Self-leadership was developed as a tool for clients to moderate their own psychiatric symptoms within Internal Family Systems (IFS) therapy (Schwartz, 2013). IFS therapy defines the self as the central leader and moderator of psychiatric symptoms, whereas self-leadership refers to the ability to comfort, regulate, and improve one’s psychiatric symptoms by achieving a state of mindfulness and nonjudgmental awareness. Similar to a family dynamic, parts of a personality may cause conflict and extremes in the family system of a person’s inner psyche, and the self cultivates cooperation within the internal ecosystem so as to be a caregiver to traumatized, sad, or resentful parts that result from psychiatric symptoms. The purpose of the present study was to investigate
the relationship between self-leadership and psychiatric symptoms. Foundational to IFS therapy is the notion that self-leadership can reduce the symptoms experienced by many of those patients suffering from mental illness (Schwartz, 1995). Self-leadership is characterized by the traits of compassion, objectivity, nonjudgment, creativity, and calmness. Schwartz described working with patients who experienced severe childhood trauma who, during the course of IFS therapy, were able to instantly access a mindful state that is a hallmark trait associated with the self. This mindful state is an indicator of the presence of self-leadership and is necessary for a client to develop the skills needed to generate their own ability to calm the psychiatric symptoms (Schwartz, 1995; Sweezy & Ziskind, 2013). Schwartz observed in clinical sessions that traits of self-leadership are lower before beginning therapy and associated with greater psychiatric symptoms. Based on these clinical observations, it has been proposed that the enhanced coping abilities associated with adequate self-leadership would lead to a reduction in symptoms of prevalent psychiatric disorders such as anxiety, depression, and posttraumatic stress disorder (PTSD; Schwartz, 1995). These enhanced coping abilities can take the form of mindful observation of extreme emotions, being present with sadness and anger, developing independent internal conflict resolution strategies, and learning to self-soothe (e.g., baths, quiet time, walks).

Although IFS therapy is currently used in several countries to treat different psychiatric disorders (e.g., anxiety, depression, PTSD; Anderson, 2013; Schwartz, 2013; Sweezy & Ziskind, 2013; Twombly, 2013; Wonder, 2013), empirical research investigating associations between self-leadership and mental health is limited. Previous correlational studies have examined self-leadership in connection with stress, coping styles, physical health, and workplace outcomes (Dolbier et al., 2001, 2010), marital problems (Green, 2008), and body dissatisfaction (Bezner et al., 1997). For example, one study found that higher self-leadership was correlated with reduced stress, healthier coping styles, increased optimism, better health, and improved work outcomes (Dolbier et al., 2001). Another study reported positive correlations between self-leadership and stress-related growth (Dolbier et al., 2010). However, to our knowledge, no studies outside of clinical observations have yet examined the relationship between self-leadership and psychological symptoms in a community sample. Given that specific case studies suggest that IFS therapy may reduce symptoms associated with different psychiatric conditions (Schwartz, 1995; Sweezy & Ziskind, 2013), there is reason to hypothesize that higher levels of self-leadership would be associated with fewer symptoms of anxiety, depression, and PTSD. The self-report questionnaires assessing psychological symptoms used in the present study are directly related to Schwartz’s clinical observations of the presence of anxiety, depression, and PTSD symptoms. In the current study, we tested this hypothesis in a nonclinical undergraduate sample of adults with primarily subclinical levels of self-reported psychiatric symptoms.

It is also unknown whether self-leadership is associated with other well-established psychological measures of self-related thought. Several studies have demonstrated relationships between self-referential cognition and psychiatric conditions, in particular when the self-focused thoughts are concentrated on negative aspects about oneself (e.g., “I am worthless”). Using a variety of different measures, a greater bias toward negative self-focused cognition has been consistently documented in depression (Hards et al., 2020; Ingram et al., 1987; Ingram & Smith, 1984; Joormann et al., 2006; Kaiser et al., 2018; Nolen-Hoeksema et al., 2008; Siegle et al., 2004; Smith & Greenberg, 1981) as well as in social anxiety/social phobia in both clinical and nonclinical populations. Consequently, in the present study, we included several self-report scales and an open-ended sentence completion task to assess both negative and positive aspects of self-related thought, including self-consciousness, rumination, self-reflection, and self-focused thought that is either positively or negatively valenced (Ingram et al., 1987; Ingram & Smith, 1984; Woodruff-Borden et al., 2001). Characterizing the relationship between self-leadership and other measures of self-referential cognition could help support the convergent validity of self-leadership and may further refine the construct of self-leadership as defined within IFS.

