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**Jimmy Widdifield, Jr.:**

Hello, and welcome everyone. My name is Jimmy Widdifield Jr., licensed professional counselor in the state of Oklahoma and the lucky person who gets to do this podcast with such amazing people across the United States. I am super excited today to talk to Paula Condol. I’ll let Paula introduce herself here in a second. I met Paula a number of years ago. Her organization was a grantee and I got to spend some time doing some training. And then from that, went back to where Paula’s at to do some additional work in that community with a friend, colleague and mentor of mine, Barbara Bonner. That was an interesting trip traveling with Barbara, but more so getting to spend some time with Paula and her team. Great! Let's get started. Paula, welcome, glad to have you.

**Paula Condol:**

Thank you.

**Jimmy Widdifield, Jr.:**

So just give us a quick introduction, a little bit about who you are and where you're at. Just what you're comfortable sharing.

**Paula Condol:**

So, like Jimmy said, my name is Paula Condol. I’m a licensed professional clinical counselor. I have been the executive director of a Children's Advocacy Center in Bismarck North Dakota for 22 years now. I’m a clinician by trade, so I do also see some clients, but my main role is to run and maintain the center.

**Jimmy Widdifield, Jr.:**

Bismarck is a beautiful place. It's just like no other in the country. You've got the part of the country that I often hear referred to as the frontier. And it's a very rural state. So just quickly as you can, what does it mean to be a frontier state or to be as rural as North Dakota can be?

**Paula Condol:**

North Dakota is a very large state and so there's lots of land mass, but there's not a lot of people. We have many counties who have less than 2,000 people or even sometimes less than 5000 people. We’ll work with counties where there's only a child abuse report once every three years, like *a* child abuse report. And then of course there's other larger counties, and I say larger kind of with air quotes because our largest city in the state is about 120,000 people. Our whole state is about 700,000 people and so I think we only have three cities in the state that actually top 60,000 people. Our smaller communities are very small. They're very rural. They don't have a lot of resources. It takes a lot of time to travel to them, so, on one hand they might be use to driving a half hour to an hour, sometimes even longer just to get groceries on a regular basis or gas. But at the same time, they still have all the same mental health needs that the larger counties have. I always say that if a kid is in need of mental services or they've been abused or they are in crisis some way, that they deserve to have the same access as somebody who lives right down the street from our center, and we have to figure out how to make that happen in our state.

**Jimmy Widdifield, Jr.:**

I really appreciate there are a number of places throughout the United States and, particularly, I think, places like Alaska that just have expansive rural everything. And something you said there toward the end, I mean, those families deserve to be able to get the same access and quality of services. When it comes to children with problematic sexual behavior, we already know there is really a dearth of resources for these kids nationally. And when it comes to rural areas even more so, and that's why I’m super excited to talk with you today because I think your program has figured some things out. Help us understand how did you get into this field of working with children with problematic sexual behavior, the recipient or child victims and their families?

