Universitas Negeri Padang & Ikatan Konselor Indonesia
Editorial Office: Jurusan Bimbingan dan Konseling | Faculty of Education | Universitas Negeri Padang
Jl. Prof. Dr. Hamka Air Tawar Barat, Kota Padang, Sumatera Barat, 25130, Indonesia.
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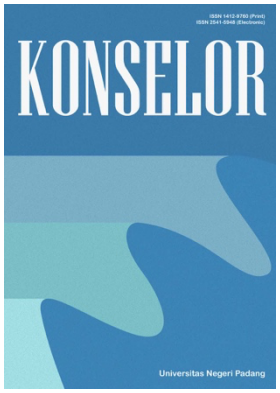
Volume 12 Number 2 2023



KONSELOR

ISSN 1412-9760 (Print) | ISSN 2541-5948 (Online)
Editor: Rima Pratiwi Fadli

Publication details, including author guidelines
URL: https://counselor.ppj.unp.ac.id/index.php/konselor/about/submissions

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Article History
Received: Friday, May 12, 2023
Revised: Sunday, May 28, 2023
Accepted: Monday, June 19, 2023

How to cite this article (APA)
Sugara, et al., (2023).Dialectical behavior therapy in the treatment of perfectionism: A Single case design. KONSELOR, 12(2), 95 - 110 https://doi.org/10.24036/0202312246-0-86

The readers can link to article via https://doi.org/10.24036/0202312246-0-86

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ISSN 1412-9760 (Print)
ISSN 2541-5948 (Electronics)

Original Article

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Dialectical behavior therapy in the treatment of perfectionism: A Single case design

Gian Sugiana Sugara♦, Alin Puspitawati, Cucu Arumsari, Anandha Putri Rahimsyah, & Muhammad Muhajirin

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Abstract: The primary goal of the study is to investigate the effect of dialectical behavior therapy in the treatment of perfectionism in high school students. Method research using single-case experimental research with an A-B-A design Participants consisted of three students (N = 3) who indicated non-perfectionism, maladaptive perfectionism, and mixed maladaptive perfectionism. The intervention of dialectical behavior therapy in the treatment of perfectionism was carried out in eight sessions. Treatment focused on developing mindfulness, distress tolerance, interpersonaleffectiveness, and self-regulation. Participants completed the Frost MultidimensionalPerfectionism Scale. Data were collected before, during, and after the DBT intervention. The results showed that dialectical behavior therapy was effective for dealing with maladaptive perfectionism during and after the intervention. This preliminary evidence suggests the potential feasibility of using DBT in school settings.

Key Words: Perfectionism; Dialectical behavior therapy; Single case design

Introduction

Adolescents who set high standards and pursue perfection in their lives are prone to experiencing feelings of depression when they fail to get something according to the expectations they have set (Frost, 1998). Adolescents who set high standards and pursue perfection unrealistically are more vulnerable to low achievement because they will not complete a job if it feels perfect to them (Jayanti, 2004). In line with the results of Laforge's research (2005), it revealed that individuals who set high self-standards and pursue perfection experience difficulties in completing a task, resulting in a delay in processing (procrastination), because individuals often feel a sense of demand. Frost et al. (1990) explained that adolescents who set high standards and pursue perfection are prone to experiencing negative feelings such as anxiety, depression, and doubt, which can affect self-esteem.

Research conducted by Hewitt & Flett (1991) on 22 individuals who experienced major depression and 13 people who experienced anxiety revealed that individuals who experienced major depression had very high standards for pursuing perfection in their life orientation. As for research conducted in Indonesia, Hendartono & Ambarwati (2020) revealed that there is a uniform influence between individuals who set high standards in their lives and psychological distress. Then the results of research by Aditomo & Retnowati (2004) revealed that setting high standards in life and self-esteem are two personality variables or personality traits that play a role in depression. Based on the thoughts of Margareta & Wahyudin (2019), individuals who set high standards and pursue perfection are perfectionists. According to the opinion of Hewitt & Fleet (1991), which defines perfectionism as a personality trait where individuals try to achieve perfection and set very high goals consisting of

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intrapersonal and interpersonal aspects. Frost et al. (1990) explain perfectionism as setting high self-standards to achieve a perfect result, and this will cause a problem if followed by critical self-evaluation. Furthermore, Thomas (2018) defines perfectionism as ideal self-expression accompanied by ambition to achieve the best goals and a demand to be perfect and not easily accept something that is not in line with his wishes.

Perfectionism can also have positive or negative effects in life; it can lead individuals to success or make them experience psychological problems (Winata, 2008). Individuals who set high standards accompanied by a sense of pride in their performance and can achieve high achievements mean that perfectionism has a positive impact on individuals, but individuals who feel dissatisfied with their performance, have no tolerance for mistakes, and are too critical of themselves mean that perfectionism has a negative impact (Chang, 2014; Sugara et al., 2020a).

In line with Hamack (1978) explains that perfectionism is divided into two types: normal perfectionism and neurotic perfectionism. According to Rice et al. (1998), individuals with normal perfectionism set achievement standards according to their limitations and strengths. Individuals with normal perfectionism will get a feeling of pleasure and pride for what has been done seriously (Hawkins et al., 2006; Sugara et al.,2020b). Meanwhile, individuals with neurotic perfectionism do not feel satisfied with what they have done (Hamack, 1978). Neurotic perfectionism can have detrimental and consequential impacts on individuals and the environment, with effects that can contribute negatively to psychological and physical development, such as physical health through stress pathways including ulcers, headaches, migraines, chronic fatigue, and hypertension (Patterson, 2021). Then Frost et al. (1990) explained that perfectionism is divided into two, categories: adaptive perfectionism, which sets high self-standards, and maladaptive perfectionism, which sets very high self-standards based on fear of making mistakes, doubts in acting, and feeling the demands and feelings of criticism from parents. According to different opinions expressed by Stober et al. (2007), perfectionism is divided into three groups: healthy perfectionism or adaptive perfectionism, where individuals show high levels of perfectionism, but have low attention levels; unhealthy perfectionism or maladaptive perfectionism, which shows a high level of perfectionism, as well as high attention to perfectionism; and finally, non-perfectionism, which shows a low level of perfectionism efforts.

