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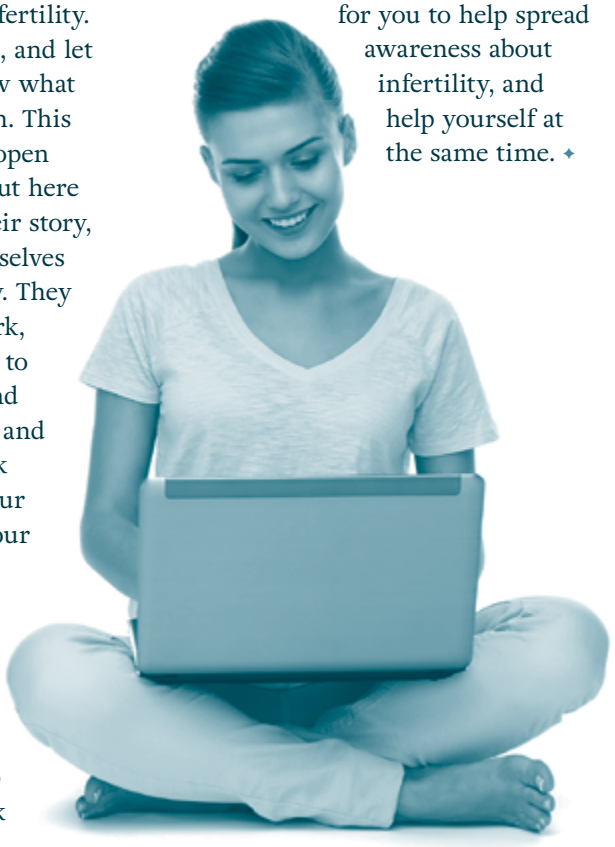
TELLING YOUR STORY

By Barbara Collura, *President, RESOLVE: The National Infertility Association*

RESOLVE just wrapped up the 25th anniversary of National Infertility Awareness Week (NIAW). One of my favorite parts of NIAW is the Bloggers Unite program, when we ask the blogging community to come together and recognize NIAW that week and write a special blog raising awareness about infertility. As I read through the blogs posted this year (159 in all), I was in awe of these amazing people for being so brave to share their story. They are choosing to write about their most private infertility journey, and share that with the world via their blog.

One of the blogs I read was not an "infertility journey" blog at all. It was a really fun blog that a couple created to document their favorite recipes (he's a chef), their home improvement projects, and their life in general as a young, newly married couple. Well, this blog post was different. They decided to come out to their followers during National Infertility Awareness Week that they have been struggling with infertility. They want to raise awareness, and let their friends and family know what they have been going through. This took tremendous courage to open themselves up to everyone. But here is what I know: by telling their story, they are in fact helping themselves on this most difficult journey. They are creating a support network, they are allowing themselves to be informed and educated, and they are breaking the silence and normalizing infertility. Thank you. Thank you for telling your story. Thank you for doing your small part in educating the public about a disease that impacts 1 in 8 couples. I am so proud that RESOLVE created the environment to allow bloggers to come together, and even those who haven't used their blog to talk about their infertility..yet. This is our mission and what we are called to do every day: educate the public about the disease of infertility.

I encourage you to read Kevin Jordan's personal story in this issue of our newsletter. It's rare that we receive article submissions from men willing to share their story, so we especially appreciate his openness. I hope you gain some comfort in reading other people's stories through this newsletter or via a blog. And I hope you too find a way that works for you to help spread awareness about infertility, and help yourself at the same time. ✦



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WHY UNEXPLAINED INFERTILITY IS SOMETIMES EXPLAINED DURING IVF

By Kara Nguyen, MD, MPH

It is humbling to put into perspective that even among fertile couples who have no issues getting pregnant, they only have a 20% chance of achieving pregnancy any given month they try. In other words, they are unsuccessful **80%** of the time! This is what we see when we look at the success of thousands of couples who start the journey to build their family. Most will achieve pregnancy within the first year of trying, but others may take longer or never achieve pregnancy at all.

When couples come to a fertility specialist, they want answers. We proceed through the diagnostic testing to identify a cause for their inability to achieve pregnancy. In about 20% of cases*, a couple will get a very unsatisfying result: unexplained infertility. It is important to understand what this really means. The diagnostic testing we have available will only identify the major reasons why a couple may have a difficult time getting pregnant, but it certainly cannot identify all the reasons. If the fallopian tubes are blocked or there is no sperm, these are obvious major obstacles to becoming pregnant. There are no tests available for more subtle infertility factors such as inadequate egg quality which could result in fertilization failure.

