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Predictive Ability of Experiential Avoidance in Symptoms of Psychosomatic Disorders in Abused Women

Prof. Yahya Mubarak Khatatbeh[1], Rawan Abdul Mahdi Neyef Al-Saliti[2],

Abstract

The study aimed to reveal the predictive ability of experiential avoidance and demographic variables (age group, marital status, and educational level) in symptoms of psychosomatic disorders in abused women. Methodology: The descriptive correlational method was used for its suitability to the objectives of the study. The study sample consisted of (267) abused women who visited the Family Accord House and the Jordanian Women's Union in Irbid city, during the period from 12/2/2024 to 2/5/2025. They were selected using the convenient method to ensure reaching the largest possible number of abused women without time or resource restrictions. Of them, (113) women visited the Family Accord House and (154) women visited the Jordanian Women's Union. They were selected using the convenient method. The experimental avoidance scale and symptoms of psychosomatic disorders were used to verify the study objectives. Results: The results revealed an average degree for both experimental avoidance and symptoms of psychosomatic disorders among abused women. The results also revealed that the variable involved in predicting the psychosomatic disorders scale is the experimental avoidance scale, which explained (3.3%) of the explained variance for the psychosomatic disorders scale, and the variance ratio for this variable was statistically significant at the significance level (α = 0.05). The variables of educational level, age, and social status were not included in the prediction of the psychosomatic disorders scale.

Keywords: *Experimental avoidance, psychosomatic disorders, abused women, violence.*

Introduction

Research suggests that experiential avoidance plays an important role in mediating the association between childhood trauma and psychosomatic symptoms in women[1] In college women, experiential avoidance somewhat mediated emotional stress and physical symptoms and totally mediated neglect and physical symptoms. It also considerably moderated the link between childhood psychological abuse and college students' mental health symptoms.[2] Avoidance of experiences can predict psychosomatic disorders in employees, and it moderated the relationship between behavioral inhibition system sensitivity and PTSD symptoms in female college students with a history of trauma, violence, and psychological abuse.

Violence against women is an important issue for the World Health Organization, as 30-65% of women experience intimate partner violence (IPV) as 65%, while 30-40%,[3] and in Mexico, femicide is among the top six countries in the world in terms of femicide rates[4] 40-50% of married women in the region experience femicide and gender-based violence, a cultural issue. South Africa and Ghana have above-average femicide and gender-based violence rates.[5] Reports show that 53.5% of women worldwide have encountered gender-based violence and 33% have experienced sexual violence. These figures show that violence against women is a global

[1] Professor of Psychology, Department of Psychology, College of Social Sciences, Imam Mohammad Ibn Saud Islamic University (IMISU). ymkatatbh@imamu.edu.sa. (Corresponding Author)
[2] Ajloun National University, Ajloun, Jordan. R.Alsalieti@anu.edu.jo.

issue that requires radical interventions and international cooperation to reform laws, strengthen social support systems, and change culture and education[6] A 2024 study reported that in 2020, one in five women in South Africa was a victim of gender-based violence and femicide[7]

Violence is defined as "harmful behavior used by an individual to inflict physical, psychological, or social harm on others, often against women for dominance and control." Married women are particularly vulnerable to physical, psychological, economic, and sexual violence. [8] Violence can harm mental and physical health and cause injuries. It also raises the risk of persistent pain, physical impairments, substance addiction, and depression in women. A study [9]showed that (87%) of women were exposed to various types of violence between partners in the past twelve months, and the most common type of violence reported was emotional abuse (47.5%), followed by wife beating (19.6%). [10] Based on data from 137 countries between 2000 and 2018, 6% of women aged 15–49 worldwide had suffered non-partner sexual violence, according to a 2024 study. [11] Jordanian women experienced more domestic abuse during the COVID-19 epidemic, according to a 2024 Nature study. Physical violence predominated, followed by economic, psychological, emotional, verbal, and sexual assault.[12]Many women experience violence in various forms, which can lead to psychological problems, such as depression, anxiety, and post-traumatic stress disorder, in addition to severe physical harm [13] Such as: neglect, helplessness, anxiety, anger, aggression, in addition to sleep disturbances, eating problems, alcohol use, and suicidal behavior. Violence is considered a major factor that leads to psychological disorders in women [14] [15] demonstrated that experiencing avoidance predicts psychosomatic disorder and that psychosomatic patients had more experiential avoidance than normal people. Experience avoidance is the urge to avoid or regulate unpleasant thoughts, feelings, memories, or bodily sensations.

