

# Division of Diabetes Treatment and Prevention

## Advancements in Diabetes Depression Screening and Follow Up

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Dr. Casey McDougall:

Hey! Hello, hello. I'm assuming everybody can hear me loud and clear. Welcome. It's kind of humbling to sit on this side of the screen when usually you're a participant. I've done this once before, but I'm really excited. I've been doing a lot of public speaking as of late. Anytime, I can disseminate information as I've learned it and even learned from you all, I think we can do good things for our patients.

My slides are a combination, as Jan said, of personal experiences both professional and personal. They may not seem relevant at the outset, but there should be a lesson as we cruise along. For time sake, there may need to be needing to go through slides quicker than I'd like to, but you have them as a handout. So, let's begin here.

Jan already went through that disclosure stuff. I think it's just kind of a disclaimer. But there are not too many original thoughts in this presentation. As Newton even stole from another 12th century scholar, I believe. If I've seen further, it is by standing on these shoulders of giants. I've had so many mentors and exposure to different disciplines that constantly always changing my philosophy while maintaining the stance as a scientist practitioner. Hopefully, that will rub off on you too. We all have a schema or a menu of doing things, but hopefully we can change our approach.

I know Jan went over some of this a little bit, but certainly, we want to improve the quality in continuity care of patients with comorbidities or co-occurring conditions. We should always strive to do things in a culturally sensitive or appropriate manner and improving our own cultural competency. And certainly poise when dealing with behavioral emergencies. When I work with so many other people, anytime they hear a hint of suicidal ideation, it's kind of run for the hills throughout the behavioral health. My hope is, by the end of this, you all are mental health ambassadors. We should all feel like we have the capability of weathering the storm with somebody.

Of course, the theme here is to just be open-minded, to be curious. I got this from a mentor of mine at the Neuropsych Research Institute, Dr. Stephen Wonderlich, fantastic gentleman. He was the director of their research component, psychologist. "To steal shamelessly and share relentlessly." I'm almost certain he stole that from somebody else.

I'm not here to give myself a pat on the back. I'm not here to embellish what I've said or done in my short, professional career here. But it kind of sets a theme on how I've evolved to work with dynamic populations. I come from the White Earth Nation, which is just kind of a stone throw from the Red Lake Nation where I work here. I'm pleased to share with you my Indian name, which is Bemossed. It means Walking Thunder. I actually got that before I went to Iraq, and I'll speak on that in a minute.



I had the pleasure of going through the Indians in the Psychology Doctoral Education program at the University of North Dakota. One of three largest Native American student populations in the country, and that is just a fantastic experience.

When I got into graduate school, Uncle Sam called me up. I was in the Army National Guard, and I thought things were going right and well. Of course, I'm just as patriotic as everybody. But I'd never thought I'd be called to duty in a combat capacity. I put my studies on a hold for a year there. I came back and hit the ground running. I did my pre-doctoral internship at the University of New Mexico. It was actually the best fit, because I wanted to go to the University of Oklahoma Health Sciences Center with Dr. D. Bigfoot, and learn all about Children's Healing Center and everything that culturally sensitive, trauma-focused, CBT had to offer. "Well, you rank for them and they rank you and they said you're going to New Mexico." It was really the best thing for my cultural competency working with Latino population and other Native American tribes that were vastly different from the Great Lakes and Plains Indians, the Great Pueblo people there in Acoma and Laguna.

And then, I went through a unique shift between entering primary care. This is where I continue to be a student myself. It's a whole different beast, if you will, between community, mental health, and what that means to be integrated care.

That's why I think you all are here today, so that we're all have that transdisciplinary aspect to it. That we are all in this together, and shouldn't be fractured.

Lastly, I'm also getting an advance degree in clinical psychopharmacology with main efforts to, at some point, get prescriptive authority. I'll have to get reciprocity through New Mexico, then apply for a conditional license to prescribe, so that I can use that privilege in federal facilities. It's not so much to the power to prescribe as it is to be one heck of a consultant, and take people off things that are unnecessary or certainly take them off when they've had the usefulness of that tool, that augmented medication.