Among couples with unexplained infertility, we also know that despite all of the normal diagnostic testing, they only have a 1-4% chance of achieving pregnancy during any given month of trying without fertility treatment — much lower odds than 20%! This is why many couples ultimately choose in vitro fertilization (IVF) ,to help attain their family goals. In fact, a large randomized trial on couples with unexplained infertility called FASTT showed that couples who are unsuccessful after three cycles of Clomid and intrauterine insemination (IUI) should proceed to IVF as their next treatment. These couples will more likely become pregnant sooner and will therefore spend less money on fertility treatment.

Oftentimes, subtle infertility factors can be seen during IVF; therefore **IVF can also be diagnostic.** Even women with excellent ovarian reserve can have inadequate egg quality — which can be seen under the microscope at the time of egg retrieval. Couples with mature eggs and normal semen parameters may have poor embryo development after fertilization which can also only be seen during IVF. Sometimes embryo development is the issue. Sometimes it is an implantation issue. These are the diagnostic benefits of IVF that cannot be detected in any other way. In addition, once identified, there are many options for treating and overcoming these infertility factors with the assistance of IVF.

The diagnostic testing available to a fertility specialist will only identify the major reasons why a couple may have a difficult time getting pregnant but it certainly cannot identify all the reasons.

Although IVF does not fix all infertility factors, it is still the most successful treatment option for many couples and affords many bonuses. The risk of multiple gestation (twins, triplets, etc.) can be controlled with the number of embryos that are implanted. The woman's fertility can be preserved by creating surplus embryos which can be frozen at her current age and transferred later when she is ready for baby two or three. ✦

*RESOLVE.com: *What Is Infertility?*

Kara Nguyen, MD, MPH, Reproductive Medicine Associates of Philadelphia & Central Pennsylvania, received her medical degree from Jefferson Medical College and Masters in Public Health at the Johns Hopkins University. During her residency training in Obstetrics and Gynecology at Christiana Care Hospital, she received awards for excellence in teaching and research. She was recognized as the first OBGYN accepted into the prestigious Clinical Investigator Training Program of Harvard Catalyst. She has also served on the Committee on Genetics for the American College of OBGYNs and is an active member of the ASRM.


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UNDERSTANDING FERTILITY MEDICATIONS

By Russell Gellis, Rph

As couples make the decision to seek advanced fertility treatment, they may often become quickly overwhelmed with all the different medications they will need to take. Before treatment begins, fertility patients will likely learn about their treatment protocol, which may include taking drugs that provide or suppress hormone activity. Throughout the treatment protocol, patients are scheduled to visit their IVF center so their physician can monitor the effects of the medications and make necessary adjusts where needed to optimize treatment outcome.

Obviously physicians practicing in this area of medicine understand all the medications and the best protocols for patients, but may not always have the time to explain in great detail all the drugs and why they are being used. This article is for fertility patients who desire to know more about fertility medications, including simple explanations about their mechanism of action and timing at which they are being prescribed.

The Natural Female Menstrual Cycle

Probably the best way to begin understanding fertility medications is to first have a solid understanding of the natural female menstrual cycle. The cycle begins when both estrogen and progesterone drop in the blood stream. We will talk more about estrogen and progesterone later but for now it is important to understand that it is the drop of these two hormones that trigger the start of the menstrual cycle. When these hormones fall in the blood stream, two main things will occur including:

1. The uterine lining will shed and menstrual bleeding will begin. Note: the first day of bleed marks the first day of the cycle.
2. Low levels of estrogen and progesterone in the blood trigger organs in the brain (hypothalamus and pituitary gland) to begin producing two hormones called FSH (follicle stimulating hormone) and LH (luteinizing hormone).

FSH and LH travel through the blood stream and activate the ovaries to begin growing follicles. Each follicle is sphere shaped and contains one egg. FSH and LH will continue to be produced in the brain for approximately the next 14-15 days, and follicles will continue to grow and eggs to mature. Throughout this time period, also known as the follicular phase of the cycle, growing follicles will produce the hormone estrogen. Estrogen in turn acts on the uterus to grow the uterine lining in preparation for embryo implantation.

