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Past research has asserted that members of the Church of Jesus Christ of Latter-day Saints (i.e., Mormons) have high rates of religious perfectionism. A historical investigation was performed examining how the perception of perfectionism has changed within the field of psychology. The study first investigates early viewpoints (e.g., Freud, Horney, Adler, Ellis, Beck) that unanimously perceived perfectionism as negative and debilitating in an individual's psychological adjustment. New research, which understood and measured perfectionism as a multidimensional construct, found both positive and negative components of perfectionism. Different theoretical understandings of perfectionism (e.g., behavioral, attachment, self-conscious emotions, acceptance, Big Five personality traits, mindfulness, etc.) are presented. Each model of perfectionism is explored with recommendations for clinicians to address religious perfectionism in treating Latter-day Saint/Mormon clients.
Keywords: perfectionism, shame, guilt, LDS/Mormon, acceptance, attachment

Until recently, if an individual were to identify herself or himself as a perfectionist, many within the field of psychology would have seen this as a detrimental and unhealthy stratagem to life. At a meeting of the American Psychological Association, Pacht declared, "Any person who thinks he or she is perfect almost certainly has real psychological problems, and the same is probably true of any person who *wants* to be perfect" (1984, p. 386). Seeking perfection is pathological, he concluded, because "perfection is not only an undesirable goal but a debilitating one as well" (p. 386).

A historical review of perfectionism demonstrates that early prominent psychologists shared this negative view of perfectionists. Freud (1959) labeled perfectionism as an obsessional neurosis and the desire to be perfect as a component of narcissism. Horney (1950) asserted that perfectionists aspire to an idealized image of themselves where they hold to a "tyranny of shoulds" (p. 65) within their behavior. Adler (1956) associated perfectionism with psychopathology. Ellis (1962) perceived perfectionists as irrational due to holding unrealistic, idealized, and unachievable standards—the primary irrational belief being "that there is invariably a right, precise and perfect solution to problems and that it is catastrophic if this perfect solution is not found" (pp. 86–87). Prominent self-psychology theorist Kohut (1971) postulated that perfectionism was brought about as a result of disruptions in early childhood self-development where caregivers were consistently unresponsive to their child's needs. Burns (1980) and Beck (1976) asserted that the core problem with perfectionists is an "all-or-none thinking" or "saint or sinner" extremism (Barrow & Moore, 1983, p. 612) in self-evaluation.

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Individuals striving for perfection often "measure their own worth entirely in terms of productivity and accomplishment" (Burns, 1980, p. 34). These extreme beliefs result in perfectionists evaluating their performance through a dichotomy—total success or absolute failure. Weisinger and Lobsenz (1981) argued the need to be perfect is self-destructive because it places the perfectionist in a double bind. If perfectionists are unable to meet the high expectations set for themselves, then they are absolute failures; however, if perfectionists manage to achieve their idealistic goals, they receive no sense of accomplishment; instead, they set a new expectation that unreasonably surpasses the original.

Accordingly, psychologists contemporary to these theorists concluded that all forms of perfectionism result in poor mental health and should always be avoided. During this period in the field of psychology, clinical treatment focused on reducing or eliminating perfectionistic strivings.

In a parallel fashion, religiousness was viewed as detrimental and harmful to mental health in the early practice of psychology. Freud (1959) declared that religious behavior is parallel to neurosis. Ellis maintained that religious belief and behavior is both irrational and representative of mental illness (Ellis, 1980; Ellis, Nielsen, & Johnson, 2001). The more dogmatic and rigid individuals become in relation to religious beliefs, the more they will suffer "emotional disturbance" (Ellis, 1980, p. 637).