In the current study, we first examined how self-leadership relates to mental health based on self-report measures of depression, anxiety, PTSD, and social anxiety symptoms in a sample of undergraduates. Second, we investigated the relationship between self-leadership and positive and negative features of self-related thought using self-report measures and a sentence completion task. The hypotheses were twofold: (a) Self-leadership was expected to negatively correlate with psychological...
symptoms, and (b) self-leadership was expected to be associated with lower levels of negative self-focus (e.g., rumination), but higher levels of positive self-reference (e.g., self-reflection).

**Method**

**Participants and Procedure**

We collected data from undergraduate students ages 18 to 61 years of age \((n = 166; 27\text{ male}/131\text{ female})\) enrolled in psychology courses at a Midwestern University. The average (SD) age of participants was 23 years old (7.1). Participants had varying levels of education including some college (20.2%), associate’s degree (16.5%), bachelor’s degree (18.6%), professional degree (17.6%), and doctoral degree (2.1%). Greater than half of participants were European American/White (56%), approximately one third of participants were African American/Black (32%), and the remaining participants were Hispanic/Latino (4.8%), Asian/Pacific Islander (3%), and other (6.6%). All participants gave informed consent according to a protocol approved by the Institutional Review Board. All students received course credit for their participation in the study. See Table 1 for all study variables (described below).

**Measures**

**Self-leadership scale.** This scale (Steinhardt et al., 2003) was used to measure self-leadership as defined by IFS. This scale has 20 items measuring qualities that are considered hallmarks of self-leadership including calmness, confidence, creativity, courage, and compassion. Participants rate each item on a scale from 1 (almost never/never occurs) to 5 (almost always/always occurs). Some example items include, “I feel a sense of inner peace” or “I treat myself with kindness.” Higher scores on this scale indicate higher levels of self-leadership (e.g., optimal psychological well-being, mindfulness, non-judgmental awareness). The internal consistency of the self-leadership scale in the present sample was high (Cronbach’s \(\alpha = .94\)).

**The Beck Depression Inventory-II.** This scale (BDI-II; Beck et al., 1996) was chosen to measure self-reported symptoms of depression. The BDI-II is one of the most widely used tools to assess depression symptoms (Beck et al., 1996). Psychometric studies have provided support for good convergent and discriminant validity of the BDI-II (Schotte et al., 1997; Steer et al., 1997). The BDI-II consists of 21 items that assess depressive symptoms such as worthlessness, loss of energy, and fatigue. Each item is rated on a scale from 0 (an absence of symptoms) to 3 (maximum severity). Example options for worthlessness item range from “I do not feel I am worthless” to “I feel utterly worthless.” The scores across all items were summed up to calculate the total depression score for each participant. Total depression scores can range from 0 to 63, with higher scores indicating greater severity of depressive symptoms. The internal consistency of the BDI-II in the present sample was high (Cronbach’s \(\alpha = .94\)).

**The Beck Anxiety Inventory.** This scale (BAI; Beck & Steer, 1990) was selected to measure self-reported anxiety symptoms because it has evidence for adequate convergent and discriminant validity (Fydrich et al., 1992; Steer et al., 1993). The BAI consists of 21 items that measure situations, sensations, and thoughts that are associated with anxiety. Items on the BAI are rated on a scale from 0 (not at all) to 3 (severely). Some example items include “numbness or tingling” and “difficulty in breathing.” Scores across all items were then summed up to compute a total anxiety score. The anxiety scores can range from 0 to 63, and higher scores indicating greater anxiety. The internal consistency of the BAI in the present sample was high (Cronbach’s \(\alpha = .93\)).

**PTSD Checklist for DSM-5.** The checklist (PCL-5; Weathers et al., 2013) is a 20-item questionnaire used to assess PTSD symptoms (Blevins et al., 2015), including re-experiencing, avoidance, negative alterations in cognition and mood, and
hyperarousal. Participants rate how much they were bothered by their symptoms in the past month from 1 (not at all) to 5 (extremely). Some examples include “repeated, disturbing dreams of the stressful experience” and “avoiding memories, thoughts, or feelings related to the stressful experience.”

