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Research Article

Perrotta Evolutionary Attachment Questionnaire” (Pea-Q1): Development, Regulation, And Validation of a Psychometric Instrument Capable of Investigating the Subjective Attachment Profile in Children (4-10 Years), Preadolescents (11-13 Years), Adolescents (14-17 Years), And Adults (18-90 Years)

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Abstract

Introduction: Unresolved childhood traumas can negatively affect an individual's psychophysical growth. Correlations between these events and the onset of psychopathologies are not yet fully known in the literature. Attachment theory attempts to explain the effects of maternal deprivation and the negative impact of traumatic events on psychophysical growth, but without succeeding in this endeavor. For this reason, a new psychometric instrument, the Perrotta Evolutionary Attachment Questionnaire (PEA-Q1), has been developed with the intent of filling this gap. Materials and **Methods:** A theory and model related to the topic under investigation were generated with a questionnaire (PEA-Q) to be administered to a selected population. After conducting the clinical interview and administration of the new questionnaire, the data were compared with the results of the administration of the "Separation Anxiety Test" (SAT) about the population sample with age <18 years and the "Adult Attachment Interview" (AAI) for adults to validate the proposed psychometric instrument.

Results: Statistical analysis showed that the psychometric test has a well-defined and stable construct ($R=0.999$; $p<0.001$), with the variables well represented ($R=0.999$; $p<0.001$) and positively correlated with another construct already validated ($R=0.903$; $p<0.001$).

Conclusions: PEA-Q1 is a valid, efficient and stable psychometric instrument for investigating attachment profiles in all developmental stages of the individual.

Keywords: attachment; attachment style; predisposing factor; facilitating factor; dysfunctional personality; psychopathology

Abbreviations/acronyms:

Separation Anxiety Test (SAT). Adult Attachment Interview (AAI). Clinical group (CG). Control group (Cg). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).

1. Background

Since the 1950s, Bowlby, Ainsworth and numerous researchers have studied how bonding develops between a child and his significant figures, starting with the effects of maternal deprivation. Over the decades, attachment theory has become a mainstay of current psychological science on the subject of bonding and attachment styles (Perrotta, 2024a, 2019a/b; Hazan, 1987). Attachment theory describes how early relationships, during infancy, structure the child's internal operating models of the world and himself, with the help of which he perceives events, predicts the future and constructs his plans (Santrock, 2017; Van Ijzendoorn, 1997; Bowlby, 1992/1989). Mary Ainsworth (1965/1978/1982) later succeeded in supporting Bowlby's theory with empirical data, first identifying 3 distinct patterns of attachment through a specially devised situation in the laboratory called the "Strange Situation Procedure" (Warren, 1997; Weiss, 1982; Vanghn, 1979). Later, Main and Solomon (1985/1990) introduced a fourth category, relating to children who at the time of reunification with their mother exhibited behaviors that could not be attributed to any of the three described patterns (Carlson, 1998; Fonagy, 1996; Lyons-Ruth, 1987). There are currently 4 adult "attachment styles" into which everyone falls (Perrotta, 2024a/b;

Espugnatore, 2023; Shepherd, 2019; Perrotta, 2019a). The DSM 5-TR (APA, 2022), counts 2 disorders related to subjective attachment and both present inappropriate attachment modes than expected for developmental age, but symptomatically the opposite of each other (Fabiano, 2021; Atkinson, 2019; Hornor, 2019; Greenberg, 1993). Finally, there are many tests of attachment style in adults. These are often self-report instruments, whose fundamental limitation is that they measure only what one is aware of. For this reason, accurate measurement requires a broader psychodiagnostic assessment with an experienced clinician (Bartholomew, 1995/1997).

1.2. Aim

A study was conducted, with a representative population sample, to test whether the proposed questionnaire can be capable of investigating the subjective attachment profile about classical attachment theory and compare results with two other already validated questionnaires. The purpose of the present discussion is to try to determine whether, in the current state of scientific knowledge, it is possible to validate the PEA-Q1 for specific clinical purposes.