Psychosomatic Disorders

Research links intimate partner abuse to increased rates of physical health disorders in women. Women who endure intimate partner violence are more likely to develop chronic pain, cardiovascular disease, gastrointestinal illnesses, and STDs.[16, 17].Intimate partner violence is associated with endocrine dysfunction, worsening of menopausal symptoms, and increased risk of diabetes [18] Mental health issues, including depression, anxiety, and post-traumatic stress disorder, are more common among survivors of intimate partner violence[8] Childhood trauma, psychosomatic symptoms, and avoidance are linked. Abused women had increased avoidance behaviors, which were linked to chronic pain, irritable bowel syndrome, and migraine. Psychosomatic diseases are one of the biggest problems in modern society, and persons with them always need counseling due to their unknown symptoms. The Diagnostic and Statistical Manual of Mental Disorders-5 now lists psychosomatic symptoms instead of somatosensory disorders. [19] Psychosomatic disorders involve both the mind and the body, with psychological factors affecting physical health [5]. These conditions may disrupt daily functioning and relationships, but proper diagnosis and treatment can provide relief, and the interaction between psychological and physiological processes [20] Psychosomatic comes from the Greek terms psyche (meaning "soul") and soma (meaning "body"), which refers to the body's physical organs. Psychosomatic disorders damage the mind and body. Psycho-emotional elements have been connected to numerous physical ailments since ancient times.[15, 21].The body and psyche influence each other and function as a single unit. Most diseases are psychosomatic. Every physical disease has some aspects of the psychological component, and how an individual reacts and adapts to it varies greatly[22] The particular hypothesis implies that a pre-specified sickness or illness occurs owing to a specific stimuli, conflicts, or stressors, and the body responds more.

The non-specific theory suggests that stress and strain predispose to many diseases. This idea proposes four stress reactions: normal, neurotic, psychotic, psychosomatic[23, 24] Psychological illnesses were studied in 2022. In rural populations, women were 1.23 to 10.85 times more likely than men to have most psychosomatic illnesses, including depression and persistent mood disorders, and older age groups were more likely to have a psychosomatic diagnosis. [25] German physician Johann Christian Heinroth (1773–1843) coined "psychosomatics." His predecessor Hippocrates noted that gloomy people have bad moods and stomach ache.[26]. Psychosomatic disorders, which involve the physical and psychological realms, vary in etiology and pathogenesis. They include psychosomatic disorders, psychological traits, and behavior that cause physical ailments.[27] Physicians know these physical problems. The Diagnostic and Statistical Manual links psychological diseases to environmental stimuli with psychological relevance, such as rheumatoid arthritis or headache. [28] They are diseases that result from direct physiological causes in the patient's psychological processes. If the medical examination fails to identify a physical or organic cause for the disease, or if the disease is the result of emotional states like anger, anxiety, depression, or guilt, the disease may be psychological, characterized by a