Frost et al., (1990) explained that maladaptive perfectionism is a structure that causes individuals to experience negative feelings such as feeling lonely and helpless. The same thing was explained by Aditomo (2004): the higher the individual's perfectionism, the higher the tendency to experience depression. Strengthened by the results of research by Argus & Thompson (2008), which revealed that maladaptive perfectionism is consistently associated with negative psychological outcomes such as depression and a lower level of self-esteem (Wang et al., 2007). Also, maladaptive perfectionism plays a role in the occurrence of psychological distress (Gnilka et al., 2012). In addition, the research of Lubis et al. (2020) revealed that maladaptive perfectionism has an impact on low academic achievement. This is due to two things: firstly, because maladaptive perfectionism finds it difficult to accept the limitations of abilities that exist in oneself, and secondly, because maladaptive perfectionism finds it difficult to accept that one can make mistakes or experience failure, which makes them unable to behave productively in carrying out academic activities.

Adaptive perfectionism describe when individuals have high self-standards and try to do something perfectly and are accompanied by the ability to accept failure, this will provide positive energy to achieve the best expectations that can be achieved (Maria & Flores, 2015). However, individuals with maladaptive perfectionism have no tolerance for failure or mistakes (Frost et al., 1990). Therefore, Linehan (2015) explains that emotional acceptance and response to an event with excess will result in low self-control, resulting in various negative feelings, such as difficulty tolerating pressure and diverting attention from emotional impulses, reacting excessively to emotional impulses, engaging in risky actions that ultimately undermine oneself, ignoring self-controlling emotions, and even criticizing oneself (Dimeff & Linehan, 2001). To deal with this, responsive services such as individual counseling can be carried out (Stober, 2018). One of the interventions that can be used to treat perfectionism is dialectical behavior therapy (Little & Codd, 2020).

Lynch et al., (2006) suggest that dialectical behavior therapy is formulated for individuals who feel they are always controlled, are closed to new experiences, are perfectionists, have cognitively rigid behavior, and are very risk averse. Dialectical behavior therapy will help the client reduce emotional dysregulation and ineffective coping behaviors and help the client achieve a life he does not want to avoid and a life worth living (Linehan, 1993). In addition, dialectical behavior therapy is also a psychotherapeutic intervention that helps clients manage negative emotions, change mindsets, and change wrong habits (Hidayati et al., 2021; Sari et al., 2022), and dialectical behavior therapy will help individuals accept situations that are beyond their control so that they can reduce the disappointment caused by an event (Linehan, 1993).

Specifically, the purpose of dialectical behavior therapy has four hierarchies of objectives: reducing behavior that can be life-threatening, reducing behavior that can interfere with ongoing counseling, reducing behavior that can reduce the quality of life, and increasing skills in behavior (Syafitri & Nuryono 2020). In addition, Supratno (2014) suggests that dialectical behavior therapy can reduce feelings of helplessness, and expressions of anger, increase social adjustment abilities, and improve individual quality of life. In dialectical behavior therapy, individuals are invited to realize and accept what is happening to them, then guided to make changes to what they feel is not right (Nuryono et al., 2020). Many researchers use dialectical behavior therapy, and it is proven to be effective for various problems, especially problems related to emotions, including Hidayati's research (2021), which revealed that dialectical behavior therapy has proven effective in treating patients who are victims of violence and are at risk of suicide. Furthermore, Suprapto's research (2014) suggests that dialectical behavior therapy can reduce feelings of helplessness and expressions of anger, increase social adjustment abilities, and improve individual quality of life. In addition, research by Syafitri & Nuryono (2020) shows that dialectical behavior therapy has proven to be effective for individuals with PTSD in reducing negative emotions and dealing with problems of emotional dysregulation.

Dialectical behavior therapy focuses on healing in four key areas. First, mindfulness, in this case, trains individual focus, whose goal is to increase one's ability to receive and be present in the current moment. Second, distress tolerance, in this case, aims to increase one's negative emotional tolerance, rather than trying to avoid it. Third, emotion regulation includes strategies to manage and change intense emotions that cause problems in one's life. Fourth, interpersonal effectiveness consists of techniques to enable a person to be able to communicate with others assertively, maintain self-esteem, and strengthen relationships (Linehan, 1993; Rilla, 2021).

METHOD

Ethical Approval

Before counseling is carried out, the researcher explains in advance the implementation procedures that will be carried out in the counseling session and then makes contracts and agreements with each counselee. After approval and a counseling contract, each counselee is asked to fill out an information sheet about himself to be collected and used as a case study. Each counseling session is recorded with the consent of the counselee, and an opportunity is given to the counselee if the counselee feels like stopping to be recorded. Then the counselee is also allowed to comment and change the counselee's details before publication.

Participants

In this study, the researcher conducted counseling with three students based on the results of the pretest, namely students with a total score obtained categorized as non-perfectionism, maladaptive perfectionism, and mixed-maladaptive perfectionism, which were used as experimental objects. The age of the counselee ranges from 15 to 16 years. The names of the counselees below are not their real names due to confidentiality.

https://doi.org/10.24036/0202312246-0-86

Participant 1. Dinda is a 15-year-old girl; the counselee is a student at High School in Tasikmalaya class X. The counselee currently lives with his family and parents; the counselee is the first child of two siblings; the counselee's relationship with his family is very good; and the counselee is very close to his family. Basically, the counselee is someone who has a quiet attitude, rarely leaves the house, and is also shy, especially when entering a new environment. Because this shy nature causes the counselee to become someone who is quite ignorant of what he does, the counselee does not have more will for himself, as if doing something he does not try or hope to do well or perfectly, has fewer feelings of regret when getting results that are unsatisfactory, and does not care about the things that are around him. In addition, the counselee also explained that he always procrastinated on assignments because he did not expect to get more than what happened to him.

