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Contents

Examining the Clinical Utility of the Moreno Social Atom Projective Test 51
Jay Edwards

Effects of Gender and Sex Type on Perceived Leadership Abilities 76
Josette M. Sywensky
Jennifer L. Madden
Thomas W. Treadwell

Therapeutic Theater and Spontaneity: Goethe and Moreno 88
Eberhard Scheiffele

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Examining the Clinical Utility of the Moreno Social Atom Projective Test

JAY EDWARDS

ABSTRACT. The Moreno Social Atom Projective Test (MSAPT) is an adaptation of an egocentric social network measure first developed by Jacob Moreno in 1936. A theory-driven clinical instrument, Moreno's Social Atom Test has not achieved wider acceptance as a diagnostic test, in part because of a lack of empirical data to support its clinical utility. The author conducted this study in order to address the issues of standardization, reliability, validity, and clinical utility of the MSAPT. One hundred nonclinical adult participants were evaluated with a battery of three instruments: the MSAPT, the Multidimensional Scale of Perceived Social Support (MSPSS), and the Symptom Checklist-90-R (SCL-90-R). Multiple regression analyses demonstrated the MSAPT's ability to predict symptomology, using the Global Severity Index, $F(6, 93) = 3.58$, $p < .01$, and each of the nine subscores of the SCL-90-R. The MSAPT conflict score was the major predictor for all SCL-90-R scores; reciprocity and gender scores also achieved significant levels. The MSAPT demonstrated good concurrent validity. The findings of this study indicate that the MSAPT is a valid and reliable clinical instrument. Suggestions for future research are presented; they include applying the MSAPT to clinical populations, establishing the instrument's test-retest reliability, and continuing the development and refinement of the individual variables.

THE IMPORTANCE OF SOCIAL RELATIONSHIPS has been long recognized by social scientists (Bateson, 1972; Durkheim 1951; Maslow, 1968). Moreno (1936) hypothesized that an individual could be diagnosed by his pattern of interpersonal contacts and social connectedness. He wrote: "When we know more about the processes going on in the social atom [social network] of individuals, we may invent means of repairing its disorders. Maybe a new profession will develop in time, the sociatrists who among other matters will treat socio-atomic disorders" (Moreno, 1951, p. 127). Social support research, which seeks empirically to validate the importance of social rela-

tionships, suggests that social identities are recognized and supported by being embedded in relationships. By expressing and embedding our social identities in a social network, we make our social network a personal community. In creating and maintaining a particular personal community, we are at least implicitly choosing how we seek to achieve meaningful participation in our culture and society (Hirsch, 1981). Individuals receive relatively stable benefits from high numbers of ties or high levels of regular and sustained contacts with others, a sense of belonging or security, a sense of purpose and behavioral guidance, and, perhaps, a global sense that support is available, should they need it (Thoits, 1985). In short, our social ties, in the aggregate, are a source of psychological sustenance.

If it is true that social bonds help maintain well being and ameliorate psychological turmoil, can strengthening or constructing viable social networks for mentally ill persons help restore them to healthy mental functioning? The need to examine a client's social network as part of the diagnostic process has not gone unnoticed in the field: "We have reached a point where patients' treatment plans should be individualized to include assessments of their social networks and the steps that may be taken in collaboration with community resources to address observed deficiencies" (Nemiah, 1988).

Given that the theoretical and practical implications of employing social networks as a diagnostic and treatment intervention have been widely accepted, it is surprising that more steps have not been taken to develop a valid and reliable clinical instrument. There is no shortage of research that uses objective measures to provide descriptive statistics, especially in the field of social support research (see Vaux, 1992, for a comprehensive review). Those instruments, however, have been developed primarily to serve as research tools and focus on the variables in question rather than the development of a comprehensive clinical instrument, thus limiting their clinical usefulness. That deficit has been roundly criticized and has been attributed to the lack of theory-driven research in the field of social network research (Barrera, 1986; Heller, Swindle, & Dusenbury, 1986). Similarly, after a comprehensive review of 32 investigative methods, Pfingstmann and Baumann (1987) stated:

> The overview shows that there is no method of collecting data about social networks [respectively social support], which can be recommended without restrictions. They all lack theoretical substantiation and empirical foundation (cited in Engelhardt, Feldkampf, & Sader, 1989, p. 53–54).

A review of the field of social network research and intervention suggests an understanding of the importance of social network intervention in clinical practice and points to a need for the development of a clinically useful, egocentric, social network measure. Since its inception in 1936, the Social Atom Test, as it was originally called by Moreno, has been widely used within the

psychodrama community in the treatment of individuals and families. Jacob L. Moreno, the developer of group psychotherapy, psychodrama, and sociometry, invented the Social Atom Test to examine an individual's social networks. A pioneer in the field of psychosocial psychotherapy, Moreno believed man was basically a social being, and he remained at odds with his contemporary, Sigmund Freud, in the belief that psychotherapy is best accomplished in a setting that examines an individual's interactions with his social environment (Moreno, 1967).

The concept of the social atom is important throughout the field of psychodrama. Moreno considered the social atom "to be a structure of interpersonal relationships where the development of personality takes place" (Engelhardt et al., 1989, p. 49). Through examination of what he termed pathological atoms, Moreno (1940) drew the conclusion that structural patterns of mentally ill persons differ from those of mentally healthy persons. Moreno took the view that the social atom is the general starting point in psychotherapy. In his opinion, the objective of psychodramatic therapy is the "restitution of damaged or dysfunctional social atoms" (Petzold, 1982, p. 162, cited in Engelhardt et al., 1989).

Whereas the social atom instrument has been used extensively within the psychodrama community, its application outside of that community has been limited, primarily because of two factors. First, it lacks standardized instructions for administration and scoring. Within the psychodrama community, as within other theoretically oriented communities, much of the knowledge and nuance of clinical practice is passed down by word of mouth and by the demonstration of clinical technique. As the theories of Moreno have been passed from one "generation" to the next, the methods have been modified, improved upon, and adapted to fit specific clinical needs. Thus, the social atom has many renditions (Hale, 1981; Hollander, 1974; Kulenkampff, 1982; Kumar & Treadwell, 1985; Moreno, 1936; Taylor, 1977; Treadwell, Stein, & Leach, 1989; Vander May, 1975), none of which has been accepted as the standard because of the lack of proven generalizability. Second, the social atom theory lacks the research findings to support the social atom test as a valid clinical tool (Engelhardt et al., 1989; Treadwell et al., 1989). Although Moreno was able to demonstrate the clinical usefulness of the social atom in his work (Moreno, 1939; 1940; 1953), he never published research to confirm his hypotheses. Some attempts have been made to develop norms and standards (Allen, 1978; Kulenkampf, 1982; Taylor, 1977; Treadwell, et al., 1989); but the psychodrama community, as a whole, has been more interested in furthering clinical expertise than in validating theory through research. As a result, there exist many forms of an instrument widely believed to have significant clinical value but without evidence to demonstrate its value to the mental health community at large.

The first step toward the development of a well-standardized clinical tool is to determine and define its constructs. Moreno described several constructs, both explicitly and implicitly, that could be seen as determinants of a healthy social atom: size as it relates to an individual's connection to other social atoms and thus determines his or her status in the community; reciprocity, which can be balanced or imbalanced; tele, which can be positive or negative; and sociostasis. Zeintlinger (1981) and Leutz (1974), in articles published in German (cited by Engelhardt et al., 1989), have also attempted to fill Moreno's theoretical suppositions with concrete determinants. They suggest the social atoms of mentally disturbed individuals differ from those of normals in terms of quantity, quality (proportion of positive and negative relationships), nearness and distance, density, and connection to other atoms. In 1980, another German researcher, Petzold (cited by Engelhardt et al., 1989), set forth the following criteria for a social atom to be considered "positive" [healthy]:

1. Positive relations must far outweigh negative ones.
2. Single elements of the social atom must be highly interconnected (density).
3. The distribution of nearness and distance must be balanced.
4. The social atoms . . . should be interconnected with other social atoms. (p. 51)

Thus, Petzold laid the foundation for the measurement of social atom constructs, offering conflict, density, and a sense of balance between closeness and distance.

In an attempt to connect social atom research with the broader field of social support and social network research, I have included a review of the literature outside that of the psychodrama community. Although social network studies have been criticized as atheoretical and nongeneralizable (Pfingstmann and Baumann, 1987, cited in Engelhardt et al., 1989), it is useful to examine their findings in order to determine which factors seem to be most related to positive mental health. The factors of size (Pattison & Pattison, 1981; Stokes, 1983; Strung & Hyman, 1981; Vaux, 1988; Veiel, Brill, Hafner, & Weiz, 1988; Westermeyer & Neider, 1988), conflict (Finch, Okun, Barrera, Zautra, & Reich, 1989; Fiore, Becker, & Coppel, 1983; Okun, Melichar, & Hill, 1990; Rook, 1984; Ruelhman & Wolchik, 1988; Sandler & Barrera, 1984), reciprocity (DiMatteo & Hayes, 1981; Fisher & Nadler, 1976; Rook, 1987; Sprecher, 1986; Van Tiburg, Van Sonderen, & Ormel, 1991), and kin vs. kith (Coyne & Downey, 1991; Pattison & Pattison, 1981; Stokes, 1983; Veiel et al., 1988) have been shown to be consistently correlated with some aspects of mental health.

Moreno (1951) and other psychodramatists have also included size, reciprocity, family relationships, and conflict (tele) as important factors in one's

social atom. Because these are similarly supported by social network research outside of psychodrama and are more easily measured than some other projective factors, they have been chosen as the central factors for this study.