Experiential Avoidance

Survival requires adaptability to changing environmental conditions. Avoidance is one of the most effective defensive responses, especially in the face of an immediate threat.[29] Psychologists have focused on experiencing avoidance. This strategy regulates emotions by focusing on subjective experience, physiological arousal, or behavioral manifestation. Third-wave behavioral therapies like dialectical behavior therapy and acceptance and commitment therapy focus on experiencing avoidance. It involves rejecting disturbing thoughts, feelings, memories, and other private experiences.[12] It reflects a strong tendency to escape or avoid internal psychological experiences and is one of the most significant psychological processes contributing to various psychological disorders[30] Mental health problems like substance abuse, obsessive-compulsive disorder, panic disorder, and borderline personality disorder involve experiential avoidance. It is thought to be damaging because it impairs emotional response and often intensifies the content people are attempting to avoid.[31] Personal experiences including physical sensations, emotions, thoughts, memories, images, and behaviors are avoided. Distraction, meditation, repression, and reassessment alter these experiences. Avoidance, dissociation, and emotional suppression can reduce stress. These are essential for experiencing avoidance. Includes suppression and emotional regulation. Experimental avoidance regulates unpleasant thoughts, sentiments, and body sensations, but it is rigid and limits reaction alternatives.[32] Experiential avoidance involves avoiding private experiences like sensations, memories, behaviors, and thoughts. The functional category includes excessive negative appraisals of intimate occurrences including thoughts, feelings, and sensations and an unwillingness to experience them. Experiential avoidance is the deliberate avoidance of private experiences and their triggers. [8] It has been proposed as a functional diagnostic category that exists on a continuum and is defined by the level of experiential acceptance [33]Experiential avoidance can be a useful short-term strategy for managing unwanted feelings associated with specific situations, but it can be harmful if generalized to other situations and used inflexibly [34] [35] showed that feeling avoidance had three types: cognitive avoidance—avoiding things that make you fear. Cognitive avoidance helps people avoid undesirable events more correctly and significantly, such as distracting from worry. This entails avoiding revealing indicators of intense emotional state and its feelings and expressions when emotional arousal occurs and avoiding

emotional experience, such as repressing melancholy. (Behavioral Avoidance): Negative emotions and distress cause direct avoidance in front of others. The delayed distress may include attempts to ignore or ease it, suppression or denial, unconscious detachment from suffering and its triggers, and enduring distress. According to studies on the variables of the current study, aggression, psychosomatic disorders, and experience avoidance are linked, but demographic and therapeutic factors affect them differently. A study[36] conducted on 137 abused women in the United States showed that they reported high levels of psychosomatic symptoms, with no statistically significant differences based on age[33] He also observed in his research of 300 married women in the Hebron Governorate that psychological violence against the wife was average and physical violence was last. Psychosomatic symptoms were minimal, with statistically significant variations between women earning more and less than the norm.[37] A study also showed that standardized diagnostic treatment was effective in reducing experiential avoidance and suicidal ideation in female victims of domestic violence. [13]A study found that compassion-based group therapy helped female survivors of violence with PTSD, reducing levels of experiential avoidance and increasing feelings of coherence and meaning in life. [38]A study showed that female survivors of rape in the United States had high levels of experiential avoidance, which was indirectly linked to depression via shame[15]found that experiential avoidance and alexithymia predicted levels of psychosomatic distress, with alexithymia being moderate, while both experiential avoidance and psychosomatic distress were low. A study[39] examining the long-term repercussions of abuse, including psychosomatic symptoms, revealed that women subjected to violence were more likely to develop mood disorders, worry, discomfort, and exhaustion.[17] A systematic review of 2012–2019 studies assessed the long-term effects of intimate partner violence on physical health and health habits. Violence against women exacerbated menopausal symptoms, diabetes risk, risky behaviors like drug and alcohol use, chronic illness, and pain. These studies help us comprehend the link between aggression, experience avoidance, and psychosomatic disorders and underline the necessity for appropriate treatment. Researchers found that alexithymia and experience avoidance lead to psychosomatic disorders, emphasizing the need for psychological and therapeutic care for the most vulnerable.

Questions

1. What are the levels of psychosomatic disorders and experiential avoidance among abused women?

2. What is the predictive ability of experiential avoidance and variables (educational level, age, economic level, and marital status) in psychosomatic disorders among abused women?