2. Materials and Methods

2.1. *Study Design*

A theory (Perrotta Evolutionary Attachment Theory, PEA-t) and model (Perrotta Evolutionary Attachment Model, PEA-m) related to the topic of subjective attachment profile were generated. From these materials, a questionnaire (PEA-Q1), with a scaled score (Perrotta Evolutionary Attachment Scale, PEA-s), was developed to administer the new psychometric instrument to a selected population for validation. Using the clinical interviews and administration of the new questionnaire, the data obtained were compared with the results of the administration of the Separation Anxiety Test (SAT) about the population sample aged <18 years and the Adult Attachment Interview (AAI) for adults, to validate the proposed psychometric instrument.

2.2. *Materials and methods*

A theory (Perrotta Evolutive Attachment Theory, PEA-t) and its model (Perrotta Evolutive Attachment Model, PEA-m) have been developed to fill the main clinical gaps in modern attachment theory. Based on these materials, the new psychometric instrument (Perrotta Evolutive Attachment Questionnaire, PEA-Q1), in 72 items with L0-5 response, and its rating scale (Perrotta Evolutive Attachment Scale, PEA-s) was developed (Perrotta, 2024a). Two questionnaires were selected to validate the PEA-Q1, the first for the age population <18 years and the second for adults:

1) "***Separation Anxiety Test - SAT***" (Perrotta, 2024a/2019b; Attili, 2001), which detects the respondent's responses to stimuli of a semiprojective nature. This test consists of 12 (6+6) vignettes depicting various situations, 6 for males and 6 for females, which are shown to the subject, telling him or her what feelings the character in the picture is feeling and what strategies he or she would implement to deal with the situation. It is administered in 15 to 30 minutes, for an age population of 4 to 17 years, and the overall score determines the subject's attachment style according to classical attachment theory. Scoring is quite complex and involves a strong interpretive component on the part of the administrator. Subjects' emotional reactions are initially classified into 17 categories, based on their responses to the first and second questions. These categories are subsequently grouped into 8 classes. These classes are given a score from -2 to +2. The scores emerging from the scoring can be associated with the mental patterns that characterize the classic types of attachment: for scores below "-2", the attachment will be disoriented-disorganized; for scores between "0" and "-2", the attachment will be insecure-avoidant; for scores between "+3" and "+1", the attachment will be insecure-ambivalent; for scores above "+3", the attachment will be secure.
2) "***Adult Attachment Interview - AAI***" (George, Kaplan and Main, 1985), which is used for an adult audience as well as for adolescent mothers, being careful, however, to keep in mind the possible underestimation of existing difficulties or the attempt to appear up to the proposed situations (degree of social desirability). The AAI is probably the best psychometric test most widely used in adults, compiled in a semistructured questionnaire with originally 20 basic questions (investigating episodes the patient has experienced about the main attachment figures), in which interviews are recorded and ranked according to various parameters. The Adult Attachment Interview allowed 4 attachment styles (preoccupied, high anxiety and low avoidance; fearful-avoidant, high anxiety and avoidance; distancing-avoidant, low anxiety and high avoidance; secure, low anxiety and avoidance) to be defined in 5 categories (Dazzi, 2010): safe-avoidant (Free, F), distancing-avoidant adults (Dismissing, Ds), worried adults (Entangled, E), unresolved adults (Unresolved, U) and Cannot classify adults (CC). It is administered in 45 to 90 minutes, for an age population of 18 to 90 years, and the overall score determines the subject's attachment style according to classical attachment theory. Scoring is quite complex and involves a strong interpretive component on the part of the administrator.