**Paula Condol:**

I don't know if my story is that different than most people. I don't think a lot of people are like, this is the field I want to go into, and they seek this out. It really came about in a sideways way because we were a children's advocacy center (CAC) and we were serving and we still do, obviously, serve kids who have been abused and neglected. And throughout the years people would be referred to us where they were a youth or a child who had touched another child. There's still that myth out there that if you are touching another child, you must have been abused. And so, law enforcement, social services would refer those cases to us as victims, and so maybe a 10-year-old would come through and they'd be the identified offender and also an identified victim without really any background story or proof that they were a victim other than that they had touched somebody. And so, they would be sent for a forensic interview, and a lot of times the child wouldn't disclose anything. But we knew these kids needed help and we researched, we called around all over the state, I googled things. I could not find people in this state that had training and evidence-based practices for working with kids who had problematic sexual behaviors. And so, then we started to try to just see them at the CAC using TF-CBT or trauma-focused cognitive behavioral therapy. And my therapists would regularly come to me as a supervisor and say, this isn't working, I feel like I’m missing something, I feel like I’m not being effective, there has to be a better answer. Like we can't just serve kids to serve kids. We want to serve them to help them and get them better. And so, we started researching again where could we get training or where could we - to be honest, my initial thought was where can I find training and convince another local agency in the community to take that. I even called some agencies and said I’ll write the grant for you and send and pay for your staff to go get training, so we have places to send these kids. And I ended up talking to Toni Cavanagh Johnson. We had some of her resources and said, what do we do, or where do we find training to do some of this stuff? And she had referred me to Barbara Bonner. I reached out to Barbara and started to talk to Jane Silovsky, and they said they were working on some trainings coming up and to keep my ear out and that they’d keep me in mind and that they were going to be at the National Children's Alliance Leadership Conference and having a session if I wanted to attend. So, I attended the session. I went up and visited with them and, shortly after that they released the request for proposals (RFP). We couldn't really get anyone else to take us up on the offer of I’ll write the grant and you can come to the training and so my staff really pushed me., It was them who said, we need to do this training. If we're going to see these kids, we have to make sure they're getting the best services possible. And so, we applied to the pilot project and were awarded a grant I think back in 2005 – no 2015 I mean.

**Jimmy Widdifield, Jr.:**

Well, thank you for sharing that. I was taking some notes here on the side and you just said so many things that I want to go back and unpack, but I know we only have a finite number of minutes together today. But one of the key things that I think you said is acknowledging there are clinicians who see a clear need to serve these kids using whatever they have available -- like Trauma-Focused Cognitive Behavioral Therapy, which we know can be, is just as effective at reducing PSB in children as a Problematic Sexual Behavior Cognitive Behavioral Therapy. But TF-CBT is for kids who have a trauma. They're in treatment for trauma symptoms, and the PSB is typically secondary to that. And so, clinicians want training and then trying to find it. Something else, you said, I thought, really sticks out is you said that you were willing to write a grant for other agencies to take this on. And that gets at, I think, people are trying to sort out who are the best organizations to do this work. It sounds like you were just casting a wide net like, we can do it. I can do it for you, and you can do it, and we can link with you. And I think that's a smart idea, because sometimes it just means reaching out to figure who really can step up to the plate, who can really help with this, because it takes the whole community. I’m also going to name drop. Toni Cavanagh Johnson is a retired clinician in the field who is very well known, has published on, then we were saying “sexual behavior problems,” and was one of really the first people in the field. And then, of course, Barbara Bonner also a retired clinical psychologist. And then, Jane Silovsky, also a clinical child psychologist. I consider Jane to be the expert in problematic sexual behavior of children. If we only had more time to unpack more. Because I think too about going to NCA Leadership or going to conferences and reaching out and like, how do we get training, what's available. It really is just about kind of pounding the pavement, isn't it?

**Paula Condol:**

Yeah, I think when I try to share advice with other people, especially new people, that's one of the things I tell them because people will say, how do you guys in North Dakota, how are you trained in all these evidence-based practices? Or how did you get on the forefront of some of this? And my simple answer really is I don't know Toni Cavanagh Johnson. I googled her name, and I found her email and her phone number, and I called her. I think that's the wonderful thing in this field is that most people are very relatable and they're willing to talk to you, they want to help. And so, they're willing to take your phone call or answer email or push you in the right direction. Sometimes it's just as simple as just trying to reach out and finding these people and asking questions to get those answers.

**Jimmy Widdifield, Jr.:**

And Paula Condol’s phone number is … no, I totally agree with you. So, you got out, you connected to people, and you were a grant recipient. Tell us a little bit about your PSB program for children and the role of the children's advocacy center and the multidisciplinary team.