Method

My objectives in the study were to standardize the administration and scoring, establish initial norms, validate for clinical usefulness, and demonstrate concurrent validity for an egocentric social network measure entitled the Moreno Social Atom Projective Test (MSAPT). Based upon a review of the literature regarding the evolution of the social atom instrument, I developed a standardized set of directions for the administration of the test, and they can be found in the appendix. To achieve the goal of establishing the MSAPT's clinical usefulness, I developed the four factors of the MSAPT—Size, Conflict, Reciprocity, and Family, using Moreno's theories on social networks and a review of related social network research. The variables were correlated with subject's scores on the Symptom Checklist 90-Revised (SCL-90-R). I used the Multidimensional Scale of Perceived Social Support (MSPSS) to provide concurrent validity data for the MSAPT.

Sample

Data were collected from 113 graduate students in special education at San Francisco State University and Saint Mary's College. Examination of the data yielded 100 usable batteries. Thirteen batteries were excluded because of missing data on the SCL-90-R (more than 18 skipped responses voids a test), nonscorable MSAPT, or one or more of the instruments being skipped by the respondent. Percentiles computed for the demographic variables showed the sample to be predominantly students from San Francisco State University (80%), female (86%), Caucasian (68%), born in the United States (90%), both parents born in the United States (mother—74%, father—77%), and single (47%). The mean and standard deviation were computed for age (M = 35.9 years, SD = 10.6) and years of graduate school (M = 1.72, SD = 1.34).

Instruments

Multidimensional Scale of Perceived Social Support (MSPSS). The MSPSS was designed to be a quick, easily administered, self-report inventory for the measurement of perceived satisfaction of social support. The MSPSS includes 12 items that divide into three factor groups (family, friends, and significant others); however, because it has a total score, it is designed to be used as an overall measure of perceived satisfaction. The participants were asked to

respond to each question, using a 7-point rating scale ranging from *very strongly disagree* to *very strongly agree.* Research has demonstrated good internal (.88) and test-retest reliability (.85) (Dahlem, Zimet, & Walker, 1991; Zimet, Dahlem, Zimet, & Farley, 1988); good internal reliability across subjects and strong factorial validity confirming the three-subscale structure (Dahlem, et al, 1991; Zimet, Powell, Farley, Werkman, & Berkhoff, 1990); and strong concurrent validity, construct validity, and differential validity (Kazarian & McCabe, 1991). Sample populations have included undergraduate college students, inpatient adolescent psychiatric, pregnant women, pediatric residents, and nonclinical adolescents (Dahlem et al., 1991; Kazarian & McCabe, 1991; Zimet et al., 1988; 1990).

Symptom Checklist-Revised (SCL-90-R). The SCL-90-R is a brief, multidimensional, self-report inventory designed to screen for symptoms of psychopathology. It consists of 90 items and has a 0 to 4 rating scale. It may be administered to participants aged 13 years and older and requires a sixth-grade reading level. Testing time is 12 to 15 min. Normative data are available for nonpatient normal adults, among other populations. The SCL-90-R provides three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total, as well as nine dimensional scales: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Research conducted on the SCL-90-R has demonstrated good internal consistency for the nine subscales, ranging from .77 for Psychoticism to .90 for Depression. Test-retest reliability scores range from .82 to .90. A comprehensive review of the numerous validity studies conducted with the SCL-90-R is included in the scoring manual (Derogatis, 1983).

Moreno Social Atom Projective Test (MSAPT). The MSAPT directions were standardized for this study and are included in Appendix A. Although there were an unlimited number of social network variables that might have been explored by using this version of Moreno's instrument, four were involved in the hypotheses:

Size was computed as the total number of network members, living and dead, included in the MSAPT diagram. All symbols, male and female, were counted and totaled to achieve the score.

Conflict was tabulated as the percentage of relationships in the social network that were designated as conflictual by the respondent (-). The percentage was calculated as # conflictual relationships/total # network members.

Reciprocity referred to the percentage of all the relationships represented in the MSAPT as imbalanced or one-way relationships and was denoted by the

arrows that the subjects drew to or from network members. Imbalances toward and away from the subject were included in a single score.

Family referred to the ratio of family members, as identified by the subject's labeling network member symbols, to all other network members.

I added two additional scores during the scoring process, and these were included in the data analyses:

Deceased was tabulated by dividing the number of deceased symbols in the diagram by the total size score.

Gender was tabulated by dividing the total number of female symbols (O) by the size score.

A research assistant and I calculated each of the above scores to provide data on interrater reliability.

Demographics

In Table 1, I have charted the relationships of the demographics (school, sex, race, birthplace, and marital status) to scores on the MSAPT. Those were analyzed by t tests and analysis of variance (ANOVA; marital status). Although no pattern of relationships emerged, there were a few significant results. The women showed significantly higher conflict scores than the men ($t = -2.12$; $df = 98$; $p < .05$), and Caucasians showed significantly lower reciprocity scores than "others" ($t = -2.05$; $df = 98$; $p < .05$). Marital status was significantly related to the size of the social atom and to the proportion of family in the social atom. Multiple comparison tests showed that married respondents had significantly larger social atoms than single respondents (Fisher protected least significant difference [LSD] = 3.589; $p < .05$) and had significantly larger proportions of family in their atoms than either single (Fisher LSD = .097; $p < .05$) or divorced respondents (Fisher LSD = .155; $p < .05$). The variable "parent's birthplace" referred to the respondent reporting at least one parent born outside the United States.

We used Pearson correlations to examine the relationships between MSAPT scores and both age and number of years of graduate school. We found no relationship between MSAPT scores and years of graduate school, with all six correlations falling near zero ($-.10 < r < .10$). The "age" variable was significantly related to the proportion of family in the social atom ($r = .238$; $df = 98$; $p < .05$), and to the proportion of deceased persons in the social atom ($r = .239$; $df = 98$; $p < .05$).

The analysis of the relationship between the seven demographic characteristics and the six MSAPT scores involved a total of 42 (6×7) analyses. With the Bonferroni adjustment, the level of significance is reduced to .05 divided

TABLE 1
Moreno Social Atom Projective Test (MSAPT) Scores, by School, Sex, Race/Ethnicity, Birthplace, and Marital Status

Variable	MSAPT score					
	Size	Conflict	Family	Reciprocity	Deceased	Gender
Overall						
M	13.5	0.11	0.59	0.32	0.08	0.55
SD	8.30	0.11	0.24	0.28	0.10	0.14
School						
SFSU (80)						
M	13.1	0.10	0.59	0.32	0.08	0.55
SD	8.34	0.11	0.25	0.28	0.11	0.15
St. M. (20)						
M	15.0	0.12	0.61	0.30	0.04	0.56
SD	8.18	0.12	0.19	0.27	0.07	0.12
Difference						
t	–0.92	–0.69	–0.44	0.34	1.51	–0.39
Sex						
M (14)						
M	13.5	0.05	0.48	0.44	0.10	0.55
SD	10.23	0.06	0.28	0.33	0.15	0.20
F (86)						
M	13.5	0.11	0.61	0.30	0.07	0.55
SD	8.02	0.11	0.22	0.26	0.10	0.13
Difference						
t	0.01	–2.12*	–1.89	1.76	0.79	–0.04

Race/ethnicity						
Cauc. (68)						
M	14.0	0.10	0.58	0.28	0.07	0.55
SD	8.42	0.10	0.24	0.28	0.10	0.15
Other (32)						
M	12.36	0.12	0.62	0.40	0.08	0.55
SD	8.06	0.12	0.23	0.26	0.11	0.12
Difference						
t	0.93	–0.87	–0.79	–2.05*	–0.35	0.34
Birthplace						
USA (90)						
M	13.9	0.11	0.60	0.31	0.08	0.55
SD	8.40	0.11	0.23	0.28	0.10	0.14
Other (10)						
M	9.5	0.09	0.51	0.38	0.06	0.55
SD	6.40	0.09	0.27	0.28	0.10	0.18
Difference						
t	1.61	0.35	1.15	–0.66	0.35	–0.54
Parents' birthplace						
USA (67)						
M	13.13	0.11	0.59	0.31	0.07	0.55
SD	7.25	0.12	0.22	0.28	0.10	0.14
Other (33)						
M	14.18	0.09	0.61	0.34	0.08	0.55
SD	10.21	0.10	0.27	0.27	0.11	0.14
Difference						
t	–0.59	1.10	–0.46	–0.44	–0.20	0.28
Marital status						
Single (47)						
M	11.48	0.12	0.51	0.32	0.06	0.58
SD	6.05	0.12	0.22	0.27	0.09	0.16

(table continues)

TABLE 1—*continued*

Variable	MSAPT score					
	Size	Conflict	Family	Reciprocity	Deceased	Gender
Married (35)						
M	15.79	0.10	0.72	0.39	0.08	0.52
SD	10.32	0.11	0.21	0.32	0.10	0.13
Significant other (8)						
M	11.06	0.08	0.56	0.30	0.10	0.51
SD	5.67	0.09	0.24	0.20	0.18	0.10
Divorced (10)						
M	16.75	0.09	0.55	0.13	0.12	0.57
SD	9.24	0.10	0.25	0.10	0.11	0.11
F test (3, 96)	2.68*	0.56	6.56***	2.35	1.43	1.19

*$p < .05$; **$p < .01$; ***$p < .001$.

by 42 = .0012. When I used this adjusted criterion, only one effect, the relationship between marital status and proportion of family in the social atom, remained statistically significant.