As psychologists began to incorporate research into theory and practice, both perfectionism and religiousness were seen in a new light. Innovative research in the last 25 years has uncovered the fact that not all perfectionists are unhealthy or maladaptive (Fedewa, Burns, & Gomez, 2005; Frost, Marten, Lahart, & Rosenblate, 1990; Hewitt & Flett, 1991b; Lundh, 2004; Shafran, Cooper, & Fairburn, 2002; Slaney, Rice, & Ashby, 2002; Sorotzkin, 1998; Stoeber, Harris, & Moon, 2007; Stoltz & Ashby, 2007; Tangney, 2002). Modern studies demonstrate that striving for perfection does not guarantee an individual will suffer with mental health issues, although there is some risk of developing maladaptive patterns. The key to whether a perfectionist experiences negative emotional health is the manner in which the individual pursues perfection (Frost et al., 1990; Hewitt & Flett, 1991b; Lundh, 2004; Stoeber, Kempe, & Keogh, 2008; Tangney, 2002). Similarly, religion was found to be a positive and protective factor in an individual's mental health (Banerjee, Boyle, Anand, Strachan, & Oremus, 2014; Brassai, Piko, & Steger, 2011; Dodor, 2012; Gearing & Lizardi, 2009; Gnomes, de Andrade, Izbicki, Moreira-Almeida, & de Oliveira, 2013; Meltzer, Dogra, Vostanis, & Ford, 2011; Mouttapa, Huang, Shakib, Sussman, & Unger, 2003; Nooney & Woodrum, 2002; van der Meer Sanchez, de Oliveira, & Nappo, 2008). A comprehensive review by Reeves, Beazley, and Adams (2011) found that almost 500 studies reported a positive association between religiousness and mental health. However, while religiousness has been found to be a positive and protective factor in regard to overall mental health, it can also increase unhealthy forms of perfectionism. The determining factor is the manner in which individuals practice their religion.

As an example, the moral or religious expectations contained within the standards of a particular belief system can function as a measure of the self. Religious individuals may equate whether or not they are acceptable to God and significant others within their religious community with their ability to meet the religious standards of their faith community. When individuals fail to live up to these standards, they often experience high levels of shame, guilt, and self-condemnation (Koenig, 2007). In addition, religious individuals may experience higher levels of anxiety and self-criticism based on perceived sins, prophecies of future events, and their worrying about their own salvation or the salvation of others (Ellison, Burdette, & Hill, 2009; Exline, 2002). This particular form of perfectionism is known as religious perfectionism. Religious perfectionism is highly prevalent among members of the Church of Jesus Christ of Latter-day Saints, often known as Mormons (Crosby, Bates, & Twohig, 2011).

The purpose of this paper is to perform a historical review of the literature on the construct of perfectionism and demonstrate how pursuing perfectionism can be either adaptive and healthy or maladaptive and unhealthy. After a discussion of how to pursue perfection in adaptive and healthy ways, the paper will demonstrate how these adaptive methods can be utilized with religious clients, ensuring that religiousness becomes a positive and protective factor. The primary focus of this paper will be working with clients from the Church of Jesus Christ of Latter-day Saints in therapy.

Seeing Perfectionism in a Different Way: Normal Versus Neurotic Perfectionists

Hamachek (1978) was one of the earliest psychologists to distinguish between "normal" and "neurotic" forms of perfectionism. Almost all of us would prefer that our personal surgeon, lawyer, accountant, car mechanic, child's teacher, etc., be somewhat perfectionistic—rather than mediocre—in their job performance. While acknowledging that being perfectionistic has its pros and cons, Hamachek investigated the problems that lead an individual to become a normal perfectionist versus a neurotic perfectionist.

Hamachek discovered that normal perfectionists, like neurotic perfectionists, set high standards; however, normal perfectionists set realistic and attainable standards given their abilities. Further, normal perfectionists experience enjoyment and a sense of accomplishment when completing an arduous goal. Lastly, they are capable of flexibility with their standards and expectations in different situations. They do not believe that they must be absolutely perfect in every endeavor. Because of these characteristics, normal perfectionists are able to recognize their strengths and skills and feel satisfied with their performance in a given task, which enhances their overall self-esteem (Hamachek, 1978).

In contrast, neurotic perfectionists place demands on themselves that are often unachievable, constantly evaluate their performance as unsatisfactory, and always believe they could have done better. When neurotic perfectionists achieve goals, they derive no sense of satisfaction or accomplishment. Neurotic perfectionists are inflexible, rarely altering their high standards no matter the contextual factors or their personal abilities. Neurotic perfectionists seldom experience a positive self-image, focusing exclusively on their flaws, weaknesses, and perceived failures. Hamachek (1978) theorized that this pattern of setting unrealistically high standards but never feeling that they can be achieved leaves neurotic perfectionists in a vicious, repetitive cycle of always reaching but never achieving. This vicious cycle brings about feelings of depression, shame, procrastination, self-depreciation, embarrassment, shyness, and a plaguing sense that they should always be doing more.