That's me. That's my mug. Okay. I've also been influenced by a lot of different things. This is important to share as I've changed my way of thinking. I think it's important to share a little bit about veterans in general, since this is the population we're working with and what that means to be a Ogichidaa warrior, and it's not so much to be a fighter as it is to be a defender. I think with the population we work with, if we're being culturally sensitive and competent, it'll do you well to know these things and what it means as you're helping someone manage their diabetes and co-occurring or co-morbid depression. 2004 through 2005, wow, it just seems like yesterday sometimes.

Of course, the Land of Enchantment is like none other. I don't know if anybody is in the audience from anywhere in the Southwest, but it will always hold a special place in my heart in terms of the unique culture. Oh, the food, green and red chili on everything, I really loved it. What you're looking at here is the Sandia Mountains. I had unique experiences with the children's psychiatric center and the outpatient programs for children and adolescence.

And then of course, I went onto my first job, technically, my post doc at the Pueblo of Acoma. This is a really unique experience. At times -- unfortunate, it would feel like us against them. It's like, "IHS isn't helping the Tribes or the Tribes aren't working with IHS." That's what we're always doing. We're trying to reinforce relationships.

Continuing to be involved with active works with the National Health Service's longer payment program, health service psychologists, and a number of divisions in American Psychological Association. My hope is to, at one say, find the time to get certified as a suicidologist. I think this is certainly nothing fascinating, but a lot of things that some people shy from to know all aspects that is to understand the behavior and mindset of suicidal ideation and intention and completions. The American Association of

Suicidology offers some excellent, excellent resources. Maybe perhaps some of you will consider that additional training as well.

So why am I telling you all of this, this concept of a paradigm shift of fundamental change in an individual or society's view of things work in the world. I only got a brief glance at looking all of these different disciplines. I've seen a lot of registered dietitians, some statisticians, pharmacists. And let's face it, we all get kind of stuck in how we're trained in our own orientations. And when we're confronted with new information, you have to change to fit that or you have some cognitive dissonance, and you can't accept it, so you chuck it away.

But here, I've gone through a lot of different paradigm shifts in what I thought the book smarts was, being that scientist practitioner going in to a major medical system and working in community health, then seeing a whole another world. If nobody's had an opportunity to maybe shadow a behavioral health consultant or an attending physician, you really need to see what a behavioral emergency looks like in the emergency room, urgent care, emergency departments.

I had an excellent opportunity to moonlight when I was a tribal staff psychologist. In our region, it was called Crisis Response Services for Beltrami County, operated through Upper Mississippi Mental Health Center, being on-call and working in teams of two and going into mostly emergency departments and being behavioral health consultants and placing individuals that were high acuity and then, moving into primary care was a big challenge for me. It was a big shift between how we did our own form of medicine. You can't have that traditional 60 minutes, every week. We're going to work on these tools and you're going to practice it, and we're going to monitor it and do functional assessments. You have to be on the fly. You have to be adaptable.

So, I tell you, who are you? Who are you in terms of as your continued growth and development? My hope that maybe an inkling of this presentation may change the way you see the world and change how you operate.

It is my esteemed pleasure to talk to you about the service network that I work in the Red Lake Nation. Red Lake Nation is a very unique tribal sovereign nation and that it's a closed Reservation. At some point, they had chosen not to be part of the Minnesota Band of Chippewa Indians, so they can maintain more of their sovereignty. It was largely to maintain their hereditary chiefs. It was just a way of how they nourish their own culture and beliefs. This population is very migratory. It's very hard to find people because of the low economic status sometimes, and the interracial marriages. People are always going from the remote areas to urban areas, in Minneapolis, Minnesota. We have four communities, as you can see a little bit on this map here. This is the Red Lake Nation with the seven clans above it. Little Rock to the far left, Red Lake proper in the middle, Red being to the right, and way, way up around this massive body of water, which you can definitely see from space is Ponemah, the more traditional hub, and as you can imagine, very difficult to access care at times. There is a little satellite clinic there, but it doesn't have all of those resources, very much an isolated hardship area. I'm sure we all can commiserate on that.

Unique marriage, I've never seen this before in IHS, where in the federal facility, the Tribal Chapter 638 program is nestled. Half of the staff is Tribal and half is IHS. Despite where you're being paid from, we all have the same mission. Dr. Cotton had recognized couple of years ago that we were doing something special in terms of depression screening. And I think that's partly why Jan may have invited me here. I'm hoping I'm doing right by everybody in this presentation and that it is a common way of life to screen, screen, screen. We consider these behavioral health vital signs and maybe that's what you're going to take away from this. Screening is a vital sign. We'll get to some of that in a bit.