Results

Primary Analyses

Using Pearson correlations, I examined the relationship between the MSAPT and the MSPSS. Six MSAPT scores (size, conflict, family, reciprocity, deceased, and gender) were correlated with each of the three subscale scores (significant other, friends, and family) and the total score for the MSPSS. The conflict score was significantly related to both the significant other score ($r = -.213$; $df = 98$; $p < .05$) and the total score ($r = -.211$; $df = 98$; $p < .05$) of the MSPSS. The reciprocity score was significantly related to both the friends score ($r = -.313$; $df = 98$; $p < .01$) and the total score ($r = -.254$; $df = 98$; $p < .05$) of the MSPSS. We found other significant relationships between the family score of the MSAPT and the friends score of the MSPSS ($r = -.257$; $df = 98$; $p < .05$) and between the deceased score of the MSAPT and both the family score ($r = -.263$; $df = 98$; $p < .01$) and the total score ($r = -.222$; $df = 98$; $p < .05$) of the MSPSS.

I used Pearson correlations to examine the relationship between the proportion of conflictual relationships, as measured by the conflict score of the MSAPT, and the level of distress, as measured by the Global Severity Index (GSI) of the SCL-90-R. The conflict score was significantly related to the GSI ($r = .349$; $df = 98$; $p < .001$) and to each of the nine subscale scores.

The relationship between the proportion of nonreciprocal relationships, as measured by the reciprocity score of the MSAPT, and level of distress, as measured by the GSI, was examined, using Pearson correlations. The reciprocity score was significantly related to the GSI ($r = .201$; $df = 98$; $p < .05$) as well as to the Interpersonal Sensitivity (INT) score ($r = .214$; $df = 98$; $p < .05$) and the Paranoid Ideation (PAR) score ($r = .241$; $df = 98$; $p < .05$). Other significant relationships were found between family (MSAPT) and Somatization ($r = .198$; $df = 98$; $p < .05$), and between gender (MSAPT) and GSI ($r = -.243$; $df = 98$; $p < .05$) as well as Somatization ($r = -.300$; $df = 98$; $p < .01$), Interpersonal Sensitivity ($r = -.205$; $df = 98$; $p < .05$), Anxiety ($r = -.217$; $df = 98$; $p < .05$), Phobic Anxiety ($r = -.253$; $df = 98$; $p < .05$), and Psychoticism ($r = -.207$; $df = 98$; $p < .05$).

There were no significant relationships found during an analysis of the relationship between size of social network, as measured by the MSAPT size score, and level of distress, as measured by the GSI. This was a two-tailed exploration based upon the assumption that especially large or small personal networks might contribute to distress.

The hypothesis that respondents with imbalances in the proportion of kin versus kith in their social atom, as measured by the MSAPT family scores in the top third or bottom third of the sample, will show greater levels of distress, as measured by the GSI, than respondents with family scores in the middle third of the sample was not substantiated. The only significant relationship was with the Social Support From Friends subscale of the MSPSS, $F(2, 97) = 3.01$; $p < .05$). Multiple comparison tests show that this is because the respondents with small proportions of family in their social atom perceive significantly greater support from their friends than those with large proportions of family in their social atoms (Fisher PLSD = .668; $p < .05$).

Secondary Analyses

Using a Pearson correlation, I found significant relationships between the MSPSS total score and the GSI of the SCL-90-R ($r = -.276$; $df = 98$; $p < .01$). In addition, I found significant relationships between each of the MSPSS subscales (significant other, friends, and family) and the GSI, as well as between the MSPSS total score and the Somatization, Interpersonal Sensitivity, Depression, Anxiety, Paranoid Ideation, and Psychoticism subscales of the SCL-90-R.

Near-perfect interrater reliability was demonstrated for each of the six MSAPT scores. The least correlated were the deceased and gender scores ($r > .99$, $df = 98$).

I conducted several post hoc analyses to clarify the results. First, I noted that age, marital status, and perceived social support were significantly correlated with some of the MSAPT scores. I used Pearson correlation coefficients to compare age and marital status (broken down into single vs. married) against the SCL-90-R scores. Neither age nor marital status correlated significantly with any of the scales of the SCL-90-R. All of these correlation coefficients were between −.175 and +.161, well under the critical value of $r = .2172$ needed for statistical significance at the 5% level. Thus, age and marital status were eliminated as potentially confounding variables.

A Pearson correlation showed that perceived social support, as measured by the MSPSS, was significantly correlated with several of the SCL-90-R scores reported above. Therefore, I included the MSPSS total score as a covariate in the following multiple regression analyses. I also conducted a series of multiple regression analyses to determine the patterns of relationships of the MSAPT scores with the SCL-90-R scales. Each of the SCL-90-R scales was regressed on the six MSAPT scores plus the MSPSS total score. Table 2 contains the results of these analyses.

For the Global Severity Index (GSI), the multiple regression analysis yielded a statistically significant overall result, $F(7, 92) = 3.51$; $p < .01$, with the

TABLE 2
Summary of Multiple Regression Analyses of SCL-90-R Scales on Moreno Social Atom Projective Test Scores and Multidimensional Scale of Perceived Social Support–Total Score (MSPSS)

Criterion	Overall		Univariate partial *F*s						
	$F(7, 92)$	R^2	MSPSS	Size	Conflict	Family	Reciprocity	Deceased	Gender
GSI	3.51**	.211	2.73	0.03	8.67**	0.56	1.37	0.00	1.93
SOM	3.67**	.218	5.20*	0.03	5.00*	1.81	0.00	0.04	3.82*
OC	2.04	.134	0.01	0.10	6.01*	0.36	1.73	1.14	0.74
INT	2.33*	.150	2.55	0.25	3.40	0.01	2.24	0.00	1.78
DEP	2.28*	.148	1.51	0.07	8.32**	0.30	1.33	0.06	0.04
ANX	3.06**	.189	1.61	0.03	10.40**	0.56	0.36	0.49	1.50
HOS	2.46*	.158	0.72	0.91	6.92**	0.00	0.04	0.10	4.36*
PHOB	2.27*	.147	0.08	0.50	5.23*	0.16	1.18	0.01	2.85
PAR	2.68*	.170	3.71	0.14	4.11*	0.04	2.83	0.00	0.81
PSY	3.23**	.197	7.59**	0.01	3.69	0.40	0.75	0.00	1.26

Note. Abbreviations: GSI = Global Severity Index; SOM = Somatization; OC = Obsessive–Compulsive; INT = Internality; DEP = Depression; ANX = Anxiety; HOS = Hostility; PHOB = Phobia; PAR = Paranoia; PSY = Psychoticism.
*$p < .05$; **$p < .01$.

MSAPT scores and MSPSS scores accounting for more than 20% of the variability in GSI score. From an examination of the individual contributions of the predictor variables, I recognized that the conflict score was the major contributor to this effect. It was the only predictor variable to show a significant contribution over and above the combined contributions of the other six predictor variables, partial $F(1, 92) = 8.67$; $p < .01$.

For the subscales of the SCL-90-R, there was a similar pattern of results. The MSAPT scores proved to be significantly predictive of all the SCL-90-R subscales except Obsessive-Compulsive, for which there was a significant trend toward significance, $F(7, 92) = 2.04$; $p = .0582$, and Psychoticism, for which perceived social support was the only independently significant contributor. The conflict score was the major predictor for most of the subscales of the SCL-90-R, with the ratio of women to men (MSAPT Gender score) in the social atom contributing significantly to the prediction of the Somatization and Hostility subscales.

A second series of multiple regression analyses was conducted to determine the patterns of relationships of the MSAPT scores with the SCL-90-R scores without the MSPSS total score. In Table 3, we show the results of these analyses. For the GSI, the multiple regression analysis yielded a statistically significant result, $F(6, 93) = 3.58$; $p < .01$, with the MSAPT scores accounting for nearly 19% of the variability of the GSI score. From an examination of the individual contributions of the predictor variables, I determined that the conflict score was the major contributor to this effect. I noticed slight increases in each of the six predictor variables, with the conflict score showing the only significant contribution over and above the combined contributions of the other five variables, partial $F(1, 93) = 10.89$; $p < .001$).

For the subscales of the SCL-90-R, the MSAPT scores proved to be significantly predictive of all the SCL-90-R subscales. The conflict score was the major predictor for all of the subscale scores, with the reciprocity score contributing significantly to the paranoid ideation score and the gender score contributing significantly to the Hostility score.