Hamachek's (1978) description of the neurotic perfectionist can apply to clients from the Church of Jesus Christ in their personal pursuit of religious perfectionism. Campbell & Monson (2002) describe the Church of Jesus Christ as a "strict church" (p. 14) because of the high religious and financial commitments expected of its members. Members of the Church of Jesus Christ are expected to maintain behavioral restrictions in their dress and grooming, speech, diet, marital status, sexual activity, and financial donations. They are also expected to volunteer numerous hours for service and worship activities. They take seriously the scriptural commands from the Bible and the Book of Mormon, a religious text sacred to members of the Church of Jesus Christ, to "be ye therefore perfect" (Matthew 5:48, King James Version) and "to come unto Christ, and be perfected in him" (Moroni 10:32, The Book of Mormon). Researchers have found that, while some members of the Church of Jesus Christ find ways to be more adaptive in their pursuit of perfection through an intrinsic religious orientation (Allen & Wang, 2014; Sanders, Allen, Fischer, Richards, Morgan, & Potts, 2015), other members' pursuit of religious perfectionism results in maladaptive components of perfectionism, as described by Hamachek (1978). Peer and McGraw (2017) performed a mixed-method study looking at perfectionism and religiosity among members of the Church of Jesus Christ. They reported that many members of the Church of Jesus Christ "defined perfection as being 'sinless'" (p. 84). Defining perfection as being "sinless" demonstrates an inflexibility in perfectionistic standards. Members of the Church of Jesus Christ who participated in the study reported that religious standards play "a big role in how [they] evaluate [themselves and] see if there are things that are lacking" (Peer & McGraw, 2017, p. 85). Moments when religious standards were disobeyed or violated were associated with extreme forms of shame, guilt, and sadness. One participant reported that when he disobeys a commandment, he gets "physically sick." Additional participants described turning to self-criticism and feelings of "utter loathing": "I feel like a sack of dust and just utter trash," "I felt worthless," and "I don't feel human" (p. 85). At times, clients who are members of the Church of Jesus Christ state they cannot feel good about themselves unless they go to bed physically exhausted, knowing they did everything they could do that day to serve others. These examples demonstrate that when religious standards

become unrealistic expectations and critical forms of self-evaluation, this religious mindset creates the vicious cycle of always reaching but never achieving—a central component of the neurotic perfectionist.

Hamachek's ideas were advanced for his time. However, because of methodological limitations, it was difficult for Hamacheck to empirically validate normal versus neurotic perfectionism. A crucial problem in the method of early psychological research on perfectionism was the mistaken assumption that perfectionism is a one-dimensional construct measured on a single continuum of unrealistic expectations, standards, and maladaptive concerns (Burns, 1980). In the early 1990s, advancements were made in the measurement and research of perfectionism, including the formulation of a multidimensional model of perfectionism (Frost et al., 1990; Hewitt & Flett, 1991b; Slaney et al., 2002). This multidimensional construct enabled researchers to differentiate between healthy/adaptive and unhealthy/maladaptive features of perfectionism (Ashby & Kottman, 1996; Fedewa et al., 2005; Hewitt & Flett, 1991b; Stoeber et al., 2007; Stoltz & Ashby, 2007; Tangney, 1995, 2002).

Historically, when perfectionism was defined as a one-dimensional construct, individuals had poor psychotherapy outcomes to brief therapies for depression related to perfectionism (see Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998; Blatt, Zuroff, Quinlan, & Pilkonis, 1996). Psychologists viewed perfectionism as a personality trait or as an individual characteristic that was not likely to change (Slaney, Rice, Mobley, Trippi, & Ashby, 2001). Identifying perfection as a multidimensional construct provided clinicians new ways to conceptualize and treat individuals for issues related to perfectionism (depression, anxiety, low self-esteem, etc.).