At the tail end of the follicular phase (approx. day 14 or 15 of the cycle), the pituitary gland in the brain will produce a large amount of LH, also known as the LH surge. The LH surge acts to final maturate the eggs and causes the largest follicle on the ovary, also known as the graafian follicle to rupture.

The rupturing follicle will then release a mature egg (ovulation) into the fallopian tube, where it may or may not become fertilized. The remaining ruptured follicle itself found on the ovary then becomes a short lived endocrine organ called the corpus luteum. The corpus luteum's funtion is to produce both progesterone and estrogen. Progesterone acts on the uterine lining to create a sticking environment for potential embryo implantation. The act of ovulation and the creation of the corpus lutuem mark the beginning of the luteal phase (approx. 16-28), the last phase of the cycle.

If fertilization takes place, the fertilized egg will become an embryo, and travel down into the uterus, where it may or may not implant onto the uterine wall. If embryo implantation (pregnancy) occurs, the implanted embryo begins to produce the hormone HCG (human chorionic gonadotropin). The production of HCG will direct the corpus luteum to continue to produce the hormone progesterone, which allows the

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This article is for fertility patients who desire to know more about fertility medications, including simple explanations about their mechanism of action and timing at which they are being prescribed.

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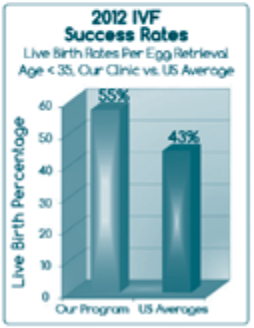

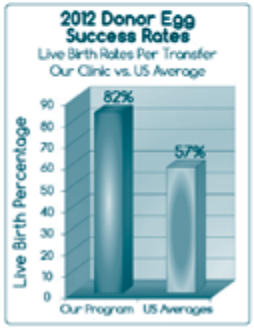

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UNDERSTANDING FERTILITY MEDICATIONS

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pregnancy to continue. If a pregnancy does not occur, HCG is never produced and eventually the corpus luteum will degenerate and stop producing the hormones estrogen and progesterone. As a result, estrogen and progesterone will drop in the blood stream, and a new menstrual cycle will begin.

The above overview of the natural menstrual cycle provides us a good foundation for understanding the various fertility medications used in fertility treatment protocols today.

FSH and LH Medications

Let's begin with FSH medications on the market today. Just like the natural FSH produced by the brain described above, commercially produced FSH drugs also act on the ovaries to produce follicles and eggs. The following FSH drugs listed below are commonly prescribed today: Follistim, Gonal-f, and Bravelle.

Menopur and Repronex also act on the ovaries to produce follicles and eggs but contain equal amounts of both FSH and LH. Physicians often prescribe these medications because they have LH activity, and it is theorized that LH is essential to the follicles ability to produce the hormone estrogen. It is not uncommon for physicians to use both FSH only drugs and FSH and LH drugs in combination in the same treatment protocol.

HCG Medications

The next class of medications contains HCG (human chorionic gonadotropin) activity, and are prescribed to mimic the LH surge that occurs in the natural menstrual cycle. From the onset this may not make sense because HCG was described as a hormone being produced by the implanted embryo in the natural menstrual cycle.

To mimic the natural LH surge, physicians can prescribe a bolus dose of HCG to final maturate the eggs because HCG has the same biological activity as LH. In case you are wondering why physicians do not just use an LH hormone to mimic the natural LH surge, there are two reasons. The first is that there is no LH alone hormone available on the market today indicated for producing an LH surge. The second reason deals with LH not having the pharmacological properties to efficiently deliver an effective LH surge.

HCG will cause your follicles to rupture, like an LH surge does in a natural menstrual cycle. However, your physician will schedule your egg retrieval well before follicle rupture will occur.

The following HCG drugs listed below are commonly prescribed today: Pregnyl, Novarel, Ovidrel, and HCG (Generic).

GnRH Agonist and Antagonist Medications

While the above HCG medications reflect naturally occurring hormones in the natural menstrual cycle, the next two medications we will discuss are hormones that impact the action of GnRH (gonadotropin releasing hormone). Naturally occurring GnRH is produced by the hypothalamus in the brain and works with the pituitary gland to produce both FSH and LH.

GnRH agonists are synthetic drugs that cause the release of FSH and LH initially but with continued use quickly suppress these hormones, thereby creating a clean slate on which to create a controlled ovarian hyperstimulation cycle for IVF. GnRH antagonists are used in controlled ovarian hyperstimulation cycles for IVF.

