Appendix: Summary of Articles in the Systematic Literature Review

Citation	Intervention Used	Sample	Sample Size	Effectiveness v. Face-to-Face	Efficiency	Obstacles
Boykin et al. (2019)	CBT: prolonged exposure and cognitive processing therapies	Veterans with PTSD	74	High satisfaction for care over VC. No differences in dropout between VC and F2F.	VC versatile delivery for meeting individual needs, by modulating the number of accompanying F2F sessions. Convenience of location and time for underserved communities. Safe discussing trauma within the home environment.	Greater emphasis on clinical expertise and competence in delivering services over VC than patient criteria. Slow widespread adoption of VC.
Brunnbauer, Simpson, and Balfour (2016)	CBT, schema, and acceptance commitment therapies	Adult psycho-therapy patients	102	Treatment via VC associated with clinical improve-ment.	Online requires less administrative time and resources.	Higher anxiety and dropout with VC therapy. Lower income a predictor of dropout.
Choi et al. (2012)	CBT: problem-solving therapy	Low-in-come home-bound adults with depression aged 50+	121	Both VC and F2F efficacious treatments with sustained results lasting longer for online group.	Low cost and wide availability to Skype VC call and required hardware. More comfort and satisfaction due to the mobility of VC.	Initial discomfort with VC that dissipates when starting the VC sessions.
Choi et al. (2014)	CBT: problem-solving therapy	Low-in-come home-bound adults with depression aged 50+	158	No significant differences between VC and F2F treatment outcomes.	Low equipment and internet transmissions costs. More convenience for homebound adults.	Occasionally experiences low-quality audio/video transmissions.
Clancy and Taylor (2016)	Motivational therapy	Clinicians working in mental health and drug and alcohol services	63	Engagement higher for F2F than online in attendance and completion rate.	--	Lower attendance and engagement in online sessions.
Demiris et al. (2012)	CBT: problem-solving therapy	Hospice caregivers	126	VC therapy is not inferior to F2F. Symptom decrease for both VC and F2F.	Nonverbal communication not inhibited by technology; audiovisual feedback is sufficient. Overcomes geograph-ic barriers. Cost-effective.	Relying on landlines a limitation of analog VC, given the trend toward abandoning landline telephones.
Ebert et al. (2013)	CBT	Inpatients with affective, neurotic and/or behavioral disorders	400	Internet-based group outcomes superior to F2F.	--	Low education and internet literacy known predictors for internet-based intervention outcomes. Reasons for dropout include technical issues, questioned the usefulness, and lack of energy.
Franklin et al. (2017)	CBT: prolonged exposure therapy	Veterans with PTSD	25	A decrease in PTSD symptoms for the online group.	High appeal of VC over iPhone to participants. More contact with participants over time yields lower dropout. Better access for rural areas and the ability to read non-verbal cues over VC.	Higher dropout with VC. Poor cell services when VC using mobile devices. Difficulty finding quiet, undisturbed rooms for VC. TV and computer distractions.
Germain et al. (2010)	CBT	Adults with PTSD	46	Alliance between therapist and patient similar between VC and F2F.	Those not accustomed to technology can successfully receive VC services despite initial discomfort or prejudice. Flexibility to complete sessions by telephone.	Uncertain, critical, and tense therapists undermine relationships with patients. Transmission issues due to power outages or power surges that cause abrupt interruptions. Time lapse in dialogue and poor image quality during VC may interrupt nonverbal communication.

Acronyms used: CBT (cognitive-behavioral therapy); PTSD (post-traumatic stress disorder); VC (virtual conference); F2F (face-to-face); CPAP (continuous positive airway pressure)