Methodology

This quantitative correlational study examined how experiential avoidance predicts psychosomatic symptoms in abused women, taking demographic variables including age, marital status, and education into account. In this quantitative investigation, well-established and validated assessment tools were used to quantify experiential avoidance and psychosomatic symptoms. The study employed descriptive correlational analysis to analyze variable relationships without changing them. This method was used to find natural data patterns and relationships. A panel of specialists developed and reviewed a checklist of important psychological instruments, including the Experiential Avoidance Scale and Psychosomatic Symptoms Scale, to improve study validity. This validation approach validated the instruments' accuracy, reliability, and relevance to the target demographic, improving the study's methodological rigor..

Participants

The study sample included 267 abused women who visited the Family Reconciliation House and Jordanian Women's Union in Irbid from 12/2/2024 to 2/5/2025. They were chosen utilizing the available technique to reach the most mistreated women without time or resource constraints. They comprised 113 Family Reconciliation House visitors and 154 Jordanian Women's Union visitors. The participants were categorized by age, socioeconomic status, and education. Participants received study tools in paper and electronic form using Google forms. This ensures that the study results can be applied to more victimized women. Research goals and study community features determined sample selection. **Table (1)** demonstrates the age, socioeconomic class, and educational level distribution of study sample members.

Table (1): Distribution of study individuals according to study variables

variable	category	N	%
Age	26 years to 40 years	88	33.20
	25 years and under	134	50.60
	41 years and above	43	16.20
Marital status	Married	147	55.50
	Single	64	24.20
	Widow or Divorced	54	20.40
Educational level	High school or below	130	49.10
	Bachelor's	101	38.10
	Postgraduate studies	34	12.80
Total		**795**	**100%**

The table shows sample demographics by age, marital status, and education. The data allows several observations and analyses: Age group: 26-40 years old at 50.6%, 41 years old and older at 16.2%, married at 55.5%, single at 24.2%, widows or divorcees at 20.4%, and educational level: 49.1% and 38.1% hold a bachelor's degree, indicating a good percentage of educated women, and postgrad at 16.2%.

Ethical Considerations

Participants were provided all the information they needed to decide in this voluntary study. Before data collection, participants had to: 1. Sign an informed consent form declaring their willingness to participate and knowing the study's goals, procedures, and risks. This permission agreed that participation was optional and that participants could leave at any moment without consequence. 2. Keep survey and personal data private. The data was private and used just for this study. - Participants were assured that study reports and publications would not identify them. Participation risks, including psychological distress, were listed. Participants were reminded they could exit the study without penalty or explanation. The study met all Research Ethics Committee ethical guidelines..

Instrument

First: Experimental Avoidance Scale

The experimental avoidance scale prepared by [40] used after Arabic translation. Initial arbitration scale contained 15 paragraphs. The developers used exploratory and confirmatory component analysis of scale texts to find two dimensions that explained 45.87 percent of the variance. Their dimensions had paragraph saturation values of 0.74-0.74 and a correlation

coefficient of 0.69. The stability coefficient (Cronbach's Alpha) was greater than 0.78 for the two dimensions and 0.45 for repetition with a two-month time delay between applications, confirming the scale's stability. The validity of the construct was verified by applying the scale to a survey sample of (30) abused women from outside the study sample, by calculating (Corrected Item-Total Correlation) between the score on the paragraph and the total score on the scale, as the values of the correlation coefficients of the scale paragraphs with the total score of the scale ranged between (0.40-0.72), and all the values of the correlation coefficients were higher than (0.20), and statistically significant at the significance level (α=0.05), and these values are acceptable for keeping the paragraphs within the scale according to the Awda criterion (2010), which indicates keeping the paragraphs whose correlation coefficient with the total score exceeds (0.20), and thus the scale in its final form consists of (14) paragraphs, and to estimate the stability of the internal consistency of the scale; (Cronbach's Alpha) was used on the data of the first application of the survey sample, which numbered (30) abused women from outside the study sample. Reapplying the scale to the previous survey sample with a two-week time difference and calculating the Pearson correlation coefficient yielded (0.75) internal consistency reliability and (0.81) re-test reliability.