Participant 2. Shinta is a 16-year-old girl who is a class X student at High School in Tasikmalaya and the last child of two siblings. The counselee is a child who comes from a family whose economy is sufficient, where the father is a sailor and the mother is a teacher. The counselee relationship with his parents is quite good but not too close. The mother of the counselee always wants the counselee to be someone who is the most superior. When the counselee is unable to achieve the expectations of his mother, her attitude and treatment are not good, and she always compares the counselee with his older brother. Therefore, the counselee becomes someone who has perfectionism, where he always hopes that whatever he does will get perfect results and get good treatment from his mother. The counselee often feels pressured by his situation, where he often feels that no one can understand him. Besides that, because he wants to get perfect results, the counselee often feels doubtful and experiences a delay in doing and collecting an assignment, which ultimately makes the counselee feel that the value is small or not following his expectations. With such incidents, the counselee often feels hopeless and unenthusiastic about his learning or tired of undergoing it.

Participant 3. Nabila, a 16-year-old girl, is a class X student at High School in Tasikmalaya. She is an only child with an affluent family background. The counselee's parents work as businessmen and entrepreneurs. The Counselee relationship with both parents is very good. The counselee loves his parents, so he always wants to make them happy. Therefore, the counselee always wants to be the most superior person in any field and anywhere. For that reason, the counselee always hopes that everything that is done or obtained must have perfect results. Having such a habit, the counselee explains that this treatment can sometimes get him into trouble, such as being slow at doing and collecting assignments, getting small grades, doubting his abilities, always being jealous of others, comparing himself to others, and finding it difficult to accept yourself when you fail.

Sampling Procedures

This study uses a quantitative approach with a single-case experimental design. The reason researchers chose a quantitative experimental approach in the form of a single case is that they will provide interventions to individual subjects or single experiments. Prahmana (2021) describes single-subject research as a research design to evaluate treatment in a single case. The research design used in this study is the A-B-A design. The A-B-A design is an extension of the basic A-B design, in which there is a repetition of the baseline condition (A2) after the intervention (B) is carried out (Prahmana, 2021). The target behavior was measured repeatedly for 3 stages, namely: A1 (measurement before being given an intervention), B (intervention), and A2 (measurement after being given an intervention). The distribution of the perfectionism scale was given to students to find out the perfectionism profile of SMA Negeri 7 Tasikmalaya students, with a total of 340 students participating. The implementation of the initial test (baseline) was carried out to get an initial picture of the level of perfectionism in SMA Negeri 7 Tasikmalaya students before choosing research subjects to be given intervention.

The scale used in this study is the Frost Multidimensional Perfectionism Scale, in which there are 6 dimensions, including Concern over Mistakes (CM), Personal Standards (PS), Parental Expectations (PE), Parental Criticism (PC), Doubts about Actions (D), and Organization (O) (FMPS; Frost et al., 1990). To find out the category of perfectionism, we use the Frost Multidimensional Perfectionism Scale. First, the researcher must know the average score of the dimensions for each

student. After the average score for each dimension was obtained, the researcher matched the score obtained back to the predetermined conditions, namely for the non-perfectionism category, which had a low average value on all six dimensions. Adaptive perfectionism has a high average score on the dimensions of CM, PS, and O and a low average value on the dimensions of PE, PC, and D. Maladaptive perfectionism has a high average value on the dimensions of PS, CM, PE, PC, and D and a low average score on dimension O. Then, for mixed maladaptive perfectionism, it has a low average score on all six dimensions. After getting an overview of the results of the initial measurement scores regarding the level of perfectionism in students, three students were obtained to be used as research subjects: three students who belonged to the categories of non-perfectionism, maladaptive perfectionism, and maladaptive perfectionism.

For the predetermined subjects, namely students who are in the non-perfectionism category, namely Dinda, Shinta's maladaptive perfectionism, and Nabila's mixed maladaptive perfectionism. The procedures used in the implementation of the intervention session were prepared based on the protocol contained in dialectical behavior therapy, namely for 8 sessions. Then, after the implementation of each session, measurements were taken again to get an overview of the changes that had occurred to them after receiving the counseling session. Measurements were carried out eight times in three days for students who were given the intervention. Re-measurement was carried out on students who were research subjects (Baseline 2) after intervention for 8 sessions, with an interval of at least 3 days a week. After completing the measurement (baseline 2), the effectiveness of the outcome score (baseline 1), intervention, and baseline 2 is then tested. Each counseling session is carried out in person or face-to-face and lasts 30–60 minutes. In each session, an evaluation is carried out regarding the obstacles and positive changes that occur and are experienced by the counselee after the session.

This helps the counselor find out more about the extent to which perfectionism changes in each counselor. The stages used in the counseling session are the first stage of building a productive therapeutic alliance with the counselee. The second stage, or middle stage, which is the process of change, is the stage where the counselee is encouraged to make changes. Counselors use DBT techniques to help change irrational thinking into new rational and productive thought patterns. And the last stage is the final stage, where the counselor needs to appreciate the changes that have occurred for the client. The fow diagram ispresented in Figure 1.

