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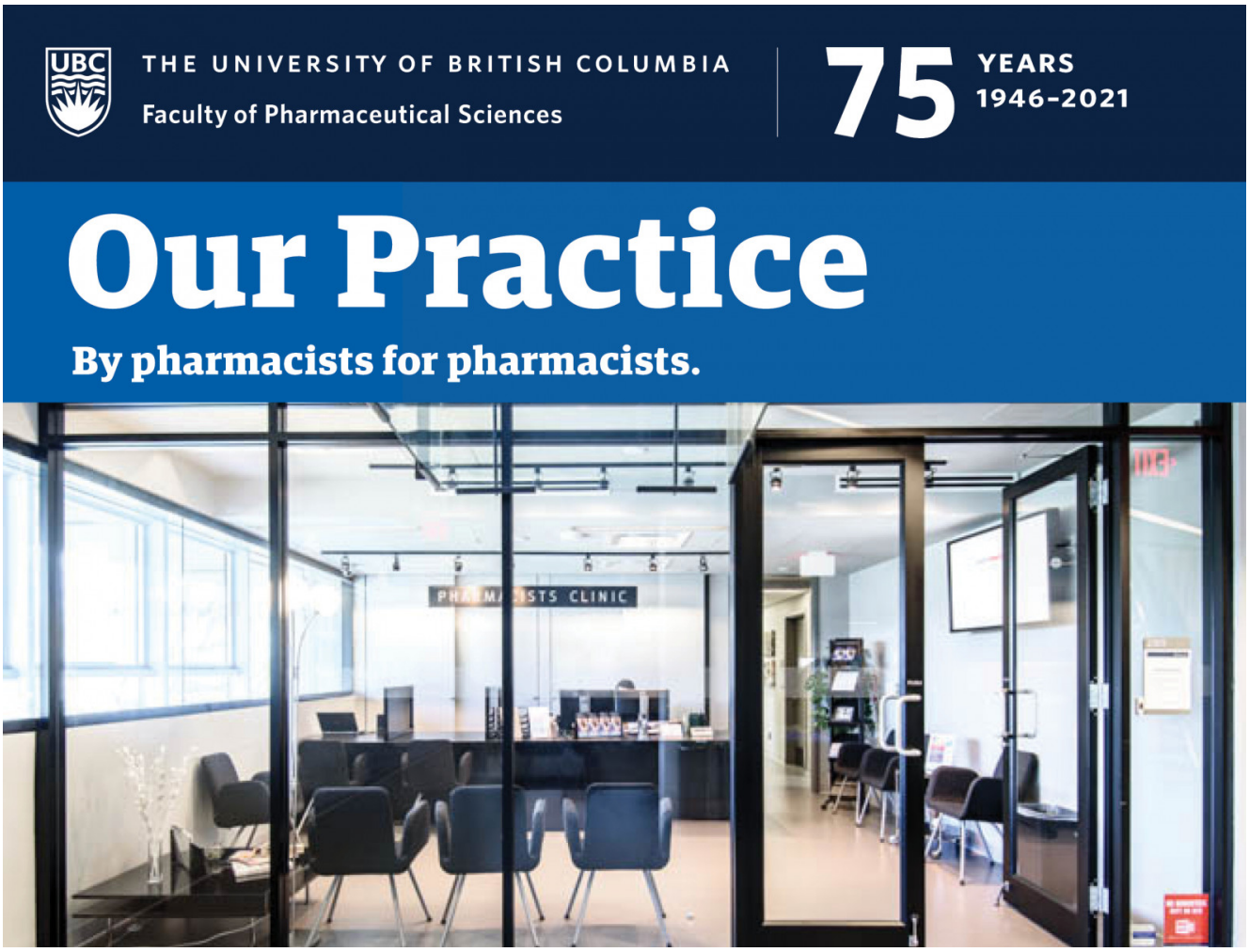

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FEATURE ARTICLE

Occupational Stress and Resilience During Trying Times

BY: JAMIE YUEN, BSC(PHARM), RPH, BCGP; BARBARA GOBIS, BSC(PHARM), RPH, ACPR, MSCPHM, PCC

Workplaces have become increasingly stressful the past year. This stress impacts both our work and home lives. Most people manage increased workload and stress through micro-adaptations (e.g., working harder, seeking support from colleagues) but these tactics are no match for persistent, progressive stress.

Prolonged workplace stress can lead to occupational burnout, a form of extreme professional exhaustion characterized by irritability, sadness, insomnia, change in appetite, negativity and decreased performance. [1-2] Occupational burnout is a mental health concern that cannot be managed alone, and is particularly prevalent in caring professions such as pharmacy. [3-5]

We have not been spared from increased stress and occupational burnout risk at the UBC Pharmacists Clinic. We are particularly aware of the personal risk factors for burnout in team members with: [6-7]

- Younger age, less work experience
- Superman/woman syndrome (high potential, low resilience)
- Tendency to be emotionally impacted by client problems
- Desire for control or perfectionism
- Conflict between personal values and work circumstances

Fortunately, we have made our team's health our highest priority to maintain our quality standards in service to our patients, our students and our profession.