**Paula Condol:**

So, like I said, we've been doing PSB for school aged kids since 2015. We wrote and got accepted into this pilot project and we started providing services. Back then we typically used the group model. We also sometimes see kids using the family individual model, but most of the kids that come through our program are through the group model. And, most recently, we sent a team of people to be trained to provide the adaptation for 13 to 14 year olds, or some of those a little older kids. And to be honest that's typically the population that gets referred to our program. Our program has really evolved over the years, and so we started out providing this program to the school aged group, and we were typically seeing a lot of young kids. They did change the state law in North Dakota, maybe four or five years ago, where they raised the age of culpability in the state and referrals to the state have significantly decreased for those younger kids. We also, though, went back to the legislature and helped change the law so that if a kid gets, if it gets reported to social services that there is a child involved that has problematic sexual behavior, social services has to do a special assessment to assess for them and do safety planning for them and refer them to appropriate services, if needed. that has helped a little bit. So, we've had this program for a while. And like I said, it's really grown and evolved over the years. Right now, we actually serve quite a few kids over the state because we opened up our program, about a year ago, to provide it over telehealth. Now instead of just serving the community that I live, we're serving kids from all over the state. we're running two older kid groups, so that 12 to 14 years of age groups. We have two of those going, and we have one younger kid group, and then of course the parent group. We run them all at the same time over telehealth so like I said, we have kids who are from all over the state. We really have expanded our access to providing these services to the kids. So because of that evolution, our multidisciplinary team (MDT) has grown also to match that a little bit. We have a very, I think, tight knit and solid team locally with our CAC and we talk about these cases on a regular basis. When a kid comes in for a forensic interview at my CAC, we will still interview a kid if the only concern is problematic sexual behaviors. We will still interview them if there's a concern or a thought that they might be a victim. We won't interview them as an offender or in any way try to do an interview to interrogate them or cause them to be charged with something. We're very clear about that up front. Sometimes we have these multiple kinds of channels of how kids get into our services and the multidisciplinary team that represents that because sometimes that happens through the forensic interview process. Kids will come in and law enforcement, social services, and our staff and the medical provider will work together and say this kid really needs the PSB group and we work with family to try to ensure that that will happen. From time to time we'll have family members just call us and say there's a concern and we walk them through the process almost in a backwards way, so we help them. Or we might have to fill out a report of child abuse and neglect or concern to get law enforcement or social services involved kind of secondary, but also to get them started in services. So, we also welcome those kids from families that are just concerned and have a need and there's identified problematic sexual behaviors. But then we've also, in the last couple of years, partnered a lot with parole and probation. And they kind of added to our multidisciplinary team process. They will reach out to us after a child's been adjudicated on a number of cases and they have contracted us for those cases. So, I would say in our older kid group about half of our kids right now are working through the education process and have a probation officer. And then I would say, out of the other half, maybe 40% have gone through that forensic interview process or their sibling or the victim has gone through the forensic interview process and identified them as somebody with sexual behavior problems and we've worked with the family to get them some assistance. And then we have that small, probably 1% where the community that just reaches out and a parent says I’m concerned, or grandparents, can we get them services.

**Jimmy Widdifield, Jr.:**

It sounds just very robust and, I think, really exciting to hear how the MDT has, you used the term become kind of “close knit.” And that's terrific because it's about just getting all of your partners to the table so these kids and their families and the children they've had the PSB with, they're all getting the help that they need, and each one of those partners can provide different kind of help or support.

**Paula Condol:**

I think the thing that's worked for us the most is just even making sure that we're being flexible and keeping the kids’ needs at the forefront of what we do. I know that when we started it was kind of like, okay, this is our policy. They have to come through this process and we have to staff this with this person, and there's this multistep in and you kind of find out after doing that for a while that it actually kicks some kids out of the program or delays their services. So, we want to make sure that they are appropriate for the program, but we also want to make sure that we're flexible enough that if kids need services we're getting them for them.

**Jimmy Widdifield, Jr.:**

You also talked about how the program opened up about a year ago to provide telehealth to youth. And I’m just kind of curious because, of course, and the times that we live in now, many of us are using virtual services to reach children and families professionally. What do you think has been the hardest thing about doing telehealth with this population and where do you see the successes being in telehealth with kids with PSB?

