



Research Paper

Preliminary psychometric evaluation of the Somatoform Dissociation Questionnaire (SDQ-20) in a Hungarian psychiatric sample

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ABSTRACT

Background: Somatoform dissociation is the somatic manifestation of dissociation. It refers to physical symptoms that resemble somatic diseases or the effect of substance use but cannot be explained by any organic disorder. Identifying the dissociative nature of a somatic symptom and its frequently hidden history of trauma can be challenging. Since no psychometric instrument is currently available in Hungary to screen for this phenomenon, the adaptation and preliminary psychometric analysis of a reliable measurement is essential.

Objective: The present study aimed to examine and adapt the psychometric properties of the Hungarian version of the Somatoform Dissociation Questionnaire (SDQ-20) while also investigating the prevalence of somatoform dissociation among psychiatric patients and its association with childhood trauma.

Method: A cross-sectional study was conducted with 112 heterogeneous adult psychiatric patients aged 18–65 years ($M = 38.36$; $SD = 13.51$) at the Department of Psychiatry and Psychotherapy of the University of Debrecen Clinical Centre. Participants were selected via convenience sampling and completed a battery of questionnaire that included the Hungarian adaptation of the SDQ-20, the Dissociative Experiences Scale (DES), the Adverse Childhood Experiences (ACE) Questionnaire and the Patient Health Questionnaire-15 (PHQ-15) Somatic Symptom Severity Scale.

Results: The Hungarian version of the SDQ-20 showed excellent internal consistency (Cronbach's $\alpha = 0.831$; McDonald's $\omega = 0.84$). A significant, positive correlation was observed between SDQ-20 and DES ($\rho = 0.521$; $p < 0.001$). Furthermore, childhood traumatization showed a stronger association with the SDQ-20 ($\rho = 0.356$; $p < 0.001$) than with the PHQ-15 ($\rho = 0.213$; $p < 0.05$). The study established the cut-off score of our sample at 29.5, revealing that 24.1 % of the participants exhibited a somatoform dissociative tendency. Adverse childhood experiences were highly frequent, with 41.1 % of the total sample and 63.0 % of those with somatoform dissociation reporting four or more ACEs. Binary logistic regression significantly associated physical abuse with higher odds of reporting both psychoform and somatoform dissociation.

Conclusion: Given the preliminary evidence regarding the psychometric properties of the Hungarian version, the SDQ-20 can be considered a reliable tool for screening somatoform dissociative symptoms in psychiatric settings. Our findings suggest the importance of screening for somatoform dissociation and considering its association with adverse childhood experiences among psychiatric patients to facilitate the identification of patients who would benefit from trauma-focused interventions. Further studies using larger samples, structured clinical interviews, test-retest designs, and independent clinical criteria are needed to establish structural validity, diagnostic thresholds, and clinical utility.

Abbreviations

ACE Adverse Childhood Experiences Questionnaire
BPD Borderline Personality Disorder

CPTSD Complex Posttraumatic Stress Disorder
DES Dissociative Experiences Scale
DES-T Dissociative Experiences Scale – Taxon
DID Dissociative Identity Disorder

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FND	Functional Neurological Disorder
ISSTD	International Society for the Study of Trauma and Dissociation
PHQ-15	Patient Health Questionnaire-15
PTSD	Posttraumatic Stress Disorder
SDQ-20	Somatoform Dissociation Questionnaire
SSD	Somatic Symptom Disorder

1. Introduction

1.1. The concept of somatoform dissociation and its measurement challenges

Dissociation is defined as a disruption in the normal integration of consciousness, identity, memory, perception, and body function (APA, 2022). Within Nijenhuis' framework of the Structural Dissociation of the Personality, dissociation can be categorized into two phenomenological forms: psychoform and somatoform dissociation. Psychoform dissociation involves disruptions in the integration of mental processes (e.g., amnesia, depersonalisation, intrusive experiences, and perceptions). Conversely, somatoform dissociation refers to the disruption of the integration of bodily experiences, reactions, and functions (Nijenhuis et al., 1996; Nijenhuis, 2001). The term "somatoform" indicates that these symptoms mimic somatic (primarily neurological) diseases or the effects of a substance, yet cannot be explained by either. Typical symptoms of somatoform dissociation include bodily anesthesia, analgesia, motor inhibition, paralysis, or dysphagia (Nijenhuis, 2001).

Despite their phenomenological disparity, both psychoform and somatoform dissociation are inherently mental phenomena. Traumatization plays a fundamental role in the etiology of dissociation, regardless of its manifestation (Nijenhuis, 2001); furthermore, chronic childhood traumatization serves as one of the primary indicators of dissociation (Van Der Kolk et al., 1996).

The broad definition of dissociation, combined with the fact that dissociative symptoms are not exclusively presented in dissociative disorders, complicates both the diagnostic process and the differential diagnosis. This necessitates a clear conceptualisation of dissociation within modern clinical nosology, particularly regarding disorders that straddle the boundaries between psychological and somatic symptom profiles.

Somatoform dissociation is not an independent diagnostic entity, but rather a transdiagnostic phenomenon that may manifest across several mental disorders. However, its weight and role may vary across distinct

clinical conditions (Table 1).

In conversion disorder—or Functional Neurological Disorder (FND) within modern nosological frameworks—pseudoneurological symptoms serve as direct and observable manifestations of somatoform dissociative processes, reflecting an impairment in the integration of mental and bodily functions (Brown, 2016). While conversion symptoms typically affect specific bodily functions and provide rapid psychological tension relief following a stressor or conflict, in severe dissociative disorders (e.g., DID), somatoform dissociation emerges as a direct reflection of personality fragmentation, typically manifesting during switches between personality parts. In FND the symptom is the dissociation itself (Holmes et al., 2005; Nijenhuis, 2004).

Regarding trauma-spectrum disorders, intrusions, avoidance, and cognitive-affective alterations lie at the core of the diagnostic criteria and clinical picture in both PTSD and CPTSD (APA, 2022). Although somatoform dissociation is present in both conditions, its manifestation and prominence differ between them. In PTSD, somatoform dissociative symptoms occur primarily during the re-experiencing of traumatic events, triggered by the reactivation of sensorimotor fragments of non-integrated trauma (Nijenhuis et al., 2010). Conversely, in CPTSD, somatoform dissociation functions as a prominent, persistent background process. Together with chronic autonomic nervous system overload, it may account for both the emerging somatoform dissociative features and the global, enduring functional clinical picture (e.g., chronic pain, muscle tension, fibromyalgia) (Burbach et al., 2024; Costa et al., 2025). Consequently, the level of somatoform dissociation may serve as a clinically useful indicator in differentiating between PTSD and CPTSD, as this symptom cluster is markedly more pronounced in the latter (Møller et al., 2021).