A multidimensional approach enables the therapist to assess some components of perfectionism as positive. Seeing the positive components of perfectionism is essential when treating LDS clients because striving for perfectionism is not only a personal goal but it is often perceived as a command given by God: "be ye therefore perfect" (see Matthew 5:48). A therapist conceptualizing striving for religious perfection as solely negative or harmful could cause a rupture within the therapeutic alliance with a client who is a member of the Church of Jesus Christ. Clients are more likely to trust and work collaboratively with a therapist who highlights the positive components of perfectionistic strivings than with a therapist who pathologizes the strivings and endorses the alternative goals of accepting mediocrity or being average. The multidimensional approach is vital to the treatment of perfectionism because it brought about new models for understanding and treating maladaptive forms of perfectionism with religious clients. A review of prominent models that are effective with religious clients will be discussed in the following section.

New Models of Understanding: Perfectionism as a Multidimensional Construct

The Six Facets Model of Perfectionism

Frost et al. (1990) uncovered five dimensions of perfectionism: (a) *personal standards*, (b) *concern over mistakes*, (c) *doubts about actions*, (d) *parental expectations*, and (e) *parental criticism*. Further research revealed a sixth dimension, (f) *preference for order and organization* (Frost, Heimberg, Holt, Mattia, & Neubauer, 1993). These six facets demonstrate that perfectionists hold to very high standards, value order and organization, believe their parents hold high expectations and will be disappointed if these expectations are not met, and work very hard to avoid mistakes, which results in indecision and procrastination.

Frost et al. (1990) developed a reliable and valid multidimensional measure of perfectionism utilizing these six facets—the Multidimensional Perfectionism Scale (MPS). Within the model, the facet personal standards was discovered to not be associated with psychopathology, while the factor concern over mistakes was found to be "most closely related to symptoms of psychopathology" (Frost et al., 1990, p. 465). Similarly, concern over mistakes can differentiate normal perfectionists, who are more flexible and understanding when they commit an error, from unhealthy perfectionists, who show little flexibility or acceptance of a flaw, perceived mistake, or error in performance. The dimensions of personal standards and preference for order and organization were, in fact, found to be related to several positive personal characteristics. Frost et al. (1990) concluded that holding to high standards is associated with positive mental health. In fact, other

research has found that setting high standards reflects a positive outlook on life (Blatt, D'Afflitti, & Quinlan, 1976). However, Frost et al. (1990) clarified that being overly critical in the self-evaluation of behavior and performance (*concern over mistakes*) while striving to meet high standards results in psychological problems.

These findings enabled clinicians to update their approach to treatment for perfectionists. In the past, studies had found that perfectionism was associated with the development of depression (Hewitt & Flett, 1991a). Through the development of the MPS, perfectionism was discovered to be more closely related to *self-critical depression* than to *dependency depression*. This new finding encourages therapists to focus treatment on internal critical thoughts and self-blaming when working with a perfectionist who is suffering with depression. Furthermore, Frost et al.'s (1990) findings uncovered that perfectionists struggle with high levels of procrastination. This is most likely associated with their critical inner voice and propensity toward self-blame.

A clinician's best approach to treatment of maladaptive perfectionism is to focus on thoughts of self-criticism and self-blame. This finding by Frost et al. (1990) is highly relevant when working with clients who are members of the Church of Jesus Christ who strive for religious perfection and come up short on one of their personal religious standards or goals. These clients not only experience blame and disappointment of the self but also feel that they have disappointed God. Disappointing deity can result in high levels of self-blame and self-criticism. Therapists are advised to assess an LDS client's tendency toward self-blame and self-critical thoughts, as well as a belief that God is disappointed when the client fails to meet a religious or spiritual behavioral standard. Interventions should focus on lowering self-critical thoughts by integrating the religious components of compassion (particularly self-compassion), mercy, and forgiveness, which results in a better understanding of the self and the character of God. The goal in treatment is not to reduce the setting of high standards. Attempting to lower standards results in perfectionistic clients being resistant to change because these clients often feel that lowering standards will condemn them to mediocrity and, by extension, failure. The goal of treatment is to help religious clients alter how they evaluate their mistakes, flaws, and imperfections. This new reframe of perfectionistic strivings often results in clients being less resistant within psychotherapy and focuses the treatment on more efficacious components, such as reducing thoughts of self-criticism and blame.