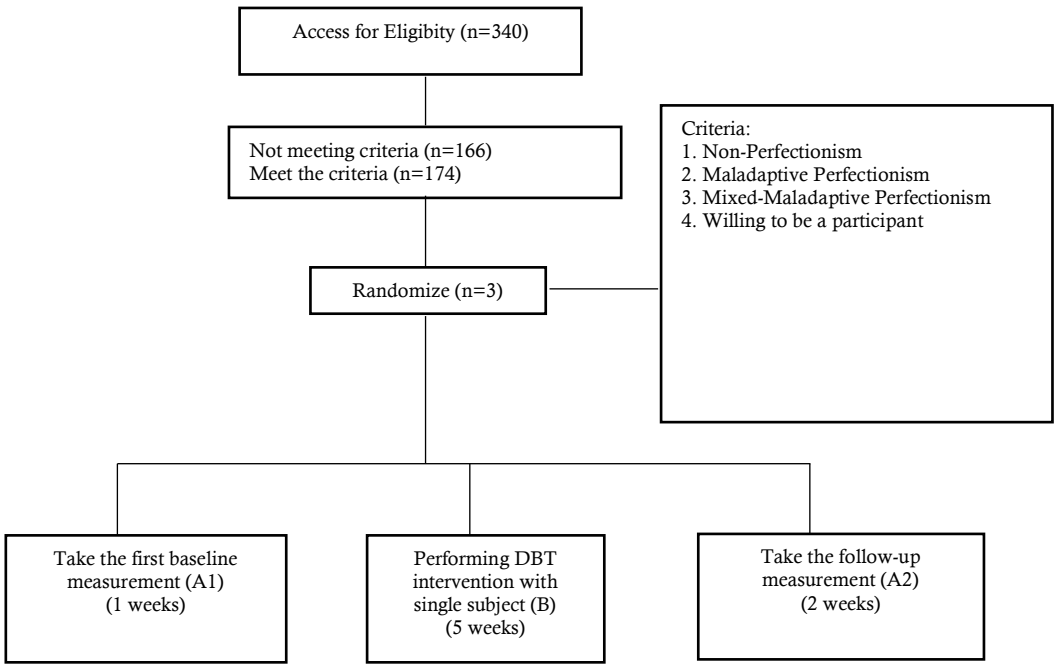

Figure 1. Participant Selection

https://doi.org/10.24036/0202312246-0-86

Dialectical Behavior Therapy Intervention

The procedure used in the implementation of dialectical behavior therapy is readjusted to the variable studied, namely perfectionism. There were 8 sessions used in this study, which were adapted from Üstünda-Budak et al. (2019). The first session uses mindfulness techniques by teaching the counselee to be able to have wise thoughts by having the counselor first know the counselee's emotional thoughts and then the reasons for those thoughts. After that, the counselor directs the counselee to his wise thoughts and shows facts about himself that are more positive. The second session uses the WHAT mindfulness technique. In this second session, the counselor is more aware of the counselee's negative assumptions, which are not facts but just thoughts (counselees can separate which are facts and which are thoughts that are happening to him). The third session uses mindfulness. In this session, the counselor directs the counselee toward self-ability and not to judge himself, so that the counselee is not trapped in his negative opinion. The fourth session used the WHAT and HOW mindfulness techniques; this session was a combination of WHAT and HOW mindfulness, so in practice, the counselor further strengthened the achievements obtained from sessions two and three. The fifth session uses the skills of "give" and "dear man" for interpersonal effectiveness. In this session, the counselor gently validates the counselee so that the counselee feels comfortable and heard (making it seem as if the counselor understands everything the counselee feels).

In this session, the counselor also asks the counselee to be able to focus on positive things that exist in the counselee and also negotiates with the counselee to do the positive things that the counselor wants so that the counselee experiences changes in behavior to become more adaptive. The sixth session uses FAST interpersonal skills. In this session, the counselor teaches the counselee to always be focused on his positive values, awakens and rebuilds the positive values that exist in him, regenerates his interest in becoming someone great that the counselee has experienced before, and regenerates his dreams and hopes so that he has a feeling of enthusiasm to achieve them. The seventh session uses emotion regulation techniques. In this session, the counselor asks the counselee to be able to change their emotional response and to have the skills to establish a healthy lifestyle so that they can reduce vulnerability. And the last session uses emotion regulation techniques; in this session, the counselor asks the counselee to always collect positive emotions, build mastery, and be able to overcome the possibilities that will occur.The schedule and sequence of contents for the rational emotive behaviortherapy intervention session carried out for six weeks are presented in the following Table 1.

Tabel 1. Dialectical Behavior Therapy Intervention

Phase	Session	Handout	Assignments
Mindfulness	1	General Handouts; Mindfulness Handouts: 1, 2 (Goals and definitions of Mindfulness) and 3 (Three states of mind, Wise-mind practices).	Practice Wise-mind
	2	Mindfulness Handouts 4, 4A, 4B, 4C ('What' skills; Observe, Describe, Participate).	Practice Mindfulness 'What' Skills
	3	Mindfulness Handouts 5, 5A, 5B, 5C ('How' Skills; Non-Judgementally, One-Mindfully, Effectively)	Practice Mindfulness 'How' Skills
	4	Mindfulness 'What' & 'How' Skills Handouts Review & Practice	PracticeMindfulness
Interpersonal Effectiveness	5	Goals of Interpersonal Effectiveness, Interpersonal Effectiveness Handouts 2, 4, 5 & 5A (Objectives Effectiveness: DEAR MAN - Describe, Express, Assert, Reinforce, Stay Mindful, Appear Confident, Negotiate); Interpersonal Effectiveness Handouts 6 & 6A (Relationship Effectiveness: GIVE – Gentle, Interested,	Practice DEAR MAN and GIVE

Phase	Session	Handout	Assignments
		Validate, Easy Manner)	
	6	Interpersonal Effectiveness Handout 7 (Self-Respect Effectiveness: FAST – Fair, Apology Free, Gentle, Stick to Values, Truthfulness); Interpersonal Effectiveness Handouts 16, 16B, 17, 18, 19, 22 (Walking in the Middle Path, Dialectics, Validation, Behavioral Change Skills)	Practice FAST, Interpersonal Effectiveness Worksheets 11, 11a, 11b.
Emotion Regulation	7	Emotion Regulation Handout 1 (Goals of Emotion Regulation), Model for Describing Emotions, Emotion Regulation Handout 8 (Check for the reality), Handout 6 (Describing Emotions) and Handout 7 (Changing Emotional Responses), Emotion Regulation Handout 20: PLEASE – Treat Physical Illness, Balanced Eating, Avoid Mood-Altering Drugs, Balanced Sleep, Get Exercise, Achieve Mastery), Mindfulness of Current Emotions	Practice Describing & Changing Emotions, and PLEASE
	8	Emotion Regulation Handout 9 (Opposite Action and Problem-Solving), Emotion Regulation Handouts 17, 18 & 19 (Accumulating Positive Emotions, Build Mastery and Cope Ahead), Emotion Regulation Handout 24 (Reducing Vulnerability).	Practice Opposite Action and Problem-Solving, Build Mastery and Reducing Vulnerability