Discussion

Standardization of the MSAPT

Two of the main roadblocks to broader acceptance of Moreno's social atom have been its lack of standardization, with nearly as many different versions as publications (Hale, 1981; Hollander, 1974; Kulenkampff, 1982; Moreno, 1936; Taylor, 1977; Treadwell et al., 1989), and the lack of research using it (Taylor, 1984). Treadwell et al. (1989) attributed the lack of research findings, in part, to the difficulty scoring the social atom in its original projective for-

TABLE 3
Summary of Multiple Regression Analyses of SCL-90-R Scales on Moreno Social Atom Projective Test Scores

Criterion	Overall		Univariate partial *F*s					
	$F(6, 93)$	R^2	Size	Conflict	Family	Reciprocity	Deceased	Gender
GSI	3.58**	.188	0.03	10.89***	0.63	2.50	0.14	1.96
SOM	3.27**	.174	0.03	7.16**	1.92	0.27	0.47	3.76
OC	2.41*	.134	0.10	6.25**	0.37	1.80	1.17	0.74
INT	2.25*	.127	0.25	4.75*	0.02	3.61	0.12	1.81
DEP	2.39*	.134	0.07	10.10**	0.34	2.17	0.00	0.04
ANX	3.29**	.175	0.02	12.46***	0.61	0.84	0.19	1.50
HOS	2.76*	.151	0.92	8.15**	0.00	0.17	0.02	4.43*
PHOB	2.65*	.146	0.50	5.76*	0.17	1.41	0.00	2.89
PAR	2.44*	.136	0.14	5.83*	0.06	4.65*	0.20	0.84
PSY	2.34*	.131	0.01	5.87*	0.47	2.23	0.38	1.26

Note. Abbreviations: GSI = Global Severity Index; SOM = Somatization; OC = Obsessive–Compulsive; INT = Internality; DEP = Depression; ANX = Anxiety; HOS = Hostility; PHOB = Phobia; PAR = Paranoia; PSY = Psychoticism.
*$p < .05$; **$p < .01$; ***$p < .001$.

mat. For the study reported here, over 95% of the participants were able to complete the MSAPT successfully. A review of the five MSAPT drawings that were unscoreable revealed two problems. There was some confusion with the number of diagrams to be completed, with 3 respondents completing four drawings, one for each step in the directions, rather than one. Two participants drew arrows at either end of the reciprocity symbol, rather than at one end as directed. These problems can be avoided in the future with clearer directions. Respondents were asked in Step 2 (see appendix) to label all family members by writing their relation to the participant; for example, father, mother, brother, sister, aunt, uncle, cousin, father-in-law, and so forth. Nine respondents listed only family members in their social atom. Although it is possible that social networks can contain only family members, it seems likely that some of these scores were brought about by a misreading of the instructions. I was unable to discern which respondents had failed to include friends versus which respondents had only family in their social networks. I believe that increased interaction between the examiner and the client, as would be typical in a clinical setting, would have prevented this confusion. Interrater reliability of over 99% demonstrates the success of the scoring established for the MSAPT and addresses Treadwell's concerns about scoring the projective version. The refined version of the MSAPT is one that has been successfully standardized in terms of administration and scoring.

The Development of Normative Data

Anastasi (1988) spoke of the lack of sufficient normative data as "another conspicuous deficiency common to many projective instruments" (p. 614). This study addressed that common criticism by developing variables that could be easily measured and analyzed. In Table 1, I list the mean scores for each of the six MSAPT scores tabulated in this study. Granted this is a modest beginning; it is, however, the only known study that attempts to develop norms with a projective version of Moreno's test. The size score (M = 13.5, SD = 8.30) confirmed the belief that nonclinical participants have between 5 and 25 members in their social atom. That belief had been part of the body of anecdotal knowledge about the social atom, yet never substantiated statistically (Taylor, 1984). The other five variables were developed for this study and are extrapolated from Moreno's theories and social network research, independent from his theories.

Concurrent Validity

Concurrent validity, a type of criterion-related validity that is different because the data for the criterion are collected at the same time as the predic-

tor variable, demonstrates a test's ability to measure some criteria that a second instrument is believed to measure (Kerlinger, 1973). The goal of the procedure is not to produce a measure that is only able to replicate another's findings. Whereas the Pearson correlations demonstrated the MSAPT's high correlation with the MSPSS, thus establishing concurrent validity, the regression analyses showed that the MSAPT provided clinical information in addition to what the MSPSS contributed to the clinical picture of a client.

Clinical Usefulness of the MSAPT

The current version of the MSAPT has administration and scoring protocols for six variables: size, conflict, reciprocity, family, deceased, and gender. Statistical analyses showed that the MSAPT was able to account for approximately 13% to 19% of the variability of the GSI and each of the nine subscale scores of the SCL-90-R, with the conflict, reciprocity, and gender scores attaining levels of significance. An examination of the SCL-90-R subscores showed the MSAPT was most predictive of the symptoms of Anxiety, Depression, Somaticism, Obsessive-Compulsive Behavior, and Hostility. Although the size and family scores were not predictive of symptomology in this study, it is possible that they would be more clinically useful with a patient population and should not be excluded from the MSAPT without further study.

Limitations of the Study

The clustering of scores in the sample did not allow for a sufficient number of extreme scores, large or small, to be grouped and analyzed. That may have been caused by the type of subjects chosen for this study. Although the goal of establishing initial norms was achieved, a clinical, rather than a nonclinical, population may have provided more extreme scores. As a result, the importance of the size and reciprocity scores of the MSAPT remains unclear, which leads to the issue of generalizability. The findings in the current study are important and can be useful for clinicians working with clients whose presenting problems are typical of adult graduate students, for example, anxiety, depression, and so forth. However, these findings cannot be generalized to more severe clinical populations without further research. Whereas demographic variables had no significant effect on MSAPT scores in this study, a more thorough examination of differences between racial or ethnic groups is needed before the MSAPT can be viewed as a bias-free instrument. Similarly, the sample for this research was predominantly Caucasian and female and consisted entirely of graduate students. Such a sample is not representative of the population at large and should not be construed as such. Future researchers should strive to use samples that will broaden the data base demographically.

A second limitation of this study was the setting in which the data were collected. The social atom has traditionally been an instrument used in clinical settings and administered verbally to individuals and small clinical groups by the clinician (Hale, 1981). The MSAPT was designed to be self-administered so that data could be collected in a group setting. I was available to answer questions during test administration, but it is unlikely that these interactions approximated the interchange that would take place between a therapist and client. It seems likely that a clinical setting would only enhance the quality of information collected with the MSAPT, and research is needed to confirm this hypothesis. Similarly, clinicians may find that they prefer to administer the test to their clients, or the clinical population being served may need the test to be administered to them, as would be the case with clients who are visually impaired, illiterate, or physically disabled. The robustness of this instrument should overcome such confounds, but the research is needed to bear this out.

Direction for Future Research

The next step in understanding the predictive value of the MSAPT is the establishment of cross-validity by researchers conducting investigations with clinical samples and nonclinical samples that are more representative of the population at large. As I stated previously, this may help clarify the importance of the size and reciprocity variables and continue the development of patterns of MSAPT variable interaction associated with symptomology and pathology.

Further study is needed to understand the apparent overlap between the conflict and reciprocity variables. This may be as simple as re-evaluating the current MSAPT diagrams to see if the same network relationships have been designated as both conflictual (-) and nonreciprocal (˜). It may, however, require that the current reciprocity score be restated as two subscores, representing nonreciprocation in both directions, to see if one correlates more significantly than the other when compared with the conflict score. It may be useful to divide the conflict score into three levels, as is the case with the MSPSS, using significant other, friends, and family (Zimet et al., 1988).

I designed the current study to examine the variables of the MSAPT that are most quantifiable and thus lend themselves to statistical analyses. Future researchers may wish to extend the pool of variables to include more projective measures such as those outlined by Taylor (1984)—placement of self symbol, overlap of symbols, and distance between symbols. Further examination of the deceased and gender variables would determine their clinical usefulness. The deceased variable might become a significant determinant with a psychotic population. It would also be interesting to see if the gender

score is more clinically significant when the gender of the participant is the same as the gender that predominates the social atom.

While scoring the MSAPT diagrams, I noted several unusual responses that may suggest the need for a special score category. These responses included the labeling of a dog, God, and the generic labels "friends" and "students." Group affiliations had been included in past social atom versions and may point toward useful clinical data (Hale, 1981). Moreover, some drawings were segregated by gender, whereas others had some confusion with the gender symbols, such as labeling father with a circle.

The MSAPT should also prove to be as useful a "barometer of progress in therapy" as the earlier versions were thought to be (Buchanan, 1984, p. 163). Future researchers should employ the MSAPT in a repeated measures design to examine that hypothesis.

Although establishing test-retest reliability has proved to be difficult for projective measures (Anastasi, 1988), it is a necessary next step for MSAPT researchers. Even though the current study showed the MSAPT to have some level of concurrent validity, replication of these findings is needed. Concurrent validity should be re-established by using instruments, such as MMPI-2 and Rorschach, that are able to describe the level of psychological distress more thoroughly.

Conclusion

Moreno (1940) theorized that social atoms of mentally healthy persons differed structurally from those of unhealthy persons. He believed that the starting point for therapy was an examination of the social network in order to identify damaged or dysfunctional social atoms and develop treatment plans based on their repair (Petzold, 1982, cited in Engelhardt et al., 1989). Moreno's social atom theory has remained largely untested and, as a result, unsubstantiated. Although this has not been a deterrent to those within the psychodrama community, it has prevented the social atom from gaining the respect it deserves from the mental health community at large. With this study, I have presented significant steps toward the standardization of the social atom that will, I hope, lead to a broader acceptance of the MSAPT, the version of the Moreno social atom developed for this study, as a clinically useful diagnostic tool and a guide to clinical intervention.

From this study, I have concluded that the MSAPT is an easily self-administered, reliably scored, clinically significant instrument. It has the potential to be used as a diagnostic tool and a guide to treatment progress. Despite not being designed as a research tool, MSAPT may also be used as such. Demographic variables, including race/ethnicity, appear to have little impact on MSAPT scores, which suggests it is appropriate for use with a broad range of

populations. I hope that future research will continue to extend knowledge about the generalizability of the MSAPT to clinical and nonclinical populations and thereby extend the norms initiated in this study.