The Three Facets Model of Perfectionism

The MPS model focuses on the intrapersonal factors of perfectionism. Hewitt & Flett (1991b) uncovered interpersonal and social factors related to perfectionism by identifying three types of perfectionism—*self-oriented perfectionism*, *other-oriented perfectionism*, and *socially prescribed perfectionism*.

Self-oriented perfectionism occurs when individuals set excessively high standards for themselves and then critically evaluate their behavior, emphasizing less-than-perfect performances. Consequently, self-oriented perfectionists are very critical and punitive toward the self, using condemnation and self-blame to motivate improvement. Motivation within self-oriented perfectionism originates in the desire to avoid self-criticism or any type of failure (Hewitt & Flett, 1991b).

Other-oriented perfectionism is defined as holding excessively high standards for others, particularly close family members and friends, rather than the self. These perfectionists often blame, distrust, and hold feelings of hostility toward others when their high expectations and demands are not met. These perfectionistic types often experience frustration, cynicism, loneliness, and conflict and disharmony in their close relationships (Hewitt & Flett, 1991b).

Socially prescribed perfectionism is when an individual believes that significant others hold excessively high standards and unrealistic expectations for his or her performance. These perfectionists suppose that others are always evaluating them in a critical manner and care intensely about meeting others' expectations and standards. They are plagued with feelings of inadequacy, disappointment, and failure. They become consummate people pleasers, yearning for attention and praise while being very fearful of disapproval. Socially prescribed perfectionists struggle with feelings of anger, anxiety, and depression because, despite their best efforts, they cannot control the opinions of others. Of the three dimensions of perfectionism, socially prescribed perfectionism is most consistently related to psychopathology, including depression, suicidal

tendencies, anxiety, and personality disorders (Hewitt & Flett, 1991b, 2002).

Quantitative research has found that members of the Church of Jesus Christ tend to be self- and other-oriented perfectionists instead of socially prescribed perfectionists (Allen & Wang, 2014; Peer & McGraw, 2017). Further, quantitative research demonstrated that the religious orientation of members of the Church of Jesus Christ is intrinsically motivated rather than extrinsically motivated (Allen & Wang, 2014). Intrinsic religious orientation is correlated with adaptive perfectionism (Allen & Wang, 2014). However, when Peer and McGraw (2017) employed a qualitative assessment measure, they found that members of the Church of Jesus Christ do subscribe to socially prescribed perfectionism when holding to the belief that perfection is a requirement by God. A common presenting concern with religious or LDS clients is the attitude that God holds them to high standards. If these standards are not kept, the clients feel they have failed God. This type of religious client often views God as demanding, punitive, strict, and exacting. Helping clients view God in a more holistic fashion, where God also exemplifies the qualities of compassion, mercy, forgiveness, grace, understanding, etc., leads to positive therapy outcomes. When ethically appropriate, this goal can be accomplished through the inclusion of biblical stories, such as the woman taken in adultery (John 8), the prodigal son (Luke 15), or the conversion of Paul (Acts 9). For clients who are members of the Church of Jesus Christ, stories from the Book of Mormon such as Alma the Younger (Alma 36) or the Brother of Jared (Ether 2) can also be used to demonstrate a deity who is merciful, forgiving, and invested in the growth of all human beings.

Socially prescribed perfectionism can also occur within religious populations when a client sees a religious leader (pastor, priest, bishop, etc.) as an individual who holds excessively high standards concerning the client's behavior or performance. As an example, a religiously perfectionistic client presented to treatment for social anxiety. His social anxiety affected his ability to sit with the congregation in church. He tried talking to his religious leader from the Church of Jesus Christ (i.e., bishop) and was told he needed to sit with the congregation every Sunday in order to meet the standards of a temple recommend (an admired religious rite within the Church of Jesus Christ). When this client presented to therapy, he perceived himself as a huge disappointment to both God and his bishop. Initially, the client was inflexible, identifying the only acceptable standard as him sitting with the congregation. If he was unable to do this, it meant he was a failure to God.

