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The Physical and Mental Health Effects of Chemical Abortion

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TOPLINE POINTS

- The use of telehealth and changes to the Risk Evaluation and Mitigation Strategy (REMS) have made chemical abortion more accessible with less oversight and acknowledgement of the known harms.
- There are known adverse health and mental health outcomes associated with chemical abortion.
- The current approach to informed consent for chemical abortion is not complete and lacks critical information necessary to meet ethical standards.
- There are solutions that can be adopted immediately to protect women from the known harms of chemical abortion.

Introduction

In 2000, the U.S. Food and Drug Administration (FDA) approved two drugs, mifepristone and misoprostol (mifepristone and misoprostol may also be referred to as *chemical abortion, abortion with pills, drugs*, and *medication*), for the sole purpose of terminating a pregnancy. At the twenty-five-year anniversary of the FDA's approval, these drugs have garnered increased concern among medical researchers who have documented both the physical and psychological harms associated with chemical abortion. Despite the intended outcome and polemical nature of the abortion issue, the majority of Americans agree that keeping women safe is the highest priority. A recent poll (McLaughlin & Associates, 2025) confirms that nearly 90% of Americans want all possible harmful side effects to be included on the abortion drug labels, and over 80% believe the pills should not be available online. Additionally, nearly 70% of Americans agree that the pre-Biden era safety standards should be brought back, roughly 75% believe chemical abortion should include an in-person visit, and 70% believe that visit should include screening for signs of abuse or that the abortion is sought under coercion (McLaughlin & Associates, 2025).

Nonetheless, in recent years, revisions were made by the Biden Administration to the way abortion drugs were regulated, distributed, and managed. The consequences of these changes must be fully understood and honestly assessed if we are to make Americans healthy again.

Despite claims from the Guttmacher Institute that say, "the science on mifepristone's safety and efficacy is settled," there is a growing body of evidence that shows that there needs to be increased scrutiny of these drugs (Baden et al., 2025). This paper highlights some of the literature regarding the harms of chemical abortion and offers recommendations for implementing safeguards.

The Chemical Abortion Process

A chemical abortion, also known as an abortion using medication, typically involves administering two drugs: mifepristone and misoprostol. Mifepristone causes a pregnancy to end by stopping the production of progesterone, which causes the embryo and placenta to detach from the endometrium. In turn, the cervix softens and dilates (Mazza et al., 2020).

A follow-up dose of misoprostol is ingested 24-48 hours after mifepristone. Misoprostol induces contractions and causes the cervix to open and the uterus to empty (Mazza et al., 2020). This process leads to bleeding and cramping that can last for weeks following the abortion. Unless a follow-up visit is scheduled with a physician (which is not routinely practiced because of changes made to the Risk Evaluation and Mitigation Strategy (REMS) a woman may not know if she has any fetal tissue remaining in her body. As a result, some women develop sepsis and can die due to the fetal tissue that remains in her uterus.

For example, two women from Georgia both died from the harmful effects of chemical abortion. One had fetal tissue that remained in her body and caused sepsis. The other obtained the abortion drugs online and developed a severe infection. Major media sources continue to claim that these women died because of the Georgia law banning abortion (Surana, 2024). In reality, if the proper safety precautions were in place, both women would not have been dispensed the drugs until an initial assessment with a physician had been conducted to rule out any pre-existing conditions and risk factors. Second, these women should've had in-person access to the dispensing physician throughout the entire abortive process. If this protocol had been followed, their lives would likely have been spared.

Changes to Chemical Abortion Access and Distribution

In 2021, the Biden Administration approved the use of telehealth to prescribe chemical abortion by lifting the "in-person" dispensing requirement that had previously existed for chemical abortion drugs – first as a "temporary" pandemic measure, which became permanent in January 2023. These were changes to the Risk Evaluation and Mitigation Strategy (REMS), which resulted in mifepristone becoming more available but with decreased physician oversight. As part of those changes, Mifepristone could now be dispensed by an abortion clinic, a pharmacy, or even online. Since then, the use of abortifacients has been on the rise. Recent estimates show that 63% of all abortions are initiated and completed through abortion pills (Jones & Friedrich-Kamik, 2024). Additionally, 95% of all first-trimester abortions are the result of a chemical abortion (Mazza et al., 2020).

