The effects of abortion and the critical thinking

Family, Abortion

Politics of Abortion Accessibility

(Author Note)

Abstract

This paper explores five peer-reviewed articles that report studies on the effects of abortion on the well-being of women who underwent abortions. It also reviews an ongoing study that touches on the effects of denied abortions. The paper examines arguments of the health effects, briefly touching also on the economic effects, of abortion and if these effects have great implications whether or not to limit the access of abortion to the female public. The published studies examined in the paper lead to suggest that abortions are generally safe and the side effects are minor and do not present huge risks. From that, the paper proceeds to present the weak link of abortion effects in the argument of restricting access to abortion and puts forth the concepts of ethical reasons for abortion as having more gravity in the decision to restricting access to abortion. This paper ends with the idea that going back to the basic problem of termination boundary line (and not the effects of induced abortion) has the weight when arguing about abortion restrictions.

Politics of Abortion Accessibility

The effects of abortion range from physical to emotional and the health risks involved greatly depend on whether the procedure is performed safely or not. Basically, safe abortions are legal abortions performed in some parts of the world especially in developed ones, while unsafe abortions, according to the World Health Organization (1995), are those performed by unqualified

individuals, with unsafe or unapproved equipment, or those performed unsanitarily.

The data available for the side effects of induced abortion are data derived from legal abortions. It is highly obvious why data from unsafe ones are not available and easy to obtain since they are illegal. Most common abortion side effects, whether performed surgically or medically, are generally minor and present low risk. Side effects also differ depending on which method is used. However, according to The National Abortion Foundation (2010), the common side effects among all procedures include: pain and cramping, bleeding, gastrointestinal side effects, thermoregulatory changes, headache and dizziness.

Currently there are six official methods of induced abortions performed in the United States. Stubblefield, Carr-Ellis and Borgatta (2004) enumerated these in their study. They described current methods used for induced abortion in the United States. First one they talked about was the most common method which is the first-trimester vacuum curettage which is also referred to as suction aspiration or vacuum aspiration. For this procedure, analgesia is given utilizing a paracervical block. Nonsteroidal analgesics and sedatives are given as pain prophylaxis for the procedure. To dilate the cervix, tapered dilators, hygroscopic dilators, or misoprostol are given. According to the paper, suction curettage is very safe and effective as the electric uterine aspiration for aborting up to 10 weeks of the conceptus. For early stages of abortion, medications are slowly replacing some of the surgical procedures. The most common drug combination therapy used is mifepristone/misoprostol and it is usually given in two regimens. Another

procedure is dilation and evacuation (D&E) which is mostly performed for second trimester abortions. Statistically, they amount to about 12% of all abortions. The cervix is dilated and ovum forceps alongside vacuum cannula systems are used to evacuate the conceptus from the uterus. To reduce blood loss during the procedure, vasopressin is injected cervically. To reduce tearing caused by dilation and evacuation, some practitioners use operative ultrasonography. For even more advanced gestations, combination methods with intact D&E are incorporated. To induce second-trimester labor, the use of vaginal misoprostol and dinoprostone are lately replacing surgical methods. As medical abortions evolve, combination therapies like mifepristone/misoprostol seem to be more effective than stand-alone medications. Second trimester misoprostol abortions has reports of uterine rapture with uterine scars. Another accepted therapy procedure is fetal intracardiac injection for selective abortion in reducing multiple or anomalous twin pregnancies. Over time, procedures have evolved to be safer with experience.

Kruse, Poppema, Creinin and Paul (2000) mentioned that other less frequent side effects following surgical methods (vacuum curettage, dilation and evacuation, dilation and extraction) are generally the same for the surgical procedures mentioned: blood clots, damage to uterine lining or the cervix, perforation of the uterus, and some possible microbial infections.

With regards to emotional and/or mental effects, it is common knowledge among scientists and medical groups that the risk for mental health problems following an abortion is similar to the occurrence of postpartum depression. Charles, Polis, Sridhara and Blum (2008) concluded that the risk

of mental health problems resulting from a procedure is equal whether an unplanned pregnancy is carried to term or terminated by abortion. Kruse et al. (2000) also argued that there is an increased emotional side effect from aborting a fetus at an advanced development stage but adds that this effect will always be relative. Edwards (1997) found no long-term effects on the emotional well-being of a woman who terminated a pregnancy. The study linked the experience of negative feelings after an abortion to pre-existing factors in a woman’s life like emotional attachment to pregnancy, lack of social support, pre-existing psychiatric illness, and conservative views on abortion.