**Paula Condol:**

I would say the hardest thing about doing telehealth with this population specifically is that a lot of kids that we've seen in the program have electronic problematic sexual behaviors. They have these electronic behaviors where they might be seeking out pornography or they're seeking out strangers online or responding to people who are seeking that. And we're saying, “Here, take this device.” We know you have a problem with electronic behavior, but we're going to provide services to you electronically. And so, it a little bit feels counterintuitive, and you got to figure out how to, in the best way we know how, minimize the risk of that and to set some controls on that and so we've done a number of things. For instance, if kids are in our PSB program over telehealth we have what we call an iPad loaner program where we loan out devices to our families for anybody in telehealth, it's not just PSB. If they don't have Internet access, if they don't have a computer, those types of things and they get an iPad that's completely data enabled, and it's completely locked down and it's very secure. If kids are in our PSB program, we require that they use our devices because it is completely locked down. So we work with the parents to try to make sure that they're in a room without another device, so they shouldn't have their phone, they shouldn't have a computer in there, their school laptop or anything like that. All they should have is their iPad, so they can't be surfing the Internet or participating in those online behaviors. At least while we're in group we can control that. And so that has worked pretty well, but we do require that. It has increased greatly the number of devices we had to write for grants for, and continue to pay for data for. But I think it's worked fairly well. Again, there's nothing that's 100%. There's nothing that says a kid can't be on their computer. I mean we can't control that if they're in their room and they're on their computer. We do try to do things like have the kids sit far enough back from the screen, so we can see their hands, we can visibly see more what they're doing in their room if they sit a little bit further back. Sometimes we have to see your hands are up depending on the kids that we work with, to make sure that they aren't which has been in other problematic sexual behaviors doing with the group. So, we try to put a lot of different things in place. And I think the other thing you learn very quickly when doing telehealth is that you just have to be willing to have very hard, direct conversations with families that you might not be used to having. So, they have to be dressed in street clothes, you can't be in your pajamas or have your shirt off during a telehealth session. You can't be in the bathroom having a telehealth session and going to the bathroom at the same time. You get very good at having those direct conversations and you need to have those conversations. I think it's a good fit with PSB because you have those kind of conversations when you're doing PSB group. I think that's probably the biggest challenge, besides figuring out telehealth itself. I think if you're not used to telehealth, and you're not used to doing telehealth creatively with kids that can be a big hurdle in itself. That would probably be the other thing I would recommend if people are going to do PSB over telehealth. Like with kids and in person, I think we're all really good about being creative and engaging. You try to use moving and fun and stickers or different kinds of things that incorporate engagement in your consult sessions. And when I've talked to people around the country, the thing that I found is we went from being very creative and doing all those engaging things to sitting in front of a screen and trying talk therapy with kids. That doesn't work and it doesn't work in our offices either. That's why we try to do a lot of that engaging things. And so that would be the other piece that I would really recommend or feel like we really overcome is figuring out how to be creative, how to make PowerPoint games, or how to use videos or other things that make it interactive so you're not just sitting there and talking at a kid.

**Jimmy Widdifield, Jr.:**

Absolutely. Having to do telehealth is really driving creativity. And, as you were talking, I thought some of the same things—like you have to make the session engaging. But then I thought well, there's so much that we do in person, how would that translate? Like modeling good social distance between people, or good boundaries we would work on. Social skills like shaking hands or just kind of figuring out some of those things and it certainly makes us think differently. Also, I think part of what you figured out in terms of providing them a device that is locked down, how that models for families that's possible that they can manage the devices their children use to help minimize exposure to sexualized material online. It sounds like, Paula, really the benefit of this or what's been best is that you're reaching families that wouldn't otherwise be able to receive services because there's just too much distance between service provider and family.