Psychometric research suggests that the PCL-5 has good internal consistency (Cronbach’s α = .96), test-retest reliability (r = .84), and convergent and discriminant validity (Bovin et al., 2016). For the present study, we focused on total PTSD severity scores, which were calculated by summing the scores across all items. The internal consistency of the PTSD checklist for DSM-5 in the present sample was high (Cronbach’s α = .96).

**Self-Consciousness Scale-Revised.** This scale (SCSR; Scheier & Carver, 1985) is a 23-item self-report questionnaire designed to measure thoughts and behaviors related to personal insight and self-focused attention. Psychometric analysis of this questionnaire has revealed adequate internal consistency (Cronbach’s α = .75-.84), test-retest reliability (.74-.77), and evidence for convergent and discriminant validity (Carver & Glass, 1976; Scheier & Carver, 1985; Turner et al., 1978). Some example items include “I’m quick to notice changes in my mood” and “I think about myself a lot.” For each item, participants used a 4-point rating scale ranging from 0 (not at all like me) to 3 (a lot like me). Separate scores were computed for the three subscales of the self-consciousness scale used most frequently in clinical and subclinical populations (Hope & Heimberg, 1988; Ingram & Smith, 1984; Jostes et al., 1999): Public Self-Consciousness, Private Self-Consciousness, and Social Anxiety. Higher scores on the SCSR indicate greater levels of self-consciousness (Cronbach’s α = .75), private self-consciousness (Cronbach’s α = .80), and social anxiety (Cronbach’s α = .85) and comparable to previous studies (Scheier & Carver, 1985). The Public and Private Self-Consciousness subscales were included in self-related thought measures whereas the Social Anxiety subscale was included in the psychopathology measures.

**Rumination-Reflection Questionnaire.** This questionnaire (Trapnell & Campbell, 1999) is a 28-item self-report questionnaire assessing aspects of ruminative thought or negative self-related thought patterns (e.g., “Often I’m playing back over in my mind how I acted in a past situation”) and self-reflection (e.g., “I love exploring my inner self”). Participants rated each item on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). As in previous studies, scores were calculated separately for Self-Rumination and Self-Reflection subscales (Trapnell & Campbell, 1999). Psychometric research indicates that these subscales have good convergent and discriminant validity (Trapnell & Campbell, 1999). In the current sample, the internal consistency was high for the Self-Rumination (Cronbach’s α = .92) and Self-reflection subscales (Cronbach’s α = .87).

**Self-Focus Sentence Completion Task.** This measure assessed self-focus and researchers have provided evidence for its reliability and validity based on six validation studies using large normative and clinical samples (Exner, 1973). For the sentence completion task, participants were given 30 different sentence stems to complete (e.g., “I think… or “My father…”). Participants were instructed to complete each sentence as they wished, with no other instruction regarding the content of their responses. As in previous research (Exner, 1973), each participant’s response was scored based on four focus categories: (a) self-focused (e.g., I think… “therefore I am.”), (b) other-focused (e.g., It upsets me when… “the Cardinals do not win.”), (c) self- and other-focused (e.g., If only I would… “have enough money to support myself and my family.”), or (d) non-person-focused (e.g., When I look in the mirror… “I see a reflection.”). We also coded each response for overall valence (as in Ingram & Smith, 1984), including positive, negative, and neutral, which resulted in focus-by-valence categories. Total scores corresponded to the sum of all responses for each response category. Four pairs of two raters, blinded to the other behavioral data, were trained in sentence completion task coding in two steps. The raters first separately scored all responses for focus and valence. Using a two-way random effects intraclass correlation coefficient, interrater reliability was calculated for these initial ratings for this group and adequate interrater reliability was found for each response category included in the analyses (self-negative responses = .85; self-positive responses = .87; reliability was averaged across raters), which was within acceptable limits (Exner, 1973). Second, the raters conferred and agreed on a final code for each response (e.g., self-focused and positive valence). The final codes for the total proportion of self-negative and self-positive responses were used in the present study (e.g., total number of self-focused negative responses / total self-focused responses).
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Data Analysis
We used SPSS 25 for all data analysis. We performed two separate multiple regression analyses to examine the association between self-leadership and measures of psychopathology and self-related thought. For each regression, we performed outlier tests using established tests of influence in regression with the following criteria: Cook's distance > 1 (Cook & Weisberg, 1982), leverage > .13 (Stevens, 2012), and Mahalanobis distance > 15 (Barnett & Lewis, 1994). Based on these tests, number of outliers varied between 0, 1, 4, 5, or 6 depending on the regression. We deleted the participant outlier score only for that specific regression analysis as opposed to using listwise deletion for outliers.