An approach to treatment was utilized where the client gained a better understanding of social anxiety and how it impacts the mind and body. Next, a more flexible view of God and his bishop was encouraged. With a more accurate understanding of social anxiety, the client signed a release for the therapist to talk to the bishop. The therapist facilitated the bishop's understanding of social anxiety and what components of anxiety were making it difficult for the client to sit with the congregation. Having a more in-depth understanding, the bishop apologized to the client and was in full approval of the treatment strategy the therapist and client collaboratively organized to help the client reach his goal. The strategy began with the client sitting in the lobby of the church. Coping approaches were taught to help the client manage his anxiety. He transitioned from sitting in the lobby to sitting in the church service next to the door, and so forth, until he could sit with the congregation. At the end of the treatment, the client reported that he had been making many assumptions about the standards and expectations God and religious leaders hold for him and that he had felt like a constant failure because these assumed expectations were often unrealistic. He stated that he came to realize that the old standard he held of his religious behavior demanded absolute success. At the conclusion of treatment, the client stated the new idea that growth and development were the standards that God and religious leaders wanted for him. This was highlighted in the last session when the client stated, "I think God just wants me to keep trying. Even if I get it wrong, the key is to not give up and keep trying to be the person I want to be." The client's religious perfectionism was no longer based on unrealistic standards accompanied with extreme forms of self-criticism and self-blame. The client was more flexible in his approach when setting personal standards and more accepting of moments that were previously perceived as failure.

The Behavioral Model of Perfectionism

Terry-Short, Owens, Slade, and Dewey (1995) formed a behavioral model of perfectionism that focuses on how reinforcement and outcomes explain the desire to be perfect. Within this model, if a perfectionist receives positive reinforcement or the avoidance of negative reinforcement for their perfectionism, this is "normal or healthy perfectionism" (p. 664). This theory is based on Skinner's (1968) finding that the occurrence of a behavior will increase or decrease dependent on whether an individual receives positive or negative reinforcement for the behavior performed. A study testing the behavioral model of perfectionism was conducted through comparing four groups (eating-disordered clients, depressed clients, nonclinical athletes, and a nonclinical control group). As predicted, the clinical populations scored much higher on negative perfectionism, whereas the nonclinical populations scored much higher for positive perfectionism. The researchers concluded that the type of reinforcement (positive vs. negative) an individual receives in their goal for perfection is what distinguishes a positive perfectionist from a negative perfectionist.

Advancing these findings, later research hypothesized that striving for perfection serves to produce feelings of success, accomplishment, and achievement (Slade & Owens, 1998). These emotions are positive and rewarding (positive reinforcement). Negative perfectionists are motivated toward high achievement, not as a way to experience emotions related to success but to avoid negative emotions, such as failure or inadequacy, and negative outcomes, such as quitting (negative reinforcement). Performance is motivated by a desire to remove or avoid an aversive stimulus. Hence, negative perfectionists are driven by negative reinforcement and a fear of failure.

Slade and Owens (1998) developed a questionnaire, the Positive and Negative Perfectionism Scale (PANPS), to measure their hypothesis. They found that "the type of behavior underlying positive perfectionism is that of approach (pursuit) behavior, whereas negative perfectionism is underpinned by avoidance (escape) behavior" (p. 380). Positive perfectionists pursue high standards and goals with the desire to become more like their ideal self, whereas negative perfectionists seek to avoid failure, imperfection, or mediocrity in an attempt to evade the feared self.

The behavioral model is beneficial in conducting clinical treatment. Therapists are advised to help clients distinguish the source of their religious and perfectionistic striving. Behavior that is motivated by a desire to be successful leads to a positive perception of the self. Further, these goal-directed behaviors are more likely to be completed. Behavior that is motivated by the desire to avoid some type of punishment or disappointment results in a negative view of the self. In addition, avoidance results in a failure to complete personal and religious goals. The outcome is that these clients perceive the self as objectionable, as evidenced by their inability to live up to self-selected religious standards.