**Paula Condol:**

Yeah, 100%. Before we were doing PSB over telehealth we had a family that was three and a half hours away from us, and they were court ordered to come to therapy three and a half hours here and three and a half hours back every week. Well, as you can imagine, they literally lasted maybe four weeks. It just wasn't possible, and they weren't set up for success, and even though, like we tried things. Like we tried to, pay their mileage or, try to make sure they had a meal when they were here. We tried different kinds of things to make it possible for them, but who can do that…drive seven hours every week just receive therapy. And to take off a whole day of work to make that happen and a whole day of school, I mean it's just not workable. And so, telehealth has been a great option, because, again, there's not a lot of resources out across the state. The other thing that I think telehealth has made possible for us with this program which I think that we're doing, that I think is very unique, but I think has a lot of potential for a lot of rural areas across the country, is that our sister CAC, which is about three hours away from us, also has done training in PSB. But, as you know, you lose people, staff turnover and those types of things. They only had two people left that were trained in PSB but wanted to continue serving that population but not really enough to hold a whole group unless you take a lot of insurance and those types of things. And so, one of the neat things that we're doing is that we actually hold a joint group. The group that we hold with all these subgroups in it is a combined effort between the two CAC. It's their two therapists and then my therapists are doing these sessions together. We're prepping together, we're breaking out, and we're acting really as one mental health collaborative in North Dakota. We're signing releases with the families, so that they know the therapists are coming from two different agencies and that they're going to communicate back and forth. But it makes those services possible for them who have a smaller mental health staff, and so I think that it's been a really neat experience. I think, for us, and I think it's something for other CACs or areas, to think about when they feel like we don't have enough staff to be able to run this program. There are creative ways that you can do when you're joining other agencies or other CAC's together to make sure that those services happen.

**Jimmy Widdifield, Jr.:**

That's just amazing to me. And again, I just find myself thinking like well, of course, why wouldn't we do that. But I don't think that would have ever come to mind for me. I was part of a training project in the state of New York with Karen Hill. She was in Olean, which is a rural town in far Western New York state, and she had pulled together therapists from a few different places because her children's advocacy center didn't have the number of therapists to run a children's group with a concurrent caregiver group. And I thought, oh that was really creative and now I’m just kind of kicking myself thinking well, of course, you can do that virtually? And how that makes sense particularly in big rural areas like where you're at. Now you mentioned your sister CAC and that's in Fargo, North Dakota?

**Paula Condol:**

Red River Children's Advocacy Center.

**Jimmy Widdifield, Jr.:**

That's right. And North Dakota has how many children's advocacy centers?

**Paula Condol:**

We have only three.

**Jimmy Widdifield, Jr.:**

So, I just think how wonderful. I mean you're just building this relationship or this network with another CAC with being so few in your state. And what strength that brings to serving children in North Dakota.

**Paula Condol:**

The other benefits that we've really found to collaborating with the other therapists across the state is we really have shared a lot of our resources and our tools and our trainings. And It's just really built a much more robust program for us across the state. One of the things that we've done is when there's been grant opportunities, we actually reach out to each other instead of competing. For instance, when we went and got that adaptation, we all said that would be something that would benefit the state, so one of us, wrote for it, but we wrote in enough training slots for the other therapists in the state to be able to attend. And we've been doing a lot of that and the thing that we found is that it really expands our access for kids, because we're all small too. Like my CAC only has 12 staff. You try to do all this work and you try to serve all these kids but, for instance, the Fargo CAC is trained in Child and Family Traumatic Stress Intervention (CFTSI), and my staff aren't, and so if I get a kid in Bismarck who needs CFTSI I can call them and say, will you take them. Or if they need a bilingual therapist which I have and they don't, they can call me. And so, we've really tried to form this system where kids all over the state have access to any evidence-based therapy that they might need and are able to do that over telehealth. I think it's been a unique approach and a program, and we really work on building that team networking with each other so that people feel comfortable with each other, and the therapists know each other.