GnRH agonists and antagonists are prescribed by physicians during fertility treatment to essentially disable the pituitary gland from producing both LH and FSH. So if FSH and LH are so important to helping the ovary produce follicles and eggs, why would a physician want to disable the production of these two hormones during an IVF treatment protocol? Simply put, the answer is control: This allows the physician to have control over the patient's response to medications that are prescribed. If a physician prescribes hormones like FSH and LH and then allows the body to also produce its own hormones, the cycle may be become unpredictable and result it poor outcomes. For example, if the pituitary gland is not disabled during an IVF treatment protocol, it is possible the pituitary gland could produce a naturally occurring LH surge. If this happened during a treatment cycle, it is likely that all the follicles would rupture and all eggs would be released, leading to spoiled treatment cycle because the physician would have no egg to retrieve.

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UNDERSTANDING FERTILITY MEDICATIONS CONTINUED FROM PAGE 7

The GnRH agonist discussed above that is commercially available is Leuprolide Acetate Injection (Generic), the GnRH antagonists under the following drug names: Ganirelix Acetate Injection and Cetrotide

Progesterone Products

The last group of medications that we will discuss are the progesterone products. As you know from the natural cycle overview above, progesterone production is generated by the corpus luteum, and is essential for helping maintain a pregnancy. The vast majority of physicians will prescribe progesterone shortly after the egg retrieval to prepare the uterine lining for embryo implantation. If it is discovered that the IVF treatment cycle resulted in a successful pregnancy, progesterone is often times continued for the first 6-12 weeks post pregnancy.

The progesterone products discussed above are commercially available under the following drug names: Crinone, Endometrin, Prometrium and Progesterone in Oil injection.

Conclusion

These medications are some of main drugs prescribed during fertility treatment, but do not represent by far all drugs being used to treat infertility today.

We have all heard the expression "Knowledge is Power," and understanding your fertility medications before you seek treatment can only help your chances of achieving a pregnancy. In closing, I would like to wish anyone reading this article that might be seeking or considering fertility treatment the best of luck. ✦

Disclaimer – this article was not written by a physician and should not in any way be considered as substitute for the medical advice of your healthcare provider.

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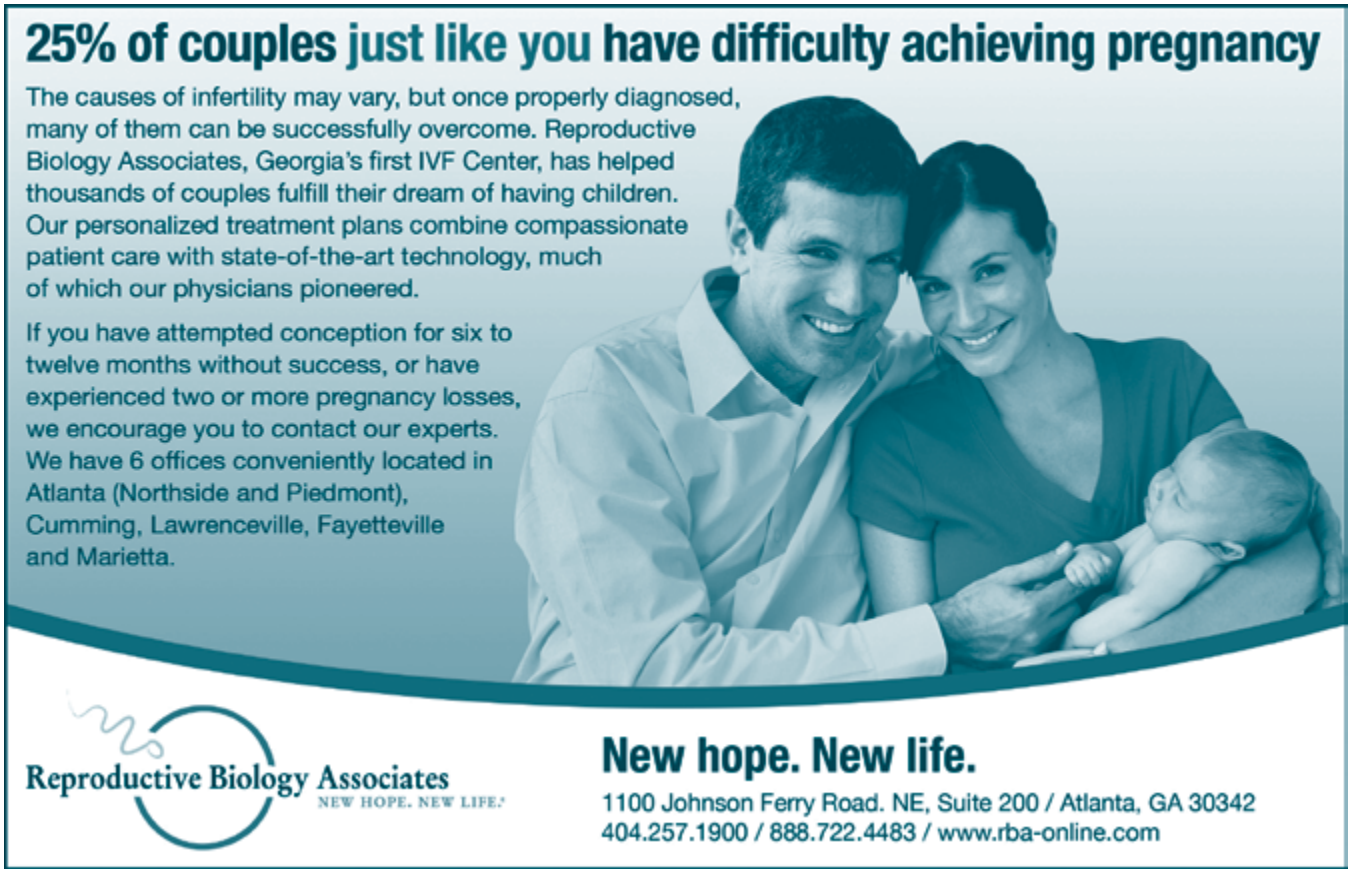

