RA, Egan SJ, Rees CS. A systematic review and meta-analysis of self-help therapeutic interventions for obsessive-compulsive disorder: Is therapeutic contact key to overall improvement? *J Behav Ther Exp Psychiatry* 2016; **51**: 74-83 [PMID: 26794856 DOI: 10.1016/j.jbtep.2015.12.007]
7. **Aboujaoude E**. Three decades of telemedicine in obsessive-compulsive disorder: A review across platforms. *J Obsessive Compuls Relat Disord* 2017; **14**: 65-70 [DOI: 10.1016/J.JOCRD.2017.06.003]
8. **Goetter EM**, Herbert JD, Forman EM, Yuen EK, Gershkovich M, Glassman LH. Delivering exposure and ritual prevention for obsessive–compulsive disorder via videoconference: clinical considerations and recommendations. *J Obsessive Compuls Relat Disord* 2013; **2**: 137–145 [DOI:10.1016/j.jocrd.2013.01.003]
9. **Fernandez E**, Woldgabreal Y, Day A, Pham T, Gleich B, Aboujaoude E. Live psychotherapy by video *vs* in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clin Psychol Psychother* 2021; **28**: 1535-1549 [PMID: 33826190 DOI: 10.1002/cpp.2594]
10. **Matsumoto K**, Hamatani S, Shimizu E. Effectiveness of Videoconference-Delivered Cognitive Behavioral Therapy for Adults With Psychiatric Disorders: Systematic and Meta-Analytic Review. *J Med Internet Res* 2021; **23**: e31293 [PMID: 34898445 DOI: 10.2196/31293]
11. **Rees C**, Anderson R. New approaches to the psychological treatment of obsessive-compulsive disorder in adults. In: Durbano F. New insights into anxiety disorders. New York: InTech Open; 2013: 427-444 [DOI: 10.5772/53070]
12. **Palmqvist B**, Carlbring P, Andersson G. Internet-delivered treatments with or without therapist input: does the therapist factor have implications for efficacy and cost? *Expert Rev Pharmacoecon Outcomes Res* 2007; 7: 291-297. [PMID: 20528315 DOI: 10.1586/14737167.7.3.291]
13. **Brand J**, McKay D. Telehealth approaches to obsessive-compulsive related disorders. *Psychother Res* 2012; **22**: 306-316 PMID: 22292675 DOI: 10.1080/10503307.2011.650655
14. **Castle D**, Feusner J, Laposa JM, Richter PMA, Hossain R, Lusicic A, Drummond LM. Psychotherapies and digital interventions for OCD in adults: What do we know, what do

we need still to explore? *Compr Psychiatry* 2023; **120**: 152357 [PMID: 36410261DOI: 10.1016/j.comppsych.2022.152357]

15. **Kayser RR**, Gershkovich M, Patel S, Simpson HB. Integrating Videoconferencing Into Treatment for Obsessive-Compulsive Disorder: Practical Strategies With Case Examples. *Psychiatr Serv* 2021; 72: 840-844 [PMID: 33765864 DOI: 10.1176/appi.ps.202000558]
16. **Babiano-Espinosa L**, Wolters LH, Weidle B, Op de Beek V, Pedersen SA, Compton S, Skokauskas N. Acceptability, feasibility, and efficacy of Internet cognitive behavioral therapy (iCBT) for pediatric obsessive-compulsive disorder: a systematic review. *Syst Rev* 2019; **8**: 284 [PMID: 31747935 DOI: 10.1186/s13643-019-1166-6]
17. **Herbst N**, Voderholzer U, Stelzer N, Knaevelsrud C, Hertenstein E, Schlegl S, Nissen C, Külz AK. The potential of telemental health applications for obsessive-compulsive disorder. *Clin Psychol Rev* 2012; **32**: 454-466 [PMID: 22705583 DOI: 10.1016/j.cpr.2012.04.005]
18. **Osborne D**, Meyer D, Moulding R, Kyrios M, Bailey E, Nedeljkovic M. Cost-effectiveness of internet-based cognitive behavioural therapy for obsessive-compulsive disorder. *Internet Interv* 2019; **18**: 100277 [PMID: 31890626 DOI: 10.1016/j.invent.2019.100277]
19. **Ferreri F**, Bourla A, Peretti CS, Segawa T, Jaafari N, Mouchabac S. How New Technologies Can Improve Prediction, Assessment, and Intervention in Obsessive-Compulsive Disorder (e-OCD): Review. *JMIR Ment Health* 2019; **6**: e11643 [PMID: 31821153 DOI: 10.2196/11643**]**
20. **Feusner JD**, Farrell NR, Kreyling J, McGrath PB, Rhode A, Faneuff T, Lonsway S, Mohideen R, Jurich JE, Trusky L, Smith SM. Online Video Teletherapy Treatment of Obsessive-Compulsive Disorder Using Exposure and Response Prevention: Clinical Outcomes From a Retrospective Longitudinal Observational Study. *J Med Internet Res* 2022; **24**: e36431 [PMID: 35587365 DOI: 10.2196/36431]

