Article

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An Online One-On-One Process Aiming to Reduce Burnout in Health Researchers, Personalized to Assist Females Regarding Clarification of Their Values Concerning Fertility Choices

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Abstract

Personalized medicine regarding the biopsychosocial model extends to females considering fertility choices through online interactions. The appropriateness of an online one-on-one intervention, personalized from an online group meeting designed to help researchers reduce their burnout, is investigated through narrative historical analysis. The change to the process was adapting it to the individual's schedule. Participants could become overwhelmed by the responsibility of schedule determination. This result is relevant for females considering their fertility choices, as recent publications suggest that online one-on-one interventions might help them in this regard. The outcome is that when they feel overburdened with decision-making concerning the timing of the intervention, personalizing a process by expecting participants to determine the timing of the intervention is ineffective. Yet, by considering their fertility choices through a clarification of their values in using a modification of the same process, females can reduce the decision-making burden, as those who are clear on their values experience the least difficulty in assuming responsibility for their participation. As such, changes are suggested to the process to improve the likelihood of success in helping females clarify their fertility values with personalization of online, one-on-one care.

Keywords: personalized medicine; biopsychosocial model; females; online healthcare; one-on-one interventions; narrative historical analysis; burnout; health researchers; values; fertility choices

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1. Introduction

Fertility choices for females refers to decisions they may make on their own or with others [1] regarding if, when, and how many times they become pregnant [2], influenced by a complex interplay of hormonal [3], emotional [4], health [5], social [6], economic [7], and cultural factors [8,9].

For this study examining fertility choices, females are those born with at least one functioning womb [10] and ovary [11] who, after the age of menarche [12], release an egg from no less than one ovary approximately every month [13] with the possibility of becoming pregnant if the released egg meets a sperm [14], either in a fallopian tube or in a Petri dish [15], and becomes successfully implanted in the womb [16]. "Females" will be the term used in this study in contrast to "women" as the latter term may extend to transgender persons in some contexts [17] without these features [18]—not a focus of this investigation.

Publications from the previous five years determine the assessment of fertility choices for females in this Introduction and for this study in general. The selection for research published within this timeframe is to correspond with the requirements for reviewers of MDPI journals, of which this journal is one, to assess the relevance of publications in relation to whether their references are no more than five years old [19].

Females may consider their fertility choices at several points in their life, when they (1) initially become aware that females can become pregnant [20,21], (2) first start to menstruate [22], (3) are given sex education [23], (4) begin sexual relations [24], (5) review their method of contraception [25,26], (6) identify a suitable mate for procreating [27], and (7) display the symptoms of perimenopause [28].

Additionally, females may consider their fertility choices for various reasons, some include if they (1) desire a child [29], (2) experience significant gynecological difficulties [30], (3) have a genetically inheritable disease [31], (4) have failed contraception [32], (5) are raped [33], (6) are unable to conceive after a year or more of unprotected sex [34], (7) experience parent pressure to conceive [35], (8) are diagnosed with a reproductive-affecting disease [36], (9) want to experience pregnancy but have no suitable mate [37], (9) become pregnant with multiple fetuses [38], (10) are pregnant with a fetus that will likely have life-affecting abnormalities [39], (11) experience an ectopic pregnancy [40], (12) are reaching the end of their reproductive years without becoming pregnant [41], (13) elect never to have children [42], or (14) fear death (especially regarding climate change) [43].

At any of these times or for any of these reasons, females may seek information regarding their fertility choices. The type of information they seek depends on several factors: (1) their life stage [44], (2) the significance of the matter [45], (3) the importance of timeliness [46], (4) access to information [47], (5) trust in the information [48], (6) support from significant others [49], and (7) the consequences of their choice [50]. Those that they may turn to for information range from a (1) mother [51], (2) partner [52,53], (3) family member [52,54], (4) friend [52,55], (5) healthcare provider [56], (6) spiritual advisor [57], (7) telephone hotline [58], (8) books [59], (9) pamphlets [60], or (10) the Internet [61]. Additionally, females can obtain fertility-related information in group settings [62], one-on-one [60], or alone [63]. Moreover, these alternatives can be used in combination at various times.