Second: Psychosomatic Disorders Scale

The Psychosomatic Disorders Scale [41] was utilized after Arabic translation. The scale sent for arbitration had 39 paragraphs, and exploratory and confirmatory factor analysis showed that it had 7 factors. In this study, the scale's validity was verified by translating it from English to Arabic and presenting it to a group of ten Jordanian university faculty members with experience and specialization in psychological counseling and educational psychology. After the arbitrators' comments, all paragraphs' linguistic wording was amended, five paragraphs were eliminated, and numerous paragraphs were consolidated, leaving the scale with 22 paragraphs. The validity of the construct was confirmed by applying the scale to a survey sample of 30 abused women from outside the study. The (Corrected Item-Total Correlation) between item and scale scores ranged from 0.41-0.79, all above 0.20 and statistically significant at α=0.05. [41] The stability coefficient (Cronbach's Alpha) ranged from (0.72-0.78) for scale dimensions to (0.95) for the scale as a whole, confirming the scale's stability. In this study, the stability of alpha was calculated on the data of the first application of the survey sample, which numbered (30) abused women from outside the study sample, and reached a value of (0.82). The scale's stability was also verified by reapplying the scale to the previous survey sample two weeks later and calculating the Pearson correlation coefficient between the first and second applications.

Results

Arithmetic means and standard deviations of the experimental avoidance items in the sample of abused women, arranged in descending order.

It is clear from Table (2) that the level of experimental avoidance (as a whole) in the sample of abused women was average with an arithmetic mean of (3.30) and a standard deviation of (0.53), and the values of the arithmetic means of the experimental avoidance items ranged between (2.56) for the item that states (anxiety prevents me from doing important things in my life) and (3.69) for the item that states (I do my best to avoid uncomfortable situations), (6) of them were at the high level, (7) of them were at the medium level, and one of them was at the low level.

Table(2)

Rank	experimental avoidance	Arithmetic Average	Standard deviation	Level
1	I do my best to avoid uncomfortable situations	3.69	1.19	High
2	I quickly leave any situation that makes me feel uncomfortable	3.65	1.16	High
3	I avoid distressing emotions in my life	3.49	1.15	High
4	I do not engage in things that cause me frustration.	3.47	1.15	High
5	When unpleasant memories come to mind, I try to stop thinking about them	3.45	1.26	High
6	I always try to avoid painful emotions.	3.44	1.24	high
7	I try to avoid pain because it leads to suffering	3.39	1.30	Medium
8	I will not do something until I am absolutely forced to.	3.27	1.19	Medium
9	I work on postponing unpleasant tasks for as long as possible.	3.23	1.28	Medium
10	If I have any doubts about doing something, I avoid it.	3.23	1.23	Medium
11	It is difficult for me to recognize my emotions	3.12	1.30	Medium
12	II give up on my goals to avoid feeling bad.	3.09	1.29	Medium
13	I feel disconnected from my emotions.	3.09	1.28	Medium
14	Anxiety prevents me from doing important things in my life.	2.56	1.19	Low
	experimental avoidance	3.30	0.53	

Arithmetic means and standard deviations of psychosomatic disorder symptoms in the sample of abused women, arranged in descending order

It is clear from Table (3) that the level of psychosomatic disorders (as a whole) in the sample of abused women was average with an arithmetic mean of (3.32) and a standard deviation of (0.58), and the values of the arithmetic means of psychosomatic disorder symptoms ranged between (2.97) for the symptom (during the past six months I experienced a state of fainting) and (3.56) for the symptom (during the past six months I experienced a state of forgetfulness and difficulty in concentration), (5) paragraphs of which were at the high level, and (17) paragraphs of which were at the medium level.