**Jimmy Widdifield, Jr.:**

And I’m really glad that you did write in for training slots with the other CACs because that meant when you came to Oklahoma, I got to have dinner with some people, including you and the folks from Fargo. It was delicious and a ton of fun. There’s a story behind that for people who are listening and maybe over a dinner sometime in the future. I do just want to mention you mentioned CFTSI, that’s Child and Family Traumatic Stress Intervention, which is a promising evidence-based treatment for children who have experienced a genuine traumatic event, which can include child sexual abuse or physical abuse, that's intended to reduce the risk of the development of chronic long term symptoms related. So really in a way to kind of prevent something like post-traumatic stress disorder. CFTSI is short term, what five sessions and includes the caregiver. It is out of Yale. Interesting, this is a total aside and not related to PSB, but I've been talking to the codeveloper of CFTSI, Carrie Epstein. The people that we know from trauma-focused cognitive behavioral therapy - they're all friends and colleagues, and they've all figured out a different piece of that puzzle around child trauma. How do we manage child trauma symptoms when they become significant, how do we prevent that from reaching that level of significance. And that's where I’m really hopeful—something like this podcast. And as we build and strengthen the network of PSB providers across the United States that we all have different answers. Like you've talked about telehealth or working in a rural state. And how that is going to help someone else, so I just want to make that connection. I’m down to really just a couple more questions, Paula. I know we went over kind of a list of questions to help you prepare but you're like the ultimate podcast guest. You have incorporated in your responses this great information that has hit multiple questions. I think it's just wonderful to hear. Some of the things that I think I’m going to kind of skip over because I am confident you have addressed were barriers and developing the program and successes achieved since the implementation, as well as kind of therapeutic options and what's a typical case scenario. Those are all things that you've kind of talked through already. As part of this experience in my mind, it just makes me think there's so much interconnectedness between the experiences you have when you start in this field, and as you learn and gain experience in it. That one thing just touches so many other things in the work that you do. So, kind of where I want to go next, 2015, that's what about seven years ago, a lot can happen in seven years. So, what do you think are some of the kind of the really noticeable differences between then and now in terms of how these children and their families are being served, managed, or their experience?

**Paula Condol:**

I think there's so many differences. One of the things I think that it's important to point out is that I think with every program too, you have a lot of different ebbs and flows. And so, one of the things I think that we did really well when we started this program is we had community meetings and we talked to our community and our MDT members about what we were doing. We brought you and Barbara up and we had the experts be able to answer questions and so people felt very comfortable when we started this program. But a lesson that I learned that has gone along with those ebbs and flows is that you have to keep those conversations going. People leave, people forget, an experience happens that maybe changes their viewpoint, like a victim gets seriously abused, severely abused and they're all of a sudden off the bandwagon of helping kids with PSB. They kind of jump back to these are evil creatures, who would only do this. And so, it's been really important throughout the years that we have to have that conversation going and keep that conversation and make sure that we're talking to people about updates and where we're at and all the good work that we're doing with this. And the other thing that I’ve found is that the more we do this, the more we expand who needs to have those conversations. When we first started it was just our local community, but like I said now we're serving people across the state. I've had to go to the legislators and had conversations with the legislators. I've had to talk to the probation officers, we've had to talk to judges. So, I think, keep in mind that when you do a program like this it's not a onetime kind of educate the community type thing. My hopes for this future, , for the field of this is that I hope this just expands and grows. Someone just called me this week from another state and said they called everywhere in their state, and nobody's been trained in this. And I thought that can't be it's been a number of years now. I reached out to Jane and said is there anybody that can help somebody in this stage, and she said, actually we haven't trained somebody yet. So, I think part of my hope is that there's enough trained people out there to meet the need, I think the need is only going to grow with the evolution of electronics and the Internet and the availability of that and that’s all starting so much younger. I think part of my hope also is the more kids that we reach, the more really that prevention happens. The more I do this program the more I see it as almost a prevention program. Yes, we're doing intervention with the child who has problematic sexual behaviors, but we're: 1) Preventing it from happening again, hopefully in most cases. 2) So many parents who graduate from the program say the same thing. They say, not only has this taught me to parent my child who's in the program differently, I’m also providing these, using these principles and parenting all my other kids in a different way. I’m talking to them about things. I’m providing more supervision and boundaries for them. We're using sexual behavior rules for all the kids in the house. We're having more open conversations. People say, I would have never guessed that coming into this program I would ever have a conversation with my child about their bodies or puberty or sexuality and I feel very comfortable having that now. And so, I think the more that we do that with people the more we raise kids or parent kids in a different way that prevent this from happening in the first place or put structures and supervision in place and so it's less likely to happen. One of my hopes for the future is that the more kids that we reached the more we're preventing this type of behavior. But of course, we also want to make sure it doesn't happen again. I also want to make sure that we're teaching the community and our partners and just general population that these are kids. They’re kids first. They're not, despite of what they might have done, they are kids. Their brains are still flexible and growing and there's lots of skills that we can teach them to try to ensure that this doesn't happen again. We want these kids to grow up to have healthy and happy futures and I think the research shows that that's very possible. I think my experience shows that's very possible. The more we talk about this, the more we serve kids in the community, I hope that we're growing a community that is empathetic and responsive to these kids. We need to get them healing and help versus we need to punish and make sure that they hurt as badly as they hurt the victims.