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PERSONAL STORY: Masculinity & My Infertility Journey

By Kevin T. Jordan

Taking these past few months to write this article, what has emerged as the most pivotal revelation has been a deeper understanding of how I grew up from a place of privilege, with access and support in ensuring I would accomplish any and all of my goals. Sure, I had to work for it. However, as I grew up, I became aware of my privileged background and how I was used to getting what I wanted to achieve. Experiencing infertility not only challenged this paradigm within my marriage, but also dealing with infertility as a male.

After years of dating my high school girlfriend, getting a college degree, securing a good paying job and buying our first house, it was easy for me to think we had made it to a comfortable stage in life that would center around enjoying building our life together and eventually starting a family. After six months of trying to get pregnant, that privileged perspective I had subconsciously grown up in began to erode. After a year of being unable to conceive, despair had set in. We knew what we wanted and could not have it. For the first time in my life, I felt defeated — unable to achieve this goal.

Upon receiving the diagnosis of "unexplained infertility," I had to be strong for my wife. This was difficult. The scientist and engineer in me just wanted to find a solution, but I had to accept that it was not that simple. The option to pursue IVF would be rather invasive for my wife. I needed to consider not only my desire to have a family but the cost that these procedures would put my wife through — physically and emotionally. I was not going to ask her to take my last name, much less manipulate hormone levels with no root cause explanation or do painful exams that leave one emotionally and physically distraught for days. It was time for a more thorough reflection. I needed to really question what was really important here.

Re-orienting myself to the idea that I may never see my wife pregnant, may never feel our baby kick inside her, may never witness my wife give birth — I determined that I needed to rebuild my concept of "family." Both raised as Catholics in our homes and education, we both came into our marriage with a desire to have a family. However, in encountering infertility, I began to passionately question and consider answers to the particular philosophy: "*What is the definition of family?*" I found the need to take up this question all the more emphatically when I would encounter questions and advice ranging from the likes of "*You guys have kids?*" to the bold and unasked for, "*When you have kids and become a parent, it just changes everything...*" I still have not found the perfect response to these insensitive remarks when I encounter them in moments at the workplace, in the grocery store, or at the doctor's office. As a guy, sometimes I just want to put on my uber-masculine face and curse them out, and other times I just don't even have the energy, time, and patience to explain to them their inability to see how those comments and questions are extremely hurtful to a married guy in his late twenties trying to mourn the fact that he may never be a dad.

Re-orienting myself to the idea that I may never see my wife pregnant, may never feel our baby kick inside her, may never witness my wife give birth — I determined that I needed to rebuild my concept of "family."