Table(3)

Rank	psychosomatic disorder	Arithmetic Average	Standard deviation	Level
	In the past six months			
1	I had experienced forgetfulness and difficulty concentrating.	3.5 6	1.12	high
2	I felt headaches	3.5 5	1.17	high
3	I was suffered from fatigue and exhaustion	3.54	1.15	high
4	I felt a lack of physical fitness	3.53	1.19	high
5	I felt pain in my bones (back, neck...).	3.49	1.13	high

6	I had suffered from chest pain and tightness.	3.40	1.22	middle
7	I felt muscle pain and weakness.	3.39	1.20	middle
8	I felt a drop in energy.	3.38	1.19	middle
9	I felt shortness of breath and inability to take a deep breath.	3.36	1.21	middle
10	I felt confusion or detachment from reality.	3.3 5	1.14	middle
11	I have suffered from palpitations or irregular heartbeats	3.3 1	1.15	middle
12	I have suffered from abdominal pain and intestinal cramps	3.32	1.18	middle
13	I felt dizziness.	3.30	1.22	middle
14	I felt excessive sweating.	3.28	1.29	middle
15	I have experienced many hot or cold flashes.	3.26	1.19	middle
16	I had suffered from a sore throat.	3.2 4	1.26	middle
17	I felt nausea and stomach pain.	3.23	1.23	middle
18	I felt heard a faint sound in my ears.	3.22	1.30	middle
19	I felt tingling in my fingers, arms, or legs.	3.18	1.21	middle
20	I felt stiffness in my fingers and trembling hands.	3.15	1.18	middle
21	I felt dry mouth and difficulty swallowing.	3.13	1.32	middle
22	I felt experienced fainting.	2.97	1.36	middle
	psychosomatic disorder	**3.32**	**0.58**	middle

Predictive ability of experiential avoidance and variables (educational level, age, marital status) in psychosomatic disorders among abused women?

The regression analysis shows that the experiential avoidance scale has a significant effect on the dependent variable (psychosomatic disorders) because the regression coefficient (B) = 0.178, meaning that every one-unit increase in the scale increases the dependent variable by 0.178. However, the low R^2 percentage of 3.3% indicates that the model only partially explains variations in the dependent variable. The effect was statistically significant with (F) = 8.869 and **(t) = 2.978** with a significance level (Sig) = 0.003, showing that the two variables are not

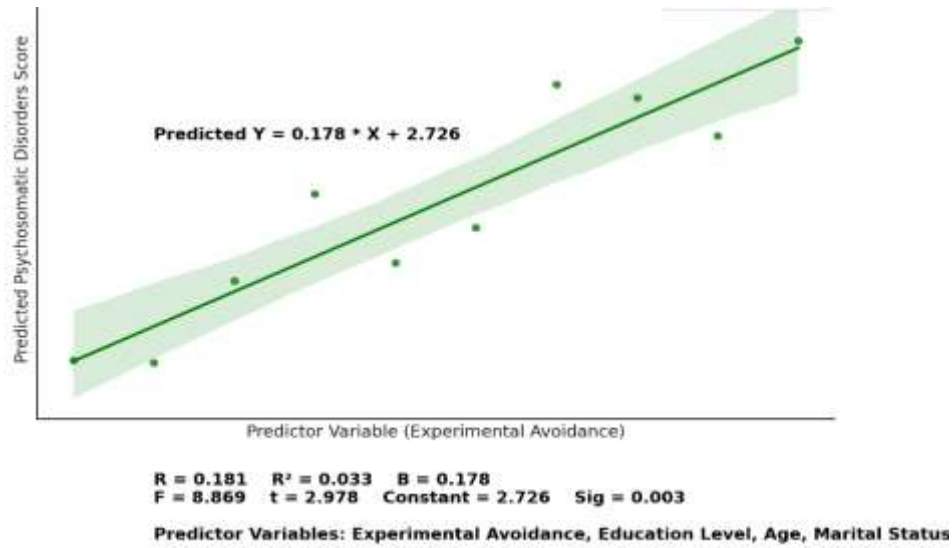
random. Finally, the regression constant (2.726) predicts the dependent variable's value when the experience avoidance scale is zero. The figure **Table (4)**