Measurement

The scale used in this study is the perfectionism scale, which has been adopted by Lubis et al. (2020) and is a construction of the Frost Multidimensional Perfectionism Scale (FMPS; Frost et al., 1990). The scale consists of 35 item statement items, which contain statements of perfectionism that refer to the dimensions: fear of making mistakes (the concern over mistakes, CM), personal standards (personal standards, PS), parental expectations (parental expectations, PE), parental criticism (parental criticism, PC), doubts about actions (D) and organization (O) (Frost et al., 1990). The Frost multidimensional perfectionist scale uses a Likert scale with five scales: 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree, and 5 = strongly agree. Based on the reliability test on the perfectionism scale, Cronbach's alpha value was 0.86. This shows that the level of reliability is very high, which means that the Frost multidimensional perfectionist scale (FMPS) instrument can produce good scores, is feasible to use, and all statement items are declared valid.

Data analysis

The data analysis technique used visual analysis and statistical analysis. Visual data analysis is the most common data analysis method used in single-subject design experimental research to determine the effectiveness of dialectical behavior therapy by displaying trends or graphs of the results of baseline 1, intervention phase, and baseline 2, which are displayed in graphical form so that when viewed visually, it will be easy to see the difference, which shows the influence of the intervention given (Harrington & Vellicer, 2015). Trend analysis provides information on a systematic increase or decrease in behavior across phases, while change latency refers to the amount of time between the cessation of one phase and a behavior change (Kazdin, 2011).

Statistical analysis can be used to see the effectiveness or changes that occur in counselees between baseline conditions and interventions (Brossart et al., 2006). By looking at changes in the trend of the graph direction (trend), it will be seen that changing trends are the best evidence to support the effect of intervention in a single-subject research design, so researchers can see trend changes in all

https://doi.org/10.24036/0202312246-0-86

data conditions and can calculate straight line changes by calculating the squared regression (Tankersley et al., 2008). To see the magnitude of the effect resulting from the provision of the intervention, it was analyzed by calculating the percentage of non-overlapping data (PND) between the baseline and the intervention. This PND is calculated by looking at and using the lowest data from the baseline score and making a horizontal straight line from that point. After that, visual and descriptive analysis was used to check the number of points in the intervention phase that were above the horizontal straight line with the lowest data on the baseline earlier. The number of points that do not overlap with the baseline horizontal point, which means that they are above the lowest point of the baseline, is added up, divided by the number of interventions, and then multiplied by 100 to get the result in percent (Schlosser et al., 2008). The percentages calculated to provide an estimate of the effect of counseling, where PND greater than 90% indicates counseling is very effective, 70–90% indicates counseling is effective, 50–69% indicates questionable effectiveness, and less than 50% is considered ineffective, Scruggs & Mastropieri, 1998; Vannest & Ninci, 2015).

In assessing the effect size of the single subject intervention calculated using Cohen's d, 0.87 indicates a small effect, 0.87–2.67 indicates a moderate effect, and > 2.67 indicates a large effect (Parker & Vannest, 2009). Then, to determine whether the magnitude of change in each participant is also determined statistically, this analysis includes calculating a reliable index of change (RCI; Jacobson & Truax, 1991). If the RCI value is greater than 1.96, then the probability of changing the score randomly is less than.05. RCI values are given for each individual on total perfectionism, hesitation to act, personal standards, parental expectations, parental criticism, hesitation to act, and organization.

Results and Discussion

Overall, there was a significant change in the total and perfectionism categories of the three participants by directly observing the trend line on the chart and statistical analysis using percentage non-overlapping data (PND) calculations. The first participant in the non-perfectionism category showed an increase of (d = 3.155), specifically indicating a change in the average perfectionism score in the first measurement, which was (M = 69), then this value changed after being given dialectical behavior therapy intervention to (M = 102, 25), and it changed to (M = 105) at the second baseline. An analysis of the validity between the baseline conditions and the intervention was shown by the standard deviation before the intervention (SD = 10.53), during the intervention (SD = 4.23), and after the counseling intervention was given (SD = 2). The second participant in the category of maladaptive perfectionism specifically showed a change of (d = 12.51) with the average score of perfectionism in the first measurement being (M = 14.25), then this value changed after being given dialectical behavior therapy intervention to (M = 126.5), and the value changed back to (M = 105.5) at the second baseline. An analysis of the variability between baseline conditions and the intervention is indicated by the standard deviation before the intervention, namely (SD = 1.25), during the counseling intervention, namely (16.70), and after the intervention (SD = 1.73). The third participant in the category of mixed-maladaptive perfectionism specifically showed a significant change (d = 9.75) with an average score of perfectionism in the first measurement (M = 157.66), then this value changed after being given behavioral counseling interventions (M = 133.12), and the value changed back to (M = 108) at the second baseline. An analysis of the validity between the baseline conditions and the intervention was shown by the standard deviation before the intervention (A1), namely (SD = 2.51), during the counseling intervention (SD = 17.45), and after the intervention (SD = 2.30).This shows that the perfectionism score has changed from the baseline phase to the post-intervention phase. To further examine the magnitude of the counseling effect, it can be seen from the results of the calculated percentage of non-overlapping data (PND). The results show that the PND statistic is 100% for Dinda, which shows that DBT is very effective for increasing total perfectionism and changing counselees who were originally in the non-perfectionism category to adaptive perfectionism. 75% for Shinta, which shows that DBT is effective in reducing total perfectionism and changing counselees who were originally in the category of maladaptive perfectionism to adaptive perfectionism. Finally, there was 87% for Nabila, who showed DBT was effective in reducing total perfectionism and

changing counselees who were originally in the mixed maladaptive perfectionism category to adaptive perfectionism. This was confirmed by the RCI, which showed a significant change in total perfectionism from pre- to post-DBT use for the three participants.