Resilience – having and continually nurturing the ability to manage adversity and adapt to change - is key.[8] We have leveraged the principles of resilience and implemented a strategy to prevent and respond to extreme occupational stress within the Clinic team.

Our resilience strategy includes:

- **Knowledge** – ensuring everyone recognizes the early warning signs/symptoms of burnout
- **Watching** – keeping an eye on each other and watching for clues that a colleague is struggling, such as unexpected behaviour changes.
- **Asking** – asking about a team member in a caring way when we are concerned about them.
- **Leadership** – scheduling regular workload check-ins to ensure no one is overloaded or overwhelmed, and taking action to help distribute workload when things get too much for one person.
- **Renewal** – supporting team members to take vacations, attend educational events and explore interests that recharge them.
- **Socializing** – incorporating social contact time (e.g., morning tea, UBC virtual sports day) and maintaining it vigilantly during hectic times.
- **Recognition** – providing sincere, meaningful recognition of accomplishments during good times as well as hard times so team members know they matter.
- **Community** – creating a culture of shared responsibility so that we support, problem-solve, struggle and succeed together.

We also talk regularly about preventive strategies such as self-care and connection. Self-care includes good sleep habits, exercise, time with friends, being in nature and mindfulness. Connection can extend beyond our social circles and include colleagues and mentors who support and value us as people and professionals.

Although some aspects of work are truly fixed, many are within our ability to change. Our commitment to our team has helped us immensely this past year. We've learned to set boundaries, normalized saying no and speaking up when things are not OK. We include our entire team in these discussions, and new personnel quickly pick up on our culture of caring. It is never too late to make resilience a priority and it's never too much to talk regularly about resilience with the team.

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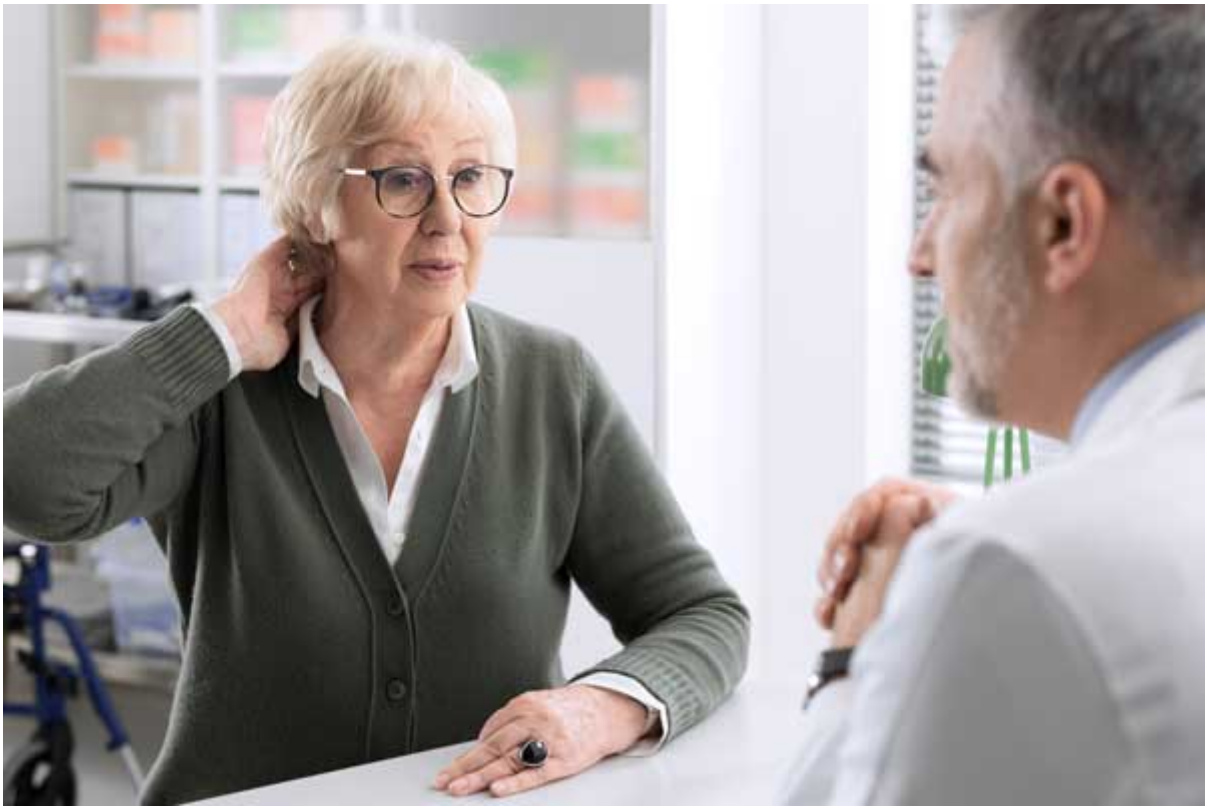
CASE STUDY