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PERSONAL STORY

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In the meantime though, as I still search for the perfect response, I have started to harness my frustrations in a constructive manner. Numerous passions have come to fruition: adopting two dogs, quiting my engineering job to start graduate school in a new discipline, running a marathon, and starting a peer-led RESOLVE support group (just to name a few). My experience with infertility has led me to all of these new journeys. And yes, some are particularly challenging — but nothing has been as challenging as facing my infertility on a daily basis in a society that often fails to make space for masculine sensitivity. Men are expected to "grow up" and "take care of the family" but what happens when these traditional expectations cannot be reached? I wish that in all of this, in coming out and writing about my infertility, more awareness will be made to the male experience with infertility and more discussion will occur about new conceptions of manhood and family.

Nothing has been as challenging as facing my infertility on a daily basis in a society that often fails to make space for masculine sensitivity.

In writing all of this, I have had to wonder, how have I transitioned from where I was three years ago from despair to contentment...maybe even happiness? Subconscious at first, it become more obvious that for the first time in my life I felt like I was being who I was called to be, I was being myself. Did this necessarily remove all the pain? No, but it has been humbling for me to see the perspectives of those around me and be resolute in my convictions that I have held all my life and act on them in a visible, valuable way. Am I saying it is necessary to have infertility to gain this perspective on life? Absolutely not. However, being able to recognize these defining moments in life as not just a time to mourn, but a time to grow will make the experience that much more bearable. I know it is has made me a better person, a better husband, and maybe someday...a better dad. ✦

Kevin T. Jordan lives in Grand Rapids, Michigan with his wife and their two dogs. Previously an engineer, he is currently a graduate student in medical physics where he intends to improve patient outcomes for those battling cancer. In his free time, he is an avid runner, reader, downhill skier, and traveler who values spending time with family and friends.

MALE WORKUP:

What to Expect When Visiting Your Doctor

The basic work-up for men begins with an appointment with a physician to discuss medical history and current medical status

Past medical problems that may affect infertility

- Mumps after puberty
- Hernia repairs
- Athletic injuries to the groin
- History of undescended testicles

Sexual history may affect fertility

- Possible STDs
- Urinary tract infections
- Prostatitis
- Impotence or ejaculatory problems
- Certain prescription medications as well as excessive smoking, drinking or drug use can affect sperm quality

The Physician will examine the following:

- Hair growth pattern in the genital area, which should be diamond shaped, extending upward toward the navel
- A general examination of the penis for abnormalities
- An examination of the scrotum with careful attention to the size and firmness of the testes
- Prostate examination

Hormone levels in the male are very important in defining normal fertility

- FSH Levels: The normal range is 4 to 10 mIU/mL
- Androgen Levels - Testosterone : The normal range is 300 to 1,111 ng/dL (nanograms per deciliter)
- Prolactin: The normal level is less than 20ng/mL

HOW DO YOU KNOW WHEN ENOUGH IS ENOUGH?

By Bonnie Cochran, LCSW

When pursuing infertility or the world of assisted reproductive technologies, how do we know when to shift gears from "full speed ahead" to "stop the engines" or "enough is enough?" With all the latest technologies, new sciences and miracle baby stories that we see at our local grocery store checkout stands and view on social media, the idea of giving up or stopping treatment becomes more unfathomable or unacceptable for many couples. After all, couples are frequently told, "hang in there — stay positive and you will get pregnant."

I recently posed the question, "How do you know when enough is enough?" to our monthly drop-in infertility support group. As standard protocol, I gave them a heads up via email reminder about our date, time, location, etc. along with the topic for this month. I also prefaced this topic with: "Please think about what this means to you psychologically, socially, spiritually, emotionally, financially, etc. Be gentle with yourselves, as I believe this is a tough piece to think about, but also important to address."

Traditionally we have ten to twelve people on any given month, but this time we had a total of only seven women walk through the door. I wouldn't have thought much about our group being a little smaller this month because people do have busy schedules, especially when engulfed in fertility related treatments. After all, there will be times when our group is a little larger and even possibly somewhat smaller.

Standard protocol for most support groups begins with welcoming any new people, (in our case, we are exclusively an all women's group) followed with what we call checking-in. This is an opportunity for everyone to get reacquainted and to catch up from the previous month — it also serves as a chance to revisit and retell their stories. Getting settled-in and comfortable with the energy of the group also supports and promotes group cohesiveness. After check-in, we share all the trials and tribulations from what had transpired from the previous month.

