Posting of this PDF is not permitted. | For reprints or permissions, contact permissions@psychiatrist.com. | © 2025 Physicians Postgraduate Press, Inc.

Back to the Office: The Room Where It Happens?

John C. Markowitz, MD; Barbara Milrod, MD; Timothy G. Heckman, PhD; Maja Bergman, PhD; Doron Amsalem, MD; and Yuval Neria, PhD

I wanna be in the room where it happens.

—Lin-Manuel Miranda, *Hamilton* (2015)

The 2020 COVID-19 pandemic forced an overnight shift from traditional in-person outpatient practice to teletherapy. The initially untreatable coronavirus killed over 1.2 million Americans.[1] Consequent fear, losses, and social isolation provoked rising depression, anxiety, posttraumatic stress disorder (PTSD), substance use, and need for psychiatric services.[2] Social distancing to avoid contagion required teletherapy,[3] to which patients and therapists quickly adapted. Many clinicians closed their offices to economize.[4] With surprising rapidity, however, the pandemic became treatable, less virulent, endemic. Past social rhythms are resuming. What about office visits?

Our 2020 commentary on remote psychotherapy[5] noted teletherapy was physically safer and more accessible during COVID. Video sessions brought unprecedented glimpses of patients' daily lives. Teletherapy obviated stigma from visiting psychiatric offices. Disadvantages of Zoom included online distractions (eg, beeping email alerts), privacy intrusions (eg, a domestic abuser in the next room), and therapist physical discomfort from protracted screen time in a restricted posture. Moreover, the remove of the screen itself increased difficulty in reading clinical phenomena like dissociation while diminishing therapeutic intensity and immediacy.[5] Physical distance risked emotional distance and avoidance of emotionally charged material. On-screen encounters are simply less engaging than sharing a room. Distance particularly hinders child therapy.[6] Other authors have echoed these concerns.[7–9]

Pundits predict teletherapy is here to stay.[10,11] Insurance reimbursement for teletherapy continues.[12,13] Interstate compacts allow psychologists to treat across many state lines,[14,15] but COVID-era suspension of interstate licensure requirements has ended for psychiatrists, and for all clinicians in states such as New York.

Does teletherapy work? Data remain limited. Biagianti and colleagues reported 84% of 104 COVID-19 patients or family members completed eight-session COVID-19-focused telepsychotherapy, self-reporting symptom improvement ($ds = 0.31–0.54$).[16]

Prepandemic research comparing in-person versus teletherapy had methodological limitations.[5] The sparse subsequent research has exploited the historical accident of COVID-interrupted in-person clinical trials continuing as teletherapy,[17–19] rather than randomizing assignment by format.

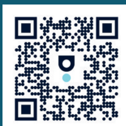
Weintraub et al[17] compared 30 adolescents with mood disorders and/or psychosis risk, treated pre-pandemic in 9 in-person 90-minute cognitive behavioral therapy (CBT) sessions, to 31 treated in COVID-era teletherapy. They found no difference in outcomes or treatment satisfaction, but better teletherapy retention.[17] Davis and colleagues[18] compared two 479-patient university counseling center cohorts pre- and postpandemic, reporting comparable alliances and outcomes. Systematic review of 18 studies indicated no difference in therapeutic alliance between formats.[20]

Swartz and colleagues[19] conducted a randomized eight-session trial comparing interpersonal psychotherapy (IPT) and CBT for major depression, treating 49 patients (25 IPT, 24 CBT) pre-COVID in-person, then 28 (17 IPT, 11 CBT) post-COVID remotely. Therapies and formats had comparable working alliance and symptomatic improvement, albeit teletherapy samples were small. Attrition was higher in-person.[19]

Thus scattered recent trials have yielded equivalent outcomes but have lacked randomization between in-person and remote formats and statistical power to detect small differences. Teletherapy evidently benefits many patients, possibly with lower attrition than face-to-face. Its trade-offs lack systematic evaluation.[5] Efficacy relative to in-person treatment, and for which patients, remains unclear.

Even assuming that teletherapy remains an important treatment option, the fate of in-person treatment is a public health issue meriting attention. It deserves input from both practitioners and patients, who in this

Scan Now



Cite and Share this article at Psychiatrist.com

Editor's Note

We encourage authors to submit papers for consideration as part of our Focus on Psychotherapy section. Please contact John C. Markowitz, MD, at psychiatrist.com/contact/markowitz, or Rachel C. Vanderkruik, PhD, at psychiatrist.com/contact/vanderkruik.

instance can literally vote with their feet. Whereas COVID presented Hobson's choice—teletherapy or no treatment—clinicians now for the first time can choose between modalities.