2.3. *Setting and participants*

The selected population was divided into 2 groups: the first (clinical group, CG); and the second (control group, Cg). Inclusive criteria for CG are: 1) Age 4-90 years old; 2) Italian nationality or citizenship for at least 2 generations; and 3) narrative of one or more unresolved youthful traumatic experiences (occurring by the time they reached the age of majority, 18 years old). Exclusive criteria for CG are: 1) Age < 4 years and > 90 years old; 2) foreign nationality or Italian nationality for less than 2 generations; 3) Absence of unresolved youth traumatic experiences. Those excluded were automatically included in the Cg. The population size of the CG is 1644 (M: 37.4, SD: 23.3). All individuals with the same characteristics but with the absence of youthful traumatic experiences, regardless of their resolution, were included in the Cg, for a combined total of 3288 units. [**Table 1**]

Age	Male (%)	Female (%)	Total	M ± SD
4-10	59 (8.3%)	77 (8.3%)	136 (8.3%)	7.1 ± 2.0
11-13	81 (11.3%)	99 (10.8%)	180 (10.9%)	12.0 ± 0.7
14-18	90 (12.3%)	119 (12.9%)	209 (12.7%)	15.8 ± 1.3
19-28	75 (10.4%)	99 (10.7%)	174 (10.6%)	22.3 ± 2.8
29-38	78 (10.8%)	102 (11.0%)	180 (10.9%)	32.7 ± 2.7
39-48	83 (11.6%)	103 (11.1%)	186 (11.3%)	42.9 ± 2.5
49-58	92 (12.8%)	110 (11.9%)	202 (12.3%)	53.2 ± 2.6
59-68	86 (11.9%)	104 (11.3%)	190 (11.6%)	63.6 ± 2.4
69-78	43 (6.0%)	60 (6.5%)	103 (6.3%)	72.7 ± 2.5
79-90	33 (4.6%)	51 (5.5%)	84 (5.1%)	85.1 ± 2.3
Total	720 (43.8%)	924 (56.2%)	**1644** (100.0%)	37.4 ± 23.3

Table 1: Population sample (numerousness – CG)

Taking into account the 2020-2022 pandemic period and the different geographical residences of the patients, it was preferred to carry out the clinical interview and administration of the questionnaires via the online video calling platforms Skype and WhatsApp. This research work was conducted from March 2019 to June 2024. As per the informed consent and data processing, all participants were guaranteed anonymity, and compliance with the ethical requirements of the Declaration of Helsinki. For participating units under the age of 18, explicit parental consent was requested. It was not necessary to request an opinion from the local Ethics Committee as the patients come from a private catchment area and the data are retrospective. The research is unfunded and free from conflicts of interest. The dropout rate was 0/3288 (0.0%).

3. Results

Having completed the procedures for selecting the population sample, divided into two groups with equal characteristics for age and sexual gender, we first proceeded to the clinical interview if not already carried out for other studies (being subjects already known to the interviewer) and then to the administration of the 3 questionnaires (PEA-Q1, SAT and AAT), to obtain the data to carry out the statistical analysis related to the descriptive of the variables and their frequency, and the comparison of the averages, transforming the investigated variables to nonparametric, using IBM SPSS software, version 27, for T-test analysis for independent data that the Chi-square or χ^2). The results of the SAT and AAT were adapted by definition to the results of the PEA-Q1 based on classical attachment theory to make comparisons. In the CG, age does not correlate with PEA-Q1 (p=0.465) and there are no significant differences among the 3 variables investigated (**Table 2**), in that the search outcomes are identical (1644/1644, 100%). In the Cg, age does not correlate with PEA-Q1 (p=0.489) but there are significant differences among the 3 variables investigated (**Tables 3-4**), as several data points differ (539/1644, 32.8%).

N	Type_variable (attachment style)		n (%)	p
1	PEA-Q1	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	46 (2.8%) 351 (21.4%) 937 (57%) 310 (18.9%)	1.000
2	SAT	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	43 (8.7%) 104 (21.1%) 262 (53.3%) 83 (18.9%)	1.000
3	AAT	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	3 (0.3%) 247 (21.4%) 675 (58.6%) 227 (19.7%)	1.000

Table 2: Statistical analysis (CG): Frequencies and correlations. p: significance.