Our group this particular evening moved ever so smoothly right into catching us up. Everyone was very engaging, offering support and validation when appropriate. Some stories were very long and detailed, and some were shorter and to the point. Some people added humor to their struggles while others shared tears. Their stories could have been anyone's stories — anyone dealing with infertility that is.

"I am getting ready for my next IUI."

"I just had another ectopic, resulting in losing my other fallopian tube."

"We have decided to go the IVF route. We think our chances are promising. "

"I just got demoted because I was told I am not focusing on my job like I should be."

"My husband has a low sperm count."

...and so on. Of course, all very difficult stories to tell and absorb. Everyone in the group was touched with heartfelt emotion. After all, the messages were filled with hope, false hope, and/or heartache. How much more confusing can that be?

After everyone finished checking-in and catching us up, I then posed the question to the group about "When do you know when enough is enough?" To my dismay, especially to a group that had been very connected up to this point — chatting away with advice, validation, support and suggestions suddenly switched gears of engagement to — a *big halt!* The room became silent. The energy had shifted. And as I looked around the room, I noticed heads were facing forward with turned down eyes. People were staring at the floor, at their feet or anywhere that suggested we had just brought up a topic that was clearly not comfortable — I suddenly felt like I was in a room with strangers.

I asked the group what they thought about the evenings' topic, and several people blurted out without hesitation, "I almost didn't come because of the topic." I was somewhat taken back, yet not convincingly surprised.

Fear of not being able to emotionally handle such a decision is a common reaction for so many, especially for women. Fear is what I felt from the support group that evening. In working with families dealing with grief and loss, we often say that women carry the emotionality for the

CONTINUED ON PAGE 15

family. I believe fear really is another way to camouflage the underlying grief associated with such a tumultuous and daunting decision as well. After all, who would choose grief over hope?

The decision to end fertility related treatment is not to be taken lightly. For most couples, ending treatment can feel like giving up, throwing in the towel — certainly not options that were discussed at length in the original plan. It is a difficult and complex process, as there is always some probability of success in further attempts.

As you may recall, the newsstand is constantly reminding us of that possibility — "one more attempt and one more try will eventually lead us to bringing home our baby."

Certainly we do not want to overlook the paucity of couples being grateful for someone else making the decision for them. Doctors and husbands usually take on these roles, and they are the ones who are most likely to put their foot down and push the "enough is enough" syndrome. For some, this can actually be a blessing in disguise. One woman in the support group confirmed this notion with, "I would welcome the decision to be taken out of my hands at this point."

In order to truly reach a decision of ending treatment, couples need to be in a place where they are willing to examine their fertility journey both individually and collectively — one that includes revisiting the past, understanding the present, and coming to terms for what possibilities are left for the future.

As one couple said it so beautifully, "What was once a beautiful dream slowly became a project filled with demands, commitments, expectations, and at times, a compromised marriage. However the gifts we have received along the way continue to hold us close. For that we are grateful!" ✦

RESOURCES:

Covington, Burns. *Infertility Counseling: A Comprehensive Handbook for Clinicians*, October 2006.

Bonnie Cochran, LCSW, is in private practice, specializing in grief and loss. She also is a founding member of 3HopefulHearts, a nonprofit organization that supports bereaved parents and families. Bonnie received both her bachelor's and master's degree in Social Work from Colorado State University. She is past chair of RESOLVE's Professionally Led Support Group Oversight Committee and currently facilitates a monthly RESOLVE infertility support group.

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You are not alone. One of the most important benefits of participating in a support group is obtaining a decreased sense of the isolation. So many people feel isolated when they are experiencing infertility. In a support group environment, feelings of anger, depression, guilt, and anxiety can be expressed, validated by others, and accepted as a normal response to infertility. Find a support group near you.

If you are ready to give back, consider leading a support group. Whether you have resolved your infertility or are still on your journey, as a peer-led support group host you will provide a valuable service to others with infertility, and no doubt you will find it beneficial — and rewarding too.

Join or Lead a Support Group

www.resolve.org/support-and-services

25 THINGS TO SAY (AND NOT TO SAY) to Someone Living With Infertility

Having infertility can feel embarrassing and isolating, and even well-intentioned people often say the "wrong thing" to people struggling with infertility. During the 2014 National Infertility Awareness Week, RESOLVE released this list to help you educate and empower your friends and family who want to support you.