Established facts about current psychotherapy office practice are few. Absent hard data, and because therapy participant preferences influence practice, opinions matter. Patient preference can affect treatment outcome[21–25]; therapist preference effect is less understood.[26] Our 2020 team[5] recently surveyed clinicians online about their practices. We predicted varying opinions, but that many practitioners and patients would welcome at least partial in-person resumption.

Methods

In October 2024, we posted a 10-item email survey (available on request) for clinicians on professional listservs. Columbia University and University of Georgia institutional review boards approved the protocol as exempt research. We posted on accessible professional/academic listservs: the Columbia University and Cornell University departments of psychiatry, American Psychiatric Association Psychotherapy Caucus, American Psychoanalytic Association, Anxiety and Depression Association of America, and International Society of Interpersonal Psychotherapy.

Encouraging elaboration, we asked participants to describe their current practice and perceptions of in-person and remote therapies, including relative patient avoidance and therapist discernment of dissociation. Participation was voluntary and uncompensated. Participation implied consent. We did not ascertain respondent demographics or training. Study authors did not complete surveys themselves.

Results

In our own practices, some patients requested resuming office visits as soon as feasible, stating they felt more involved, sessions were more productive, even that we seemed more attentive in-person. Others, citing convenience, preferred ongoing teletherapy. As therapists, we favored in-person but acknowledged teletherapy convenience.

We received 45 survey responses, most apparently from the New York area. Some therapists reported never having left their offices; others had abandoned them. Thirty-two (71%) reported mostly office practice with a mix of in-person and remote sessions, the latter generally predominating. Eight (18%) worked largely remotely and 5 (11%) fully remotely.

In estimating their in-person treatment, 14 (32%) reported ≤10% in-person, 13 (30%) 11%–49%, 8 (18%) 50%–79%, and 9 (20%) 80%–100% in-person practices. Virtual sessions thus predominated. All but 4 (9%) respondents reported some virtual sessions. Leading explanations for in-person sessions were greater connection (n = 19), privacy (n = 3), and needing to see children and adolescents in-person (n = 4). For remote treatment, the modal rationale was convenience (n = 28), although one respondent decried the "profession hav[ing] chosen the comfort of our pajamas over what is best for our patients." Six therapists had geographically relocated during COVID. Six saw patients only online or only in-person. One neatly summarized: "Remote is convenient, but those returning to in-person find it much better and [more] gratifying."

Most responding therapists were flexible, recommending in-person but letting patients choose ("…unless I feel something is being lost online," wrote one), sometimes alternating formats. Reading bodily cues was easier in-person. Ten clinicians let patients choose format. Seven dictated their preference, with 2 asserting that severe patient psychopathology required in-person visits, and 3 that children did. Four clinicians required initial in-person visits for new patients.

The authors had anticipated that most therapists would feel more involved in-person. They generally did. Nearly half endorsed in-person treatment as "more real," "deeper," "more intimate," "better data." Several found teletherapy more intellectualized. One reported a patient cried often in-person, but never during COVID-era tele-sessions. (One author had similar experience.) A third of respondents saw no difference. One found teletherapy screen close-ups "more vivid."

Clinicians favored in-person for new, sicker, and technologically challenged patients and for presenting fewer distractions. (None mentioned domestic violence, an important consideration.) Remote advantages included observing the patient's environment, better attendance, therapist ease (shoeless attire), easier chart access, but greater difficulty in remaining silent.

The authors had predicted that clinicians would report greater in-person engagement. Indeed, 58% concurred; 40% felt equally, if differently, engaged in each format; and 4% felt less engaged in-person. Two noted remote patient engagement required greater concentration and focus.

The authors, who are PTSD researchers, perceive greater avoidance in remote sessions. Respondents did not entirely agree. Nineteen saw no difference by format; 14 less avoidance in-person (one wrote, "less avoidance, but more nuanced avoidance"); and 5 greater avoidance—as patients canceled more in-person sessions. Four considered avoidance patient- rather than format-dependent. Similarly, we find assessing dissociation and other symptoms easier in-person. Eighteen respondents agreed, 2 found screen close-ups more revealing, 20 reported no difference. Six deemed dissociation rare in their practices.

The authors consider in-person treatment more engaging, hence likely to progress faster. Most respondents (n = 26), however, reported no difference; 13 reported in-person

Posting of this PDF is not permitted. | For reprints or permissions, contact permissions@psychiatrist.com. | © 2025 Physicians Postgraduate Press, Inc.

treatment moved faster, 2 slower, and 3 considered it patient-dependent.

Overall, 52% of respondents preferred in-person treatment. Sixteen percent preferred teletherapy, citing lifestyle, access, and convenience, yet generally sought some balance: "I would feel bereft and totally weird if I did not preserve the in-person option." Twenty-seven percent endorsed hybrid practice or had no preference.