So we got awarded twice in a row and we're able to do more integrated behavioral healthcare and advance our technology with telepsychology and getting more advanced equipment to help our

workflow. This is always the dilemma as you know in IHS, this fiscal dilemma that we're always trying to get third party reimbursement.

This is my staff for Indian Health Service. I think this is pretty robust. We're currently in a time when you think of feast and famine, a little bit of famine. We lost some really great NPs, but we're putting our fillers out there. We'll be back at the full capacity at some point.

So how do we detect, manage, and track depression? I don't have all the answers, but I'll tell you what we're doing up here anyway.

First, I want to talk about this whole concept as a clinical depression in general. You take something that's a very well-known general medical condition like diabetes or any other metabolic syndrome. And these are bonafide real issues that can have profound complications if not managed. That's something you can't dispute. You can find that readily in a lab, too to have some confidence of the diagnosis you're working with. But clinical depression, that's something we made up. That is a construct. That is a western medicine kind of mindset. So you have to know at the outset that you need to better understand that person across from you, how they define and explain their unbalance and their unrest. It's not a disease. It's a dis-ease, if you've ever heard of that.

Very heterogeneous. You could put 100 people on a bus, certainly, as long as you have those core quintessential symptoms of low depressed mood or anhedonia, which is loss of interest or pleasure. For more days than not, you could have a positive screen. But of the other symptoms, it's kind of this cascade of how we're all unique snowflakes, because there are many different etiologies in how we can develop depression. Obviously, diabetes is going to be one of them.

As a co-occurring, co-morbid or dual diagnosis, can anybody tell me in the chat box any differences between those? I'm not trying to insult anybody's intelligence, but their big difference is --

Right. The co-occurring is going to be parallel. You might have a history of depression, and then you develop diabetes. Co-morbid, the diabetes has some manifestations of depression, and then you developed depression along with it, and dual diagnosis more often than not is that pure psychiatric plus substance abuse connotation to it. Obviously, we shouldn't rule out how colonialism and I'm not here to belabor historical trauma. It has its place, but there are other educators more wise than me that can touch on that. But, if you look at colonialism from a standpoint on how over the ages, there was inter-generational trauma that can even lead into this kind of late and chronic bereavement, you have to fully explore the sources in that biopsychosocial spectrum. So many times in primary care, we're just looking at things from a biomedical lens, so expand your horizon.

Yes, the diabetes depression connection. I was able to borrow this from Dr. Kaltman. I found an article online in doing my research for this presentation. It's very closely linked. You see it, you know it, and sometimes you can feel a little powerless as people struggle with their mental health or even able to access mental health. It's a real struggle. Now, in fact, you all by virtue of trying to build up your own growth and development, you should be able to have conversations with people about their any emotional duress. We're all healers and helpers at the end.

"A lifelong condition like diabetes can take a toll out of mental health. Depression in turn makes it harder to find the motivation to care for diabetes. Getting exercise, eating right, and completing other basic tasks are difficult when you're struggling just to get out of bed in the morning." I usually don't read slides verbatim, but that's a good one to start it off and we're going to see some more complicated junctures here. Taken from the American Diabetes Association, right?

What are the most common things that are going to have some overlap? What are some common symptoms of diabetes that are going to look like depression? Anybody? Bueller? All right Nancy you're going to be the first one, yes, okay anymore? Theresa, Rejoice. I like that name Rejoice. So

are you in your energy, right? You know you're just going to have problems with just kind of your alertness in general, right? Yeah, lack of motivation, very good. Seeing more of a connection here about the time of day too. That's really important about checking those blood sugars. During the day, high or a little blood sugar, may feel like you're tired or anxious, more over the stress of diabetes management and the significant complications. Oh my goodness, right? Neuropathy, retinopathy, amputation, dialysis, it is tough!

The next few slides, I would be remiss without crediting somebody that is just absolutely brilliant. I came across her work online and made touch with this brilliant doctor, Sherita Hill Golden who works for John Hopkins and I got permission to use the next few slides that I think if you're a visual learner like myself, it really put things into perspective. So, without a doubt, you're going to want to look into her work and I do have her PowerPoint presentation if anybody wants to email me and I'm more than willing to share that. These are really, really interesting visual aids.