The fertility choice of females thus depends on a myriad of considerations, with the various options relevant in different dimensions, making the decision-making process confusing, complicated [64], and often overwhelming [65]. One way females can reduce the amount to consider is by contemplating their fertility choices in relation to what they value, as those who are clear on their values experience the least difficulty in making a choice [66]. Personal values are the broadly desirable goals that motivate individual action and serve as guiding life principles, affecting perception, cognition, and behavior over time and across situations—systematically studied in mainstream psychology since the 1990s [67]. Consequently, given their relevance to fertility choices, clarifying their values is the aim of interventions that aid females in making fertility decisions [68]. Females who aim to clarify their values assess the most helpful interventions regarding their fertility choices to be personalized [68] and one-on-one [60].

According to the World Health Organization, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [69]." In this regard, the effect of the environment on the individual and their psychosocial response to it on their biological functioning has been a focus in the literature on personalized medicine [70–72]. Personalized medicine, corresponding with this WHO definition of health, therefore includes consideration of the environment and living conditions of the person, beyond the biological characteristics of their disease [72]. Approaching personalized medicine from the perspective of the biopsychosocial model, individual responsibilities, social environments, and biological actions together account for the individual's health [73]. However, to integrate a wide range of data regarding machine learning technology, adaptations are necessary for the biopsychosocial model to accommodate the range of possibilities for personalized medicine [74]. As such, to include a comprehensive understanding of various factors grounded in personal values, personalized medicine goes beyond a narrow focus on genetic predisposition [75]. In doing so, it becomes the more inclusive precision medicine demarcating diseases using multiple data sources to facilitate individualized therapeutic approaches [76].

Personalized medicine for aiding females in making fertility decisions extends to online one-on-one interventions [77]. One-on-one interaction beyond relevant information accessible online checks misleading claims and narratives from online information alone [78]. One study highlights the

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necessity of online interventions to include a one-on-one aspect, especially for contraceptive choices [79]. Fertility choice discussed in group settings is less desirable than one-on-one, as females downplay their vulnerability and avoid emotional arousal in a group [80]. Online one-on-one interventions, as one form of telemedicine, are found to help reduce stigma and embarrassment associated with seeking emotional support regarding fertility decisions [81].

The Health Narratives Research Process (HeNReP) is an author-designed and facilitated online one-on-one intervention. It evolved from the earlier online group process of the hospital-affiliated Health Narrative Research Group (HeNReG) to help alleviate burnout in researchers. The investigation of this study concerns its applicability for modification to aid females in clarifying what they value when considering their fertility options.. Gender-related factors are the foundation of this investigation. They are regarding a 2025 publication on the UN Sustainable Development Goals of Well-Being, Gender Equality, and Climate Action [82] by the author. Why females who participated in this Process may need clarification of their values was investigated more recently in [83]. The result was that females participating in the HeNReP who felt unsupported in their decisions by significant others were those who reported an additional burden in deciding the timing of their engagement in the HeNReP.

This study examines data using narrative historical analysis [84] from publications regarding the online one-on-one HeNReP in comparison with the earlier online group process of the HeNReG, with other source data collected and available to the author. The aim is to identify the type of changes that are relevant to helping females clarify what they value regarding their fertility choices based on the results of these previous publications and data. The supported assumption is that females who are clear about their values can commit themselves to their fertility choices at the appropriate time, considering relevant biological and environmental factors [85].

2. Materials and Methods

The method is historical narrative inquiry [86]. Its selection is for analyzing the materials, including the relevant details of publications by the author on the HeNReP and records concerning the group process of the earlier online HeNReG. For the HeNReP, these records include (1) the individual Messenger entries for the one-on-one HeNReP, (2) annual reports, (3) email exchanges between the process facilitator and the participant, (4) in-person communications between the facilitator and the participant, (5) membership records tallied during the individual years of participants engaging in the HeNReP, and (6) feedback form responses of the participant provided to the facilitator at the end of the HeNReP. Regarding relevant records of the earlier online group meetings of the HeNReG, these records include (1) the weekly posts on the yearly private Facebook group of the HeNReG, (2) individual Messenger entries, and (3) the responses to the feedback forms provided by the participants to the facilitator at two points in the HeNReG.

An inquiry beyond a text description, historical narrative analysis is a social and historical contextualization of the content and structure of these publications and records [87]. The chosen approach for this analysis is the most common for historical data interpretation [88,89]—chronological descriptive ordering [90]. The purpose is to reveal relevant aspects of the published works and records identifiable when considering those females who participated in the HeNReP but expressed an increased burden from being required to control the timing of the intervention process. A triangulation of sources is employed to reduce bias and increase confidence in the robustness of the research results. This triangulation determines the external and internal validity, situating the data within historical contexts. [89].