Women who choose to have chemical abortions rather than aborting in a clinic

Some of the top reasons women report inducing an abortion at home rather than going to a clinic relate to logistical and financial constraints. For example, in some studies, women reported difficulties traveling to a clinic, finding childcare for an in-person appointment, wait times, and a desire not to be seen going to an abortion clinic (Killinger et al., 2022; Aiken et al., 2018). Other women said that taking chemical abortion drugs at home gave them the ability to manage the process from their home and, therefore, they had more control over the abortion (Newton et al., 2016). Still others noted that a chemical abortion seemed more natural, and they equated the experience to having a miscarriage rather than an abortion (Newton et al., 2016). Last, some women reported the abortion pill as an alternative to driving across state lines for an in-person procedure (Baker, 2023).

The adverse physical health risks associated with chemical abortion

A recent study found that one in ten women who took abortion pills ended up in the hospital with at least one serious adverse event, including hemorrhaging, sepsis, infections, and other life-threatening complications (Hall & Anderson, 2025). In fact, most emergency room visits following a chemical abortion are due to symptoms of infection and hemorrhaging. Women with these conditions are twice as likely to be flagged as having a "severe" or "critical" condition compared to nonpregnant women (Studnicki et al., 2021).

One reason women visit the emergency room in an acute state is because of the potential for the uterus to retain fetal tissue following abortion. When this happens, an infection can occur, which can lead to sepsis and infertility issues if it is not promptly treated (Russo et al., 2014). All these health complications are much more common with chemical abortion compared to surgical abortion (Bridwell et al., 2022).

Adverse Mental Health Effects Associated with an Abortion

A recent study that included 28,000 post-abortive women found induced abortion to be a risk factor for psychiatric hospitalization when compared to women who chose to carry to term (Auger et al., 2025). Post-abortive women were admitted for substance abuse, suicide attempts, and other psychiatric issues. Two meta-analyses were conducted, which lend further support to this finding and show that having an abortion is a key risk factor for negative mental health outcomes (Coleman, 2011; Bellieni & Buonocore, 2013).

Similarly, there is evidence that some women seeking abortion may have trauma histories, including intimate partner violence (Hall et al., 2014). In this vein, several studies have revealed a relationship between having an abortion and posttraumatic stress symptoms (Kelly et al., 2010) and suicidal thoughts (Rafferty & Longbons, 2020). Notably, a few of the risk factors for PTSD symptomatology following abortion were found to include exposure to trauma and adverse childhood events (Seng et al., 2009; Rue et al., 2004). Additionally, in a recent study of self-identified trauma and abuse survivors, women noted they had few options before having their abortion, and their situation brought up many traumatic feelings (Chalmers et. al., 2025). These women went on to say that they had a desire for more support around their abortion experiences, but nothing was available.

Differences in mental health outcomes following a chemical versus a surgical abortion

In terms of the method chosen to terminate pregnancy, there appear to be differences in the level of psychological distress between women who chose chemical over surgical abortion.

Women who chose a chemical abortion tended to have more negative psychological symptoms compared to those who chose a surgical abortion (Lowenstein, 2006).

This may be partly due to the fact that a chemical abortion involves a different level of participation for the woman seeking to end pregnancy and therefore it carries the potential for a greater negative response (Slade et al., 1998). In this case, the woman becomes both the patient and the "doctor," or the administrator of the procedure, which results in the termination of the baby's life. Through the process, the patient handles human remains, a substantial amount of blood, and all while experiencing physical pain from the abortion. Many women reported that they were not prepared for the experience (see informed consent).

Another potential risk factor for an adverse mental health outcome stems from the abortion location itself. Chemical abortion often occurs in the woman's home rather than in a clinic. The location where the abortion takes place is an important yet understudied factor that has the potential to create adverse mental health outcomes. Understanding the responses that might follow an "at-home abortion" is essential, given that some studies have found that women were ill-informed about the shockingly morbid nature of the event, and the known potential for the abortive experience to be associated with posttraumatic stress symptoms like intrusive thoughts, nightmares, and flashbacks (Aamlid et al., 2021).