Although somatic symptom disorder (SSD) and somatoform dissociation present with similar manifestations, they are grounded in distinct mechanisms. While individuals with SSD may also exhibit somatoform dissociative symptoms—such as loss of bodily functions, depersonalization (a sense of bodily estrangement), or heightened pain perception/analgesia—an integrative deficit is not a defining characteristic of this condition. Instead, the central feature of SSD is hypervigilance toward somatic sensations, accompanied by their catastrophisation and excessive health anxiety (APA, 2022). Although childhood traumatic experiences may serve as a risk factor, the onset of SSD can also be linked to other stressors or psychological factors, with the symptomatology itself often exacerbating distress (APA, 2022; Marks & Hunter, 2015).

Given that these phenomena often share a traumatic etiology, they

Table 1
Characteristics of trauma-related and somatoform phenomena.

Diagnosis	Characteristic somatic symptoms	Prominence of somatoform dissociation	Primary underlying mechanism	Triggering Factors
Conversion Disorder (FND)	Selective and dramatic pseudoneurological symptoms	Primary, direct manifestation	Direct channelisation of tension through the disruption of mental and bodily integration	Unbearable or perceived unsolvable conflict, severe stressor
Severe dissociative disorders (e.g., DID)	Sudden changes in physiological functioning (e.g., drastic shifts in visual acuity)	Prominent	Result of switches between personality parts	Trigger-induced switches; complex traumatization
PTSD	Transient functional deficits occurring during flashbacks or exposure to triggers (e.g., anesthesia, numbness, motor inhibition, mutism)	Episodic	Reactivation of sensorimotor fragments of traumatic memories in the present	Single traumatic event
CPTSD	Sensory deficits, motor dysfunctions, and global, diffuse functional complaints (e.g., chronic pain, gastrointestinal symptoms)	Substantial, but not exclusive	Chronic somatic-affective detachment and persistent autonomic nervous system overload	Complex traumatization
Somatic symptom disorder (SSD)	Diverse somatic symptoms, which may be functional or organically based	May be present, but integrative deficit is not cardinal	Hypervigilance toward somatic sensations, catastrophisation, and excessive anxiety	Childhood trauma is a risk factor, but onset is linked to other stressors; symptomatology itself exacerbates distress

may be subsumed under the umbrella of "trauma-related bodily dysregulation" in cases where childhood traumatization is identifiable. Exposure to adverse experiences during sensitive developmental periods can alter the nervous system, potentially maintaining the body in a persistent "fight, flight, or freeze" state. This psychophysiological state often culminates in functional somatic complaints. It is imperative to note, however, that in these conditions, early childhood trauma may increase individual vulnerability rather than acting as a singular, direct cause. Therefore, assessment and clinical history-taking should prioritize examining the temporal correlation between physical symptoms and traumatic memories or their associated triggers, as well as the functional nature of the symptoms, which assists in distinguishing between organic pathologies and the aforementioned overlapping clinical entities (APA, 2022; Costa et al., 2025).

1.2. Epidemiology and sociodemographic factors

Despite its significant prevalence, dissociation remains a frequently overlooked or hidden phenomenon. While in 2011 it was estimated at 10 % in both clinical and general populations (Sar, 2011), later data from 2017 showed a consistent increase to 20 % across both Asian and Western psychiatric samples (Chiu et al., 2017). Certain demographics exhibit even more pronounced rates; for instance, prevalence climbs to 15–39 % among individuals with substance use disorders and remains notably high among women in sex work (Sar, 2011). Furthermore, dissociative disorders are disproportionately represented among women, children, individuals with emotionally unstable personality traits, and those from lower socioeconomic or educational backgrounds (Osváth et al., 2020).

Data regarding the frequency of somatoform dissociation remain limited. A study conducted at an Italian university among students aged 18–28 found the prevalence of somatoform dissociative tendency to be 4.7 % (2.6 % for men and 5.1 % for women) (Farina et al., 2011), while a large-scale Finnish study of the general population aged 26–65 reported a 9.4 % prevalence of somatoform dissociation, with higher values observed in men than in women (Maaranen et al., 2005). In contrast, an estimated 25–60 % of patients in general medical care present with symptoms that cannot be explained by organic pathology—suggesting a potential dissociative or conversion etiology (Brown, 2004). Consequently, clinical observations imply that the actual prevalence of somatoform dissociation may significantly exceed current empirical estimates.

1.3. Barriers to clinical recognition and the Hungarian context

Despite their distinct clinical characteristics, somatoform dissociative symptoms remain challenging to recognize in clinical practice. The clinical presentation often mirrors other psychiatric or somatic, primarily neurological complaints, which frequently leads to misdiagnosis (Nijenhuis, 2004). An additional difficulty arises from the fact that dissociative experiences typically originate in early childhood; consequently, patients may perceive them as ordinary, lifelong experiences and may not report them as significant or pathological (Nagy & Kuritárné Szabó, 2018). Approximately 40–60 % of patients suffering from somatoform dissociation or somatization-based mental disorders believe they have a physical illness (Ford & Folks, 1985), leading the majority to primarily seek help within primary care or general medicine (Nijenhuis, 2004).

The guidelines of the International Society for the Study of Trauma and Dissociation (ISSTD) (Guidelines for Treating Dissociative Identity Disorder in Adults) emphasize that the assessment of dissociation should be an indispensable component of every diagnostic interview, highlighting the critical importance of exploring somatoform dissociative complaints alongside psychoform symptoms (ISSTD, 2011). This underscores the necessity for standardised assessment tools that facilitate clinical recognition, differential diagnosis, and the formulation of

appropriate treatment plans.

Currently, no validated psychometric instrument is available in Hungary for screening somatoform dissociation. Although the Somatoform Dissociation Questionnaire (SDQ-20) is internationally accessible in numerous languages (e.g., Danish, German, English, French, Dutch, Hebrew, Mandarin Chinese, Polish, Turkish), its absence from the Hungarian clinical toolkit inhibits both the recognition of somatoform dissociation in clinical practice and the advancement of related research activities.

The aims of our study are: a) to adapt and examine the psychometric properties of the Hungarian version of the SDQ-20, and b) to explore the prevalence of somatoform dissociation and its relationship with adverse childhood experiences among a heterogeneous Hungarian psychiatric sample.

2. Methods

2.1. Participants

Adult psychiatric patients were recruited from the Department of Psychiatry and Psychotherapy at the University of Debrecen Clinical Centre. Our study utilised a heterogeneous clinical sample. It consisted of patients with diverse diagnostic backgrounds, encompassing all admitted participants who met the inclusion criteria and consented to participate, without selecting for specific diagnostic categories.