N	Type_variable (attachment style)		n (%)
1	PEA-Q1	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	1030 (62.7%) 562 (34.2%) 52 (3.2%) 0 (0.0%)
2	SAT	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	466 (94.7%) 24 (4.9%) 2 (0.4%) 0 (0.0%)
3	AAT	1 (Secure) 2 (Ambivalente) 3 (Avoidant) 4 (Disorganized)	1105 (95.9%) 39 (3.4%) 8 (0.7%) 0 (0.0%)

Table 3: Statistical analysis (Cg): Frequencies.

Questionnaire	SAT	AAT
	R (p)	*R (p)*
PEA-Q1	0.307 (**<0.001**)	0.293 (**<0.001**)

Table 4: Statistical analysis (Cg): Correlations. R: Pearson's correlation, p: significance.

A binary correlation analysis was conducted between the first administration of PEA-Q1 and the second administration after 1 month to check the stability of the test, obtaining a Pearson coefficient (R) of 0.999, with p=<0.001. Statistical analysis: ANOVA test for paired data. (**Figure 1**)

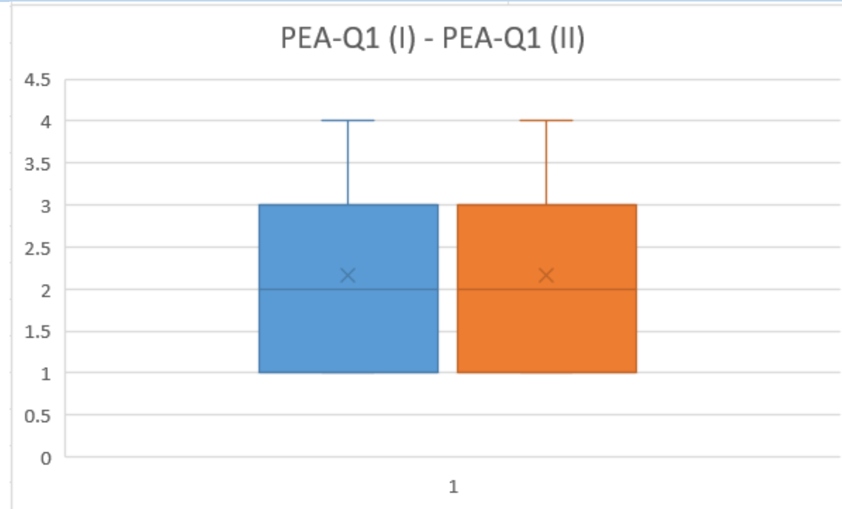

Figure 1. ANOVA test for paired data (PEA-Q1_score_I / PEA-Q1_score_II)