Things to Say:

1. **Let them know that you care.** The best thing you can do is let your infertile friends know that you care.
2. **Do your research.** Read up about infertility, and possibly treatments or other family building options your friend is considering, so that you are informed when your friend needs to talk.
3. **Act interested.** Some people don't want to talk about infertility, but some do. Let them know you're available if they want to talk.
4. **Ask them what they need.** They may also appreciate if you ask them what the most helpful things to say are.
5. **Provide extra outreach to your male friends.** Infertility is not a woman's-centric issue; your male friends are most likely grieving silently. Don't push, but let them know you're available.
6. **When appropriate, encourage therapy.** If you feel your friend could benefit from talking to a professional to handle his or her grief, suggest therapy gently. If you go to therapy regularly, or ever have, share your personal story.
7. **Support their decision to stop treatment.** No couple can endure infertility treatments forever. At some point, they will stop. This is an agonizing decision to make, and it involves even more grief.
8. **Remember them on Mother's and Father's Day.** With all of the activity on Mother's Day and Father's Day, people tend to forget about those who cannot become mothers and fathers. Remember your infertile friends on these days; they will appreciate knowing that you haven't forgotten them.
9. **Attend difficult appointments with them.** You can offer to stay in the waiting room or come into the appointment with them. But the offer lets them know how committed you are to supporting them.
10. **Watch their older kids.** Attending appointments may be difficult if they have older kids at home.
11. **Offer to be an exercise buddy.** Sometimes losing weight is necessary to make treatments more effective. If you know they are trying to lose weight, you could offer to join them because it would help you achieve your personal fitness goals as well.
12. **Let them know about your pregnancy.** But deliver the news in a way that lets them handle their initial reaction privately — email is best.

Things Not to Say:

13. **Don't tell them to relax.** Comments such as "just relax" create even more stress for the infertile couple, particularly the woman. The woman feels like she is doing something wrong when, in fact, there is a good chance that there is a physical problem preventing her from becoming pregnant.
14. **Don't minimize the problem.** Failure to conceive a baby is a very painful journey. Comments like, "Just enjoy being able to sleep late...travel...etc.," do not offer comfort. Instead, these comments make infertile people feel like you are minimizing their pain.
15. **Don't say there are worse things that could happen.** Who is the final authority on what is the "worst" thing that could happen to someone? Different people react to different life experiences in different ways.
16. **Don't say they are not meant to be parents.** "One of the cruelest things anyone ever said to me is, 'Maybe God doesn't intend for you to be a mother.'" Infertility is a medical condition, not a punishment from God or Mother Nature.
17. **Don't ask why they are not trying IVF.** Because most insurance plans do not cover IVF treatment, many are unable to pay for the out-of-pocket expenses. Infertility stress is physical, emotional, and financial.
18. **Don't push adoption or another solution.** So often infertile couples are asked, "Why don't you just adopt?" The couple needs to work through many issues before they will be ready to make an adoption decision or chose another family building option.
19. **Don't say, "You're young, you have plenty of time to get pregnant."** Know the facts. It's recommended that women under 35 see a fertility specialist after being unable to conceive for one year. Being young increases your chance of fertility treatments working, but it does not guarantee success.
20. **Don't gossip about your friend's condition.** For some, infertility treatments are a very private matter, which is why you should respect your friend's privacy.
21. **Don't be crude.** Don't make crude jokes about your friend's vulnerable position. Crude comments like, "I'll donate the sperm" or "Make sure the doctor uses your sperm for the insemination" are not funny, and they only irritate your friends.

CONTINUED ON PAGE 17

Things Not to Say *(continued)*

22. **Don't complain about your pregnancy.** For many facing infertility, it can be hard to be around other women who are pregnant. Seeing your belly grow is a constant reminder of what your infertile friend cannot have. Not complaining can make things a little easier for your friend.
23. **Don't question their sadness about being unable to conceive a second child.** Having one child does not mean a couple feels they have completed their family. Also, a couple may have had their first child naturally and easily but are now experiencing secondary infertility — infertility that comes after you've already had a child.
24. **Don't ask whose "fault" it is.** Male or female factor. Just because a friend has told you he or she is experiencing infertility as a couple, does not mean he or she wants to discuss the details.
25. **On the other hand, don't assume the infertility is female factor.** 1/3 of infertility is female factor, 1/3 is male factor, and 1/3 is unexplained. ✦

SOURCES:
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http://infertility.about.com/od/familyandfriends/a/12-Things-Not-To-Say-To-Someone-With-Infertility.htm
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