

ABORTION

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1. Core Definition

Abortion refers fundamentally to the termination of a pregnancy, resulting in the expulsion or removal of a fetus or embryo from the woman's uterus prior to the point of fetal viability, which is the stage at which a fetus can survive outside the womb, usually considered to be around 24 weeks of gestation, though this threshold is constantly being redefined by medical advancements. The term encompasses a range of clinical events, both intended and unintended, which necessitate careful distinction in both medical and legal contexts. While medically the process involves either surgical removal or pharmaceutical induction to clear the uterine contents, the societal definition is often centered around the concept of **induced termination**, which involves intentional intervention.

The medical classification distinguishes between two broad categories: spontaneous abortion and induced abortion. **Spontaneous abortion**, commonly referred to as a miscarriage, represents the unintentional loss of a pregnancy before 20 weeks of gestation and occurs due to natural causes, such as genetic anomalies, hormonal imbalances, or underlying maternal health conditions. The term **missed abortion** is specifically used to describe a medically recognized, unintentional loss where the fetus has died but the contents of conception have not yet been expelled from the uterus, requiring medical management. These unintentional losses are critical public health concerns related to maternal and reproductive health.

In contrast, **induced abortion** involves deliberate steps taken to end the pregnancy. This may be categorized as therapeutic, performed for compelling medical reasons concerning the health of the mother or the prognosis of the fetus, or **elective abortion**, undertaken at the request of the pregnant individual for personal, social, or economic reasons. It is this intentional act--elective abortion--that forms the nexus of intense legal, moral, and political debate globally. Understanding abortion requires moving beyond the single act to consider the complex interplay of physiological processes, medical technology, personal autonomy, and legal regulation that define the experience.

2. Etymology and Historical Development

The term 'abortion' derives from the Latin *abortio*, meaning "a miscarrying" or "failure to rise," reflecting its initial broad definition encompassing any failed or premature birth. Historically, the practice of intentionally terminating a pregnancy has been documented across nearly every human civilization, dating back to ancient Egypt, Rome, and Greece. Methods employed ranged from

herbal concoctions (abortifacients) and physical manipulation to early forms of surgical intervention. These practices, while often dangerous due to lack of sanitation and medical knowledge, highlight that the control over reproduction is not a modern phenomenon but an enduring feature of human society.

During the 19th century, particularly in Western nations, regulatory efforts intensified, driven largely by professionalizing medical bodies and moral movements. Before the 1800s, abortion was often treated differently depending on whether the fetus was "quickened" (the point when fetal movement was felt). However, by the late 19th and early 20th centuries, most developed nations enacted stringent laws prohibiting or heavily restricting induced abortion, often making it a criminal offense. This shift marked the beginning of a long period where the procedure was driven underground, leading to high rates of unsafe, clandestine abortions and resulting morbidity and mortality, a major public health crisis.

The major shift toward liberalization in many Western countries began in the mid-to-late 20th century, spurred by the feminist movement, advances in medical safety, and growing recognition of women's rights to bodily autonomy. Landmark legal decisions, such as *Roe v. Wade* (1973) in the United States, established constitutional rights regarding privacy and liberty that encompassed the decision to terminate a pregnancy, radically changing the landscape of reproductive health care and making **elective abortions** legal in many jurisdictions, subject to various gestational limits, often up to 14 or 24 weeks, depending on the jurisdiction, as noted in general legal summaries. This period of liberalization established the legal framework upon which current debates are founded, though these rights remain continually contested.

3. Types of Termination and Terminology

The methodology and timing of pregnancy termination are central to medical classification, determining both the procedure used and the associated risks. Induced abortions are generally categorized by the method employed: surgical or medical. **Surgical abortion** involves the physical removal of the embryo or fetus and associated tissues from the uterus. The most common form in the first trimester is vacuum aspiration (or suction curettage), a minimally invasive and highly safe procedure. For later stages, procedures may include dilation and evacuation (D&E), which requires dilation of the cervix followed by instrumental evacuation and is typically reserved for second-trimester terminations.

Medical abortion utilizes pharmacological agents to induce the process, mimicking a miscarriage. This typically involves a combination of medications, most commonly mifepristone (a progesterone receptor antagonist) followed by misoprostol (a prostaglandin analog), which cause the uterine lining to shed and the uterus to contract, expelling the pregnancy. Medical abortion is highly effective and increasingly common, especially in the early weeks of gestation (up to 10 or 12

weeks), offering a non-invasive alternative to surgery. Access to these medications, particularly mifepristone, has become a key point of political and legal contention in recent years, particularly in jurisdictions seeking to restrict abortion access.

Distinctions must also be made based on gestational age, as this dictates the procedure and the legal status. **First-trimester abortions** (up to 12 weeks) are the most common, safest, and least complex. Second-trimester abortions (13 to 24 weeks) are medically more complex and carry higher risks, often prompting stricter legal regulation. Abortions performed after the point of viability, which are exceedingly rare and typically reserved for grave maternal health crises or severe fetal anomalies, fall under the classification of late-term procedures and are subject to the highest degree of legal and ethical scrutiny.

Key Terminology

Viability: The developmental stage (typically around 24 weeks gestation) at which a fetus has a realistic chance of survival outside the uterus, albeit often with significant medical intervention.