The inclusion criteria were as follows: age 18–65 years; absence of acute psychotic states or severe cognitive impairments that would preclude comprehension or communication; proficiency in the Hungarian language; and the provision of written informed consent. Participants were selected via convenience sampling, facilitated by the clinical staff at the research site.

2.2. Procedure

The study was conducted between 2024 and 2025 across both inpatient and outpatient settings. Following a detailed briefing and written informed consent, all assessments were administered in a one-on-one format by the first and second authors. To ensure complete anonymity, participation was strictly voluntary. The clinical staff assessed the inclusion criteria. However, the research team did not access the participants' medical records; instead, all diagnostic and clinical data were collected via self-report. The battery of questionnaires took approximately 20–40 min to complete. The study was conducted in accordance with the principles of the Declaration of Helsinki and received ethical approval from the Regional Research Ethics Committee and the Medical Research Council (Approval numbers: RKEB.6871A-2024 (11.09.2024); BM/20802-1/2024 (03.09.2024)).

2.3. Measures

In addition to the Hungarian version of the SDQ-20, the Dissociative Experiences Scale (DES) was administered to assess the association with other dissociative measurements to explore preliminary convergent validity, while the Adverse Childhood Experiences (ACE) Questionnaire was employed to evaluate the association with childhood traumatization to analyze preliminary etiological validity. The Patient Health Questionnaire-15 (PHQ-15) Somatic Symptom Severity Scale was used to examine the differences between somatoform dissociation and general somatization to ensure preliminary discriminant validity.

2.3.1. Somatoform Dissociation Questionnaire (SDQ-20)

The SDQ-20 is a self-reporting instrument designed to assess the presence and severity of somatoform dissociation, developed by Nijenhuis, Spinhoven, van Dyck, van der Hart and Vanderlinden in 1996. The authors developed a list of 75 items, which included somatoform dissociative symptoms selected based on clinical experience and expert

judgment. These items were tested on patients with dissociative and other psychiatric diagnoses. Based on logistic regression analyses, 20 items were selected that best discriminated between those with and without dissociative disorders (Nijenhuis et al., 1996). The items encompass medically unexplained symptoms that manifest during the activation of dissociative parts of the personality. The questionnaire evaluates both positive (e.g., "I have an attack that resembles an epileptic seizure") and negative dissociative symptoms (e.g., "My body, or a part of it, is insensitive to pain"), on a 5-point Likert scale (1 = this applies to me NOT AT ALL, 5 = this applies to me EXTREMELY) based on the person's experiences over the past year. For each item, participants must indicate whether a physician has attributed the symptom to a confirmed physical illness. In clinical applications, if a medical etiology is identified, the score for that item is adjusted to 1. While the authors suggest retaining original scores for research purposes, the present study adopted the clinical scoring procedure to enhance the interpretability of prevalence data. The total score ranges from 20 to 100 (Nijenhuis, 2010). A cutoff score of 29.5 has been established to identify clinical levels of somatoform dissociation (Pietkiewicz et al., 2019). The SDQ-20 is a brief screening tool, though it does not replace comprehensive medical examinations or formal clinical diagnostic procedures.

The original Dutch version demonstrated excellent internal consistency (Cronbach's $\alpha = 0.96$; Nijenhuis et al., 1998) and satisfactory test-retest reliability (Sar, 2011). Convergent validity is supported by robust correlations with other measures of dissociation. Specifically, Nijenhuis et al. (1996) reported strong correlations between the SDQ-20 total score and the Dissociation Questionnaire (DIS-Q) ($0.71 < r < 0.76$; $p < 0.001$), while correlations with absorption scales remain moderate ($r = 0.46$; $p < 0.001$). Subsequent studies found even stronger correlations with the DIS-Q ($r = 0.82$; Nijenhuis et al., 1998) and the Dissociative Experiences Scale (DES) ($r = 0.85$; Nijenhuis et al., 1997). Furthermore, somatoform dissociation is consistently linked to childhood traumatization, reinforcing the trauma-related etiology of these disorders (Nijenhuis, 2010). In psychiatric samples, SDQ-20 scores were best predicted by self-reported physical and sexual abuse (Nijenhuis et al., 1998).

2.3.2. Translation of the Somatoform Dissociation Questionnaire

Before the preparation of the Hungarian version formal permission for the translation and validation was obtained from the original author in 2019.

The procedure comprised forward translations by two native speakers who independently translated the questionnaire. Both translators held a degree in Human Behavior Analysis and one of them possessed a C1 advanced-level English proficiency certification. This process was followed by a synthesis of the translation into a consensus version. In the next step, two independent translators who were unfamiliar with the original instrument back-translated the text into English. Both translators are senior clinical psychologists possessing high-level English proficiency, with one being a certified psychological translator.

The pre-final version was then reviewed by a third independent certified psychological translator. Finally, a pilot study ($N = 10$) was conducted before formal psychometric evaluation. All participants found the translated items to be perfectly comprehensible.

2.3.3. Dissociative experience scale (DES)

The DES is a 28-item self-report instrument developed to quantify trait-like dissociative experiences, specifically addressing disruptions in memory, identity, awareness, and cognition (Carlson & Putnam, 1993) on an 11-point scale ranging from 0 % ("never") to 100 % ("always"). The total score is derived by averaging all item responses (Bernstein & Putnam, 1986; Hungarian trans. Kocsis-Bogár & Komlósi, 2012). The instrument was developed for both clinical and research applications (Carlson & Putnam, 1993). Meta-analyses suggest a cutoff of 35 to distinguish high and low levels of dissociation (Lyssenko et al., 2018). The scale demonstrates high reliability in both normal and clinical

samples (Cronbach's $\alpha = 0.96$; Dubester & Braun, 1995).

2.3.4. Dissociative experiences scale - taxon (DES-T)

The DES-T is a specific 8-item short form of the DES (items 3, 5, 7, 8, 12, 13, 22, 27) developed by Waller et al. (1996). Unlike the original DES, which conceptualises dissociation as a continuum, the DES-T aims to identify a specific pathological dissociative group (taxon). It effectively differentiates normative dissociative experiences (e.g., highway hypnosis) from true psychopathological phenomena (e.g., not recognizing acquaintances or family). Following Modestin and Erni (2004), scores exceeding 35 indicate the presence of the pathological taxon.

2.3.5. Adverse childhood experiences (ACE) questionnaire

The ACE Questionnaire assesses ten types of childhood trauma occurring before age 18 (Anda et al., 2010), including emotional, physical, and sexual abuse; emotional and physical neglect; and household dysfunction (substance abuse, mental illness, domestic violence, parental separation/divorce, or incarcerated household members). It is a 10-item, retrospective self-report tool with binary (yes/no) responses. The cumulative ACE score (0–10) reflects the total number of distinct adversity types, serving as a cumulative index of severity. The Hungarian version was adapted by Ujhelyiné Nagy and Kuritárné Szabó (2020) and validated by Kovács-Tóth et al. (2023). The original authors treated the scale as a cumulative index, reporting test-retest reliability ($Kappa: 0.41–0.86$; Dube et al., 2004).

