



## Correction to: Rapid, Full-Scale Change to Virtual PCIT During the COVID-19 Pandemic: Implementation and Clinical Implications

Dainelys Garcia<sup>1</sup> · Angela M. Blizzard<sup>1</sup> · Abigail Peskin<sup>1</sup> · W. Andrew Rothenberg<sup>1,2</sup> · Ellyn Schmidt<sup>1</sup> · Jennifer Piscitello<sup>1</sup> · Natalie Espinosa<sup>1</sup> · Hanan Salem<sup>1</sup> · Gabriela M. Rodriguez<sup>3</sup> · Jamie A. Sherman<sup>1</sup> · Meaghan V. Parlade<sup>1</sup> · Alexis L. Landa<sup>1</sup> · Eileen M. Davis<sup>1</sup> · Allison Weinstein<sup>1</sup> · Angela Garcia<sup>1</sup> · Camille Perez<sup>1</sup> · Jessica M. Rivera<sup>1</sup> · Chary Martinez<sup>1</sup> · Jason F. Jent<sup>1</sup>

Published online: 1 April 2021

© Society for Prevention Research 2021

### Correction to: Prevention Science

<https://doi.org/10.1007/s11121-021-01211-0>

The original version of this article unfortunately contained mistakes. Tables 1 and 2 were inadvertently interchanged. Table 1 should be changed to Table 2 and vice versa in order to coincide with the descriptions in the text body. Several occurrences of Table 2 citations should be changed to Table 1 as well.

The citation changes and correct tables are presented below:

- Under "Evaluating PCIT Efficacy" section [first paragraph], the sentence "Paired-sample *t* tests revealed that during-COVID-19 measures demonstrated significant improvement compared with pre-COVID-19 measures on all child and caregiver outcomes (Table 2)." should be updated to "Paired-sample *t* tests revealed that during-COVID-19 measures demonstrated significant improve-

ment compared with pre-COVID-19 measures on all child and caregiver outcomes (Table 1)."

- Under "Evaluating PCIT Efficacy" section [second paragraph], the sentence "The effect sizes of all child and caregiver outcomes were medium-to-large (see Hedges' *g* section of Table 2; Cohen, 1988)." should be updated to "The effect sizes of all child and caregiver outcomes were medium-to-large (see Hedges' *g* section of Table 1; Cohen, 1988)."
- Under "Discussion" section [second paragraph], the sentence "Findings revealed that children demonstrated large reduction in caregiver-reported disruptive behaviors (Table 2)." should be updated to "Findings revealed that children demonstrated large reduction in caregiver-reported disruptive behaviors (Table 1)."

The original article has been corrected.

---

The original article can be found online at <https://doi.org/10.1007/s11121-021-01211-0>.

---

✉ Dainelys Garcia  
[ngarcia09@med.miami.edu](mailto:ngarcia09@med.miami.edu)

<sup>1</sup> Mailman Center for Child Development, University of Miami Miller School of Medicine, Miami 33137, USA

<sup>2</sup> Duke University Center for Child and Family Policy, Coral Gables 33146, USA

<sup>3</sup> Department of Psychiatry, Indiana University School of Medicine, Indianapolis 46202, USA

**Table 1** Dependent variable and covariate descriptive statistics and pre-COVID-19/during-COVID-19 comparisons

	Pre-COVID-19		During-COVID-19	
	<i>M</i> (SD)		<i>M</i> (SD)	Hedges' <i>g</i>
Dependent variables: treatment outcomes and parent skills				
ECBI intensity score	146.57** (30.14)		111.79** (35.37)	1.05
BASC-3 internalizing <i>T</i> score	58.60** (11.91)		53.95** (11.19)	0.40
PSI-4 parent stress percentile	68.65** (18.33)		51.78** (27.09)	0.72
Do skills (total number)	4.79** (5.13)		23.38** (12.47)	−1.93
Don't skills (total number)	31.68** (18.39)		7.69** (7.44)	1.69
Effective command rate (%)	18.76** (15.67)		68.08** (25.86)	−2.25
Follow-through rate (%)	0.77** (3.63)		64.18** (34.39)	−2.56
Compliance rate (%)	47.81** (42.34)		85.48** (22.18)	−1.09
Covariates				
Child gender (% male)	74.42		N/A	
Child age	4.75		1.62	
Child race	79% White; 10.47% multiracial; 5.81% Black; 3.49% other, 1.16% native American			
Child ethnicity	70.93% Hispanic/Latinx; 29.07% Non-Hispanic/Latinx			
Parent gender (% male)	17.44		N/A	
Parent race	81.40% White; 9.30% multiracial; 5.81% Black; 2.33% other, 1.16% Native American			
Parent ethnicity	70.93% Hispanic/Latinx; 29.07% Non-Hispanic/Latinx			
Parent education	6.98% HS diploma; 12.79% some college; 15.12% associates degree; 22.09% bachelor's degree; 43.02% advanced degree			
No. of treatment weeks	13.07		5.95	
No. of treatment sessions	11.80		4.62	
Pre-COVID-19 sessions	5.21		5.22	
During-COVID-19 sessions	6.59		2.41	