Supplementary Table 2: Videoconferencing-delivered treatment of obsessive-compulsive disorder: a summary of the evidence

Ref.	Study designs	Results
Storch et al., 2011[1]	12-week VC-delivered CBT versus waitlist controls for 31 children/adolescents; 3-month post-treatment follow-up	VC-delivered CBT was superior to waitlist controls in reducing OC symptoms, global improvement, and remission rates. Gains from treatment were maintained for 3 months. Response was obtained in 81% of the patients and 56% remitted.
Stubbings et al., 2013[2]	12 weeks of VC-delivered versus in-person CBT for mood and anxiety disorders including OCD (n=4) for 26 adults	There were no significant differences between VC-delivered and in-person ERP in terms of reduction of symptoms, quality of life, and working alliance.
Vogel et al., 2014[3]	12-week VC-delivered ERP versus self-help ERP or waitlist controls for 30 adults; 3-month post-treatment follow-up	VC- delivered ERP was superior to control treatments in reducing OC but not depressive symptoms. Clinically significant change was seen in 60% of the patients in the VC group. Gains from treatment were maintained for 3 months. Patients were satisfied with the VC treatment and strong working alliances were formed during VC-delivered ERP.
Comer et al., 2017[4]	14-week VC-delivered versus clinic-based family CBT for 22 children; 6-month post-treatment follow-up	There were no significant differences in treatment alliance, attrition rates, clinical response, and family accommodation between VC-delivered and in-person ERP at the end of treatment or at 6 months. Response rate at 6 months was 80% in the VC group.
Hollmann et al., 2022[5]	16-week VC-delivered CBT versus waitlist controls for 60 children/adolescents; 8 months post-treatment follow-up	VC-based CBT was superior to waitlist controls in reducing OC symptoms. Remission was achieved in 68% of the VC group by 8 months.

Open trials/case reports

Baer et al., 1995[6]	VC-based and in-person rating of OC, depressive, and anxiety symptoms for 26 adults	There were no significant differences between the VC and in-person ratings of symptoms.
Himle et al., 2006[7]	12-week VC-delivered CBT for 3 adults; 3-month post-treatment follow-up	The VC treatment led to significant reductions in OC and depressive symptoms, global illness severity, and improvement in working alliance. Gains from treatment were maintained at 3 months for 2 patients.
Vogel et al., 2012[8]	12-week VC-delivered ERP for 6 adults; 3-month post-treatment follow-up	There was a 50% reduction in OC, depressive, and anxiety symptoms and a remission rate of 67% at the end of treatment. The treatment was acceptable and ratings of working alliance were high. Gains from treatment were maintained at 3 months.
Goetter et al., 2013[9]	8-week, 16-session VC-delivered ERP for 1 adult patient	The VC treatment led to reductions in OC and depressive symptoms, and improvement in quality of life were observed at the end of treatment. The patient was satisfied with the treatment and ratings of working alliance were high.
Goetter et al., 2014[10]	16-18-week VC-delivered ERP for 15 adults; 3-month post-treatment follow-up	The VC treatment led to significant reductions in OC symptoms and improvement in quality of life in all 15 patients. At 3 months, 30% had remitted and 80% were significantly improved. The treatment was feasible and acceptable.
Comer et al., 2014[11]	14-week VC-delivered family CBT for 5 children	All patients showed significant reductions in OC symptoms and global illness severity.