HRT for Sleep Without the Heat: Exploring the Use of Hormone Replacement Therapy for

Insomnia in the Absence of Vasomotor Symptoms

BY: ADRIAN ZIEMCZONEK, BSC(PHARM), RPH; NICOLE (NIKKI) DOMANSKI, BSC, PHARMD, RPH, ACPR



PT*, a 63-year-old female, was referred to the Clinic to review the safety of long-term hormonal replacement therapy (HRT). Following menopause at the age of 52, PT struggled with severe vasomotor symptoms (VMS) and insomnia and was started on oral conjugated estrogen 0.625mg daily and micronized progesterone 100mg daily. This HRT regimen was very effective and continued for 5 years, until her hot flashes completely resolved. Thereafter, she was tapered off HRT without any recurrence in hot flashes, but began to suffer from insomnia. PT asked to resume her previous regimen to help her sleep, but her physician had reservations about the use of HRT solely for this indication.

Instead, PT was tried on valerian and melatonin, which were not effective, followed by trials of trazodone 50mg and zopiclone 2.5mg, which made her extremely groggy. She continued to request HRT, stating that she did not care about the risks when her sleep was so poor. Two years ago, PT was reinitiated on the same HRT regimen and experienced satisfactory improvements in her sleep. The referral to the Pharmacists Clinic was prompted by concerns from her physician about the use of HRT for insomnia without VMS.

Prior to re-starting HT for insomnia, PT reported inability to maintain sleep, waking up at least twice per night and difficulty falling back asleep. Most awakenings lasted for 1 or 2 hours. She used multiple sleep hygiene techniques such as avoiding daytime naps, using black-out blinds and restricting water at bedtime. She could not identify any triggers and

denied nocturia. Since re-starting HRT two years ago the awakenings have resolved. She is otherwise healthy and does not currently take any other medications.

Although HRT with either estrogen or estrogen/progestin is considered the most effective treatment for VMS, there is very limited evidence to support the its use in older women experiencing insomnia without VMS. A recent systematic review evaluated the effect of HRT on sleep in menopausal women and concluded that although self-reported sleep quality is modestly improved in women with VMS at baseline, the effect is uncertain in women without symptoms.[1] Overall the use of HRT for insomnia alone is not indicated.

Moreover, HRT carries an increased risk of coronary events, stroke, venous thromboembolism and breast cancer. The overall risk is believed to be lowest in women within 10 years of menopause or those under the age of 60.[2-5] PT is eleven years post menopause but does not have cardiovascular risk factors besides advancing age. Despite understanding these risks and evidence, PT's preference was to continue HRT.

With a goal of minimizing long-term risks, we discussed trialing a lower estrogen dose and transdermal methods of administration. A nested case-study compared the stroke risks between oral and transdermal HRT, finding that transdermal estradiol ≤50mcg did not increase the risk of stroke compared to non-users.[6] Other studies have shown similar findings.[7-10]

We recommended a trial of transdermal estrogen (25mcg patch) while maintaining her current progesterone dose, which she was agreeable to. We reinforced good sleep hygiene and helped PT set exercise goals to promote deeper sleep. We scheduled a follow-up appointment in 3 months and PT said she would consider stopping HRT if her sleep remained stable.

The incidence of women using HRT primarily for insomnia is not known but may be more common than we suspect. For most patients the risks outweigh the benefits; however, patients also weigh their own risks and benefits, and their perception of each may significantly differ from evidence-based literature. Pharmacists are involved in supporting patients through shared decision-making and by providing education. It is important to ensure patients are well informed and efforts are made to minimize potential risks of therapy where possible.

**PT is a fictional patient combining the characteristics of several cases that have been referred to the Clinic for HRT safety review.*

We would like to thank Cindy Zhang, BSc(Pharm), RPh, PharmD Candidate for her contributions to the case.

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Note

Each case study has been peer reviewed and qualifies as a non-accredited learning activity (CE-Plus) within the annual professional development requirement for licensure by the College of Pharmacists of British Columbia.

Your Responsibility

The recommendations in this case are based on the views of our clinicians after careful consideration of the best available evidence and needs of a specific patient. As a health care professional, you will assess each of your cases based on the patient's unique circumstances and in consultation with the patient and their care team.

If you would like to discuss one of your patients with us please contact the Clinic team.