In this case, the bathroom or room where the abortion occurs may become a continuous reminder of a potentially traumatic scene (chemical abortion can involve a lot of blood), rather than a room that was once filled with a different or neutral emotional response pre-abortion. Bringing the abortive process into the home environment presents a woman with less ability to psychologically distance herself from the event. In this way, the home may prove to be a continuous reminder of the experience and, therefore, poses a greater mental health risk than an in-office abortion, which already carries the potential for a negative psychological outcome (Auger et al., 2025).

Chemical abortion and coerced or forced pregnancy terminations

There is evidence that women who are coerced to abort have an increase in posttraumatic stress symptoms, unresolved grief, and an overall decline in mental health (Reardon & Longbons, 2023). Instances of forced abortion are known to happen in cases of domestic violence, sexual abuse of minors, and with trafficked victims (Hall et al., 2014; McGirr et al., 2017; Price et. al., 2022). Some studies have found that 58% to 71% victims become pregnant while being trafficked (Muftić & Finn, 2013; Lederer & Wetzelm, 2014). Roughly 55% had at least one forced abortion while trafficked, and nearly one-third of these victims had several abortions (Lederer & Wetzelm, 2014).

As part of obtaining informed consent, women should be assessed to see if they are truly consenting to an abortion or if coercion is involved from anyone else. Without regulations around chemical abortion, the likelihood of a forced abortion is made more possible, and a chemical abortion can be freely used to hide a sexual perpetrator's behavior (Miller, 2023).

Professional Organizations Ignore Adverse Mental Health Effects Associated with Abortion

The current position of the major psychological professional organizations is that abortion is not a substantive factor for adverse mental health effects. The American Psychological Association (APA) argues instead that mental distress is caused by not having access to abortion rather than the abortion itself (American Psychological Association, 2022a). The "access" argument is often presented as settled science and as if a woman's ability to access abortion is an established causal relationship with psychological distress. Claiming that an area of the social sciences is settled, however, is the antithesis of the scientific method, which should allow for any finding to be held loosely and subject to new research. The practice of this aspect of the scientific method is particularly important when it comes to an area of the literature that has not been well researched or is the source of potential bias.

Groups like the APA have been clear about their positions and biases. Months before the *Dobbs v. Jackson* decision was announced by the Supreme Court, the APA put out a preemptive statement in support of abortion. In the statement, they noted that abortion fell under their umbrella term of *reproductive justice*. Here, abortion was a right to be advocated for, "with a particular emphasis on individuals from marginalized communities" (American Psychological Association, 2022b).

Likewise, the American Psychiatric Association also put out a statement on *reproductive rights* emphasizing abortion as a human right. Therefore, they opposed any "constitutional amendments, legislation, and regulation to curtail abortion" (American Psychiatric Association, 2023). The psychiatric organization went on to say that "interrupting a pregnancy must be considered a mental health imperative with major social and mental health implications" (American Psychiatric Association, 2023).

The American Psychological and Psychiatric organizations have clearly articulated their stance on abortion and their belief that it is a civil rights issue. Therefore, it stands to reason that any research or practice that is contrary to their organizing principles might be discredited. For example, there is robust research that has shown a relationship between psychological sequelae and abortion, as there also is solid research questioning the salubrity of this practice (Coleman, 2011; Udzma & Achadi, 2019). Some of these studies have been dismissed, and, in some cases, there were attempts to retract the research (Coleman, 2011; Studnicki et al., 2019; Studnicki et al., 2021; Studnicki et al., 2022; Udzma & Achadi, 2019).

On the other hand, there is one commonly cited study used by the APA and other abortion proponents as evidence to support the claim that abortion is innocuous. This study, called the Turnaway study, was highly funded and conducted by researchers with a known history of activism for a pro-abortion agenda (Foster, 2020; Biggs et al., 2018). The study contains several methodological flaws, and the participants were enlisted based on a non-representative clinic sampling (Coleman, 2022; Reardon, 2024). Still, it is frequently touted as the primary evidence to claim that the inability to access an abortion is what causes distress (Dobkin et al., 2014).

A recent population representative sample, however, challenges the findings from the Turnaway study. Using a more robust sample, Sullins (2025) found that almost half of the participants in his study experienced moderate to high levels of distress about their abortion. These post-abortive women reported posttraumatic stress symptoms (in 25% of the sample) and grief and sadness

(in 31% of the sample). In this study, adverse mental health symptoms were present regardless of whether abortion was long ago or more recent.