Discussion

Surveyed therapists favored in-person therapy but conducted predominantly teletherapy. Remote therapy appears here to stay, yet most therapists still appreciate a typically deeper connection in-person. Some noted better teletherapy attendance. Poll results thus largely corroborated our 2020 assertions about remote therapy.[5]

The survey findings clearly warrant caution as a small, nonrepresentative, anonymous, New York–centric convenience sample drawn from potentially thousands of listserv members. We elicited subjective therapist impressions but could not sample patient views. The survey questions themselves had limitations: in seeking simplicity, we courted ambiguity. We assumed "remote" connoted video, yet 5 respondents mentioned telephone sessions. We did not differentiate among psychotherapy, pharmacotherapy, and combined treatments. Among many unanswered questions is whether more avoidant patients tend to seek remote therapy.

These loose, limited findings nevertheless have value in a data-poor field. They may shed some dim light on current outpatient practice, about which much remains unknown. Study findings hint that remote therapy remains widespread,[11] the modal treatment format. Nonetheless, many therapists prefer in-person therapy, believing it imbues a different feel and greater intimacy. Further research is needed.

What will the future bring? Social memory is short, and this is a time of upheaval. There is a danger that in-person therapy may not recover from the COVID-driven push to remote treatment. In our opinion, that would be a shame, costing future generations the experience of in-person treatment, which offers a level of closer interpersonal intimacy in therapy and is an option important to preserve.

Article Information

Published Online: March 3, 2025.
https://doi.org/10.4088/JCP.24com15710

© 2025 Physicians Postgraduate Press, Inc.

J Clin Psychiatry 2025;86(2):24com15710

Submitted: November 13, 2024; accepted January 23, 2025.

To Cite: Markowitz JC, Milrod B, Heckman T, et al. Back to the office: the room where it happens? *J Clin Psychiatry.* 2025;86(2):24com15710.

Author Affiliations: Department of Psychiatry, Columbia University Vagelos College of Physicians & Surgeons, New York, New York (Markowitz, Bergman, Amsalem, Neria); New York State Psychiatric Institute, New York, New York (Markowitz, Bergman, Amsalem, Neria); Department of Psychiatry, Albert Einstein College of Medicine, New York, New York (Milrod); College of Public Health, University of Georgia, Athens, Georgia (Heckman).

Corresponding Author: John C. Markowitz, MD, New York State Psychiatric Institute, 1051 Riverside Dr, Unit #129, New York, NY 10032 (jcm42@cumc.columbia.edu).

Relevant Financial Relationships: The authors report no potential conflicts of interest or relevant financial relationships. **Dr Markowitz** receives salary support from the New York State Psychiatric Institute; grant support from National Institute of Mental Health, Department of Defense, and Shalvata Mental Health Center; and minor book royalties from American Psychiatric Publishing, Basic Books/Perseus, and Oxford University Press. **Dr Milrod** receives grant support from the American Psychoanalytic Association Fund for Psychoanalytic Research, Einstein-Rockefeller-CUNY CFAR grant P30 AI124414, and the support of Jonathan Alpert, M.D., Ph.D., University Chair, Department of Psychiatry, Albert Einstein College of Medicine. **Dr Heckman** reports support from the Health Resources and Services Administration and the Department of Education. **Dr Amsalem** reports support from the Research Foundation for Mental Health and Columbia Psychiatry. **Dr Bergman** receives support from the David Lynch and Acorn Hill Foundations. **Dr Neria** reports support from the National Institute on Aging, Shalvata Mental Health Center, United States-Israel Binational Science Foundation, Acorn Hill Foundation, and New York City Council.

Funding/Support: None.