Elective Abortion: An induced termination performed at the request of the pregnant individual for non-medical reasons. This is the category most often subject to legal restriction and public debate.

Therapeutic Abortion: An induced termination performed to preserve the life or health of the pregnant individual, or when the fetus has a lethal anomaly.

Spontaneous Abortion (Miscarriage): The involuntary termination of a pregnancy before 20 weeks gestation.

4. Legal and Policy Frameworks

The legality of abortion varies dramatically across the globe, ranging from highly restrictive regimes where the procedure is banned outright (even in cases of rape or incest) to liberal policies where it is available on demand throughout the early stages of pregnancy. These legal frameworks reflect deep cultural, religious, and political differences regarding the status of the fetus, maternal autonomy, and the role of the state in reproductive decision-making. The American context, specifically, has seen continuous legislative and judicial upheaval concerning the limits of access, particularly following the overturning of *Roe v. Wade* in 2022, which returned the authority to regulate or ban abortion entirely to individual states.

In jurisdictions where abortion is legal, regulation usually centers on two major policy levers: gestational limits and procedural requirements. Gestational limits define the maximum point in pregnancy at which an abortion may be performed, often tied to the concept of fetal viability. Furthermore, procedural requirements include mandatory waiting periods, parental consent for minors, requirements for counseling intended to discourage the procedure, and restrictions on the type of facility that can provide care. These requirements, often framed as measures to ensure patient safety or informed consent, are frequently criticized by reproductive rights advocates as

targeted restrictions on abortion providers (TRAPs) designed to impede access.

The impact of restrictive legal frameworks is highly significant on public health outcomes. When safe, legal abortion is unavailable, rates of unsafe abortion inevitably rise, leading to catastrophic consequences, including hemorrhage, infection, and death, particularly in developing nations or regions with limited healthcare infrastructure. International bodies, including the **World Health Organization (WHO)**, advocate for the decriminalization of abortion and the provision of high-quality, comprehensive abortion care as a fundamental component of universal health coverage and reproductive rights, emphasizing that restricting access does not eliminate abortion but makes it deadly.

5. Ethical and Moral Debates

Abortion resides at the center of one of the most persistent and impassioned ethical debates in contemporary society, primarily revolving around the moral status of the fetus and the extent of a woman's right to **bodily autonomy**. Proponents of reproductive rights argue that the ability to control one's own reproductive health is fundamental to equality and self-determination, positing that since the fetus is entirely dependent on the pregnant individual, the moral obligation of sustaining the pregnancy should ultimately remain a private decision. This perspective often emphasizes the social and economic hardships imposed by involuntary parenthood.

Conversely, opposition to abortion is generally rooted in the belief that human life begins at conception (or shortly thereafter) and that the fetus, regardless of its developmental stage, possesses an inherent right to life. This viewpoint holds that abortion constitutes the taking of an innocent human life and is therefore morally impermissible. Religious and philosophical traditions frequently underpin this stance, defining the fetus as a patient whose rights must be protected by law. The debate often hinges on defining when personhood begins--whether at conception, implantation, quickening, viability, or birth--a question for which there is no scientific or universal moral consensus.

The complexity is further heightened by cases involving fetal anomalies or threats to maternal health. While highly polarized views often dominate the public sphere, a significant portion of ethical inquiry focuses on the grey areas, considering factors such as quality of life, potential suffering, and the balance between competing fundamental interests. Bioethicists often explore the concept of **gradualism**, suggesting that the moral status of the fetus increases with gestational development, potentially justifying different moral and legal standards for early versus late-term procedures. These intense moral divisions underscore why abortion remains a uniquely challenging issue for public policy creation.

6. Global Public Health Context

From a public health perspective, the availability of safe abortion services is inextricably linked to maternal mortality and morbidity rates. Unsafe abortion is defined as a procedure carried out by persons lacking the necessary skills or in an environment lacking minimal medical standards, or both. According to global health estimates, unsafe abortions account for a significant percentage of preventable maternal deaths worldwide, with the vast majority occurring in developing regions with highly restrictive laws and poor access to contraception and comprehensive sexual health education.

The provision of comprehensive abortion care--including pre-abortion counseling, the procedure itself, and post-abortion care--is recognized by global health organizations as essential health care. When integrated into primary health systems, access to safe termination services reduces the incidence of unsafe procedures and lessens the burden on healthcare systems caused by complications arising from self-induced or clandestine procedures. Furthermore, access to elective abortion is strongly correlated with improved educational attainment, workforce participation, and long-term economic stability for women, thereby yielding significant positive social and public health returns.

However, the global context is characterized by massive disparities in access. While high-income countries typically offer services that are safe and readily available (though often still politically contested), women in poverty or those living in rural areas, especially in lower-income countries, often face insurmountable barriers, including prohibitive costs, geographical distance, and societal stigma. Public health efforts are therefore concentrated on expanding access to effective contraception to reduce unintended pregnancies, ensuring the legality of abortion, and, crucially, training providers to deliver high-quality, non-judgmental care in line with best medical practices.

Further Reading

[World Health Organization \(WHO\) - Abortion Fact Sheet](#)

[Wikipedia - Abortion Overview](#)

[Guttmacher Institute - Reproductive Health Research and Policy](#)