2.3.6. Patient health questionnaire-15 (PHQ-15)

The PHQ-15 was developed by Kroenke et al. (2002) to measure somatic symptom distress. It contains 15 common somatic symptoms or symptom groups which align with the symptoms of the DSM-IV somatization disorder. Respondents rate the degree to which they were bothered by symptoms over the past month on a 3-point scale (0 = "not at all", 1 = "bothered a little", 2 = "bothered a lot"). Item 4 (menstrual cramps) is often excluded in research to avoid gender bias in total scores (Stauder et al., 2021). Scores range from 0 to 30, with cutoffs of 5, 10, and 15 representing mild, moderate, and severe somatic symptom severity. The Hungarian version demonstrated good internal consistency (Cronbach's $\alpha = 0.810$) in a large-scale sample (Stauder et al., 2021).

2.4. Statistical analysis

Statistical analyses were conducted using IBM SPSS Statistics v.31 and Jamovi 2.7.29. Following the exclusion of three participants due to incomplete data, the final sample comprised 112 individuals. The sample was initially characterised using descriptive statistics, including means, standard deviations, and frequency distributions.

Normality was assessed via Shapiro-Wilk tests and skewness indices. Given the significant right-skewness of the SDQ-20 and DES scores, non-parametric test was employed.

Internal consistency was evaluated using Cronbach's alpha and McDonald's omega coefficients, and homogeneity via item-total correlations.

Relationships between variables were analyzed using Spearman's rank-order correlations. Group differences were analysed using Mann-Whitney U and Kruskal-Wallis tests. Binary logistic regression evaluated the predictive power of adverse childhood experiences on dissociative outcomes. An exploratory factor analysis (EFA) was conducted to investigate the internal structure and factor loadings of the questionnaire.

To establish the clinical cut-off, SDQ-20 scores underwent logarithmic transformation and K-means cluster analysis was used to differentiate between high-symptom (clinical-range) and low-symptom (non-clinical) clusters. Crosstabulation and Chi-square analysis—supplemented by Fisher's exact test—were then employed to evaluate the degree of concordance between the resulting SDQ-20 group memberships and the categories established by the DES-T.

Finally, Cohen's kappa was calculated to determine the actual classification accuracy between the two criteria.

For all statistical tests, the level of significance was set at $p < 0.05$.

3. Results

3.1. Sample

Out of the 115 individuals initially enrolled, three were excluded due to incomplete data, yielding a final analytical sample of $N = 112$. The mean age of the participants was 38.36 years ($SD = 13.51$; range 18-65). The sample was predominantly female (70.5 %). Most respondents had completed secondary education (50.9 %), resided in urban areas (61.6 %), and were either married or in a committed relationship (54.4 %).

At the time of the assessment, 38 % of the sample were undergoing their first psychiatric evaluation or hospitalization. The majority of participants (78.5 %) were recruited from inpatient units, while 21.5 % were receiving outpatient care (Table 2).

3.2. Scores and frequency of dissociation in a Hungarian psychiatric sample

Scores of DES ranged from 0 to 75.26 ($M = 30.08$; $SD = 16.17$), with only three participants (2.7 %) scoring at the floor (0). Based on the established cutoff of 35 (Lyssenko et al., 2018), 35.7 % of the sample exhibited clinically significant psychoform dissociative tendency.

The SDQ-20 scores ranged between 20 and 65 ($M = 26.85$; $SD = 8.28$), with 18 respondents (16.1 %) reaching the lowest possible score of 20. In our sample, 24.1 % of participants exceeded the clinical cutoff of 29.5, signaling a somatoform dissociative tendency.

Cross-categorization revealed that 8.0 % of the sample presented exclusively with somatoform dissociative tendencies, 19.6 % exclusively with psychoform dissociation, and 16.1 % met the criteria for both.

Both SDQ-20 ($W = 0.760$, $p < 0.001$) and DES ($W = 0.967$, $p = 0.007$) scores deviated significantly from a normal distribution. The distribution of the SDQ-20 was highly right-skewed ($skewness = 2.217$), suggesting a substantial floor effect.

The SDQ-20 scores showed no significant associations with gender ($U = 1201$; $p = 0.680$), educational attainment ($\chi^2 = 6.42$; $p = 0.093$), marital status ($\chi^2 = 0.0665$; $p = 0.967$), place of residence ($\chi^2 = 0.0898$; $p = 0.956$), age ($\rho = -0.167$; $p = 0.078$) or the form of hospital care ($U = 929$; $p = 0.366$).

In contrast, while DES scores were also independent of gender ($U =$

1092; $p = 0.264$), marital status ($\chi^2 = 1.0588$; $p = 0.589$), place of residence ($\chi^2 = 0.1378$; $p = 0.933$) and the form of hospital care ($U = 1022$; $p = 0.812$), but both age ($\rho = -0.195$; $p = 0.039$) and education ($\chi^2 = 19.16$; $p < 0.001$) emerged as significant factors, showing higher scores among younger and less-educated respondents.

3.3. Most prevalent symptoms and item-level discrimination between high-SDQ-20 and low-SDQ-20 clusters

In the next step, we identified the most prevalent somatoform dissociative symptoms within the high-SDQ-20 cluster. The highest frequencies (70.4 %) were reported for difficulty falling asleep at night combined with daytime activity (Item 18;), bodily numbness (Item 2), and dysphagia (difficulty swallowing; Item 15). These were followed by difficulty speaking or whispering (Item 13; 63 %) and alterations in the sense of smell (Item 14; 51.9 %). Weighting frequencies by symptom severity — as indicated on the 5-point Likert scale — yielded identical prominent symptoms.

To examine the discriminating power of the individual SDQ-20 items between the high-SDQ-20 and low-SDQ-20 clusters, binary logistic regression was performed to analyse each item. Perceiving nearby sounds as distant (Item 3) emerged as the most robust discriminator between the clusters ($Wald \chi^2 (1) = 20.96$; $p < 0.001$), increasing the odds of considering the higher-SDQ-20 cluster more than eighteenfold ($OR = 18.80$). Other items also demonstrated strong discriminating capacity, including the sensation of disappearing body parts ($OR = 17.47$), distorted vision resembling tunnel vision ($OR = 16.20$), sudden aversion to familiar smells ($OR = 16.08$), and transient paralysis ($OR = 14.52$) also have a high likelihood factor, all significant at the $p < .001$ level. These analyses identify items that most effectively differentiate between patients with higher versus lower levels of somatoform dissociative symptoms, but they should not be interpreted as independent diagnostic predictors.