**Jimmy Widdifield, Jr.:**

And the only thing you forgot to mention was world peace. Paula, I mean talk about a vision and a dream for the future. In terms of, like you mentioned, stopping these behaviors from recurring and we know from the research that when children get treatment such as problematic sexual behavior cognitive behavioral therapy it's a 98% success rate. And that's looking over, doing some follow-up on cases over 10 years, which, even though the white paper is on children, it's similar rates for adolescents, when we look at a meta-analysis by Michael Caldwell. But stopping these behaviors from recurring. But also, something that was just beautiful you said that the parents are telling you, caregivers are saying, I've changed as a parent and I’m talking with my other kids and we're having these conversations that still maybe aren’t very comfortable, but now I’m at least having them, and it makes a difference. I had similar experiences when I was doing the school-age group. And world peace, I mean that's it.

**Paula Condol:**

What else can you ask for.

**Jimmy Widdifield, Jr.:**

I want to go back to one other thing that you started off with, in this kind of before and after, and that is it's not a one and done presentation to your community. And I think years ago, someone would come in and would do an hour and a half or maybe even a day long presentation and then nothing seemed to change much, if at all, in a community until there are people like you. And some of the other program directors and clinicians and researchers that we've talked to, that they just see this as an area that is, I don't want to say is easy to do, but the payoff, the success rate, and how it impacts families more than just the child who initiated the PSB like you were talking about., But how other children are parented, how we're helping the kids who were the recipient of the PSBs, like it just, the benefits multiply significantly. And that makes a huge difference in your community, your state, in the world. Paula Condol, I have run out of things to say, which is not common for me, as you well know. It has just been a pleasure to hear you share your thoughts and your ideas and your experiences. I honestly think that your voice can be one of a million. People who are sitting out there that are just thinking, what am I going to do in my state? Like you mentioned, I’ve called around everywhere and there's no one trained here. When you said that all I could think was they're going to be a Paula and they're going to start calling everyone that they can find online like Jane Silovsky. And they start pounding the pavement like you did and it's about looking for any and every opportunity to get information, training, presentations, and that manifest eventually in getting services established. Thank you. Thank you so much for everything that you shared with us today and your time, but I mean the amazing work that you're doing in North Dakota that is certainly impacting more than just people in Bismarck or Fargo and North Dakota but across the United States. So, it's excellent work and I appreciate it.

**Paula Condol:**

Thank you, thank you for having me.