So, the psychological demands imposed by diabetes are many and sometimes subtle, sometimes overt and I think we need to recognize that you know -- well you guys see this more than me, you know just even that fear aversion to having to take insulin and prolonging it or even being in denial. The Nile is on the eastern river of Egypt, right? So, the complications and the full-time job it is to manage diabetes and if you don't have the right tools and support, and motivation and for some, even cognitive capabilities, it's just going to come hand in glove at some point that you can develop depression.

Then on the flip side, better understanding how depression could be a precursor for diabetes is very interesting, right? When you're down, you are engaging in maybe too many unhealthy behaviors, maladapted behaviors or the lack of coping skills. And then at some point, you're going to develop poor lifestyle choices that are going to affect your metabolism and increase the probability of getting diabetes and then in turn, you know I'm not going site off and rattle stats and articles for you off the top of my head, but we do know that depression can impair our immune system, certainly can make one insulin-resistant, at risk for stroke and congestive heart failure and the list goes on. So, we're trying to help people, even though they're dealing with their acute problems now, invest for the future because everybody is entitled to satisfaction and quality of life and I'm not trying to discount people in general, but the indirect care associated with depression far outweighs the direct care. You know you're talking absenteeism and other costs for going to emergency rooms and other specialties and the list goes on and on. I think it's just a fantastic slide that we're seeing here.

Then if you really want to get nitty-gritty into it, I saw a couple of pharmacists and maybe you might appreciate some of this especially when it comes to the hypothalamus, pituitary adrenal access. When you're walking around aroused and have all that cortisol, all that stress floating around, you're going to be at risk of all of this cascade. All I can think about it is -- you know Krebs cycles for some reason. The pharmacist might correct me here, but all of this has the potency to develop insulin-resistance which is often going to be linked with legitimate diabetes, very preventable, but you know we live stressful lives.

SNS for anybody that's not familiar that, that's the Sympathetic Nervous System, individuals that have anxiety, anxiety and depression go hand in glove and when you're having false alarms in the brain, the neuroanatomy in the amygdala which in Latin means the almond, is that fear center, fight or flight. When that is going off as a false alarm, you can imagine the cascade of sympathetic nervous system going off in terms of your heart rate, your lungs, everything dilating. You're always on watch and you know we got to calm that. We got to learn how to calm that down.

I wasn't able to pull from the slide as well, but this is also another Dr. Golden slide, but just understanding how hyperglycemia left unchecked can do some really nasty things to your central nervous system in terms of shrinking and creating atrophy in compartmental structures like the hippocampus and elsewhere, apoptosis, the pruning, the programmed death of cells, and then obviously the limbic system which has to do quite a bit about your mood.

Everything is a relay station. I always joke that you know in Stark Trek it was, "Space: the Final Frontier". Well it's really the brain, there's so much we know, but so much more that we don't know and it's really a fascinating system and I think that's how we have to look at depression. It's just another system, but a lot of people come up with some really taboo and romanticized ways about the mind.

As I'm sharing resources here straight from the 2016 American Diabetes Association Guidelines, when you're trying to bolster in more of your assessment and diagnostic capabilities and moving towards intervention, this might serve you well in looking at some things to include in your management and referral process.

Cultural competency. I'm going to assume -- I saw a lot of IHS emails, maybe there's still a lot Tribal programs. I'm going to assume we all have some stake in indigenous people, their direct descendants or families and it really behooves us, we can't really go much farther into the interventions without having -- how can I say? - at least speaking the language, the language of understanding somebody else's world view, not certainly their spoken language. The know-how and the elbow grease, an ongoing ability to interact effectively with people from different cultures. Summarize into the awareness of one's own world view added towards different cultures, knowledge of other cultural practice and these hard skills and I don't want to get lost in the skill so much. But as we see across the nation, you know it's too bad that -- you know ethnicity is the focal point.

I don't know if anybody got to take any of this motivational interviewing work that I was able to do recently. Well anyways, I heard this quote do something like, "If we only listened as compassionately as we want to be heard, boy we could do a lot of great things together." I think there'd be some more solidifying of our strengths rather than trying to see our differences.