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APPENDIX

MORENO SOCIAL ATOM PROJECTIVE TEST

Directions for Administration

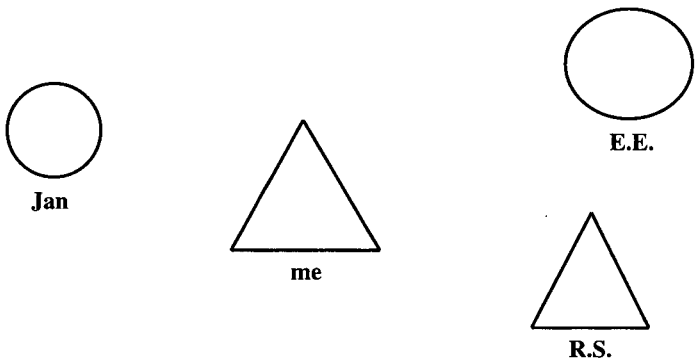
Think of the people with whom you now have an important or significant relationship. These people may be family, friends, or people you know through work or other organizations. Acquaintances should not be included because they are not significant relationships. Think of who plays a large role in your life. Don't forget to mention also those people who are important to you, but with whom you have a difficult or conflictual relationship. If you have important relationships with people who have died or who, for one reason or another, cannot be in contact with you, you should include them as well. You may include as many or as few people as you like.

Follow the directions step by step and please read each step completely before responding to the directions. You may return to earlier steps if you would like to provide additional information. Please write and draw clearly.

STEP 1 On the following blank piece of paper, choose a spot and draw a symbol representing yourself, a triangle (Δ) if you are a male and a circle (o) if you are a female. Label the symbol "me". Using the same symbols, triangle for males and circles for females, represent each of the individuals who play an important role in your life. Place the symbols as close to or as far away from your own symbol as you feel the relationship merits. Please label each symbol with initials or a first name so it can be easily identified by you. Sym-

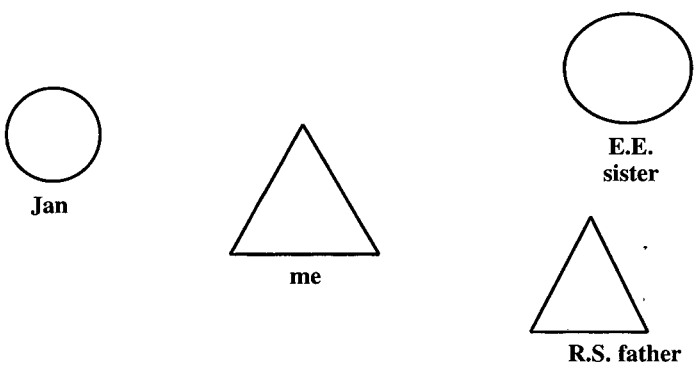
bols representing deceased individuals should be marked "deceased," and drawn as follows (⏃ , ⊖).

Example:



STEP 2 Using the same diagram, label all family members by writing their relation to you, for example, father, mother, brother, sister, aunt, uncle, cousin, father-in-law, and so forth.

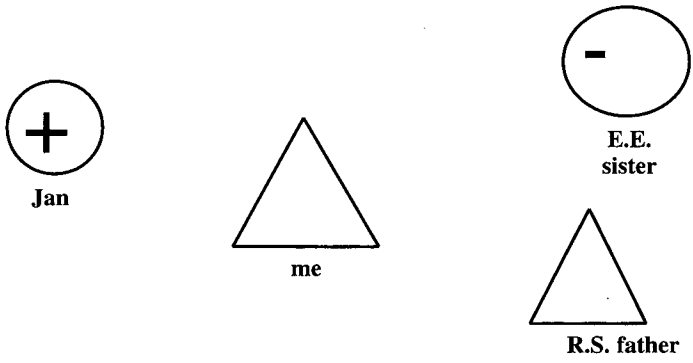
Example:



STEP 3 Continue to use the same diagram. Think of the impact each relationship has on you at this time. Consider the amount of personal energy required to maintain each individual relationship. If you feel the relationship has a positive impact on you, for example, is energizing, rejuvenating, stimulating, or involves somebody you look forward to spending time with, then mark the corresponding symbol with a plus sign (+). If you feel the relationship has a negative impact on you because it is physically draining, conflict-

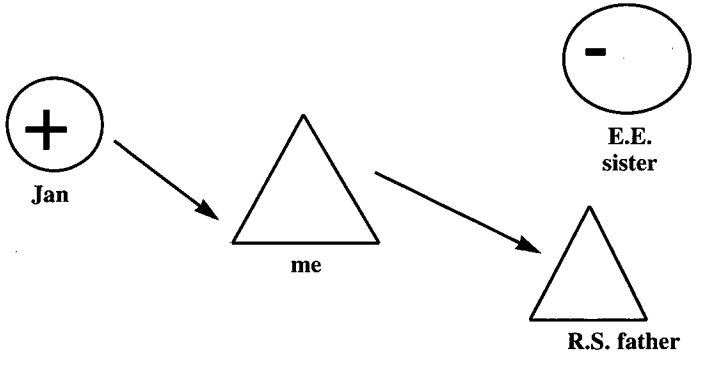
ual, or if the person in the relationship is somebody you do not wish to spend time with, then mark the corresponding symbol with a minus sign (-). If the relationship is neutral at this time, then leave the corresponding symbol unmarked.

Example:



STEP 4 Continue to use the same diagram. Most relationships are a matter of give and take. This trade-off can be in the form of emotional support, friendship, material goods, or favors, among other things. At times these trade-offs can become imbalanced. If you feel, at this point in time, that you give more to a relationship than you receive from it, draw an arrow from your symbol to the other symbol or symbols. If you feel you receive more from a relationship than you give, draw an arrow from that person's symbol to yours. Do this for each relationship you feel is imbalanced. Do not draw an arrow between your symbol and another's symbol if you feel the current relationship is balanced equally between give and take.

Example:



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Effects of Gender and Sex Type on Perceived Leadership Abilities

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ABSTRACT. The effects of gender and sex type on perceived leadership abilities were investigated. The participants consisted of 33 resident assistants at a state university. They completed the Bem Sex Role Inventory and a sociometric instrument that measured perceived leadership abilities. The researchers hypothesized that the men in the study would tend to be perceived as leaders and that those men would be androgynous, possessing a high number of both feminine and masculine characteristics. Further, the women in the study would be perceived as single faceted by their peers; if a woman emerged as a leader, she would be perceived as effective in either disciplinary situations or in interpersonal situations, but not effective in both areas. The researchers also hypothesized that female leaders would be sex typed as either androgynous or masculine. From the results of the study, the researchers concluded that instead of one single male leader emerging within each residence hall, a group of co-ed leaders emerged within each hall. The overall gender orientation of that leader group was predominantly masculine in all residence halls, with the exception of the all-female hall, for which the leader group was predominantly feminine. The participants' gender did not appear to affect their being viewed as single faceted in their leadership strengths by their peers. Even though the distribution of sex type among all the subjects studied was found not to differ from that of the general population, the participants were found to be more sex typed than the general population.

THE LEADERSHIP CATEGORIZATION THEORY proposes that a person's schematic conception of a leader strongly influences how that person will perceive a leader's effectiveness (Nye & Forsyth, 1991). If the leader possesses a high number of characteristics that match the observer's schematic conception, the leader will be perceived as effective; likewise, if the leader possesses few or none of the schematic characteristics, he or she will be perceived as ineffective.

Traditionally, characteristics that are associated with an effective leader have been stereotypically masculine, such as being task oriented, ambitious, and assertive; however, stereotypically feminine characteristics, such as being interpersonally oriented, compassionate, and sensitive, tend not to be associated with leader effectiveness (Bem, 1974; Eagly & Johnson, 1990).

Thus, according to the leadership categorization theory, men more than women will tend to be viewed as effective leaders. Several studies have found this to be the case (Dobbins, Long, Dedrick, & Clemons, 1990; Eagly & Karau, 1991). When women do emerge as leaders, they are in groups that require complex social interaction, a stereotypical female task (Eagly & Karau, 1991). In other studies, researchers have found no significant differences in leadership emergence or effectiveness as a function of gender (Goktepe & Schneier, 1988, 1989; Ragins, 1991). The studies conducted by Goktepe and Schneier are divided, though, on the effects of psychological gender, or sex type, on leadership effectiveness and emergence. It was first found that those participants who were androgynous, or high in both feminine and masculine qualities, received higher ratings on measuring events of leadership effectiveness than did masculine or feminine sex-type participants (Goktepe & Schneier, 1988). In a subsequent study that measured leadership emergence, those participants who were sex typed as masculine emerged as leaders significantly more than did feminine or androgynous participants (Goktepe & Schneier, 1989).

Cann and Siegfried (1990) found that consideration behaviors are perceived as being feminine, whereas structuring behaviors are perceived as being masculine. Thus, both of these qualities should be present in one's leadership style in order to be effective. Researchers have also found that when women leaders are perceived as possessing a stereotypically masculine style, such as being authoritarian and potent, they tended to be less positively valued and viewed as more threatening than their male counterparts (Eagly, Makhijani, & Klonsky, 1992; Morrison, Greene, & Tischler, 1985).

Because stereotypical gender characteristics are often associated with leadership effectiveness, it can be inferred that both physical gender and psychological gender can influence others' perceptions of the leader's abilities. If such stereotypes hold true, women would be expected to be perceived as more effective leaders in situations that involve social interaction and require strong interpersonal skills. Men would be perceived as more effective leaders in situations that require strong assertive and disciplinary skills

Resident assistants (RAs) on a college campus are required, as a part of their job description, to oversee the smooth running of the residence hall. These duties require resident assistants to work together in responding to both disciplinary situations and interpersonal situations, demanding the use of both types of stereotyped skills and abilities. We hypothesized that within each of

the co-ed groups, one leader would emerge who would be more likely to be male than female. Each one of these male leaders would be androgynous, possessing a high number of both masculine and feminine characteristics. If a female leader did emerge, we predicted that she too would be androgynous. We hypothesized, however, that female leaders would be viewed as single-faceted by their peers, being perceived as effective either in disciplinary situations or in interpersonal situations, but not effective in both areas. Gender stereotypical characteristics would predict that, overall, men, or masculine sex-typed women would be perceived as most effective in dealing with disciplinary problems and would tend to be chosen by others to lead in disciplinary situations. Women, or feminine sex-typed men, would be perceived as most effective in dealing with interpersonal problems and would tend to be chosen to lead in interpersonal situations.