Two years ago, one study particularly gained attention around the time that anti-abortion movements were regrouping and challenging women’s rights to choose. This particular study was used by anti-abortion groups to imply a huge risk to women’s mental health when getting an abortion and seemed to support the restriction of women’s rights to choose abortion. Coleman (2011) concluded in her paper:

This review offers the largest quantitative estimate of mental health risks associated with abortion available in the world literature. Calling into question the conclusions from traditional reviews, the results revealed a moderate to highly increased risk of mental health problems after abortion. Consistent with the tenets of evidence-based medicine, this information should inform the delivery of abortion services.

In an article review of Coleman’s paper, Coyne (2011) questioned Coleman’s findings to be “ dispassionate scientific findings”.

Another perspective of interest is the mental health and economic effects to

mothers who were denied abortions. In an ongoing study called the Turnaway study, Foster (2013) found out that women denied of abortions suffered from higher levels of anxiety in the first six months after being denied abortions but 9% of the subjects eventually had their children adopted. Economically, the results are more notable. Those who were denied of abortions ended up below the federal poverty line two years after.

The general consensus among scientists and medical groups regarding the effects of induced abortion on mental and physical health is that they are generally safe and the risks and complications involved are always circumstantial.

Although I am for restricting the accessibility to abortion, I find the argument for the effects of induced abortion on physical and mental health highly unsubstantial to limit abortion access. I would argue that regarding the low risk that surgical and medical abortions present, it should not be available freely to anyone and should be a reasonable decision based on the ethical applications of modern biological concepts. The British Broadcasting Corporation (2013) articulated their stand on this quite well and their reasons for abortion seem to be agreeable to my opinion:

- Abortion in favor of a mother’s health including her mental health
- Abortion where pregnancy results from a crime like rape, incest, or child abuse
- Abortion in considering that the child of the pregnancy would have an unacceptable quality of life where the child would have crucial physical handicaps, grave genetic problems, or serious mental defects
- Abortion because of social reasons like poverty, or when a mother would

have a severe situation of coping with a child or another child, or when a mother would be too young to cope with a child

The problem with the abortion debate is and will always be rooted at the boundary line whether the termination of pregnancy is considered murder or not and that is a totally different topic to discuss.

References

Charles, V. E., Polis, C. B., Sridhara, S. K., & Blum, R. W. (2008). Abortion and long-term mental health outcomes: a systematic review of the evidence. Contraceptions, 78(6), 436-50. doi: 10. 1016/j. contraception. 2008. 07. 005. PMID 19014789

Coleman, P. K. (2011). Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. The British Journal of Psychiatry, 199, 180-186. doi: 10. 1192/bjp. bp. 110. 077230

Coyne, J. C. (2011). Negative mental health effects of abortion. Psychology Today. Retrieved from http://www. psychologytoday. com/blog/the-skeptical-sleuth/201110/negative-mental-health-effects-abortion

Edwards, S. (1997). Abortion study finds no long-term III effects on emotional well-being. Family Planning Perspectives, 29(4), 193-194. doi: 10. 2307/2953388. JSTOR 2953388

Foster, D., Biggs, A., Chibber, K., Gerdts, C., Roberts, S., Rocca, C., Upadhyay, U., & Gould, H. (2013). Turnaway study. Advancing New Standards in Reproductive Health. Retrieved from http://ansirh. org/research/turnaway. php

Kruse, B., Poppema, S., Creinin, M. D., & Paul, M. (2000). Management of side effects and complications in medical abortion. American Journal of

Obstetrics and Gynecology, 183(2 Suppl), S65-75. Retrieved from http://www. ncbi. nlm. nih. gov/pubmed/10944371

National Abortion Federation. (2010). Expected side effects of medical abortion. Retrieved from http://www. prochoice. org/education/cme/online_cme/m2expected2

Stubblefield, P. G., Carr-Ellis, S., & Borgatta, L. (2004). Methods for induced abortion. Obstetrics Gynecology, 104(1), 174-85. Retrieved from http://www. ncbi. nlm. nih. gov/pubmed/15229018

World Health Organization. (1995). The prevention and management of unsafe abortion. Retrieved from http://web. archive. org/web/20100530072310/http://whqlibdoc. who. int/hq/1992/WHO_MSM_92. 5. pdf