		Three patients (60%) remitted. There were no adverse effects with treatment.
Ojserkis et al., 2014[12]	5-day VC-delivered intensive ERP for a child; 3-month post-treatment follow-up	The VC treatment led to significant reductions in OC symptoms and improvement in functioning was observed at 3 months.
Farrell and Milner, 2014[13]	In-person education and massed ERP sessions followed by 3-week VC-delivered maintenance treatment for a child.	The VC treatment led to significant reductions in OC symptoms on completion.
Farrell et al., 2016[14]	In-person education and massed ERP sessions followed by 3-week VC-delivered maintenance treatment for 10 children; 6-month follow-up post-treatment	The VC treatment led to significant reductions in OC, anxiety, depressive symptoms, and global illness severity at completion. Improvement in quality of life was also observed following treatment. Remission rate was 70% by 6 months.
Matsumoto et al., 2018[15]	16-week VC-delivered CBT for 30 adults with mood and anxiety disorders including OCD (n=10)	The VC treatment led to significant reductions in OC, anxiety, and depressive symptoms but no change in quality of life. Patients were satisfied with the treatment and ratings of working alliance were high. Response rate was 20% and remission rate was 40%. One patient (10%) had an adverse event.
Matsumoto et al., 2019[16]	Secondary analysis of the 16-week trial of VC-delivered CBT for 30 adults with mood and anxiety disorders including OCD (n=10)	Treatment alliance (patients' agreement on therapeutic goals and tasks) moderated the improvement following VC-delivered CBT.
Matsumoto et al., 2020[17]	One-year follow-up the 16-week trial of VC-delivered CBT for 25 adults with mood and anxiety disorders including OCD (n=10)	Significant changes in reduction of OC, anxiety, and depressive symptoms were observed at 12 months. Quality of life also improved significantly. The VC treatment was cost-effective.

Kayser et al., 2021[18]	VC-delivered ERP including hybrid care for 7 adults.	The VC treatment with hybrid care led to significant reductions in OC symptoms. Patients were satisfied with the easier access, convenience, the opportunity to have sessions at home, and the support offered.
Babiano-Espinosa et al., 2021[19]	14-week combination treatment of in-person CBT, VC and smartphone app-based ERP (E-CBT) in 25 children; 3 and 6-month follow-up post treatment	64% reduction in OC symptoms post-treatment. Parent and children satisfied with treatment. No dropouts.
Fletcher et al., 2022[20]	6-8-week VC-delivered ERP for 11 adults.	The VC treatment led to significant reductions in OC and posttraumatic stress disorder but not anxiety and depressive symptoms on completion. Dropout rate was 18%. Patients appreciated the benefits of treatment and considered it equivalent to in-person treatment. Therapists had positive attitudes about VC-based CBT, which allowed them to conduct ERP at home.
Babiano-Espinosa et al., 2023[21]	Controlled study of 25 children treated with 14 weeks of E-CBT versus 269 children who received in-person CBT	Decline in symptoms more in the E-CBT group. No differences between E-CBT and in-person CBT in terms of response and remission rates.
Wang et al., 2024[22]	14-week E-CBT in 25 children; 3, 6, and 12-month follow-up post treatment	Significant decline in comorbid mood and anxiety symptoms. Quality of life reduced and family accommodation declined.

Naturalistic studies

Milosevic et al., 2021[23]	Retrospective comparison of 413 adults with anxiety disorders (29 with OCD) treated with 12 weeks of individual and group sessions of VC-delivered or in-person CBT	There were no significant differences between the VC-based and in-person treatments in terms of symptom reduction. Patients in the VC-group had slightly higher attendance rates, but there were no differences in functional improvement and attrition rates.
Feusner et al., 2022[24]	9-week VC-delivered ERP in 3552 adults; 12 months of post-treatment follow-up	The VC-based treatment led to a 43% reduction in OC symptoms. Response rates were 63%. A similar extent of improvement in depressive and anxiety symptoms, and reduction in stress was observed. Quality of life improved. Gains from treatment were maintained for 12 months. The treatment was cost-effective because of savings in the clinician's time.
Pinciotti et al., 2022[25]	Comparison of a group who received in-person ERP (n=239) with a group that received VC-delivered CBT/ERP (n=239)	Both groups had significant improvements in OC and depressive symptoms and there were no significant differences between the two groups in symptom reduction. The VC group required an additional 3 days of treatment. Comorbidity did not affect treatment response.
Wiese et al., 2022[26]	Views of 113 providers on VC-delivered ERP	Providers felt that it was more feasible to deliver VC-based ERP to patients between 13-65 years of age and those with lower symptom-severity. It was felt that VC-based ERP was less likely to detect behaviours that interfered with ERP.
Gittins Stone et al., 2023[27]	Comparison of 4 weeks of group ERP delivered either in-person (n=70) or by VC (n=60) in 130 children and adolescents with OCD and comorbid anxiety	There was improvement in patient- and caregiver-rated anxiety and functional impairment with both treatments. There were no significant differences in symptom reduction and functional improvement