As an example, a common presenting concern with religious clients is failure to hold to a religious standard concerning sexual forms of sin. Within therapy, members of the Church of Jesus Christ often request help to reduce or stop viewing pornography. It should be noted that viewing pornography can result in an individual who is a member of the Church of Jesus Christ being unable to attend significant religious events or take the sacrament. The inability to attend these events is often accompanied with inquiries from family members, friends, or their partner. Thus, a private behavior and remediation becomes public and accompanied by the emotions of shame and embarrassment. When a therapist investigates why the client wants to discontinue their use of pornography, a common response is that viewing pornography is not in accordance with standards of the Church of Jesus Christ. While this reason for discontinuing pornography may be commendable, it is motivated by avoidance. A more effective technique is to assign homework for clients to come up with reasons for why they personally want to achieve their goal of discontinuing pornography and process these reasons in the next session. The desire to view pornography is also normalized to interrupt negative reinforcement patterns of thinking, wherein clients often report a view of their self as "disgusting," "evil," or "vile" for common human desires. Sexual desires are reframed just as healthy as eating is for the body, and, just as we do with eating, we often place self-imposed boundaries on our desires to achieve our preferred outcomes. Clients who generate meaningful,

personal reasons for why they want to achieve their religious goals are more likely to succeed and gain a sense of accomplishment. Their behavior is now a source of positive reinforcement leading to a favorable view of the self and a higher likelihood that the desired behavior will continue to occur.

The Attachment Model of Perfectionism

Parents who are supportive, emotionally responsive, accessible, encouraging, and positive produce children with secure attachment (Johnson, 2004). Securely attached children are more likely to be confident, competent, and willing to take risks; they also see others as trustworthy and see themselves as a person of worth and value (Sorotzkin, 1998). Securely attached children have the ability to see the positive strengths they hold as well as their imperfections and weaknesses from a balanced perspective (Harter, 1998). Ulu and Tezer (2010) found that secure attachments lead a perfectionist to be more adaptive, whereas anxious or avoidant attachment styles lead perfectionists to be maladaptive. Avoidantly attached individuals often evade connection with others and show a preference to remain alone and isolated. Anxiously attached individuals have the tendency to worry intensely that others will not be available or accessible. Their deepest fear is that others will abandon them suddenly.

Research comparing the attachment styles of adaptive and maladaptive perfectionists found that maladaptive perfectionists reported that their parents were significantly critical of their performance and held high expectations (Rice, Ashby, & Preusser, 1996). Findings demonstrated that critical parents are more likely to pay attention to children's performance rather than the primary emotional needs of the children. Within these families, children learn that their identity is synonymous with their performance. Consequently, they evaluate the self on performance factors and living up to others' expectations (Sorotzkin, 1998). Research on secure attachment discovered that if children perceive that they have a strong bond with either a parent or a caregiver, this significantly increases the chances that they will be an adaptive perfectionist (Rice & Mirzadeh, 2000). This is similar to the findings of Allen, Wang, and Stokes (2015), who investigated 421 members of the Church of Jesus Christ to examine the relationship between family, perfectionism, scrupulosity, legalism, guilt, and shame. Results indicated that caregivers' maladaptive perfectionism significantly intensified levels of scrupulosity and shame within college students who are members of the Church of Jesus Christ.

Another study showed that adult-aged college students who are securely attached are less impacted by elements of maladaptive perfectionism, such as feelings of self-doubt and concerns over mistakes, because they have a "more accurate and balanced 'self-referential' feedback" (Rice & Lopez, 2004, p. 124). In addition, securely attached adults have a broader social network, increasing emotional support resources and providing more appropriate corrective feedback. Insecurely attached young adults are more likely to view the self negatively and lack an emotionally supportive social network—factors that are linked to maladaptive perfectionism (Rice & Lopez, 2004).

Gnika, Ashby, and Noble (2013) postulated that adaptive perfectionism acted as a "psychological buffer" (p. 79) in an individual's life. The authors investigated the relationships between adaptive and maladaptive perfectionism with secure, anxious, and avoidant adult attachment styles, as well as depression, hopelessness, and life satisfaction. Adaptive perfectionism was positively associated with life satisfaction and negatively associated with depression, hopelessness, and both avoidant and anxious attachment styles. Maladaptive perfectionism was negatively associated with life satisfaction and positively associated with depression, hopelessness, and both avoidant and anxious attachment styles. These findings indicate that maladaptive perfectionism mediated the relationship between both anxious and avoidant attachment styles and also depression, hopelessness, and life satisfaction. An increase in levels of avoidant or anxious attachment will result in an increase in maladaptive perfectionism. These researchers concluded that adaptive perfectionism "may reduce the tendency of individuals to withdraw from intimate relationships, which mitigates feelings of hopelessness and increases overall life satisfaction" (Gnika et al., 2013, p. 82).