3.4. Internal consistency and reliability

The instruments demonstrated adequate reliability: DES (Cronbach's $\alpha = 0.919$), ACE (Cronbach's $\alpha = 0.788$), and PHQ-15 (Cronbach's $\alpha = 0.814$).

The internal consistency of the Hungarian SDQ-20 was excellent, with McDonald's omega coefficient of 0.84 and a Cronbach's alpha coefficient of 0.831 for the total scale.

Corrected item-total correlations indicated varying levels of item homogeneity, with coefficients ranged from 0.11 and 0.63, with the strongest association for Item 16 (difficulty swallowing; $\rho = 0.633$). However, Item 1 (difficulty urinating), Item 4 (painful urination), Item 6 (objects appearing larger than they are), and Item 10 (genital pain) fell below the conventional 0.30 threshold.

Nonetheless, item-deletion analysis indicated that removing these items would not substantially augment overall reliability, all items were retained to preserve the scale's original structure and ensure comparability with international normative data. The attenuated correlations for these specific items are likely attributable to the pronounced floor effect, as these symptoms represent highly specific conversion phenomena with low frequency in the current sample.

3.5. Dimensionality and item-level characteristics of the SDQ-20

To characterize the underlying structure of the SDQ-20 in our sample ($N = 112$), we performed an Exploratory Factor Analysis (EFA) using Principal Axis Factoring with no rotation. Our objective was to examine the empirical grouping of items rather than to establish structural validity, as our sample size limited the applicability of confirmatory factor analysis.

The analysis of the factor loading matrix revealed that the SDQ-20 does not form a strictly unidimensional structure (Table 3). While

Table 2
Sociodemographic and clinical characteristics of the sample ($N = 112$).

Measure	Item	Count (Total $N = 112$)	Percentage (%)
Gender	Male	32	28,5
	Female	79	70,5
	Missing	1	1
Place of residence	Village	21	18,8
	Town	69	61,6
	County seat	22	19,6
Marital Status	Single	41	36,6
	In a relationship (marriage or relationship)	61	54,4
	Divorced/widow	9	8
Education	Missing	1	1
	Incomplete primary education	1	1
	Primary education	17	15,1
Previous psychiatric care	Secondary education	57	50,9
	Higher education	37	33
	Yes	69	62
Hospital care	No	43	38
	In-patient	88	78,5
	Out-patient	24	21,5

Table 3

Exploratory factor analysis of the SDQ-20 items.

	Factor			Uniqueness
	1	2	3	
Item1 - Trouble urinating		0.345		0.816
Item2 - Dislike usual tastes	0.352		0.397	0.637
Item3 - Sounds seem distant	0.543	0.417		0.530
Item4 - Painful urination				0.952
Item5 - Numb body parts	0.447		-0.390	0.568
Item6 - Objects look bigger				0.882
Item7 - Seizure-like attack	0.397	-0.405		0.622
Item8 - Insensitivity to pain	0.635	-0.301		0.506
Item9 - Dislike usual smells	0.544	0.471		0.411
Item10 - Genital pain				0.893
Item11 - Temporary deafness	0.434			0.778
Item12 - Temporary blindness	0.627			0.517
Item13 - Visual distortions	0.514			0.713
Item14 - Altered sense of smell	0.407		0.318	0.729
Item15 - Feeling of body part disappearance	0.629	0.341		0.469
Item16 - Swallowing difficulty	0.693			0.518
Item17 - Sleep loss with daytime activity	0.445			0.782
Item18 - Speech difficulty	0.671	-0.301		0.450
Item19 - Temporary paralysis	0.471		-0.371	0.628
Item20 - Temporary stiffness	0.529		-0.439	0.441

Note. 'Principal axis factoring' extraction method was used in combination with a 'none' rotation

most items contribute to a primary latent factor (Factor 1), the extraction of a three-factor solution provided a more nuanced representation of the data. Several items showed non-trivial loadings across these three factors, indicating that the SDQ-20, in this sample, captures multiple facets of somatoform dissociation rather than a single uniform construct.

The item-level descriptive statistics for the SDQ-20 demonstrate a strong floor effect. The distribution of responses is highly asymmetric, with skewness values ranging from 0.902 to 9.34, indicating consistent positive skewness. This is further supported by a median value of 1.00 for all items and mean scores ranging from 1.04 to 2.16.

3.6. Preliminary psychometric evaluation of the SDQ-20

To evaluate the preliminary evidence of construct validity of the SDQ-20, total scores were correlated with measures of psychoform dissociation (DES) and its taxon-derived version (DES-T), somatic symptom distress (PHQ-15), and adverse childhood experiences (ACE) (Table 4).

Preliminary construct validity was supported by significant positive correlations between the SDQ-20 and the DES ($\rho = 0.521$; $p < 0.001$; 95 % CI: [0.427–0.681]), as well as with pathological dissociation represented by the DES-T ($\rho = 0.485$; $p < 0.001$; 95 % CI: [0.390–0.657]).

Since we do not have the Hungarian version of the SCID-D interview, known-groups validity was evaluated by comparing scores between participants classified as having high versus low dissociative symptoms according to the DES-T taxon (high DES-T: $n = 28$; low DES-T: $n = 84$). A Mann-Whitney U test revealed that individuals in the high DES-T group scored significantly higher on the SDQ-20 compared to the low DES-T group ($U = 1892.000$, $z = 4.833$, $p < 0.001$).

A significant, moderately strong positive association was found between the total scores of the SDQ-20 and the PHQ-15 ($\rho = 0.546$; $p < 0.001$; 95 % CI: [0.346–0.627]). Notably, while a significant moderate positive correlation was observed between SDQ-20 total scores and adverse childhood experiences ($\rho = 0.356$; $p < 0.001$; 95 % CI: [0.135–0.472]), the correlation between PHQ-15 total scores and ACE scores was substantially weaker ($\rho = 0.213$; $p = 0.025$; 95 % CI: [0.023–0.381]).

As for the possible conceptual overlap between dissociative (SDQ-20) and general (PHQ-15) somatic symptoms, a partial correlation

Table 4

Spearman's rank-order correlations between the SDQ-20, DES, DES-T, PHQ-15, and ACE scores.