Demographic information was not available for all participants (missing age for n = 25; gender for n = 8; education for n = 15; ethnicity for n = 15), therefore analyses reported below controlling for demographic variables did not include these participants. A few participants (n = 5) were also missing for depression, anxiety, and PTSD measures. In this case, these participants were not included in the analyses with these psychopathology measures, but they were included in the other analyses.

Results
Demographic Information
Age was significantly correlated with self-reflection, r = .31, p < .001, but not with any other psychological symptoms or self-related thought variables (p ≥ .28–.95). Differences between female and male participants were present for anxiety, t(154) = -3.87, p < .001, social anxiety, t(156) = -3.07, p = .003, self- rumination, t(153) = -2.06, p = .041, and self-reflection variables, t(155) = -3.87, p < .001. There was a significant difference in education level for positive, F(6,142) = 4.33, p < .001, and negative, F(6,142) = 7.48, p < .001, self-related responses on the sentence completion task, but not for any other variables (p ≥ .11–.98). There was a significant difference in ethnicity for self-leadership, F(4, 144) = 2.88, p = .025, but not for any other variables (p ≥ .13–.75). As a result of these analyses and outlier tests, we also report the results of two follow-up multiple regression analyses controlling for age, gender, education, and ethnicity and excluding outliers in all analyses below.

Self-Leadership and Psychological Symptoms
Consistent with our first hypothesis, participants who scored higher on self-leadership had significantly fewer psychological symptoms across almost all measures including self-report symptoms of depression, f(156) = -9.34, p < .001, PTSD, f(156) = -2.16, p < .05, f(2) = .03, and social anxiety, f(156) = -5.73, p < .001, f(2) = .21. Self-leadership was not significantly related to anxiety symptoms, f(156) = 1.00, p = .32. Collinearity statistics for all variables were within normal limits: VIF = 1.1–1.9, tolerance = .5–.9. All results remained significant after controlling for age, gender, education, and ethnicity and excluding outliers (see Table 2).

Self-Leadership and Measures of Self-Related Thought
In line with our second hypothesis, self-leadership was inversely correlated with almost all measures assessing negative aspects of self-related thought, and positively correlated with measures assessing positive aspects of self-related thought. Specifically, higher levels of self-leadership were associated with lower levels of self- rumination, f(159) = -2.83, p = .005, f(2) = .05, and negative self-related responses on the sentence completion task, f(159) = -3.09, p = .002, f(2) = .06. On the other hand, higher levels of self-leadership were associated with greater levels of self-reflection, f(159) = 4.29, p < .001, f(2) = .12, and positive self-related responses on the sentence completion task, f(159) = 2.34, p = .021, f(2) = .03. There was no significant relationship between self-leadership and private self-consciousness, f(159) = -0.67, p = .51, or public self-consciousness, f(159) = -0.51, p = .61. Collinearity statistics for all variables were within normal limits: VIF = 1.1–1.9, tolerance = .5–.9. After controlling for all demographic variables and removing outliers, all results remained significant (see Table 3).

Discussion
In the present study, we investigated the connections between self-leadership, psychological symptoms, and self-related thought in a nonclinical setting. Our results supported our hypotheses. First, we found that higher levels of self-leadership were associated with less severe self-reported symptoms of depression, PTSD, and social anxiety even after controlling for age, gender, education, and ethnicity. Second, we also demonstrated that higher levels of self-leadership were correlated with reduced negative self-related thought as well as greater positive self-reference.

Our results indicating that higher levels of
self-leadership were correlated with diminished psychological symptoms are consistent with past research on self-leadership in nonclinical samples showing enhanced psychological functioning (e.g., healthy coping styles), reduced stress, greater perceived wellness, and stress-related resilience (Bezner et al., 1997; Dolbier et al., 2001, 2010). To our knowledge, this was the first empirical study to reveal a (negative) correlation between the self-leadership scale and psychological symptoms of depression, PTSD, and social anxiety in a nonclinical sample. Importantly, these findings remained significant after controlling for age, gender, education, and ethnicity. Broadly, our results are consistent with the IFS model, in which appropriate self-leadership as cultivated through IFS therapy is thought to be associated with reduced symptoms in patients with mental health conditions (Anderson, 2013; Schwartz, 1995, 2013; Sweezy & Ziskind, 2013; Twombly, 2013; Wonder, 2013). However, the present findings were correlational and based on a nonclinical sample of individuals with lower levels of psychological symptoms. As a result, replication in a clinical sample will be necessary. A recent randomized control trial suggested that IFS may be associated with sustained increases in self-compassion and decreases in depressive symptoms (Shadick et al., 2013). This is relevant to our findings because the largest effect size we found was for the analysis relating self-leadership to depressive symptoms. However, Shadick et al. did not assess changes in self-leadership. Longitudinal treatment studies will be necessary to investigate whether IFS therapy increases self-leadership and diminishes psychiatric symptoms in clinical samples and how IFS differs from other forms of therapy in promoting self-leadership.