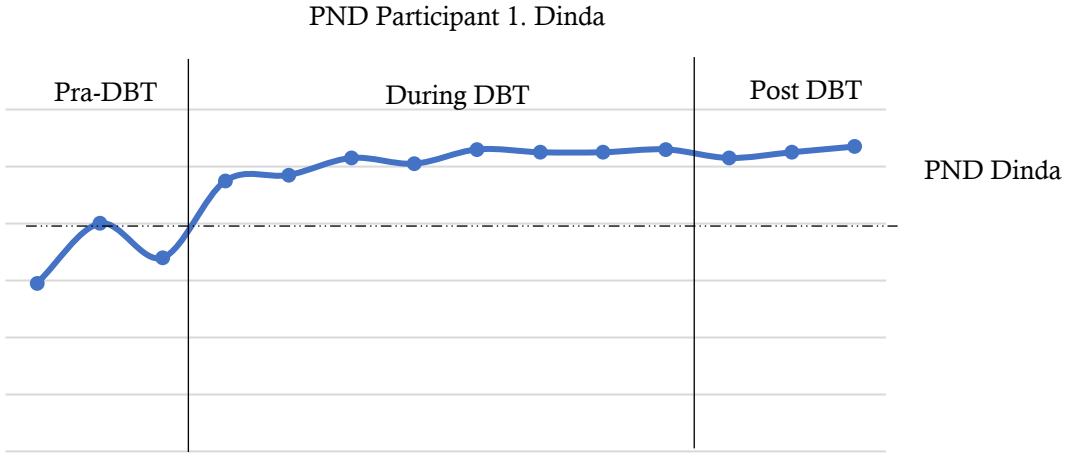

Figure 2 The Level of Perfectionism of all Participants 1

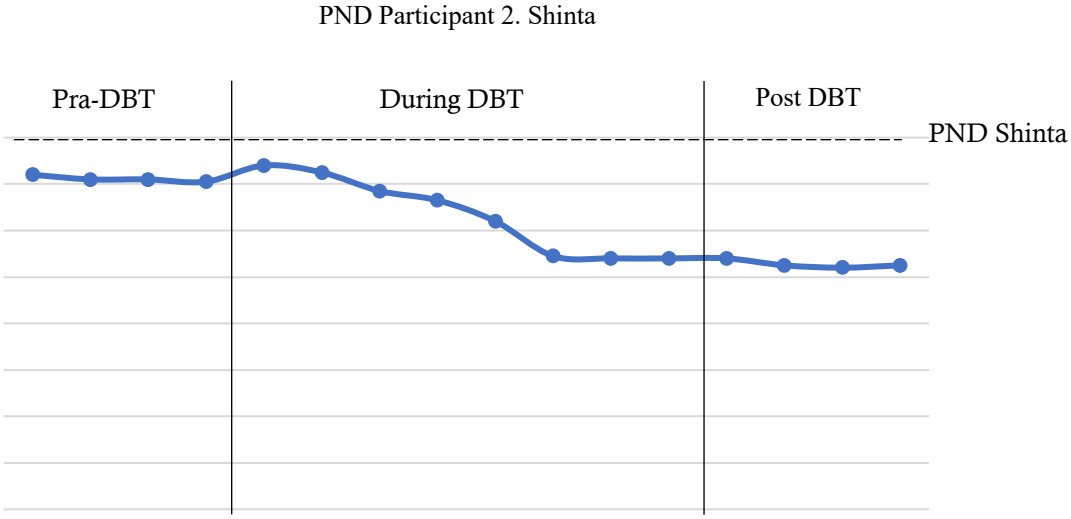

Figure 3 The Level of Perfectionism of all Participants 2

The dimensions of fear of error for all participants are presented in table 3. The first participant showed a change of (d=1.33) with the value before the intervention (M=16.66) (STD = 6.11) during the intervention (M=24.75) (STD=1.48) and after intervention (M=27) (STD=1). The second participant showed a change (d=10.56) with the value before the intervention (M=42) (STD=0.81) during the intervention (M=33.37) (STD=7.19) and after the intervention (M=25) (STD=0). The third participant showed changes (d =13.27) with values before the intervention was given (M=43.66) (STD=0.57) during the intervention (M=36) (STD=6.11) and after the intervention was given (M=27) (STD=1).

The standard personal dimensions for all participants are presented in table 3. The first participant showed a change of (d=2.92) in scores before the intervention (M=16) (STD=2.64) during the intervention (M=23.75) (STD=1.83) and after intervention (M=26.66) (STD=0.57). The second participant showed a change of (d=1.93) with the value before the intervention (M=32.75) (STD=1.25) during the intervention (M=31) (STD=1.77) and after the intervention (M=29) (STD=0). The third

https://doi.org/10.24036/0202312246-0-86

participant showed a change of (d = 1.01) with the value before the intervention was given (M = 33.66) (STD = 1.15) during the intervention (M = 33.12) (STD = 0.83) and after the intervention (M=33) (STD=0.57).