	SDQ-20 total score	DES mean score	DES-T mean score	PHQ-15 total score
DES mean score	0.521	—		
p-value	< 0.001			
[95 % CI]	[0.427–0.681]			
DES-T mean score	0.485	0.614	—	
p-value	< 0.001	< 0.001		
[95 % CI]	[0.390–0.657]	[0.563–0.767]		
PHQ-15 total score	0.546	0.369	0.234	—
p-value	< 0.001	< 0.001	0.013	
[95 % CI]	[0.346–0.627]	[0.219–0.536]	[0.139–0.474]	
ACE total score	0.356	0.482	0.440	0.213
p-value	< 0.001	< 0.001	< 0.001	0.025
[95 % CI]	[0.135–0.427]	[0.267–0.573]	[0.283–0.584]	[0.023–0.381]

Spearman's rho

Note. $N = 112$, except for the ACE total score, where $n = 111$ due to one missing data point.

analysis was conducted to determine whether the observed associations remain robust after controlling for PHQ-15 scores. According to the results, the associations between the SDQ-20 and the DES ($\rho = 0.410$; $p < 0.001$), DES-T ($\rho = 0.439$; $p < 0.001$), and ACE ($\rho = 0.293$; $p = 0.002$) total scores remained statistically significant.

The Standard Error of Measurement (SEM) was calculated to be 3.40 points (based on a standard deviation of 8.28 and a Cronbach's alpha of 0.831). This relatively low SEM suggests that the SDQ-20 provides a precise estimate of dissociative symptoms in our sample.

3.7. Determination of the cut-off score

K-means cluster analysis was performed on log-transformed data, utilising a forced two-cluster solution to differentiate between high-symptom (clinical) and low-symptom (non-clinical) clusters. The results indicated that the non-clinical group followed a uniform distribution, whereas the clinical-range exhibited a mixture distribution (a combination of normal and uniform distributions) (Fig. 1).

The analysis identified a discrimination threshold at 29.5 points. Consequently, scores between 20 and 29 fall within the normal range, while scores of 30 or higher classify the respondent in the clinical range.

The obtained cutoff value was evaluated against the classification generated by the international cutoff of the DES-T questionnaire, which differentiates between individuals with and without a dissociative tendency.

Crosstabulation and Chi-square analysis were employed to evaluate the degree of concordance between the SDQ-20 group memberships derived from the cluster analysis and the categories established by the DES-T. The association between the two categorizations proved to be highly significant ($\chi^2(1) = 20.64$, $p < 0.001$; Fisher's exact test $p < 0.001$). In terms of diagnostic performance, the SDQ-20 demonstrated acceptable specificity: 86.7 % ($n = 72$) of the individuals classified as non-pathological by the DES-T were correctly assigned to the non-pathological group by the SDQ-20 cutoff. Furthermore, the cutoff successfully identified 55.2 % ($n = 16$) of the individuals in the DES-T clinical group.

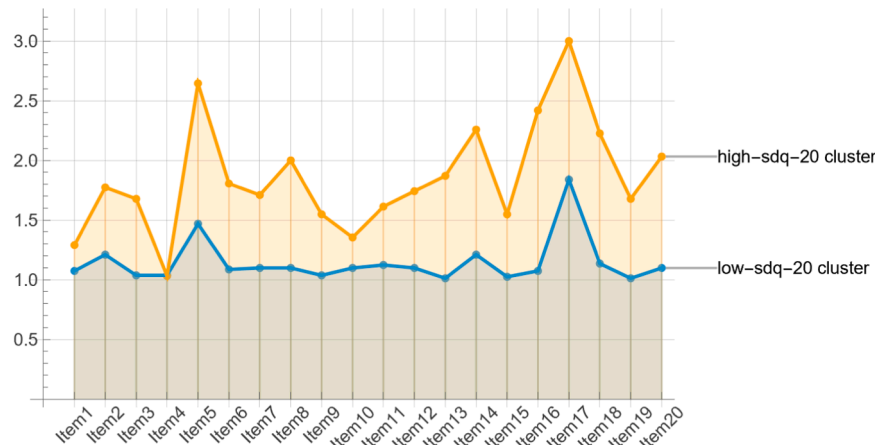


Fig. 1. Mean item profiles of the SDQ-20 for the clinical and non-clinical clusters.

Cohen’s kappa, reflecting the actual classification accuracy between the categories, indicated a moderate-to-good level of agreement ($\kappa = 0.429, p < 0.001$). Taken together, these findings confirm that the SDQ-20 cutoff value of 29.5 obtained through cluster analysis provides a stable differentiation when evaluated against an external criterion.

3.8. Associations between adverse childhood experiences and dissociative symptoms

The prevalence of adversity was high in our sample: 77.8 % of participants reported at least one ACE, 55.4 % experiences abuse/neglect, while 67.9 % were exposed to household dysfunction (e.g., parental divorce, or a family member with mental illness or substance use problems). Following the cumulative framework (based on Felitti et al., 1998), severe traumatization was frequent: 41.1 % of the sample reported four or more ACEs (Table 5). The most common form of adversity was emotional neglect (46.4 %), and household substance abuse (45.5 %).

Cumulative ACE scores correlated moderately with both psychoform ($\rho = 0.482; p < 0.001; 95 \% CI: [0.267-0.573]$) and somatoform dissociation tendencies ($\rho = 0.356; p < 0.001; 95 \% CI: [0.135-0.472]$). Both direct childhood trauma (ACE items 1–5) and household dysfunction (ACE items 6–10) exhibited significant, moderate correlations with psychoform dissociation ($\rho_{ACE1-5} = 0.425, p < 0.001, 95 \% CI: [0.228-0.543]; \rho_{ACE6-10} = 0.429, p < 0.001, 95 \% CI: [0.196-0.519]$) and somatoform dissociation ($\rho_{ACE1-5} = 0.317, p < 0.001, 95 \% CI: [0.123-0.463]; \rho_{ACE6-10} = 0.320, p < 0.001, 95 \% CI: [0.066-0.417]$). Pathological dissociation (DES-T), correlated slightly more with trauma ($\rho_{ACE1-5} = 0.420; p < 0.001; 95 \% CI: [0.273-0.577]$) than household dysfunction ($\rho_{ACE6-10} = 0.362; p < 0.001; 95 \% CI: [0.172-0.501]$). Somatic symptoms (PHQ-15) correlated significantly with trauma ($\rho = 0.204; p < 0.05; 95 \% CI: [0.032-0.388]$) but showed no significant association with household dysfunction (Table 6).

In the group with psychoform dissociative tendencies ($DES > 35$), 95 % had experienced at least one ACE, and 60 % reached four or more,

with trauma scores significantly exceeding those without dissociative tendencies ($U = 724.00; p < 0.001$). Similarly, 85.2 % of those with somatoform dissociation reported at least one ACE, and 63 % reported four or more, with scores significantly exceeding those of the normative group ($U = 662.00; p = 0.002$).

Binary logistic regression analyses were conducted to examine the extent to which adverse experiences contribute to the likelihood of psychoform and somatoform dissociation. To control for confounding effects, all ten ACE categories were entered simultaneously into each multivariate model.