Method

Participants

Our participant group consisted of resident assistants ($N = 33$) at a state university. Four residence halls were represented, with each hall having its own RA staff. Three of the halls were co-ed, with the staff including both men and women; all of the staff in the fourth hall were women.

Materials

Materials consisted of a sociometric instrument containing 14 questions designed to measure four aspects of perceived leadership: leadership qualities, leadership abilities, disciplinary leadership, and interpersonal receptiveness (Treadwell, Saxton, & Mulholland, 1995). Ten of these questions were later rejected when they were determined to be inadequate predictors of perceived leadership aspects either because of their vagueness or their irrelevant nature.

The sociometric questions (Table 1) used in the analysis measured four aspects of leadership: interpersonal, disciplinary, qualities of leadership, and perceived leadership abilities.

We also used the Bem Sex Role Inventory (BSRI; Bem, 1974) to identify sex-typed individuals according to their self-concepts or self-ratings of their personal attributes, such as instrumentality and expressiveness.

Procedure

The resident hall directors instructed the participants to complete the sociometric questions; the BSRI was administered to the participants 1 month later.

TABLE 1
Instrument Used to Measure Aspects of Perceived Leadership

Aspect of perceived leadership	Question
Interpersonal receptiveness	Which resident assistant (RA) would you select as a therapist?
Disciplinary leadership	Residents are drinking beer in their room. Which RA would you ask to back you up when you confront the residents?
Leadership qualities	Select an RA who exemplifies the leadership qualities you desire.
Leadership abilities	The RAs have a complaint about your resident director (RD). Which RA would you choose to represent the RAs and confront the RD?

Results

The staff of all of the residence halls examined were high in cohesiveness, as determined by the number of reciprocal choices among the group members on the sociometric instrument that were administered. Only a few participants among all the staff of the residence halls were found to be rejected, having received no reciprocated choices among the leadership dimensions examined. Figure 1 demonstrates that high degree of cohesiveness. Each participant in that residence hall received at least one reciprocal choice; no separate subgroups or "cliques" of mutual choices were formed nor was anyone rejected.

Our analysis of the sociograms also showed that no single leader emerged among any of the residence hall groups. Instead, a group of two or more individuals were chosen by the subjects as leaders on all of the four dimensions. These sets of group leaders always contained both men and women who had consistently chosen each other on the sociometric instrument, indicating strong mutual relationships. The coleader groups of each of the residence halls are represented in Table 2.

We used Bem's Stanford subject scores to calculate the normative data (1974). The results of the BSRI indicated that the distribution of sex type among all of the participants was no different from that of the general population, as shown in Table 3. The majority of all participants, 52%, were of a masculine gender orientation; 27% were androgynous; 21% were feminine. There was also no difference demonstrated in the distribution of sex type among the perceived leaders in the study. The only difference in the distribution of sex types among the participants and those of the expected norms was among the female perceived leaders, compared with women in the general

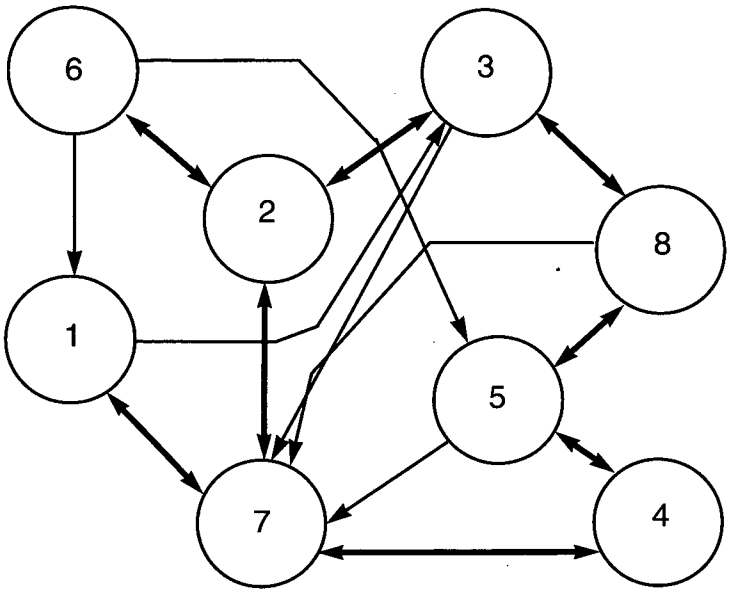

FIGURE 1. Sociogram generated from one subject group's responses to the question: Whom would you select as a therapist? The high number of reciprocal choices among these subjects, as well as the lack of any subgroups, demonstrates this group's high level of cohesiveness. Computerized sociogram created by *GraphPlot* (Saxton, 1996).

TABLE 2
Sex Type and Gender of Perceived Leader Groups in Four Residence Halls

Residence hall			
1	2	3	4 (all women)
Masculine man	Masculine man	Masculine man	Feminine woman
Masculine man	Androgynous man	Masculine woman	Feminine woman
Masculine woman	Masculine woman		Masculine woman
Androgynous woman			

population; the distribution of masculine and feminine sex types was almost the reverse of the expected female norm (subject group: 57% masculine, 21% feminine; expected norm: 20% masculine, 54% feminine).

Among all four of the leadership dimensions examined, masculine sex-typed participants, both men and women, received a greater proportion of the

TABLE 3
Results of the Bem Sex Role Inventory

Category	O^1	Exp. prop.	E^2	$O - E$	$(O - E)^2$	$(O - E)^2/E$
Distribution of sex type among all participants						
Masculine	17	.413	13.63	3.37	11.36	0.834
Androgynous	9	.313	10.33	–1.33	1.77	0.171
Feminine	7	.274	9.04	–2.04	4.16	0.460
Sum	33	1.000	33.00		χ^2 =	1.465
					$\chi^2_{crit(.05, 2)}$ =	5.990
Distribution of sex type among participants who are perceived leaders						
Masculine	8	.413	4.96	3.04	9.24	1.863
Androgynous	1	.313	3.76	–2.76	7.618	2.026
Feminine	3	.274	3.29	–0.29	0.084	0.026
Sum	12	1.000	12.00		χ^2 =	3.915
					$\chi^2_{crit(.05, 2)}$ =	5.990
Distribution of sex type among female participants who are perceived leaders						
Masculine	4	.20	1.40	2.60	6.76	4.83
Androgynous	1	.27	1.89	–0.89	0.79	0.43
Feminine	2	.54	3.78	–1.78	3.17	0.84
Sum	7	1.00	7.00		χ^2 =	6.09
					$\chi^2_{crit(.05, 2)}$ =	5.99
Distribution of choices received for all leadership dimensions (leadership abilities, leadership qualities, disciplinary situations, and interpersonal situations) according to participants' sex types						
Masculine	165	.52	126.36	38.64	1493.05	11.82
Androgynous	35	.27	65.61	–30.61	936.97	14.28
Feminine	43	.21	51.03	–8.03	64.48	1.26
Sum	243	1.00	243.00		χ^2 =	27.36
					$\chi^2_{crit(.05, 2)}$ =	5.99
Distribution of choices received in interpersonal situations according to participants' sex types						
Masculine	34	.52	32.76	1.24	1.54	0.047
Androgynous	17	.27	17.01	–0.01	0.0001	0.000
Feminine	12	.21	13.23	–1.23	1.50	0.114
Sum	63	1.00	63.00		χ^2 =	0.161
					$\chi^2_{crit(.05, 2)}$ =	5.99

(table continues)

TABLE 3—*continued*

Category	O^1	Exp. prop.	E^2	$O - E$	$(O - E)^2$	$(O - E)^2/E$
Distribution of choices received for leadership qualities according to participants' sex types						
Masculine	38	.52	31.72	6.28	39.44	1.240
Androgynous	10	.27	16.47	–6.47	41.86	2.540
Feminine	13	.21	12.81	–0.19	0.04	0.003
Sum	61	1.00	67.00			$\chi^2 =$ 3.783
						$\chi^2_{crit(.05, 2)} =$ 5.99
Distribution of choices received for disciplinary situations according to participants' sex types						
Masculine	49	.52	34.84	14.16	200.51	5.76
Androgynous	9	.27	18.09	–9.09	82.63	4.57
Feminine	9	.21	14.07	–5.07	25.70	1.83
Sum	67	1.00	67.00			$\chi^2 = 12.16$
						$\chi^2_{crit(.05, 2)} =$ 5.99
Distribution of choices received for leadership abilities according to participants' sex types						
Masculine	44	.52	32.24	11.76	138.30	4.29
Androgynous	7	.27	16.74	–9.74	94.87	5.67
Feminine	11	.21	13.02	–2.02	4.08	0.31
Sum	62	1.00	62.00			$\chi^2 = 10.27$
						$\chi^2_{crit(.05, 2)} =$ 5.99
Distribution of choices received for leadership abilities according to participants' gender						
Males	21	.33	20.79	–.21	.044	0.002
Females	42	.67	42.21	.21	.044	0.001
Sum	63	1.00	63.00			$\chi^2 = 0.003$
						$\chi^2_{crit(.05, 2)} = 3.84$
Distribution of choices received for leadership qualities according to participants' gender						
Males	17	.33	20.13	–3.13	9.80	0.47
Females	44	.67	40.87	3.13	9.80	0.24
Sum	61	1.00	61.00			$\chi^2 = 0.71$
						$\chi^2_{crit(.05, 2)} = 3.84$