	disorders.	between the two treatment groups at the end of treatment.
Voderholzer et al., 2023[28]	Comparison of two groups of 64 adult inpatients, one of which received inpatient CBT augmented by VC-delivered CBT and the other received only inpatient ERP.	The hybrid group had larger reductions in OCD symptoms compared with the in-person CBT group. Patients in the hybrid group reported satisfaction with various aspects of the VC treatment and had high scores on working alliance.
Hezel et al., 2023[29]	8-12 weeks of VC-delivered ERP for 33 adults	The VC treatment led to significant reductions in OC symptoms. Clinically significant response was noted in 48% patients and the remission rate was 45%. Dropout rate was 6%. The opportunity to conduct sessions at home was considered a major benefit of VC-based ERP.
Kathiravan and Chakrabarti, 2023[30]	12-month prospective, observational study of 43 adult patients receiving VC-delivered ERP in a low-resource setting	The treatment was feasible and acceptable to the patients and their caregivers. There was an 83% reduction in OC symptoms and a response rate of 100% in the 11 patients who had completed ERP. Dropout rate was 6%. Gains from treatment were maintained for 12 months or longer.

1. **Storch EA**, Caporino NE, Morgan JR, Lewin AB, Rojas A, Brauer L, Larson MJ, Murphy TK. Preliminary investigation of web-camera delivered cognitive-behavioral therapy for youth with obsessive-compulsive disorder. *Psychiatry Res* 2011; **189**: 407-412 [PMID: 21684018 DOI: 10.1016/j.psychres.2011.05.047]
2. **Stubbings DR**, Rees CS, Roberts LD, Kane RT. Comparing in-person to videoconference-based cognitive behavioral therapy for mood and anxiety disorders: randomized controlled trial. *J Med Internet Res* 2013; **15**: e258 [PMID: 24252663 DOI: 10.2196/jmir.2564]

3. **Vogel PA**, Solem S, Hagen K, Moen EM, Launes G, Håland ÅT, Hansen B, Himle JA. A pilot randomized controlled trial of videoconference-assisted treatment for obsessive-compulsive disorder. *Behav Res Ther* 2014; **63**: 162-168 [PMID: 25461792 DOI: 10.1016/j.brat.2014.10.007]
4. **Comer JS**, Furr JM, Kerns CE, Miguel E, Coxe S, Elkins RM, Carpenter AL, Cornacchio D, Cooper-Vince CE, DeSerisy M, Chou T, Sanchez AL, Khanna M, Franklin ME, Garcia AM, Freeman JB. Internet-delivered, family-based treatment for early-onset OCD: A pilot randomized trial. *J Consult Clin Psychol* 2017; **85**: 178-186 [PMID: 27869451 DOI: 10.1037/ccp0000155]
5. **Hollmann K**, Hohnecker CS, Haigis A, Alt AK, Kühnhausen J, Pascher A, Wörz U, App R, Lautenbacher H, Renner TJ, Conzelmann A. Internet-based cognitive behavioral therapy in children and adolescents with obsessive-compulsive disorder: A randomized controlled trial. *Front Psychiatry* 2022; **13**: 989550 [PMID: 36329915 DOI: 10.3389/fpsyt.2022.989550]
6. **Baer L**, Cukor P, Jenike MA, Leahy L, O'Laughlen J, Coyle JT. Pilot studies of telemedicine for patients with obsessive-compulsive disorder. *Am J Psychiatry* 1995; 152: 1383-1385 [PMID: 7653700 DOI: 10.1176/ajp.152.9.1383]
7. **Himle JA**, Fischer DJ, Muroff JR, Van Etten ML, Lokers LM, Abelson JL, Hanna GL. Videoconferencing-based cognitive-behavioral therapy for obsessive-compulsive disorder. *Behav Res Ther* 2006; **44**: 1821-1829 [PMID: 16466688 DOI: 10.1016/j.brat.2005.12.010]
8. **Vogel PA**, Launes G, Moen EM, Solem S, Hansen B, Håland AT, Himle JA. Videoconference- and cell phone-based cognitive-behavioral therapy of obsessive-compulsive disorder: a case series. *J Anxiety Disord* 2012; **26**: 158-164 [PMID: 22119331 DOI: 10.1016/j.janxdis.2011.10.009]
9. **Goetter EM**, Herbert JD, Forman EM, Yuen EK, Gershkovich M, Glassman LH. Delivering exposure and ritual prevention for obsessive–compulsive disorder via videoconference: clinical considerations and recommendations. *J Obsessive Compuls Relat Disord* 2013; **2**: 137–145 [DOI:10.1016/j.jocrd.2013.01.003]
10. **Goetter EM**, Herbert JD, Forman EM, Yuen EK, Thomas JG. An open trial of videoconference-mediated exposure and ritual prevention for obsessive-compulsive