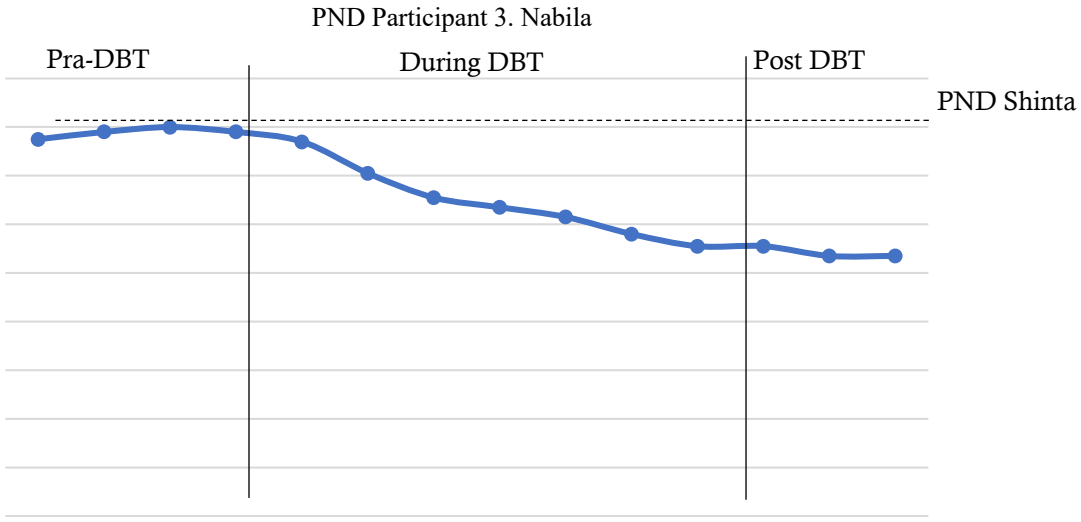

Figure 4 The Level of Perfectionism of all Participants 3

The dimensions of parental expectations for all participants are presented in table 3. The first participant showed a change of (d=5.99) with the value before the intervention (M=8.66) (STD=0.57) during the intervention (M=12,12) (STD=0.35) and after intervention (M=12) (STD=0). The second participant showed a change of (d=9.73) with a value of (M=19.23) (STD=0.5) during the intervention (M=14.37) (STD=2.50) and after the intervention was given (M=10.75) (STD=0.95). The third participant showed a change of (d=13.49) with the value before the intervention (M = 23.66) (STD=0.57) during the intervention (M=15.87) (STD=4.32) and after the intervention (M=9.66) (STD=1.15).

The dimensions of parental criticism for all participants are presented in table 3. The first participant showed a change of (d = 5.12) with the value before the intervention (M = 6.66) (STD = 0.57) during the intervention (M= 9.62) (STD=0.51) and after intervention (M=8) (STD=0). The second participant showed a change (d=5.19) with the value before the intervention (M = 13.5) (STD = 0.57) during the intervention (M=10.5) (STD = 2.72) and after the intervention (M=5.5) (STD=0.57). The third participant showed a change (d = 2.57) with the value before the intervention (M=13) (STD=1.73) during the intervention (M=8.37) (STD=2.97) and after the intervention (M=4) (STD=0).

The dimension of hesitation to act for all participants is presented in table 3. The first participant showed a change of (d = 0.79) with the value before the intervention (M = 8) (STD = 1.73) during the intervention (M = 9.37) (STD=1.40) and after intervention (M=7.33) (STD=0.57). The second participant showed a change (d=7.83) with the value before the intervention was given (M=19.25) (STD=0.95) during the intervention (M=11.75) (STD=4.68) and after it was given intervention (M=8) (STD=0). The third participant showed a change of (d = 10.75) with the value before the intervention (M = 19.33) (STD = 0.57) during the intervention (M = 13.12) (STD = 5.48) and after the intervention (M=5) (STD=0).

Organizational dimensions for all participants are presented in table 3. The first participant showed a change of (d=5.55) with the value before the intervention (M=13) (STD=1.73) during the intervention (M=22.62) (STD = 1.30 and after the intervention was given (M = 24) (STD = 0). The second participant showed a change of (d = 7.83) with the value before the intervention was given (M = 13.75) (STD = 1.15) during the intervention (M=25.5) (STD=1.41) and after the intervention (M=27.25) (STD=0.5). The third participant showed a change of (d=1.98) with the value before given the intervention (M=24.33) (STD=1.15) during the intervention (M=26.62) (STD=1.30) and after the intervention (M=29) (STD=0).

Tabel 2. Perfectionism (M ± SD) of pre-DBT, during-DBT and post- DBT for all participants, Reliability Change Index (RCI) & Effect Size

	Pra-DBT		During-BDT		Post-DBT		Gain	RCI	Effecr Size
Total Perfesionism	M	SD	M	SD	M	SD	33,25		
Participants 1:	69	10,53	102,2	4,23	105	2		5,96	3,15
Participants 2 :	142,25	1,25	126,5	16,70	105,5	1,73	15,75	23,66	12,51
Participants 3 :	157,66	2,51	133,12	17,45	108,33	2,30	24,54	18,43	9,75
	Concern over Mistakes								
Participants 1:	16,66	6,11	24,75	1,48	27	1	8,08	1,95	1,15
Participants 2:	42	0,81	33,37	7,19	25	0	8,62	15,59	10,56
Participants 3:	43,66	0,57	36	6,11	27	1	7,66	19,60	13,27
	Personal Standard								
Participants 1:	16	2,64	23,75	1,83	26,66	0,57	7,75	3,13	2,97
Participants 2:	32,75	1,25	31	1,77	29	0	1,75	1,49	1,39
Participants 3:	33,66	1,15	33,12	0,83	33,66	0,57	0,57	0,50	1,01
	Parental Expectations								
Participants 1:	8,66	0,57	12,12	0,35	12	0	3,45	8,01	5,99
Participants 2:	19,23	0,5	14,37	2,50	10,75	0,95	4,87	13,04	9,73
Participants 3:	23,66	0,57	15,87	4,32	9,66	1,15	7,79	18,05	13,49
	Parental Critism								
Participants 1:	6,66	0,57	9,62	0,51	8	0	2,95	4,93	5,12
Participants 2:	13,5	0,57	10,5	2,72	5,5	0,57	3	5,00	5,19
Participants 3:	13	1,73	8,37	2,97	4	0	4,64	2,57	2,67
	Doubts About Actions								
Participants 1:	8	1,73	9,37	1,40	7,33	0,57	1,37	0,91	0,79
Participants 2:	19,25	0,95	11,73	4,68	8	0	9,05	7,5	7,83
Participants 3:	19,33	0,57	13,12	5,48	5	0	6,20	12,43	10,75
	Organzation								
Participants 1:	13	1,73	22,62	1,30	24	0	9,62	8,61	5,55
Participants 2:	13,75	1,5	25,5	1,41	27,25	0,5	11,75	12,14	7,83
Participants 3:	24,33	1,15	26,62	1,30	29	0	2,29	3,07	1,98

The purpose of this study was to determine the effectiveness of dialectical behavior therapy to deal with perfectionism in students. This is the first study in Indonesia that applies DBT with perfectionism to students. The results of the study show that dialectical behavior therapy is effective in dealing with perfectionism in students. Visual analysis showed consistent improvement in perfectionism scores from the baseline and intervention phases for the three participants. The effectiveness of dialectical behavior therapy is also supported by changes in almost all dimensions of perfectionism.