(table continues)

TABLE 3—*continued*

Category	O^1	Exp. prop.	E^2	$O - E$	$(O - E)^2$	$(O - E)^2/E$
Distribution of choices received for leadership abilities according to participants' gender						
Males	24	.33	20.46	3.54	12.53	0.612
Females	38	.67	41.54	–3.54	12.53	0.302
Sum	62	1.00	62.00		χ^2 =	0.914
					$\chi^2_{crit(.05, 2)}$ =	3.84
Distribution of choices received disciplinary situations according to participants' gender						
Males	35	.33	22.11	12.89	166	7.51
Females	32	.67	44.89	–12.89	166	3.70
Sum	67	1.00	67.00		χ^2 =	11.21
					$\chi^2_{crit(.05, 2)}$ =	3.84
Distribution of all participants who are determined to be single faceted according to their gender						
Males	4	.33	2.31	1.69	2.87	1.24
Females	3	.67	4.69	–1.69	2.87	0.61
Sum	7	1.00	7.00		χ^2 =	1.85
					$\chi^2_{crit(.05, 2)}$ =	3.84

Note. O represents "observed frequencies." E represents "expected frequencies."

choices from other participants than what would normally be expected. Normative figures were calculated by assuming that the distribution of each sex-type in the sample would be equal to the distribution of choices received. There was no difference among the different sex types in the number of choices received from both the interpersonal situation and leadership qualities from what would be expected. However, we found significant differences for both the disciplinary situation and leadership abilities. In these areas, masculine sex-typed participants received a greater proportion of choices than what would be expected if the choices were distributed evenly, whereas the feminine sex-typed participants received a lesser proportion of choices in these same areas. Androgynous sex-typed participants received a slightly lesser proportion of choices in the disciplinary dimension, but they received the expected proportion of choices for the leadership abilities dimension.

TABLE 4
Mean Comparison Between Participant Groups and Normative Sample

Group	Men (n = 11)	Women (n = 22)
Masculine		
M	5.71	5.19
SD	0.313	0.662
t	23.125*	15.12*
Feminine		
M	4.95	5.17
SD	0.383	0.357
t	15.93*	5.16*
Androgynous		
M	–1.823	–0.099
SD	1.067	2.081
t	–0.426*	–8.76*

*$p < .05$.

Examining these same dimensions in terms of gender, we found no differences between male and female participants and their perceived interpersonal leadership abilities, their perceived leadership qualities, or their perceived leadership abilities. Men, however, were chosen more often than women in disciplinary abilities. There were instances in which men and women received a high number of choices on either the interpersonal dimension or the disciplinary dimension, but not on both dimensions simultaneously.

Participants were determined to be "single-faceted" if they received very many choices in either the interpersonal or disciplinary situation while receiving very few choices in the contrasting situation. Using these guidelines, we determined that 36% of all the men and 13% of all the women were single faceted. No significant difference was found between that gender distribution. There was, however, a significant gender difference among those single-faceted participants who were leaders. Fifty-two percent of all of the perceived leaders were single faceted. The distribution of sex type among all the single-faceted participants was not significant.

When we compared the means of the participant groups' sex-type scores and the normative figures, we found significant differences in almost all of the gender/sex type relationships, as summarized in Table 4. The only group that did not differ from the expected norm was the androgynous males; all other groups were more sex typed than one would expect in the general population.

Discussion

Although the small sample size of this study prevents us from making generalizations, we did find certain trends. The high number of mutual choices, as well as the emergence of a group of two or three leaders, supports our assertions about the strong cohesiveness within the halls' staffs. Perhaps this is because of the resident assistants' working and living arrangements; the resident assistants work and live in the residence halls.

Contrary to the hypothesis that a single leader would emerge among each of the residence hall staffs, we found that a small group of two or three individuals emerged as coleaders within each hall. This coleader group always consisted of at least one man and one woman, perhaps the result of a need to have complementing leadership abilities, which the two genders supposedly provide. Gender stereotypes and prejudices may continue to limit people's perceptions and expectations of the two sexes. A single gender may not be viewed as competent in handling situations that require both stereotypically masculine and feminine abilities. To compensate for this limitation, people may turn to a group of leaders who represent both genders, satisfying their preconceptions of certain genders being more suited for certain tasks.

Despite previous research that asserted that an effective leader should be androgynous (Cann & Siegfried, 1990), our findings have shown that the majority of the group leaders were of a masculine gender orientation. So despite the presence of a woman within each leader group, the overall gender orientation of the group was nonetheless predominantly masculine. This was not the case, of course, in the all-female hall. The overall orientation in that leader group was predominantly feminine, and it was the only hall to have feminine sex-typed leaders. Only one participant in the entire hall showed a masculine gender orientation, going against the masculine trend seen in the other halls (it is interesting to note that this lone "masculine" participant within the all-female hall was also the third member of the otherwise all-female leader group). The reason this group did not follow the masculine pattern seen in the other halls is unclear. Perhaps the dynamics of an all-female group differs from a co-ed group, providing an interesting premise for further study.

Although there were instances of female leaders being viewed as effective in either interpersonal or disciplinary situations, but not both, the frequency did not differ from that of male leaders. Thus, it appears that gender did not play a part in being perceived as being single faceted in leadership strengths. There was, however, a significant difference between the number of perceived leaders and nonleaders who were determined to be single faceted; 85% of those participants who were determined to be single faceted were also perceived leaders. It appears that possessing a strength in one of these areas, even if he or she is lacking in the other, causes the resident assistant to be seen still

as a leader. This may also help to explain the emergence of a group of coleaders rather than a single leader within each hall. Each resident assistant brings to the group his or her own strengths as well as weaknesses; by combining their abilities, the coleaders can compensate for each other's shortcomings.

Although women are just as likely as men to be viewed as possessing both leadership qualities and leadership abilities, this does not hold true for feminine sex-typed participants versus masculine sex-typed participants. It appears that a feminine sex-typed individual who has all the qualities and characteristics of an effective leader will still have difficulty in persuading other group members that he or she is indeed capable of being a leader. This may be the result of enduring beliefs that maintain that feminine qualities are not part of the recipe that makes up an effective leader.

Whereas the distribution of sex type among the resident assistants studied did not differ from the distribution of sex type among the general population, the degree to which the resident assistants were found to be sex typed was greater than what would be expected. Perhaps the very leadership characteristics that presumably secured the resident assistants' positions caused them also to score above average on the sex-type inventory. The characteristics of a strong and effective leader may inherently manifest themselves in a strong sex-typed personality, be it masculine, feminine, or androgynous.

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Therapeutic Theater and Spontaneity: Goethe and Moreno

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ABSTRACT. Moreno noted a similarity between a late 18th-century play by the great German scholar and artist, Goethe, and some elements of psychodrama, which can be substantiated; however, Goethe was not, as Moreno suggested, an early promoter of spontaneity. The similarities and contrasts between these two men are intriguing.

IN 1973, MORENO ADDED TO THE SECOND, ENLARGED EDITION of *The Theatre of Spontaneity* a chapter entitled "Goethe and Psychodrama," which is a reprint of Diener (1971) and Moreno (1971). In the preface to this new edition, he proclaimed "the importance of Goethe as a forerunner of both therapeusis through drama and his esthetic sense for spontaneous production" (Moreno, 1973, p. 1). This is surprising because Goethe is rarely related to therapy and spontaneity.

Johann Wolfgang von Goethe (1749–1832) is probably the most important and prolific German-speaking author of any time. He was already famous by the time he was 25 and is widely acknowledged as a "universal genius," excelling equally as a politician, poet, novelist, playwright, actor, theater director, and scientist. His fame only grew after his death, and up to this day, he is one of the most written-about figures of European history and continues to be an idol for many German-speaking youth.

Jacob Levy Moreno (1889–1974), on the other hand, never achieved the recognition he felt he deserved. Although best known as a psychiatrist, Moreno also developed a theory of the nature and function of theater, and his ideas have influenced a number of American theater companies (for an assessment of Moreno's contribution to the field of theater, see Scheiffele, 1995).

Of the dramatic theorists that came before him, Moreno commented main-

ly on Aristotle, from whom he adapted the concept of catharsis, and on Goethe. Having himself grown up in a German-speaking culture, he joined in the admiration for Goethe:

> It is therefore a special honor to know that the great poet and philosopher Johann Wolfgang von Goethe thought along psychodramatic lines and that he wrote plays on the subject. There is no writer in the Anglo-Saxon literature, not even Shakespeare, who has attained Goethe's rank as an overall creator in the sciences and arts. (Moreno, 1973, p. 122)

Therapy Through Drama: Goethe's *Lila*

The main evidence Moreno presented for Goethe's knowledge of the therapeutic effects of dramatic enactment is his little known "Singspiel" (a play with songs) *Lila* (Goethe, 1968, p. 181–214). The play tells the story of the baroness Lila, who is being cured from madness. After she is mistakenly notified that her husband has died, she no longer recognizes anybody, not even her husband when he returns. Questioned by Doctor Verazio (originally in 1777 played by Goethe himself; see Carlson, 1978, p. 28), she proves to be living under the delusion that her husband has been imprisoned by evil spirits. She also thinks that these spirits are after her and that she has to find a way to rescue her husband. Doctor Verazio now starts to direct everybody in a "psychodrama" in which Lila's friends and family portray Lila's subjective world, complete with fairies and evil spirits. Lila goes on a long journey in which she interacts with the fairies and fights with the evil spirits. Only after she has "conquered" the demons, is her husband introduced to her. Now she recognizes him and thus regains her sense of reality.