Problems with Obtaining Informed Consent for a Chemical Abortion

True informed consent for a chemical approach cannot be met by the current approach to dispensing mifepristone and misoprostol. The Belmont Report was written following the National Research Act of 1974 and in response to an era of egregious Nazi experimentation and deceptive medical and psychological research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). This report highlighted ethical principles for research participants. The ideas from this framework are woven into medical and psychological practices to ensure patients are properly informed about interventions and treatment protocols (referred to as informed consent). Regardless of where an intervention is employed, whether in a research or practice setting, ethical treatment demands that the research participant or patient truly has been informed and they have subsequently given their consent.

For a patient to give consent, they must be an adult and have all the information about the treatment. This includes the potential benefits and risks, alternative interventions, and the person must have the capacity to give both consent and to withdraw their consent for treatment. Notably, the patient must be able to maintain their autonomy and not be coerced into a treatment. The current approach to the distribution and use of a chemical abortion, however, raises concerns about the authenticity of informed consent.

In one study, women who underwent chemical abortion reported that they were not sufficiently informed about the deleterious effects of the drugs, nor were they offered enough support through the process (Aamlid, Dahl, & Sommerseth, 2021). These same post-abortive women said they were surprised by the amount of bleeding and pain they experienced from the drug protocol. In another study, women said that the effects of their chemically induced abortion were more harmful than they anticipated. Over half of these women said, if given the opportunity, they would not have a chemical abortion again (Kelly et al., 2010).

Taken together, this body of research should support better assessment and informed consent practices when speaking to a woman seeking an abortion. The current approach does not account for pre-existing mental health and traumatic experiences or the possibility of poor post-abortive negative mental health outcomes following any type of abortion, particularly a chemical abortion. Hence, health and mental health risk factors go equally unnoticed, and women are left without health or mental health support surrounding a chemical abortion.

These studies highlight the lack of informed consent with the current approach to obtaining a chemical abortion. For informed consent to be obtained, the components below need to be addressed in accordance with the tenets formulated in the Belmont Report and The American Medical Association Medical Ethics:

Missing aspects of informed consent reported in the aforementioned literature:

- The patient should be an adult over the age of 18.

- There should be a discussion with a medical doctor (e.g., not an online forum or an abortion hotline) about the effects the drugs will have during and after the entire protocol has been completed.
- There should be a medical evaluation (e.g., assessment of ectopic pregnancy and risk factors) and access to a doctor before, during, and after the entire chemical abortion process. Follow-up visits should be part of the protocol (e.g., to prevent sepsis and death due to an incomplete abortion).
- The patient should know about alternatives to chemical abortion.
- The patient should be informed and given access to the chemical abortion reversal protocol.
- Doctors should assess for coercion, intimate partner violence, and signs of trafficking before offering the chemical abortion protocol.
- Doctors should inform their patients about mental health risk factors, both historical and post-abortion.
- The drugs should only be dispensed by a medical doctor (e.g., not a pharmacist or an online distributor) and following true informed consent. The initial visit should entail both reviewing and obtaining informed consent.

What Can Be Done to Protect Women and Preborn Children Immediately?

First, the scientific community should call for greater understanding of how chemical abortion affects women's physical and psychological health over time. Further, the changes to the abortive process made during the Biden Administration should warrant a reevaluation of both the science used to support FDA approvals and the current practices used to access and initiate terminating pregnancy.

To protect women from the potential harms of chemical abortion, below are policies that can be implemented immediately:

- The U.S. Health and Human Services (HHS) should reinstate Risk Evaluation and Mitigation Strategy (REMS) for mifepristone, requiring in-person visits before and after taking the drug.
- The FDA should complete the study on mifepristone and provide new recommendations, such as safety measures and regulations for how the drug is dispensed.
- The FDA should restore the REMs and create a new federal policy requiring improved reporting and monitoring of adverse events.
- States and medical boards should develop and implement informed consent policies and develop metrics to assess the level of fidelity.
- States should mandate that their medical boards require physicians to be the only distributors of the abortion pill within their respective state borders.

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