This change is shown as one of the goals of dialectical behavior therapy, namely to help counselees be able to accept conditions that are beyond the counselee's control (Linehan, 1993), to be able to change the counselee's emotional responses so that they have wiser thoughts and behaviors again (Linehan, 2015), to reduce behaviors that can reduce the quality of life, and to increase skills in behavior (Syafitri & Nuryono 2020). These findings support much of the literature that advocates the use of dialectical behavior therapy to reduce negative emotions, feelings of helplessness, and expressions of anger, increase social adjustment abilities, and improve individual quality of life (Supratno, 2014; Nuryono et al., 2020).

Participant 1 showed very effective results in increasing non-perfectionism to adaptive perfectionism by using dialectical behavior therapy. Before getting the intervention, the counselee was someone insecure, shy, and quiet, so the counselee set his standards very low by not having big expectations in his daily life, so that when doing something, the counselee always did it as it was without any hope of wanting to do something as well, perhaps not even expecting a major accomplishment. The counselee often thinks that he is stupid, helpless, thinks negatively of others,

https://doi.org/10.24036/0202312246-0-86

procrastinates on a task, and is lazy. However, after the intervention is given, the counselee has a new belief and a wiser mind, so it encourages the counselee to be able to change his negative behavior and emotional response. The second participant showed an effective score in reducing maladaptive perfectionism to adaptive perfectionism by using dialectical behavior therapy. Before giving the intervention, the counselee is someone who has high self-standards and wants to achieve perfect results to get acknowledgement or more affection from his mother. When experiencing failure, the counselee cannot forgive himself, and he often feels pressured while following the lesson. In addition, the counselee also has great doubts about his performance, so he often experiences delays and does not even collect his school assignments. The counselor often curses himself by assuming he is worthless when he experiences failure. After being given intervention with counselee dialectical behavior therapy, there is complete self-acceptance; the counselee is more enthusiastic about learning, no longer doubts himself, and has the view that difficulty or failure is a process towards success. Then the third participant showed an effective score in reducing mixed maladaptive perfectionism to adaptive perfectionism. The counselee often compares his abilities with others when the counselee experiences failure. The counselee has doubts about himself, so assignments are often delayed or submitted late. The counselee often feels jealous of the achievements of others. After doing dialectical behavior therapy, he can accept and love himself more and have great confidence in his abilities. The counselee believes that failure is a delayed success; therefore, he is more enthusiastic about returning to his studies and does not give up easily.

These findings indicate that dialectical behavior therapy can have a positive impact on counselees, meaning that dialectical behavior therapy is effective in dealing with perfectionism. This success can be seen from the effectiveness of the analysis of changes from starting before counseling to after conducting counseling sessions for 8 sessions. These changes can be seen in the behavior, feelings, and actions shown in each counseling session. Before counseling interventions are given, the counselee has negative behaviors such as uncontrolled emotions, difficulty accepting failure, and many doubts about his potential. Some behaviors lead to an inability to set goals, feel that they have no expectations of themselves, and do not have high self-standards. In line with the opinion of Lynch et al. (2006), who argued that dialectical behavior therapy is formulated for individuals who feel they are always controlled, are close to having new experiences, are perfectionists, have cognitively rigid behavior, and are very risk-averse, Also in line with the opinion of Linehan (1993), who argues that dialectical behavior therapy will help counselees reduce emotional dysregulation and ineffective coping behaviors and help clients achieve a life they don't want to avoid and a life worth living.

Through dialectical behavior therapy interventions, counselees are helped to find the roots of their problems and the sources of negative emotional feelings that have existed within them. The changes experienced by the counselee through this counseling force include being able to fully accept themselves. Linehan (1993) explains that dialectical behavior therapy can be said to be effective if the counselee can accept situations that are beyond self-control and has the ability to manage the emotional response to an event that occurs. In addition, in practice, the counselor also acts as a motivator and teacher by always paying attention to a familiar tone of voice and the same tone from the counselee. Because in DBT can also be said to be successful or effective when the counselor can encourage a sincere relationship with the counselee, entertain and speak honestly to the counselee, and not show that the counselee is destroying himself (Linehan 1993). By carrying out dialectical behavior therapy interventions using mindfulness techniques, besides being able to provide a feeling of calm to the counselee, it can also make the counselee able to accept circumstances that the counselee cannot control. For example, when the counselee experiences failure as a result of his hard work, the counselee can accept a failure. The counselee realizes that a failure is a delayed success and a failure is not the end of everything, and this failure is made a lesson in the future.

The next change that occurs in the counselee is emotional control. With emotion regulation techniques, the counselee can change his emotional response and manage his emotions by diverting a negative feeling he feels to better things and providing many benefits by doing self-care in the form of regular exercise, eating a balanced diet, sleeping on time, and doing physical care. This is following the opinion of John & Eich (2015) that when individuals do not meet their physical needs, they tend to be more emotional, making it more difficult to deal with stress.

Then, after the intervention, the counselee can control his negative thoughts and change his behavior in his daily life by being aware of his thoughts and facts. From there, the counselee realizes that his perception of himself is just a thought, not a fact. From there, the counselee begins to experience changes in behavior, such as being able to work on and collect assignments with confidence, schedule study routines at night, and become more organized at work. This is in line with Supratno's (2014) opinion that dialectical behavior therapy can reduce feelings of helplessness and expressions of anger, increase social adjustment abilities, and improve individual quality of life. It has become evident that the use of dialectical behavior therapy has proven effective in dealing with perfectionism.

Conclusion

This research showed that DBT was effective in the treatment of the perfectionism type in the respondents. This is because there was a significant change before and after the treatment. BeforeDialectical Behavior Therapy treatment, the respondentswereinthe maladaptive category, however,after the treatment they were inthe adaptive perfectionism category. This research also has implications for school counselors in providing services to overcome problems related to student perfectionism so that students are successful in the process of achieving academic success.

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