Really important slide to here, nothing in terms of your targeted interventions in diabetes or pre-diabetes management is going to go much farther than this cultural competency, it impacts everything.. Culture, ethnicity has a direct correlation with the phenotype and the genotypes and all the pharmacology involved. Expectations, desires, motivations, boy, you really have to -- in the concept of psychology or even family and marriage counseling is a joining, joining with that family, joining with that person.

Throughout -- I don't know, we have to be cautious here because I think it's dangerous to assume that all people of one ethnicity are entrenched in that tradition or those cultural values. You have to always look at different acculturation models and certainly anybody that does have an investment in their ethnic identity of being Native. Boy, with 566 plus federally recognized not to miss out on the 200 plus state recognized, there's so many within and between group differences. I don't want to assume that the medicine wheel has its place in depression screening, but I like it. I like it here and it's not so much the continuity and the circle of life and all the symbolism involved in it as it is how we stay balance is investing in being emotionally adjusted, physically fit, mentally stimulated, socially or spiritually connected. The saying in Anishinaabe if you break it down into consonants here, we know Minobimaadiziwin, the good life, the healthy life. Waking up with a positive attitude, wanting to be active and that's easier said than done. I think if we maybe share with this mantra that maybe used, other people might adapt it.

As I've just shared with you some of the different quadrants and that's how I sometimes look at some people's clinically significant distress or impairment, where in your life is there an imbalance? Where do we maybe need to invest some more energy, how is this a manifestation of something that's absent from your life. You can develop treatment plans around this medicine wheel model, in fact at the Ho-Chunk Nation, Dr. Ted Hall is a pharmacist, fantastic pharmacist. They developed integrated treatment plans around this medicine wheel mentality model.

This comes out in Minnesota. I think this is always important when you're talking to people about their depression, and I think this is something maybe more of the audience can relate to, you know these concentric circles of physical activity, nutrition, decreasing tobacco and alcohol, practice positive thinking and improved hygiene. So sleep hygiene, I see it as kind of a cornerstone of a lot of people, how their mood is regulated. Practicing positive thinking, it's not all about puppies and kittens, but positive imagery in how we reframe the language we use goes a lot into how our mood can be modulated and moderated.

If anybody wants to pick up a really great resource, free resource at SAMHSA, this Live To See The Great Day That Dawns. It's up in the right corner there, and I think it's just fantastic as we move into some of the underpinnings that you might be dealt with, with self-injurious behavior or suicidal ideation or intent and you have to kind of understand all the different risk factors involved in that to have a better appreciation, and to be honest with you, not feeling so frightful about it.

I think there's a big division, although one may lead to the other of self-injurious behavior. Too many times we say in adolescent populations, you might see self-injurious behavior and cutting is the most common one, but there's also burning or hair pulling and many other ways to stimulate one self. I think you have to appreciate the many ways what that behavior, what's the function of it, whether it's communicating something, trying to feel something because you're so empty, a way of punishment. Very seldomly do I actually see it as being manipulative and I think a lot of people target that as being a chief source. I would be skeptical if your colleagues assume it's from manipulation. Lots of different ways in self-injurious behavior can impact and even with the management of diabetes itself.

Screening tools, I think we have to remind our self that screening tools are often not very culturally sensitive. They're not diagnostic. They're just that. They're collateral and you can't discount your own clinical judgment or consultation or review of the literature. So keep yourself always informed, but these are some tools that we use in terms of trying to better assess for risk or just the intensity of depression in general. So we'll go through some of those.

SAD PERSONS is really old school and in fact it was meant for more medical residents, maybe some psychiatry residents. Sometimes some audiences may not feel that it has any place in terms of ethnicity or even emergency rooms. But I like to use it to at least demonstrate why I make a definitive choice to take somebody's basic rights away like putting them on a 72-hour hold.

Each letter of the SAD PERSONS, yeah each letter in this acronym could stand for some elevated risks. I have to tell you that I've hospitalized individuals' just on pure palpable hopelessness alone, sign and symptom of depression. Or I've gone through a safety plan and it's structured, organized, step-wise method, just like a fire drill to try to reduce the probability of harm. And if we get to the end and they can't think of a reason worth living or comprehend what they just did, I don't trust it. I think you're at risk. And it's not so much trying to help people understand the reasons worth dying. The reasons worth living, you have to also validate and not discount the reason worth dying because they're very important and oftentimes, family members or even professionals kind of discount that and shrug it off.