4. Discussion

The high specificity of the proposed new questionnaire, in light of the results obtained from the statistical analysis of the research data, suggests that the PEA-Q1 can perform the investigation of the subjective attachment profile as the 2 questionnaires used for comparisons do, but adding correctives. Specifically, in the CG it emerges that the data are essentially identical, demonstrating that in the presence of specific clinical symptoms, the PEA-Q1 can identify and classify them according to the 4 classical attachment styles but using a diagnostic language: in fact, the new questionnaire does not use the classical styles but identifies them in the 4 clinical styles (secure-sane, avoidant-neurotic, ambivalent-dramatic, and disorganized-fragmented), thus bringing the symptomatology back according to a more clinical perspective. The lack of differences between the outcomes in the 3 questionnaires indicates that in the clinical population, all questionaries are well aligned, efficient, and effective in capturing the attachment style of belonging (p=1,000). In the Cg, however, significant differences emerge that are the product of structural and functional differences among the 3 questionnaires. In fact: the first comparison was between the outcomes of the PEA-Q1 about the population under the age of 18 and the SAT, precisely because this questionnaire is calibrated only for that type of population; the second comparison was between the outcomes of the PEA-Q1 about the population under the age of 18 and older and the AAT, precisely because this questionnaire is calibrated only for that type of population. In the first case, the results differed by 32.1% (158/492), while in the second case, the results differed by 36.9% (425/1152). These values can be attributed precisely to the specific characteristics of the PEA-Q1, which, in addition to being able to investigate the subjective attachment profile according to the classical model (secure, avoidant, ambivalent and disorganized) but with the clinical meaning (secure-sound, neurotic, dramatic and fragmented, according to the Perrotta Integrative Clinical Interviews, PICI-3), it is also able to identify according to the correspondent model (PEA-s) the structural elements (emotional stability, bonding strength, capacity to love and trust in the future) and the functional elements (secure-insecure and organized-disorganized), and related 16 sub-styles. Specifically, again in the Cg, the PEA-Q1 was able to redefine the subjective attachment profile of 205/1644 (12.5%) by identifying dysfunctional and/or pathological features in the absence of self-reported symptoms or elevations in the other 2 questionnaires. The subsequent clinical interview then confirmed the findings from the participants themselves. Administration of the PEA-Q1 after 1 month also produced the same data, confirming its stability over time. In light of the results obtained, the PEA-Q1 is a candidate as an optimal tool for use during psychotherapies, helping the therapist in the exact clinical framing of the patient.

5. Limitations and future prospects

This research work has some limitations in the study design that may partly influence the results. In particular, the structure of the PEA-Q1 is substantially different from the other 2 questionnaires, which only trace the outcome of the test back to one of the 4 classical attachment styles; instead, the PEA-Q1 starts from the clinical assumption of the symptomatological manifestation to reconstruct the structural and functional framework. For this reason, comparisons were only possible by equalizing the results of the 2 selected questionnaires with the outcome of the PEA-Q1, precisely to best ensure as objective an analytical response as possible. However, the size of the population sample selected and the outcome obtained are elements that can reinforce the results.

6. Conclusions

Perrotta Evolutive Attachment Questionnaire (PEA-Q1) is a valid, efficient and stable psychometric instrument for investigating attachment profiles in all developmental stages of the individual, being able to comprehensively investigate the subjective attachment profile, and its structural and functional components, to facilitate better clinical framing during psychotherapy.

Funding: This work received no external funding.

Ethics statement: All participants were assured of compliance with the ethical requirements of the Charter of Human Rights, the Declaration of Helsinki in its most up-to-date version, the Oviedo Convention, the guidelines of the National Bioethics Committee, the standards of "Good Clinical Practice" (GCP) in the most recent version, the national and international codes of ethics of reference, as well as the fundamental principles of state law and international laws according to the updated guidelines on observation studies and clinical trial studies. According to Legislative Decree No. 52/2019 and Law No. 3/2018, this research does not require the prior opinion of an Ethics Committee in the implementation of Regulation (EU) no. 536/2014. In compliance with Regulation (EU) 2017/745, the Declaration of Helsinki, and the Oviedo Convention, the scientific research contained in the manuscript: (a) does not involve new or already on-the-market drugs or medical devices; (b) does not involve the administration of a new or already on-the-market drug or medical device; (c) is not for commercial purposes; (d) is not sponsored or funded; (e) the participants have signed the informed consent and data processing, in compliance with applicable national and EU regulations (f) refers to non-interventional but observational-comparative diagnostic topics, for validation of the newly proposed questionnaire; (g) the population sample was collected at a date before the

start of this study and is part of a private, non-public database. I remain at your disposal.

Informed Consent Statement: Subjects who gave regular informed consent agreements were recruited; moreover, these subjects requested and obtained from GP, as the sole examiner and project manager, not to meet the other study collaborators, thus remaining completely anonymous.

Data Availability Statement: The subjects who participated in the study requested and obtained that GP be the sole examiner during the therapeutic sessions and that all other authors be aware of the participant's data in an exclusively anonymous form.

Conflicts of Interest: The author declares no conflicts of interest.

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