The publications concerning the HeNReP are [83,91]. There are several works on the HeNReG [92–97]. They include information regarding the HeNReG before and after the COVID-19 restrictions required that the group be online. The focus of this study is the online HeNReG meetings, not the in-person meetings held preceding the COVID-19 limitations. These publications are available for scrutiny by any interested researcher, aiding in the avoidance of bias. However, an informed consent agreement between the participant and the facilitator—approved in writing by the participant before commencing either intervention—means that the original records of the participant's contributions in the Facebook groups, Messenger, the feedback forms, and emails are private. The permission granted by the participants is for only anonymous reference to participant-recorded comments in the Facebook groups, Messenger, or feedback forms.

The questions asked regarding the publications and records are two: (1) How do the female participants who did not complete the online one-on-one HeNReP compare with those females who did not complete the online group process of the HeNReG? and (2) How is the HeNReP modifiable to help females make values-based fertility decisions? The answer to the first question is the data presented in the Results. The answer to the second is an analysis of the results in the Discussion..

3. Results

Both the HeNReG, a group process, and the HeNReP, a one-on-one process, were freely offered interventions delivered online to researchers who self-identified as burned out. The HeNReG, a pre-COVID-19 in-person weekly two-hour group meeting, became a weekly two-hour online meeting on the private Facebook group created yearly for HeNReG participants. The details of the HeNReG are reported elsewhere [92–97]. There is no repetition of them here.. The HeNReG evolved into the HeNReP based on the perceived participant preference to interact with the facilitator alone during the online HeNReG [92–97] rather than with group members. What primarily differentiated the HeNReG and the HeNReP was that the meetings between the participant and the facilitator were no longer weekly or two hours in length. When it was convenient for them, for the length of time they preferred, was when they occurred. It was the participant's responsibility to respond to the questions asked by the facilitator at a time they selected.

There is a historical ordering of the data in Table 1. The group process of the HeNReG had more than twice as many participants per year as in the years with the most HeNReP participants. At least three-quarters of the participants in the HeNReG completed the process, whereas at most a little more than half of its participants completed the HeNReP. There were various reasons participants did not complete the process. The focus of this study is on females, their representation in both of these interventions, and those who completed the process. Table 1 shows that females represented the greater number of participants in both the HeNReG and the HeNReP. However, they represented a greater percentage of the participants in the HeNReP. Females were approximately two-thirds of the HeNReG regarding the percentage of those who completed either program. The percentages for the three years of the HeNReP were wide-ranging with no pattern. These number results from an examination of relevant documents and websites over the five years of offering these online programs.

Table 1. Number of participants of the HeNReG between 2020 and 2022 by academic year, and number of those of the HeNReP from 2022 to 2025 by each academic year, the number who completed either process (percentage), those who were female (percentage of participants), and, of the females, those who completed the process (percentage of completed).

	HeNReG: 2020–2022		**HeNReP 2022–2025**		
	2020/2021	**2021/2022**	**2022/2023**	**2023/2024**	**2024/2025**
Participants	20	19	7	7	2
Completed	15 (75%)	15 (79%)	4 (57%)	0 (0%)	1 (50%)
Female	13 (65%)	12 (63%)	6 (86%)	5 (71%)	2 (100%)
Female completed	10 (67%)	9 (60%)	4 (100%)	0 (0%)	1 (50%)

Source: for the HeNReG from [92], and for the HeNReP from [91]. Both publications report these numbers from an analysis of Facebook or Messenger participation and feedback form results.

Of those females who did not complete either the HeNReG or the HeNReP, some left because of feeling overwhelmed. For the HeNReG, this was a result of residual depression they reported to the facilitator, separate from their burnout. In the case of the HeNReP, there was no identification of depression as a factor. Instead, participants described the feeling of being overwhelmed as resulting from the responsibility of having to decide when to participate in the online interaction, as they lacked support from significant others in their lives. This result is particularly remarkable because only two participants felt overwhelmed in this way, and they had been members of both online groups.

Table 2 demonstrates that neither participant 1 nor participant 2 was a member of the HeNReG in its first year online. However, both were members in the second year it was online, and neither completed the process. Both related that residual depression beyond their burnout was the reason for leaving the group. Yet, both participants demonstrated their interest in the program by later joining the online one-on-one process of the HeNReP. Participant 1 waited until the second year of the offering to participate. Participant 2 engaged in the HeNReP but did not complete it in the last year. In each case, both participants informed the facilitator that they could not complete the program because they were overwhelmed by having to remember and decide when to participate, lacking support from significant others.