IS PATH WARM probably more popular in American Association of Suicidality? Yes. I think this probably has more relevance particularly with youth in terms of trying to be more confident that somebody could at risk, very excellent tool, and we embed these by the way if somebody you work with EHR into some of the templates we use. And if you have clinical application coordinators that would like to talk to our clinical application coordinator, Pam Spath, we could share those templates if that will help.

Early detection, all right, knowing the signs of symptoms, I just can't stress enough that it takes a village, we're all in this together. So many times, we may see say from outpatient, I'm not discounting our outpatient, you know? They'll just throw this PHQ score in the consult and say, they undoubtedly need medication management from a mental health specialist. Not often the case. I think if it's mono

therapy and that's just a baseline, and we're going to talk about how we're going to use these behavioral health vital signs on establishing some kind of progress, of course a treatment.

So the patient health questionnaire, the PHQ-9, everything I already mentioned about interpret with caution, is developed by Pfizer, but they yield hand in glove with DSM's interpretation of the criteria for depression. So it has its place but there are many different uses of the PHQ, you just have to be creative, but at the least it's a conversation starter.

The Suicide Prevention Resource Center. I don't know if any of you have heard of that or not, but you need to get on it and they have excellent resources and a whole tool kit for better identifying and intervening with suicidality. This is the safety plan that I was talking about. We've actually, in our region incorporated this txt4life program. Almost everybody has a cellphone now and you're never without help and support. So there are both crisis lines, cellphones and the safety plan. It's very fantastic.

This is a little wordy and messy, but do you recommend depression screening tool for adolescents. There is a version of it called the Teen Version, Lisa, the patient health questionnaire teen version and really the only difference is one or two questions has a little bit of a language difference and then they capture things like -- sorry, my memory is kind of lapsing here for a second. Would you rate this stress not at all making life difficult, somewhat, very or extremely. Then they ask questions about in your whole life, have you thought about it? In your life, have you ever attempted?" So it would expand on the PHQ-9 proper. It's a pretty good tool, so PHQ-9 teen version.

Here for any of you, statisticians or individuals wanting to tell a story throughout the year or even trying to get some grant funding, if you're not entering in data into the suicide tracking form, you're really missing out on year's worth of wax and wane behavior, and these are some pathways to enter this data there.

Not long ago, even the chairman of Red Lake Nation sat on this Senate hearing, it's a big deal talking about the epidemic of suicides in Indian country. If you ever want to ever check that out there's the link for you.

Universal screening, I think this is why it fits so well in primary care. This is the hub. This is where people come when they're not feeling well. These things help expand on finding some accuracy in the things we're trying to help manage like depression and anxiety. Patient questionnaire generalized anxiety disorders, seven either questionnaires. The patient stress questionnaires composed of five things. A pain screen, primary care post-traumatic, stress disorder screen, audit which is the alcohol use disorders, and identification test. Some other agencies in outpatients might use the cage or the desk. I'm not as savvy with them, but they have their place.

This is an example how behavioral health vital signs very much to serve you well. Particularly, if you're having that person struggling with their diabetes management, complications, and concurrently co-morbidly recognizing their depression, there's nothing wrong with you entering in a PHQ-9 score, and then you're able to track that data overtime and maybe seeing if some of your interventions are working, and knowing some of the peaks and valleys. You weren't doing any of your readings when you were at this high skill, your depression must be flaring up again. How can we work on that multi-model tool box?

Does this sink in, behavior health vital signs? It's a different paradigm shift from looking at your typical vitals. I think it's fantastic and I would encourage everybody. They even have a place for the audit, a place for the craft which is an adolescent's substance use screener where each letter is an acronym for problems of their use: driving in a car, using it to relax, using it alone, have you ever been in trouble, have you ever been told you're use is excessive, and family and friends.