Results of the multiple regression test to detect the predictive ability of experiential avoidance and variables (educational level, age, and marital status) in psychosomatic disorders among abused woman

Predictive variables	R	Cumulative percentage of explained variance R2	R2	B	F	t	constant slope	sig
Experimental Avoidance Scale	.181	.033	.033	.178	8.869	2.978	2.726	.003

Dependent Variable: Psychosomatic Disorders Scale

The results of the regression analysis indicate that the experimental avoidance scale has a significant effect on the dependent variable (psychosomatic disorders), as the value of the regression coefficient (B) = 0.178, indicating that every one-unit increase in the experimental avoidance scale leads to an increase in the dependent variable by 0.178. However, the percentage of explained variance (R^2) is very low at 3.3%, which means that the model explains only a small part of the changes in the dependent variable. Significance tests also showed that the effect is statistically significant, as the value of (F) = 8.869 and **(t) = 2.978** with a significance level (Sig) = 0.003, indicating that the relationship between the two variables is not random. Finally, the regression constant (2.726) represents the expected value of the dependent variable when the experimental avoidance scale is zero. As shown in Figure**(1)**



FIGURER 1 "The Predictive Relationship Between Experimental Avoidance and

Discussion

Overall, the sample of abused women had average experience avoidance with an arithmetic mean of 3.30 and a standard deviation of 0.53. Experiential avoidance is a strategy abused women use to cope with negative feelings and painful memories, but it is moderate and does not interfere with their daily lives. Abused women may suppress negative thoughts but know the significance of accepting reality and adapting to new situations. Women who receive psychological or social assistance may display mild experiential avoidance because it reduces denial or complete avoidance of reality and psychological anguish. Some survivors of violence can process trauma in a balanced way, resulting in modest avoidance that doesn't impede their life. Some women employ cognitive tactics like positive reappraisal to lessen excessive avoidance to a moderate level. This intermediate degree balances psychological protection and adaptation to reality and may show psychological flexibility in battered women. This suggests that battered women may have to face their everyday reality and deal with tough conditions, reducing the possibility of extreme avoidance of life and violence. With family, friends, or specialized institutions, individuals may discover an atmosphere that helps them face reality instead of avoiding it. This matches the study. [42]and the study of Etzel (2005), whose results indicated that the level of experiential avoidance was moderate among abused women. It differed from the results of the study of [34, 38, 43]

research showed that mistreated women avoided experience. The sample of abused women had an average degree of psychosomatic diseases with an arithmetic mean of (3.32) and a standard deviation of (0.58). Violence produces persistent nervous system stress, which includes headaches, stomach pains, and sleep problems. Some mistreated women do not have significant issues. Many of them use avoidance, denial, or cognitive reappraisal to manage stress, which lessens psychosomatic symptoms but does not eliminate them, resulting in an average level of illnesses. Social assistance for battered women reduces the detrimental impacts of violence, reducing psychosomatic symptoms. Psychosomatic symptoms also depend on violence degree and duration. Intermittent aggression can cause moderate psychosomatic illnesses in certain women. Due to the balance between negative psychological effects and the ability to adapt or support, women with high alexithymia (difficulty expressing emotions) may have more psychosomatic symptoms, which prevent them from worsening but remain noticeable.