When comparing self-leadership with other measures of self-related thought, we identified distinct relationships with both negative and positive aspects of self-referential cognition. Specifically, self-leadership was inversely correlated with lower levels of self-rumination after covarying for demographic factors. These findings are consistent with a previous study in undergraduate students reporting a negative correlation between self-leadership and ineffectiveness or the tendency to perceive oneself as inadequate, worthless, and insecure (Dolbier et al., 2001). By contrast, greater self-leadership was positively correlated with increased positive self-reference on the sentence completion task. Our results mirror prior work demonstrating relationships between self-leadership and increased optimism (Dolbier et al., 2001), physical self-esteem (Bezner et al., 1997), and stress-related growth (Dolbier et al., 2010). Given that self-leadership is comprised of qualities such as compassion and confidence, it is not surprising that greater self-leadership would be related to both diminished negative self-reference and increased positive self-perception. Our findings are also relevant to compassion-focused therapy, which includes training individuals to cultivate self-compassion (Gilbert, 2009; Gilbert & Irons, 2018). Similar to research on self-leadership, greater self-compassion has been associated with several benefits to psychological and physical health (see Bluth & Neff, 2018, for review). Together, these findings also provide support for convergent validity of the self-leadership scale as a measure of positive aspects of self-referential cognition. This is particularly relevant to IFS therapy, which seeks

### TABLE 2

<table>
<thead>
<tr>
<th>Psychological Symptom Measures</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>-.58</td>
<td>.10</td>
<td>-.45</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.06</td>
<td>.08</td>
<td>.06</td>
<td>.46</td>
</tr>
<tr>
<td>PTSD</td>
<td>-.12</td>
<td>.06</td>
<td>-.19</td>
<td>.03</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>-1.27</td>
<td>.26</td>
<td>-.34</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Note. PTSD = posttraumatic stress disorder.

In a follow-up multiple regression analysis controlling for age, gender, education, and ethnicity and excluding outliers, relationships between self-leadership and all psychological symptom measures remained significant, except for anxiety. Collinearity statistics were within the normal limits: VIF = 1.1–2.0, tolerance = .5–.9. Participants without age, gender, education, or ethnicity information were not included in the multiple regression analyses.

### TABLE 3

<table>
<thead>
<tr>
<th>Self-Related Thought Measures</th>
<th>B</th>
<th>SE</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Self-Consciousness (SCSR)</td>
<td>-.04</td>
<td>.31</td>
<td>-.01</td>
<td>.89</td>
</tr>
<tr>
<td>Public Self-Consciousness (SCSR)</td>
<td>-.20</td>
<td>.31</td>
<td>-.07</td>
<td>.52</td>
</tr>
<tr>
<td>Self-Rumination (RRQ)</td>
<td>-.48</td>
<td>.14</td>
<td>-.35</td>
<td>.001</td>
</tr>
<tr>
<td>Self-Reflection (RRQ)</td>
<td>.40</td>
<td>.16</td>
<td>.25</td>
<td>.01</td>
</tr>
<tr>
<td>Negative Self-Related Responses (SCT)</td>
<td>-.1658</td>
<td>7.83</td>
<td>-.19</td>
<td>.04</td>
</tr>
<tr>
<td>Positive Self-Related Responses (SCT)</td>
<td>20.93</td>
<td>6.75</td>
<td>.26</td>
<td>.002</td>
</tr>
</tbody>
</table>

Note. SCSR = Self-Consciousness Scale-Revised; RRQ = Rumination–Reflection Questionnaire; SCT = Sentence Completion Task.