Table 2. Female participants of the HeNReG between 2020 and 2022 by academic year, and those of the HeNReP from 2022 to 2025 by each academic year, who could not complete the online process and indicated an additional burden beyond their burnout. During the years of the HeNReG, reported as from residual depression. During the HeNReP, the process ended with a participant feeling overwhelmed in determining when to participate, due to a lack of support.

	HeNReG: 2020–2022		**HeNReP 2022–2025**		
	2020/2021	**2021/2022**	**2022/2023**	**2023/2024**	**2024/2025**
Participant 1		X		X	
Participant 2		X			X

Source: for the HeNReG from [92], and for the HeNReP from [91]. Both publications report these results from an analysis of Facebook or Messenger participation and feedback form results.

It is relevant to consider the demographic information of these two participants and the reasons for their residual depression, causing them to leave the HeNReG. Table 3 presents that both females were middle-aged. One was a graduate student and the other a social worker. The first participant assumed the role of caregiver of a parent with a terminal illness as a result of other family members providing insufficient and ineffective support. By the time of her participation in the HeNReP, that parent had died. This loss left her unclear on what she now valued in life and overwhelmed with daily decision-making, including participating in the HeNReP. The second participant was diagnosed with a neurodivergent condition that made it difficult for her to make decisions. However, her focus during her participation in the HeNReG was not on this difficulty. Instead, it was the residual depression she experienced as a result of the lack of support she received from her family members, given her neurodivergence. Yet, as a member of the weekly, two-hour group process of the HeNReG, she was not required to decide the timing of the intervention. The problem with her inability to decide when to participate was not evident until making this decision was her responsibility. The reason for being unable to complete the process then became feeling overwhelmed because she was unclear on what she valued in making decisions, given the continued lack of support by her siblings for her neurodivergence.

Table 3. Participants who could not complete the HeNReG (who also could not complete the HeNReP), their demographic, and the reason given by each participant for their non-burnout-related depression expressed during their participation in the HeNReG.

	Demographic	Participant perceived reason for onset of non-burnout-related depression
Participant 1	Middle-aged Graduate student	Assuming the role of caregiver for a parent with terminal illness, with insufficient and ineffective support from other family members
Participant 2	Middle-aged Neurodivergent Social worker	Lacking support for neurodivergence from siblings

Source: Information gathered from emails, messages, and in-person communications.

4. Discussion

The publications on the HeNReG [92–98] and the HeNReP [83,91] outline the process of these interventions. Participants respond to question prompts regarding how they define themselves as researchers. These questions encourage the most objective answers for those promoting the most subjective responses. Questions then follow an order of when, where, who, what, how, and why, with one question asked of the participant by the facilitator each session. The asking of when, where, who, and what questions is over four sessions, how questions for five sessions, and why questions for six sessions. How questions and why questions gain by one over the first four types of questions because the process provides the conditions for the participant to consider what they value to answer the more subjective questions. Over the 28 sessions, the participant develops a trust in the process for considering values and looks to the facilitator as an "authentic leader" [99–104] in doing so.

As an authentic leader, the facilitator of the online one-on-one HeNReP can structure the questions asked of participants to change the process to a Health Narratives Fertility Process, or the HeNFeP. As such, examples of the questions, after initially asking the participant to describe themselves, are in Table 4.

Table 4. The asking order of questions and the first word of each type of question asked regarding examples of the twenty-eight questions posed to female participants of a HeNFeP for clarifying their values regarding their fertility choices.

Order	First Word	Body of Question
1	Describe	yourself regarding your fertility choices
2	When	have you thought about your fertility
3	When	did you consider whether you could become pregnant
4	When	did you idealize the male to impregnate you
5	When	have you worried about the possibility of pregnancy
6	Where	could you ask for help in making fertility choices
7	Where	do you locate the most trusted fertility information
8	Where	is the healthcare provider you confide in with fertility choices
9	Where	would you go online to find fertility information
10	Who	has spent time with you talking about fertility choices
11	Who	would support your fertility choices
12	Who	would you trust with your fertility choices
13	Who	has given you valuable information regarding fertility choices
14	What	would you do if you became pregnant
15	What	conditions would make you want to be pregnant
16	What	support would the father provide if you were pregnant