Lila's doctor Verazio indeed appears to be speaking of psychodrama:

> If we could cure fantasy through fantasy, we would have created a masterpiece. . . . Let us enact for the lady the story of her fantasy. . . . At last fantasy and reality will meet. (Goethe, 1968, p. 191f; translations are mine)

Goethe's words here remind us of Moreno's prescription for the use of psychodrama with psychotic patients, as described for example in a chapter entitled *Psychodramatic Treatment of Psychoses* (in Fox, 1987, p. 68–80). First the therapist enters the patient's reality and places his or her delusions and hallucinations in front of him through a psychodramatic enactment, with the help of what Moreno calls *auxiliary egos,* psychiatric aids, or other patients who play the different parts. Thus the patient sees his psychotic experiences objectified. In this fashion, the patient is brought out of his internal fantasy world and starts to relate to these new "anchors" on the psychodramatic stage. As more and more of these anchors are introduced to the stage, the patient regains his connection to his environment.

It is remarkable to see how Goethe's *Lila* contains elements of Moreno's psychodrama, although the term was of course unknown in Goethe's time. Goethe himself was, however, well aware of the psychotherapeutic significance of his play, as he stated in a letter dated October 1, 1818: "The subject is actually a psychological cure in which one lets madness enter in order to heal madness" (Goethe, 1968, p. 682). The name he chose for the doctor, *Verazio,* is formed from the Latin word *verax*, meaning truthful or speaking the truth. This reminds us of Moreno's definition of psychodrama as "the science which explores the 'truth' by dramatic methods" (Moreno, 1946, p. a).

Historians have generally attached little importance to the play. As one critic puts it: "*Lila*, an operetta presented on the Duchess Luise's birthday, was a work of less literary significance, apparently hastily put together by Goethe for the occasion" (Carlson, 1978, p. 28). Even more unimaginatively, another writes: "The Singspiel *Lila* is a piece of occasional poetry, whose origin and deeper meaning cannot be directly deduced from the text" (Gertrud Rudloff-Hille in: Goethe, 1968, p. 679).

A classical psychoanalyst writes about *Lila* in *Goethe: A Psychoanalytic Study,* in which he explains for several pages the importance of the fact that "Goethe was constipated on the day when he started to write *Lila*" (Eissler, 1963, p. 246). Perhaps not surprisingly, he sees support for analysis even in an example of a nonanalytic method:

> Far away as Verazio's therapeutic methods were from Freud's marvelous therapeutic instrument, it is valid to see in them a remote historical precursor. Thus *Lila* bears witness to Goethe's preoccupation with finding an intellectual program for removing the shadow that the unconscious throws upon the conscious mind. (Eissler, 1963, p. 237)

Moreno's and Freud's ideas were antithetical: Moreno emphasized dramatic action, whereas Freud stressed intellectual analysis.

In his own tribute to Goethe, Moreno was quick to point out that, although the play is *about* psychodrama, it is by no means itself a psychodrama. As a written play it is, rather, what Moreno called a *cultural conserve*—his term for the finished product of a creative effort that is then being repeated without spontaneity.

Reuchlein (1983) compared Goethe's ideas with other psychological views and concluded (on p. 57) that the healing methods exhibited in *Lila*, although part of a literary tradition, are also founded on views about psychotherapy proposed and practiced by progressive therapists of the period. He reported, for instance, that as early as 1758, Ernst Anton Nicolai had commented on the cure of a psychotic who believed that he carried an elephant's trunk instead of his nose. A surgeon put a cut in the man's nose and claimed he removed the trunk. Nicolai argued that this was an example of a cure effected through a

trick by pretending to believe in the patient's delusion and then removing it (Reuchlein, 1983, p. 52f).

In his discussion of *Lila*, Moreno reached the following conclusion:

> And if one wants to give full credit to Goethe, one can say that, at least to my knowledge, no other playwright has constructed *an entire play*, that is, *every scene, every word*, the *entire structure of the play*, to demonstrate drama itself as cure. (1973, p. 123)

Spontaneity in Goethe's Work

Although Moreno's previous point is well substantiated, it is more questionable to link Goethe to spontaneity and improvisation. Goethe is mostly known as a part, if not the beginning, of the tradition of German directors who took complete control of every aspect of the production. Nevertheless, Moreno stated:

> I was aware that Goethe was interested in impromptu theatre. In his book *Die Lehrjahre*, second book, ninth chapter, he wrote: "Spontaneity theater should be introduced into every theater. The ensemble should be trained regularly in this manner. The public would benefit if an unwritten play were produced once a month." (1973, p. 122)

Moreno was talking here about Goethe's novel *Wilhelm Meisters Lehrjahre*. In the chapter referred to, the protagonist and a group of friends are on a boat ride, when one of them suggests that they should improvise a scene. Everyone takes on a role, and they have to pay a forfeit whenever they fall out of character. They all enjoy the game with great wit and humor. During this game, they also pick up a stranger who immediately joins in and plays the role of a country priest. It is this man who is speaking in the passage Moreno quoted:

> "I find this exercise," said the stranger, "among actors, even in the company of friends and acquaintances, very useful. It is the best way to lead people out of themselves and after a detour back into themselves. It should be introduced to every company, that they have to practice sometimes in this way, and the audience would surely benefit if every few months a non-scripted piece would be performed, for which the actors of course would have to be prepared through several rehearsals."
>
> "One should not," added Wilhelm, "think of an impromptu piece as composed on the spur of the moment, but rather as having known plot, action, and division into acts and leaving the way of performing to the actor." (Goethe, 1962, p. 123)

This may be questionable, but it is certainly not uncommon to attribute statements by characters in Goethe's novels to their author. But even if we accept Moreno's thesis for staging plays in this fashion, the above quote, espe-

cially Wilhelm's response, conjures up images of Commedia dell'arte rather than Moreno's spontaneity theater. Moreno, however, rejected the idea that psychodrama or his theatre of spontaneity was derived from Commedia dell'arte (Moreno, 1946, p. 12; see also Scheiffele, 1995, p. 79–86).

As director of the Weimar Court theater from 1791 to 1817, Goethe directed only written plays—his own as well as others'. Carlson's (1978) account of Goethe as a director contains only one reference to improvisation: "Goethe's constant attention to rhythmic delivery eventually brought his actors to the point where, it is reported, they could even extemporize in blank verse" (p. 304).

Whereas this suggests that improvisation was not completely foreign to Goethe and his actors, the rest of the account seems to contradict, rather than support, Moreno's claim. Goethe was concerned with educating the audience and with a unified aesthetic effect. This drove him to exercise total precision and control.

> Goethe seemed to be seeking a striking and carefully composed stage picture—composed even down to the placement of the individual fingers and the angle of the head, as we see represented in paintings of Weimar productions and described in detail in Goethe's instructions to the young actor Heinrich Schmidt in 1801. (Carlson, 1978, p. 305f)

There is no talk about Goethe letting his actors explore their true emotions and expressing their creativity. On the contrary, the image we get is that of a director reducing the actors to robots expressing his own ideals of beauty. Goethe as a director thus epitomizes the kind of directing that Moreno rebelled against: the kind concerned with perfecting cultural conserves and reducing the actor to a tool.

Both Goethe and Moreno wanted to reform the theater that came before them (Table 1). Goethe found himself surrounded by sloppy theater and hence started to exercise strong control as a director. Moreno, in turn, rebelled against the theater that he found too controlled, predictable, and removed from the lives of the actors and the audience. Thus, he started to experiment with improvisation and audience involvement.

Whereas Goethe emphasized external qualities such as pronunciation, posture, appearance, and memorization, Moreno emphasized internal qualities such as spontaneity, truthfulness, and creativity. Moreno was intent on exploring the actors experience; Goethe was mainly concerned with the effect on the spectator.

Conclusion

Goethe's play *Lila* did represent a precursor of some principles of psychodrama; but as a director, Goethe's actual style and emphasis were sup-

TABLE 1
A Listing of Goethe's and Moreno's Ideals of Acting

Goethe's acting	Moreno's acting
External	Internal
For the (passive) audience	For the actor/active spectator
Self-concealment	Self-revealing
Memorized	Improvised
Controlled	Expressive
Aesthetic goals	Therapeutic goals
Professional actors	Nonprofessional actors
Proscenium stage	Open stage
Poetic language	Natural language
Ensemble work	Spectators join actors
Classic themes	Personal themes

porting highly conserved productions and led to exactly the kind of theater that Moreno condemned.

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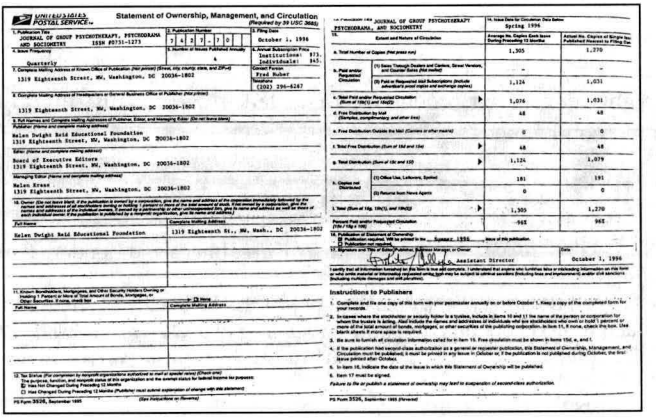

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