In a follow-up multiple regression analysis controlling for age, gender, education, and ethnicity and excluding outliers, all relationships remained significant, except for private and public self-consciousness. Collinearity statistics were within the normal limits: VIF = 1.2–2.3, tolerance = .5–.9. Participants without age, gender, education, or ethnicity information were not included in the multiple regression analyses.
to cultivate a healthy and mindful self (Schwartz, 1995; Sweezy & Ziskind, 2013). In future studies, it would be interesting to explore whether established measures of self-related thought also change after successful treatment with IFS therapy.

Our results suggest that self-leadership is not entirely explained by the self-referential cognition measures. The associations between self-leadership and self-rumination and positive self-related responses on the sentence completion task revealed small effect sizes ($f^2 < .05$). More generally, these measures of self-related thought do not appear to be overlapping with all of the characteristics of self-leadership. Given that self-leadership is defined by calmness, confidence, creativity, courage, and compassion, it is possible that self-leadership may be more highly correlated with measures that specifically assess those traits. Relatedly, cultivating self-leadership relies in part on engaging cognitive skills associated with mindfulness, including the ability for the self to control the more undesirable aspects of one’s personality and psychiatric symptoms (Schwartz, 1995). Further, mindfulness based stress reduction training and greater trait mindfulness have been associated with reduced psychological symptoms across different psychiatric disorders, including depression, anxiety, PTSD, and social anxiety (Boyd et al., 2018; Chi et al., 2018; Hjeltnes et al., 2018; Hoge et al., 2013; Paul et al., 2012). As such, measures of trait mindfulness may provide stronger support for the convergent validity of the self-leadership scale. However, additional research will be needed to further establish the convergent and discriminant validity of this scale.

There are limitations to this study that should be mentioned. First, our study used an undergraduate sample with self-reported psychological symptoms not assessed by a clinical psychologist and with relatively low levels of symptoms, possibly limiting the generalizability of the findings. Further studies will be critical to determine whether these findings replicate in other populations such as middle-aged or older adults as well as individuals diagnosed with psychiatric conditions. Second, there are several possible confounding variables such as sleep quality, exercise, and drug use that were not measured in the present study. Given that our sample was comprised of undergraduate students, these factors might have influenced our findings (Fox, 2000; Singleton & Wolfson, 2009). For example, given that increased alcohol consumption and poor sleep quality have been associated with worse academic performance in undergraduate samples (e.g., Singleton & Wolfson), these same factors may have a general impact on ratings for the self-report measures. It is also possible that regular physical exercise may increase positive self-regard because exercise has been associated with greater self-esteem (Fox, 2000). Third, we had fewer male participants in our sample, which may limit our ability to generalize these results. Fourth, we did not examine measures that were entirely distinct from self-leadership, which could more precisely assess discriminant validity. Thus, additional research should investigate discriminant validity of the self-leadership scale in more detail. Fifth, we focused only on self-leadership and not the various components of the IFS theory, such as the distinction between self and parts. Additional research is warranted to examine whether measure of the parts or subpersonalities described in IFS theory also align with psychological research related to self and personality. Future studies may also help clarify the similarities and differences between self-leadership defined within IFS and the concept of self-leadership defined in industrial organizational psychology as a form of leadership that challenges common notions of how followers take after workplace setting supervisors (Shek et al., 2015). Self-leadership as defined in industrial organizational psychology involves leading oneself to perform work in a timely manner and to provide internal motivation to carry out workplace responsibilities (Manz, 1986; cf. Stewart et al., 2019). Effective self-leadership has been associated with better workplace outcomes, enhanced socialization for new employees, and favorable personality characteristics (Amundsen & Martinsen, 2015; Cranmer et al., 2019; Ho & Nesbit, 2018; Stewart et al., 2019).

Conclusion

In sum, we provided novel empirical evidence for a connection between the concept of self-leadership in IFS and symptoms of depression, PTSD, and social anxiety in a nonclinical sample. We also found evidence for convergent validity between self-leadership and traditional measures of self-related thought. Although these results await replication in a clinical sample, these findings suggest that self-leadership may be useful as a dimensional measure of more positive aspects of self-referential cognition.


Shek, D. T. L., Ma, C. M. S., Liu, T. T., & Siu, A. M. H. (2015). The role of self-leadership in service leadership. International Journal on Disability and
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https://doi.org/10.1337/j002-3514.76.2.284

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This study was supported by the University of Missouri–St. Louis Undergraduate Research Grant Program.
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