This is consistent with the findings of a study [44] that examined South Asian women's psychological and physical repercussions from domestic violence. Women subjected to domestic violence often have psychosomatic symptoms such sleep difficulties, exhaustion, respiratory issues, headaches, back pain, stomach discomfort, and inexplicable pain. Emotional or mental issues typically caused these symptoms. This contradicts a study.[36, 45], battered women had significant rates of psychosomatic problems. The WHO European Framework for Action on Mental Health 2021-2025 found that home neglect and abuse can severely impact cognitive and emotional development. This implies that aggression may cause psychosomatic illnesses in women. [6]. A study [39] also revealed that COVID-19 pandemic domestic violence increased mental (29.5%–35.0%) and physical (12.7%–17.6%) abuse against women. An increase in experiential avoidance by one standard unit (standard deviation) increased psychosomatic disorder by 0.178 standard units. Experience avoidance implies avoiding unpleasant feelings or thoughts. Internal psychological pressure from emotional suppression causes headaches, stomach problems, and muscle tightness. When an abused woman hides her feelings, her nervous

system stays aroused, causing high blood pressure, digestive issues, and a poor immune system. Avoidance also stops the abuser from acquiring good stress-management methods, making her more susceptible to prolonged stress, which can lead to psychosomatic problems. Abused women with experiential avoidance may focus on physical symptoms rather than psychological causes, keeping them in a cycle of physical pain and anguish. Abused women who adopt experiential avoidance may also avoid psychiatric help or emotional issues, worsening psychosomatic symptoms. Experiential avoidance hinders the abused from healthily processing her feelings, which increases internal stress and turns psychological pressures into persistent physical problems. This result is consistent with the result of [15]which indicated that experiential avoidance can predict psychosomatic disorders, consistent with the result of the study and consistent with the study(Clark et al., 2023) which significantly predicted interpersonal violence with the appearance of chronic pain ($\beta = 0.42$, $p < 0.001$) and other psychosomatic symptoms ($\beta = 0.38$, $p < 0.001$). Prolonged exposure to violence increases the likelihood of developing these conditions, especially in women with weak coping mechanisms. A study (Freitag et al., 2025) Sexual assault was found to substantially predict reproductive health difficulties at odds ratios of 1.8 for pelvic inflammatory disease ($p < 0.01$) and 2.2 for menstrual abnormalities ($p < 0.001$). Stigma delayed health care seeking, worsening these outcomes. A study [13] found that workplace harassment predicted gastrointestinal diseases (OR = 2.7, $p < 0.001$), with psychological distress mediating the connection (indirect effect = 0.42, $p < 0.01$). Stress-induced gut-brain axis dysregulation was a crucial mechanism.

Strengths and Limitations

This study shows how avoidance experiences predict psychosomatic symptoms in abused women and reveals psychological mechanisms that may worsen their distress. Focusing on a vulnerable group, using a predictive model to identify intervention targets, and applying a rigorous process with validated instruments improves dependability and applicability. Self-reported data may be biassed, and the cross-sectional design limits causal findings. The sample may also lack diversity, impacting generalizability. Future longitudinal research should investigate causality and improve psychosomatic distress support for abused women.

Recommendations

1. Avoiding uncomfortable emotions delays the effects of avoidance on awareness and self-reported effects, affecting psychosomatic symptoms.
2. Creating psychological support programs for abused women showed no substantial correlation between age, education, or social status and psychosomatic diseases. Educational programs about mental health, only for journalists, emotionally, and healthy cancer management for women should be included.
3. Training in early intervention skills related to avoidance and successful treatment participation from mental illness beginning. Psychologists can achieve this by learning selection and avoidance skills and using proper treatment.

Conclusion

This study found a significant relationship between avoidance and psychosomatic disorders in abused women, where age, educational level, and social status are important. The most important point is the importance of focusing on the psychological and collective aspect in explaining psychological symptoms in cases of violence, which calls for therapeutic examinations and

important psychological interventions for the ef Psychological support, interventions, and side effects are part of therapy. Counselors should raise awareness of the impacts of violence on women and help victims overcome the negative repercussions of violence, whether short-term or long-term.

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