\*\* $p < 0.01$  in paired-sample  $t$  test comparing pre- and during-COVID-19 scores. Hedges'  $g$ , also known as the corrected effect size, is an effect size measure wherein values of  $< 0.2$  indicate a small effect, values of approximately 0.5 indicate a medium effect and values  $> 0.8$  indicate a large effect. In covariates section mean is listed in first column and standard deviation in second column unless %s are reported, then %s are reported in only 1 column

**Table 2** Describing and characterizing virtual implementation strategies

Independent variables: virtual implementation strategies			
Name of support	% of families whose therapist participated	Description	Created internally or externally?
Strategy 1: web conference trainings from outside agencies	43.02%	Webinars and recorded trainings released by psychologists in the American Psychological Association (APA), Division 53, PCIT International, etc. Content varied from trainings specific to PCIT, to more general discussions of how to conduct virtual services successfully, including how to establish rapport and maintain privacy virtually	External
Strategy 2: recorded trainings developed by PCIT team	56.98%	The team shared recorded trainings created previously internally for conferences and training new therapists in I-PCIT	Internal
Strategy 3: one-on-one consultation	73.26%	Four therapists on the team who had previously conducted I-PCIT created a schedule of available “office hours” (approximately 10 h per therapist) each week for on-call consultation. Consultants helped therapists troubleshoot with families about both clinical and technological difficulties until therapists felt comfortable leading the troubleshooting on their own. After 1 month, this was discontinued, as therapists expressed confidence working through pitfalls on their own	Internal
Strategy 4: skills practice	41.86%	Therapists were given the opportunity to practice specific scenarios in a role-play with another therapist before needing to coach a client through the same scenario. Scenarios included unique difficulties that would occur in a virtual setting, including the parent having difficulty hearing the clinician, the call dropping unexpectedly, the child leaving the room, etc	Internal
Strategy 5: shadowing cases	1.16%	Therapists new to virtual services shadowed the cases of experienced clinicians to observe the strategies they used to successfully complete PCIT virtually	Internal
Strategy 6: reviewing cases	26.74%	Videos of previous cases who received services virtually were available for therapists to review	Internal
Strategy 7: FAQ document	70.93%	As therapists reported the technological difficulties they encountered, consultants (the three clinic therapists with more than 5 h of prior training in virtual service delivery) recorded these problems and the corresponding solutions on a Google document accessible to the rest of the team	Internal
Strategy 8: online community of practice	80.23%	The clinic’s therapists met as a group to discuss common challenges encountered during I-PCIT, as well as ways to increase the strength of virtual PCIT. This group met weekly at the beginning of the stay-at-home order, and then biweekly. All trainees were encouraged to participate, both in the reporting of difficult therapeutic scenarios and in the generation of potential strategies for addressing the situations	Internal
Strategy 9: live observation and feedback	37.20%	For particularly difficult cases, or challenging sessions, therapists could request that a supervisor or I-PCIT consultant shadow them, joining them for the session	Internal
Strategy 10: virtual training materials (I-PCIT Guide)	69.77%	I-PCIT-experienced therapists on this team compiled and distributed a 53-page manual for transitioning PCIT successfully to virtual services	Internal

**Table 2** (continued)

Independent variables: virtual implementation strategies

Name of support	% of families whose therapist participated	Description	Created internally or externally?
Strategy 11: in-session co-therapist support	31.40%	This clinic utilizes a co-therapy model to train new clinicians in PCIT. During the transition to I-PCIT, clinicians used this co-therapy structure to scaffold the training of new clinicians to become comfortable with I-PCIT as well	Internal

**Publisher's Note** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.