The overall model for somatoform dissociation was statistically significant ($\chi^2 (10) = 20.80, p = 0.023, R^2 = 0.274$), demonstrating adequate goodness-of-fit. Physical abuse was significantly associated with higher odds of somatoform dissociation ($B = 2.768; SE = 1.193; Wald(1) = 5.387; p = 0.020$). Individuals reporting physical abuse showed a more than fifteenfold increase in the odds of manifesting somatoform dissociative tendencies ($OR = 15.93; 95 \% CI [1.54-164.89]$). Additionally, growing up with a mentally ill family member more than tripled the odds of somatoform dissociation ($B = 1.226, SE = 0.583, Wald (1) = 4.425, p = 0.035, OR = 3.41, 95 \% CI [1.09, 10.69]$).

The overall model for psychoform dissociation was likewise statistically significant ($\chi^2 (10) = 30.42, p = 0.001, R^2 = 0.347$). When adjusting for all other adverse experiences, physical abuse ($B = 2.344; SE = 0.898; Wald(1) = 6.810; p = 0.009$) and emotional neglect ($B = 1.272, SE = 0.599, Wald (1) = 4.513, p = 0.034$) retained significant independent associations with psychoform dissociation. Individuals reporting physical abuse showed a tenfold increase in the odds of psychoform dissociative tendencies ($OR = 10.42; 95 \% CI [1.79-60.58]$), while emotional neglect was associated with a more than threefold increase in risk ($OR = 3.57; 95 \% CI [1.10-11.58] p = 0.034$).

Other adverse experiences did not demonstrate statistically significant independent contributions within these models. Given the limited sample size and the wide confidence intervals observed, these results should be interpreted as exploratory and with caution, as the effect size estimates may be inflated.

To explore the associations between the variables under investigation, a factor analysis (Principal Axis Factoring) was conducted. Based on theoretical precedents in the literature, the following measures were included: somatoform dissociation (SDQ-20), psychoform dissociation (DES), and somatic symptom distress (PHQ-15). A single factor was extracted, which explains 50.39 % of the total variance of the three variables (*eigenvalue* = 1.51). Somatoform dissociation exhibited the strongest loading (0.851), while psychoform dissociation (0.666) and somatic symptom distress (0.586) also showed high factor loadings on the identified dimension. This latent variable effectively reflects the intertwining of somatic and dissociative components in

Table 5
Frequency and prevalence of cumulative adverse childhood experience (ACE) scores ($N = 112$).

ACE	Frequency	Percentage
0	24	21.4
1	19	17.0
2	15	13.4
3	7	6.3
≥4	46	41.1
Missing	1	0.9
Total	112	100.0

Table 6

Spearman's rank-order correlations between ACE components, dissociative measures (SDQ-20, DES, DES-T), and somatic symptom distress (PHQ-15).

	SDQ-20 total score	DES mean score	DES-T mean score	PHQ-15 total score
ACE total score	0.356	0.482	0.440	0.213
p-value	< 0.001	< 0.001	< 0.001	0.025
[95 %CI]	[0.135–0.472]	[0.267–0.573]	[0.283–0.584]	[0.023–0.381]
ACE 1-5 item (trauma)	0.317	0.425	0.420	0.204
p-value	< 0.001	< 0.001	< 0.001	0.031
[95 %CI]	[0.123–0.463]	[0.228–0.543]	[0.273–0.577]	[0.032–0.388]
ACE 6-10 item (dysfunctional environment)	0.320	0.429	0.362	0.163
p-value	< 0.001	< 0.001	< 0.001	0.087
[95 %CI]	[0.066–0.417]	[0.196–0.519]	[0.172–0.501]	[-0.040 – 0.325]

Spearman's rho

Note. $N = 112$, except for the ACE total score, where $n = 111$ due to one missing data point.

psychopathological symptoms. A significant positive correlation was observed between the extracted factor score and the total score of adverse childhood experiences (ACE; $\rho = 0.377$; $p < 0.001$)

4. Discussion

The primary objective of this study was the adaptation and clinical application of the Hungarian version of the SDQ-20 within a psychiatric population ($N = 112$). Our findings support that the SDQ-20 is a reliable instrument, and indicate that, based on the data and frequencies observed, its application appears appropriate. Furthermore, our results underscore the clinical importance of assessing adverse childhood experiences alongside dissociation.

The internal consistency (Cronbach's $\alpha = 0.831$; McDonald's $\omega = 0.84$) was lower than that of the original version (Cronbach's $\alpha = 0.95$; Nijenhuis et al., 1996). Yet it remains comparable to other European validations conducted on psychiatric samples, such as the French (Cronbach's $\alpha = 0.83$; El-Hage et al., 2002), Portuguese (Cronbach's $\alpha = 0.88$; Santo & Pio-Abreu, 2007) and Spanish versions (Cronbach's $\alpha = 0.86$; González-Vázquez et al., 2017). Despite the overall excellent reliability, the lower performance of some specific items (Items 1, 4, 6, and 10) can be explained by a pronounced floor effect. These symptoms represent highly specific dissociative phenomena with low frequency in the current sample as indicated by the mean score ranging from 1.04 to 2.16. Furthermore, clinical observations (Murray et al., 2025) suggest that urological complaints in emergency and psychiatric settings are frequently misattributed to urinary tract infections and treated with antibiotics without meeting full diagnostic criteria. Since the clinical scoring procedure adjusts items with a medical explanation to 1 point, the dissociative nature of these symptoms may be systematically underreported. Cultural factors may also contribute to a reluctance among Hungarian respondents to report medically unexplained symptoms in intimate regions. All things considered, we elected to retain these items to ensure international comparability and due to their clinical relevance.

During the factor structure analysis, Exploratory Factor Analysis (EFA) using Principal Axis Factoring did not yield a clearly unidimensional structure, unlike the original Dutch (Nijenhuis et al., 1996) and German (Mueller-Pfeiffer et al., 2010) versions. The analysis of the factor loading matrix revealed that while the items generally contribute to a primary latent factor, they do not form a strictly unidimensional structure. Evidence for a multidimensional approach is provided by the French (El-Hage et al., 2002) version of the questionnaire, where results support a three-factor model. A definitive determination of the factor structure for the Hungarian version would require a larger sample size.

The preliminary convergent validity analysis confirmed that the SDQ-20 captures the construct of dissociation, showing moderately strong correlations with both general psychoform dissociation (DES) and the pathological taxon (DES-T). This is consistent with the findings of the original authors (Nijenhuis et al., 1997) and reinforces the view that

somatoform dissociation belongs to the same spectrum as psychoform dissociation yet remains a distinct construct. Our results suggest that the DES and SDQ-20 appear to measure phenomenologically different manifestations of dissociation within our sample; thus, their joint application may provide a more comprehensive diagnostic picture.