Primary Care, PTSD screen. What's interesting about this and I don't know if anybody has every used this one where you're trying to screen for that true A1 trauma. Have you ever been exposed to something that was so horrible and terrifying that you experienced XYZ? The fourth question there felt numb or detached from other's activities or your surrounding is more indicative of acute stress disorder, acute stress reaction. I think we have to remind ourselves that there are common reactions to uncommon events. But we have to be cautious with the screener because I think it's prone to over pathologizing people, because in many of the cities, they might have different ways of grieving and mourning their losses. Bereavement, I find that so many times people that are in mourning exhibits characteristics of PTSD, and that's problematic. Somebody might be put on a medication that's unnecessary or being mislabeled.

Just a little article that I found that might go a long way in recognizing the connection here by Lustman et al, insulin-resistance linked to depression, which we know is now a risk factor of diabetes, the reduction of that hemoglobin A1c improves during depression treatment. So we've actually seen -- I don't know if it's a randomized controlled trial here anyway. I didn't go that much into the article. But once you begin to treat the depression, we've now been treating their diabetes. Maintenance anti-depression pharmacotherapy is more effective than placebo.

I was told it might be beneficial if I talk about a real world example. I had working with the gentleman that I had the privilege of working with. We were kindred spirits. We're both veterans. This gentleman had come in to me, largely due to bereavement. He had basically, not personally adopted, but taken into his own identified with this young adolescent as his own preteen, 12, as his own granddaughter even though it wasn't. That's the thing about some Plains Tribes, even though this is more Woodland, is that concept of 'Tiyospaye', which is extended family. You're uncles and aunties can be legitimately moms and dads. Anyways, she died unexpectedly. I think it was either an enlarged heart, maybe she might have asphyxiated on something I can't recall. But he had been really in the druthers of his depression, which in turn exacerbated complications of his diabetes, his neuropathy was just nonstop. How could you not wish to never wake up some days with this level of pain? The Gabapentin is only going to take you so far some days.

He actually developed his diabetes well into his early adulthood, and he admits, "I wasn't eating right. I was a little bit of drinker. I wasn't taking care of myself, and I wasn't listening to doctors. Well, it snuck up on me and bit me in the butt good." But it wasn't until later in life that he had to have a kidney transplant, and that's when some things start being difficult for him.

We know that surgery and post-operative care, any general medical condition has correlations with our mood. I think there was that prodromal depression prior to the bereavement that that just really made things worst. And he was working with me with his major depression. We probably were trying to be all inclusive. He met often with me. I respected him enough. He was bright enough that I didn't have to go into the mechanics of cognitive and behavioral therapy. Being a presence, being client-centered in accepting them completely and just letting them tell their story and being a rudder in their storm can go so far. Trying to help them weather through -- sometimes that full job of making all these appointments is really, really tough and trying to comply with all recommendations. Hey, who doesn't want to cheat once in a while on their diet?

Physical fitness, traditional medicine and healing which largely took the form of prayers and beliefs. You don't have to go this sweat or powwow to be doing the medicine. It's what you hold in your heart. Increasing your social support, a little bit older, he invested a lot his time into his occupation at the time. Now he'd missed out on maintaining some peer networks. So we had to build on that and be creative on it. At times we invited other family members in. I think anytime you can do that, it can just be exponential to the effect of the work that we're doing.

I lament that this isn't actually his PHQ-9 chart. I had to steal it from somebody, because I don't think at the time I was being a good clinician and entering in his vital signs. But at the outset, we started

treating him and he screened positive for depression, 18 moderately severe signs and symptoms of depression. By the time we were done, we were at a very manageable sub clinical 5 out of 27. And I waited probably about three sessions before I said, "Let's consider termination."

I put up this PTSD screener to mention that every time I screened him, he was coming out positive for PTSD when in fact it was still the low chronic, complicated bereavement that he was struggling with. It really was a toughie. When I think in western philosophy, you hear about these stages of denial, bargaining, anger, depression and eventually acceptance. Well, that's a linear model. Sometimes you can experience them parallel or revisit stages but you really have to recognize that it's that end case study of one to really appreciate what they're going through.

Some resources that might serve you well in your quest to better understand depression and suicidal behavior and anything of that ilk, I really like these fundamentals of crisis counseling. Again, I'm not getting a paycheck. I'm not being endorsing it. It's just I really enjoyed it as a good read. We're helping someone. We're the rudder in their storm.

'Migwitch' means thank you. I really appreciate all of your time in listening me out.