disorder. *J Anxiety Disord* 2014; **28**: 460-462 [PMID: 24873883 DOI: 10.1016/j.janxdis.2014.05.004]

11. **Comer JS,** Furr JM, Cooper-Vince CE, Kerns CE, Chan PT, Edson AL, Khanna M, Franklin ME, Garcia AM, Freeman JB. Internet-delivered, family-based treatment for early-onset OCD: a preliminary case series. *J Clin Child Adolesc Psychol* 2014; 43: 74-87 [PMID: 24295036 DOI: 10.1080/15374416.2013.855127]
12. **Ojserkis R**, Morris B, McKay D. Pediatric obsessive-compulsive disorder: an illustration of intensive family-based treatment delivered via web camera. *Clin Case Stud* 2014; **13**: 68–79 [DOI: 10.1177/1534650113504489]
13. **Farrell LJ**, Milliner EL. Intensive cognitive behavioural treatment for obsessive compulsive disorder in children and adolescents. *Psychopathol Rev* 2014; **1**: 182-188 [DOI: 10.5127/pr.034113]
14. **Farrell LJ,** Oar EL, Waters AM, McConnell H, Tiralongo E, Garbharran V, Ollendick T. Brief intensive CBT for pediatric OCD with E-therapy maintenance. *J Anxiety Disord* 2016; **42**: 85-94 [PMID: 27395805 DOI: 10.1016/j.janxdis.2016.06.005]
15. **Matsumoto K**, Sutoh C, Asano K, Seki Y, Urao Y, Yokoo M, Takanashi R, Yoshida T, Tanaka M, Noguchi R, Nagata S, Oshiro K, Numata N, Hirose M, Yoshimura K, Nagai K, Sato Y, Kishimoto T, Nakagawa A, Shimizu E. Internet-Based Cognitive Behavioral Therapy With Real-Time Therapist Support *via* Videoconference for Patients With Obsessive-Compulsive Disorder, Panic Disorder, and Social Anxiety Disorder: Pilot Single-Arm Trial. *J Med Internet Res* 2018; **20**: e12091 [PMID: 30559094 DOI: 10.2196/12091]
16. **Matsumoto K,** Yoshida T, Hamatani S, Sutoh C, Hirano Y, Shimizu E. Prognosis Prediction Using Therapeutic Agreement of Video Conference-Delivered Cognitive Behavioral Therapy: Retrospective Secondary Analysis of a Single-Arm Pilot Trial. *JMIR Ment Health* 2019; **6**: e15747 [PMID: 31730037 DOI: 10.2196/15747]
17. **Matsumoto** K, Hamatani S, Nagai K, Sutoh C, Nakagawa A, Shimizu E. Long-Term Effectiveness and Cost-Effectiveness of Videoconference-Delivered Cognitive Behavioral Therapy for Obsessive-Compulsive Disorder, Panic Disorder, and Social Anxiety Disorder in Japan: One-Year Follow-Up of a Single-Arm Trial. *JMIR Ment Health* 2020; **7**: e17157 [PMID: 32324150 DOI: 10.2196/17157]