While a significant relationship was found between the SDQ-20 and the PHQ-15, indicating an overlap between somatization and somatoform dissociative symptoms, the SDQ-20 showed a significantly stronger association with childhood trauma (ACE) than the PHQ-15. Furthermore, partial correlation analyses confirmed that the associations between the SDQ-20, dissociation measures and ACE scores remained statistically significant even after controlling for general somatic symptoms (PHQ-15). This constitutes the true discriminant validity of the instrument, as it underscores the SDQ-20's utility in identifying somatic symptoms specifically rooted in trauma. Moreover, the extracted latent factor, representing the intersection of dissociative symptoms and somatic distress, showed a significant positive correlation with adverse childhood experiences. Within this dimension, somatoform dissociation (SDQ-20) exhibited the strongest factor loading (0.851), providing further evidence for its trauma-related conceptualization.

Furthermore, the correlation between the SDQ-20 and PHQ-15 scores suggests that dissociative processes may underpin the symptoms of a significant portion of "somatising" patients. The SDQ-20 appears to be a reliable tool for screening psychiatric patients whose somatic complaints may be driven by underlying dissociation and potential trauma history.

The clinical cut-off for the Hungarian version in our study was established at 29.5 points, mirroring the original findings (Nijenhuis et al., 1996) and due to the absence of formal clinical diagnoses, the diagnostic performance of the obtained cutoff value was evaluated against the categories of the Dissociative Experiences Scale - Taxon (DES-T), a widely accepted screening tool. The measures of agreement—including the significant Chi-square test and Cohen's kappa ($\kappa = 0.429$), which indicates acceptable agreement—demonstrate that the cutoff value derived from the cluster analysis adequately corresponds to the classification established by the DES-T from a screening standpoint.

In our psychiatric sample, 24.1 % of participants exceeded this threshold, a noteworthy prevalence that justifies the importance of routine screening.

Furthermore, the Hungarian SDQ-20 proved remarkably robust against demographic influences, indicating that scores directly reflect pathology rather than demographic variables such as gender, age, education or the form of the hospital care. This contradicts some previous studies where females scored significantly higher than males (El-Hage et al., 2002; Mueller-Pfeiffer et al., 2010; Nijenhuis, 2001).

The most frequent somatoform dissociative symptoms identified were nocturnal sleep difficulties with daytime activity, numbness, and dysphagia. The items that most effectively differentiate between higher and lower levels of somatoform dissociative symptoms were perceiving

nearby sounds as distant and the feeling of a "disappearing" body part. Such symptoms often remain hidden during standard psychiatric interviews, as patients rarely report them spontaneously and typically present with other complaints (Nagy & Kuritárné Szabó, 2018). Although recognizing these symptoms do not replace assessing the full questionnaire, they can signal the need for further dissociative screening.

The prevalence of severe childhood traumatization (>4 ACEs: 41,1 %) was exceptionally high in our sample - particularly in groups with high dissociative tendencies (>4 ACEs: 60 % in the psychoform dissociation group; 63 % in the somatoform dissociation group) and significantly exceeded rates in the general Hungarian or international populations, where only 5–10 % typically report >4 ACEs (Felitti et al., 1998; Ujhelyi Nagy et al., 2019).

Our findings confirm a significant relationship between childhood adversity and dissociation, aligning with extensive empirical evidence (Briere, 2006; Draijer & Langeland, 1999; Mueller-Pfeiffer et al., 2010; Watson et al., 2006). While some literature suggests somatoform symptoms have a stronger link to cumulative trauma than psychoform symptoms (Nijenhuis et al., 2003; Waller et al., 2003), our results showed a slightly closer relationship between psychoform dissociation and cumulative ACE scores. This may support Nijenhuis's theory that somatoform symptoms often require more specific, life-threatening, or complex chronic traumatization (Hart et al., 2006; Nijenhuis, 2004). Both forms of dissociation showed balanced sensitivity to trauma (ACE 1–5) and household dysfunction (ACE 6–10).

Physical abuse was significantly associated with higher odds of reporting both phenomenological forms of dissociation. Additional factors showing significant association included a mentally ill family member related to somatoform dissociation, while emotional neglect related to psychoform dissociation.

4.1. Limitations

A primary limitation of this study is the exclusive reliance on self-report instruments rather than structured clinical interviews, as a validated Hungarian version of the latter was unavailable during data collection. Consequently, the study lacks independent diagnostic confirmation to support the symptoms identified by the SDQ-20.

Furthermore, several characteristics of the sample restrict the generalizability of the findings. The study utilized a small convenience sample with a predominance of female participants and inpatients, and it lacked a healthy control group. This limited and specific sample size also restricted the formation of robust subgroups, which may have contributed to the observed lack of a strictly unidimensional factor structure.

Additionally, the retrospective assessment of Adverse Childhood Experiences (ACE) introduces the possibility of recall bias.

Given these limitations, the resulting subgroups are modest, necessitating caution when drawing generalised conclusions, and underscoring the need for future research with larger, more representative samples to further examine the scale's psychometric properties.

5. Conclusion

In summary, this study provides preliminary evidence that the Hungarian version of the SDQ-20 is a reliable instrument for screening somatoform dissociative symptoms within a heterogeneous psychiatric population. Our findings suggest that the questionnaire possesses appropriate psychometric properties for screening trauma-related somatoform dissociative phenomena in psychiatric patients, effectively complementing with relevant trauma histories.

The observed prevalence of somatoform dissociative tendencies underscores the clinical importance of routine screening, as these symptoms often remain undetected during standard diagnostic interviews.

Furthermore, the associations between somatoform dissociation,

psychoform dissociation and adverse childhood experiences support the conceptualization of these symptoms as potential manifestations of trauma-related somatic dysregulation.

Consequently, integrating the SDQ-20 into clinical practice may facilitate the identification of patients who would benefit from trauma-focused interventions. Future research involving larger, more representative samples and structured clinical interviews is warranted to further validate these findings and to establish the instrument's broader clinical utility.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work the authors used Google AI Pro in order to perform the translation of the article. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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Bianka Dorottya Kovács: Investigation, Data curation, Writing – original draft. **Boglárka Matejkó:** Investigation. **Noémi Eszenyi:** Investigation. **Eszter Varga:** Resources, Methodology. **Tímea Evelin Mércse-Kovács:** Resources, Methodology. **Ákos Münnich:** Formal analysis. **Anikó Ujhelyiné Nagy:** Resources, Methodology, Writing – review & editing. **Judit Molnár:** Conceptualization, Methodology, Project administration, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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Data availability

Data is available from the corresponding author upon reasonable request.

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