References

1. Centers for Disease Control and Prevention. Trends in United States COVID-19 Deaths, Emergency Department (ED) Visits, and Test Positivity by Geographic Area. Accessed May 4, 2024. https://covid.cdc.gov/covid-data-tracker/#trends_totaldeaths_select_00
2. Markowitz JC. *In the Aftermath of the Pandemic: Interpersonal Psychotherapy for Anxiety, Depression, and PTSD*. Oxford University Press; 2021.
3. Molla R. The pandemic was great for Zoom. What happens when there's a vaccine? *Vox*. December 4, 2020. Accessed May 4, 2024. https://www.vox.com/recode/21726260/zoom-microsoft-teams-video-conferencing-post-pandemic-coronavirus
4. Quinlan A. Manhattan is awash in empty therapist offices. Curbed. 2023. Accessed May 18, 2024. https://www.curbed.com/2023/04/post-pandemic-market-therapist-offices.html
5. Markowitz JC, Milrod B, Heckman TG, et al. Psychotherapy at a distance. *Am J Psychiatry*. 2021; 178(3):240–246.
6. Erlandsson A, Forsström D, Rozental A, et al. Accessibility at what price? therapists' experiences of remote psychotherapy with children and adolescents during the COVID-19 pandemic. *J Infant Child Adolesc Psychotherapy*. 2022;21(4):293–308.
7. Benzel S, Graneist A. "Bye, click, and gone"—a qualitative study about the experiences of psychotherapists and adolescent patients on remote treatment during the COVID-19 pandemic. *Psychoanal Psychol*. 2023;40(3):190–198.
8. Ruble AE, Romanowicz M, Bhatt-Mackin S, et al. Teaching the fundamentals of remote psychotherapy to psychiatry residents in the COVID-19 pandemic. *Acad Psychiatry*. 2021;45(5):629–635.
9. Lin T, Stone SJ, Anderson T. A head start in the long race: therapists are learning to adapt their therapeutic skills within teletherapy. *Prof Psychol Res Pract*. 2024;55(3):219–228.
10. Swartz HA. Telepsychotherapy: the new normal. *Am J Psychother*. 2021;74(1):2–3.
11. Perman J. Virtual psychiatry is here to stay. *Psychiatric Times*. Published; 2022. https://www.psychiatrictimes.com/view/virtual-psychiatry-is-here-to-stay
12. Telehealth.hhs.gov. Telehealth for Behavioral Health Care. Accessed January 25, 2025. https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-behavioral-health/billing-for-telebehavioral-health
13. NYS Department of Health. New York State Department of Health announces Medicaid telehealth coverage extended beyond COVID-19 public health emergency. Accessed January 25, 2025. https://www.health.ny.gov/press/releases/2023/2023-07-31_medicaid_telehealth_coverage.htm
14. PSYPACT. Advancing the Interjurisdictional Practice of Psychology. Accessed January 25, 2025. https://psypact.org/
15. American Counseling Association. Counseling Compact. Accessed January 25, 2025. https://www.counseling.org/advocacy/counseling-compact
16. Biagianti B, Lisi I, Di Liberto A, et al. Feasibility and preliminary efficacy of brief tele-psychotherapy for COVID-19 patients and their first-degree relatives. *J Affect Disord*. 2023;330:300–308.
17. Weintraub MJ, Ichinose MC, Zinberg JL, et al. In-person versus remote CBT groups during COVID-19 for adolescents with mood disorders or psychosis-risk syndromes. *J Affect Disord*. 2023;341:346–348.
18. Davis KA, Zhao F, Janis RA, et al. Therapeutic alliance and clinical outcomes in teletherapy and in-person psychotherapy: a noninferiority study during the COVID-19 pandemic. *Psychother Res*. 2024;34(5): 589–600.
19. Swartz HA, Bylsma LM, Fournier JC, et al. Randomized trial of brief interpersonal psychotherapy and cognitive behavioral therapy for depression delivered both in-person and by telehealth. *J Affect Disord*. 2023;333:543–552.
20. Seuling PD, Fendel JC, Spille L, et al. Therapeutic alliance in videoconferencing psychotherapy compared to psychotherapy in person: a systematic review and meta-analysis. *J Telemed Telecare*. 2024; 30(10):1521–1531.

Posting of this PDF is not permitted. | For reprints or permissions, contact permissions@psychiatrist.com. | © 2025 Physicians Postgraduate Press, Inc.

21. Kocsis JH, Leon AC, Markowitz JC, et al. Patient preference as a moderator of outcome for chronic forms of major depressive disorder treated with nefazodone, cognitive behavioral analysis system of psychotherapy, or their combination. *J Clin Psychiatry*. 2009;70(3):354–361.
22. Markowitz JC, Meehan KB, Petkova E, et al. Treatment preferences of psychotherapy patients with chronic PTSD. *J Clin Psychiatry*. 2016;77(3):363–370.
23. Kwan BM, Dimidjian S, Rizvi SL. Treatment preference, engagement, and clinical improvement in pharmacotherapy versus psychotherapy for depression. *Behav Res Ther*. 2010;48(8):799–804.
24. Markowitz JC, Hellerstein DJ, Falabella G, et al. Psychopharmaphobia: elevated fear of antidepressant medication among patients with major depression and breast cancer. *Gen Hosp Psychiatry*. 2023;83:117–122.
25. Swift JK, Callahan JL, Cooper M, et al. The impact of accommodating client preference in psychotherapy: a meta-analysis. *J Clin Psychol*. 2018;74(11): 1924–1937.
26. Falkenström F, Markowitz JC, Jonker H, et al. Can psychotherapists function as their own controls? meta-analysis of the crossed therapist design in comparative psychotherapy trials. *J Clin Psychiatry*. 2013;74(5):482–491.

Posting of this PDF is not permitted. | For reprints or permissions, contact permissions@psychiatrist.com. | © 2025 Physicians Postgraduate Press, Inc.