17	What	would you do if you couldn't realize your fertility choices
18	How	would you organize your time commitments if pregnant
19	How	would your health matter if you became pregnant
20	How	much would you tell the father about your pregnancy
21	How	would you know if you wanted to be pregnant
22	How	do you decide what information is relevant about pregnancy
23	Why	are you unsure this the right time to be pregnant
24	Why	does climate change matter regarding fertility choices
25	Why	is there tension between males and females about pregnancy
26	Why	does it matter how you respond to a pregnancy
27	Why	should you know the health-related issues of pregnancy
28	Why	are you reconsidering what you value in your fertility choices

From the results of the females who did not complete the HeNReP because they were overwhelmed with deciding when to participate, the structure of a HeNFeP would take on the characteristics of the HeNReG by being at a regularly scheduled time. However, what that regular time would be would depend on the urgency of clarifying a female's values regarding her fertility choices. The examples of questions posed above are the type that a female might ask to determine what she values if seriously considering pregnancy, either to become pregnant in the traditional manner or through fertility treatments. These would not be appropriate to ask if a female has become pregnant unexpectedly and does not want to continue the pregnancy. A female in this condition must make decisions quickly and is not prepared to think speculatively as complexity arises when women feel they lack choice without a justification judged as legitimate for ending a pregnancy [105]. Similarly, these questions are not appropriate for children who first learn that females can become pregnant because they are not yet aware of all that is associated with this knowledge—an unfortunate limitation for female children undergoing fertility-affecting cancer treatments [106]. For those who are at the stage in life of actively thinking about fertility choices, the online one-on-one HeNFeP could be once a week for twenty-eight weeks. A question would be posed to the female each week at the same time over the online platform agreed to between the facilitator and the participant. If a female is about to undergo fertility treatments, she might instead opt to complete the HeNFeP in a shorter time span [107], possibly even in one day. Ending fertility treatments may be a reason for a female to consider these types of questions over an extended time period [108].

There are limitations to this study. The first is that much of the data for this assessment is not publicly available due to the agreement between participants and the facilitator at the time participants joined either process. Open to scrutiny is the anonymous information related to the HeNReG and HeNReP available from the author upon request—along with the relevant publications on HeNReG [92–98] and the HeNReP [83,91]. Secondly, the results focus on two participants in a program that had only sixteen participants over its three years. Yet, these results are the basis of the suggestion that the meeting schedule of the HeNReP not be determined by the participants. Not, not only is the number of participants who were unable to complete the process low, but the reasons for their inability to complete the process were not dependent on the HeNReP. Instead, they are attributed to a lack of support by significant others and may represent a function of the residual depression these two participants experienced during their first membership in the HeNReG. Therefore, there may be no need to adjust the method of HeNFeP to be more in line with the original HeNReG. Future research in this area would compare the results of offering a HeNFeP at a specific time according to a schedule, with the participant deciding when and for how long they would engage with the process online. Also to be investigated are the types of questions that are most appropriate as prompts. Those suggested are general questions. The female's circumstances in making fertility choices could inform modifications to the questions designed by the facilitator. An additional limitation is that a facilitator of a HeNFeP must be considered an authentic leader [99–104] to have the trust of participants. Becoming an authentic leader requires dedicated practice [99]. Lastly, it would be significant to determine whether there could be a creation of age-appropriate questions for children who first become aware of fertility choices. If so, they could be asked online one-on-one as part of health classes in educational settings.

5. Conclusions

There were two questions regarding an online one-on-one process for reducing burnout in health researchers, one personalized to assist females in clarifying their values concerning fertility choices. (1) How do the female participants who did not complete the online one-on-one HeNReP compare with those females who did not complete the online group process of the HeNReG? and (2) How is the HeNReP modifiable to help females make values-based fertility decisions? What was determined is that those females who did not complete the HeNReP were overwhelmed with the decision-making involved in determining the schedule for the intervention because of a lack of support from significant others. This result was in contrast to those females who did not complete the HeNReG, as their reason was residual depression. Nevertheless, the consideration was that possibly it was residual depression that affected their perception of support and made them overwhelmed. Based on these results, the HeNReP can evolve to become the HeNFeP for considering fertility choices, both in the type of prompts provided to participants and in setting up an agreed-upon schedule for online one-on-one meetings within the selected online platform. In making these changes, the expectation is that female participants can become more aware of what they value concerning their fertility choices.

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Institutional Review Board Statement: Ethical review and approval were waived for this study due to it being historical research.

Informed Consent Statement: Written informed consent was obtained from all individuals when they initially agreed to participate in the HeNReP or the HeNReG.

Data Availability Statement: No new data were created as this is a historical study.

Conflicts of Interest: The authors declare no conflicts of interest.

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