18. **Kayser RR**, Gershkovich M, Patel S, Simpson HB. Integrating Videoconferencing Into Treatment for Obsessive-Compulsive Disorder: Practical Strategies With Case Examples. *Psychiatr Serv* 2021; 72: 840-844 [PMID: 33765864 DOI:10.1176/appi.ps.202000558]
19. **Babiano-Espinosa L**, Wolters LH, Weidle B, Compton SN, Lydersen S, Skokauskas N. Acceptability and feasibility of enhanced cognitive behavioral therapy (eCBT) for children and adolescents with obsessive-compulsive disorder. *Child Adolesc Psychiatry Ment Health* 2021; **15**: 47 [PMID: 34481523 DOI: 10.1186/s13034-021-00400-7]
20. **Fletcher TL**, Boykin DM, Helm A, Dawson DB, Ecker AH, Freshour J, Teng E, Lindsay J, Hundt NE. A pilot open trial of video telehealth-delivered exposure and response prevention for obsessive-compulsive disorder in rural Veterans. *Mil Psychol* 2021; 34: 83-90 [PMID: 38536285 DOI:10.1080/08995605.2021.1970983]
21. **Babiano-Espinosa L**, Skarphedinsson G, Weidle B, Wolters LH, Compton S, Ivarsson T, Skokauskas N. eCBT Versus Standard Individual CBT for Paediatric Obsessive-Compulsive Disorder. *Child Psychiatry Hum Dev* 2023; **54**: 1567-1576 [PMID: 35460057 DOI: 10.1007/s10578-022-01350-7]
22. **Wang B**, Skarphedinsson G, Weidle B, Babiano-Espinosa L, Wolters L, Arntzen J, Skokauskas N. Secondary outcomes of enhanced cognitive behavioral therapy (eCBT) for children and adolescents with obsessive-compulsive disorder. *Front Hum Neurosci* 2024; **17**: 1330435 [PMID: 38259330 DOI: 10.3389/fnhum.2023.1330435]
23. **Milosevic I**, Cameron DH, Milanovic M, McCabe RE, Rowa K. Face-to-face versus Video Teleconference Group Cognitive Behavioural Therapy for Anxiety and Related Disorders: A Preliminary Comparison. *Can J Psychiatry* 2022; **67**: 391-402 [PMID: 34159838DOI: 10.1177/07067437211027319]
24. **Feusner JD**, Farrell NR, Kreyling J, McGrath PB, Rhode A, Faneuff T, Lonsway S, Mohideen R, Jurich JE, Trusky L, Smith SM. Online Video Teletherapy Treatment of Obsessive-Compulsive Disorder Using Exposure and Response Prevention: Clinical Outcomes From a Retrospective Longitudinal Observational Study. *J Med Internet Res* 2022; **24**: e36431 [PMID: 35587365 DOI: 10.2196/36431]
25. **Pinciotti CM**, Bulkes NZ, Horvath G, Riemann BC. Efficacy of intensive CBT telehealth for obsessive-compulsive disorder during the COVID-19 pandemic. *J Obsessive Compuls Relat Disord* 2022; **32**: 100705 [PMID: 34956827 DOI:10.1016/j.jocrd.2021.100705]

26. **Wiese AD**, Drummond KN, Fuselier MN, Sheu JC, Liu G, Guzick AG, Goodman WK, Storch EA. Provider perceptions of telehealth and in-person exposure and response prevention for obsessive-compulsive disorder. *Psychiatry Res* 2022; **313**: 114610 [PMID: 35567851 DOI: 10.1016/j.psychres.2022.114610]
27. **Gittins Stone DI**, Elkins RM, Gardner M, Boger K, Sperling J. Examining the Effectiveness of an Intensive Telemental Health Treatment for Pediatric Anxiety and OCD During the COVID-19 Pandemic and Pediatric Mental Health Crisis. *Child Psychiatry Hum Dev* 2024; **55**: 1398-1412 [PMID: 36749490 DOI: 10.1007/s10578-023-01500-5]
28. **Voderholzer U**, Meule A, Koch S, Pfeuffer S, Netter AL, Lehr D, Zisler EM. Effectiveness of One Videoconference-Based Exposure and Response Prevention Session at Home in Adjunction to Inpatient Treatment in Persons With Obsessive-Compulsive Disorder: Nonrandomized Study. *JMIR Ment Health* 2024; **11**: e52790 [PMID: 38477970 DOI: 10.2196/52790]
29. **Hezel DM**, Rapp AM, Glasgow S, Cridland G, Simpson HB. Year of Zoom in a Year of Doom: Lessons Learned Delivering ERP Remotely During the COVID-19 Pandemic. *Cogn Behav Pract* 2023; **30**: 263-272 [PMID: 35228790 DOI: 10.1016/j.cbpra.2021.12.005]
30. **Kathiravan S**, Chakrabarti S. Development of a protocol for videoconferencing-based exposure and response prevention treatment of obsessive-compulsive disorder during the COVID-19 pandemic. *World J Psychiatry* 2023; **13**: 60-74 [PMID: 36925949 DOI: 10.5498/wjp.v13.i2.60]