Within the theology of the Church of Jesus Christ, close family relationships are highly valued (Family Proclamation, para. 3). Members of the Church of Jesus Christ often report that when they live up to the teachings and commandments of their religious beliefs, their parents are "proud and happy" (Peer &

McGraw, 2017, p. 86). However, when they fail to keep the commandments or the teachings of the Church, members of the Church of Jesus Christ report that their parents often express disappointment ("I never saw anger ever, just major disappointment") or a loss of trust in their child ("They would always trust me a lot more, a lot more [if I kept the commandments]") (Peer & McGraw, 2017, p. 86). Accordingly, clients are more likely to have an anxious or avoidant attachment style resulting in maladaptive perfectionism if they believe that the connection, closeness, and attachment they can feel with others (e.g., parents, siblings, peers, God, etc.) is directly related to their abilities to keep the commandments and the teachings of the Church of Jesus Christ.

Rice and Lopez (2004) advise clinicians to look into a client's peer relationships, as well as early childhood relationships, in an effort to get a more contextualized understanding of the client's perfectionism. This would be advisable when working with clients who are members of the Church of Jesus Christ. Attachment models of perfectionism emphasize that helping clients develop more securely attached relationships can bring about a reduction in maladaptive perfectionism within treatment. Compassion, rather than the use of shame, disappointment, or nonacceptance, is more likely to lead to secure attachment (Neff, 2011). Family or individual therapy that encourages the client's being more compassionate toward personal sins or mistakes and the caregiver's being more understanding and compassionate toward the client's mistakes or sins is more likely to lead to adaptive forms of perfectionism and higher levels of life satisfaction.

The Self-Conscious Emotions Model of Perfectionism

Innovative research investigated the possible link of perfectionism and self-conscious emotions (see Fee & Tangney, 2000; Tangney, 2002; Tangney & Dearing, 2002). Perfectionists spend an overwhelming amount of time evaluating themselves since they are "oriented toward the process of evaluation. Life is a series of quizzes, tests, and final exams" (Tangney, 2002, p. 199). "Self-conscious emotions" are a specific subset of emotions where the fundamental feature of these emotions is composed of self-reflection and self-evaluation. These emotions play a pivotal role in perfectionism. Self-conscious emotions include guilt, shame, embarrassment, and pride (Tangney, 2002).

Guilt. When an individual feels guilt, they feel bad about the behavior they just performed and the behavior only. For example, if an individual accidentally bumped into someone when walking down a crowded hallway and he or she were to experience guilt, a common internal thought would be, "That was a thoughtless mistake I just made." When guilt is experienced, the negative evaluation is based on the behavior that was performed, not the self. Guilt moves an individual to feel remorse and regret for the behavior performed, often motivating the individual to apologize or make amends. The individual is motivated to say sorry or repair the relationship because they do not feel they are a bad person. The individual only sees their behavior as a mistake.

Shame. This emotion centers on a negative evaluation of the self, not the behavior. Accordingly, in the same scenario where an individual accidentally bumps into someone when walking down a crowded hallway, she or he would likely think, "I am a thoughtless and stupid person for bumping into that individual." Shame causes the individual to feel exposed and embarrassed. With the focus on the self, the person experiencing shame quickly moves to hide or shrink from what has occurred. Feelings of remorse, regret, or repair are replaced with the larger need to hide, disappear, or escape. When individuals experience shame, a mistake is perceived as a confirmation that they, themselves, are objectionable, worthless, insignificant, unacceptable, or defective. In the end, shame is a phenomenologically different experience than guilt.

Embarrassment. Tangney, Miller, Flicker, and Barlow (1996) compared embarrassment to shame to see whether they were different from one another. Their findings demonstrated that those who experienced shame felt the emotion of embarrassment more intensely, feeling and believing they had done something morally wrong. While the emotion of embarrassment causes an individual to show more physiological signs (e.g., blushing) as well as a higher sense of exposure, shame was much more instrumental in making an individual feel anger and disgust toward the self. In addition, shame causes individuals to suppose that others close to them also feel these same levels of anger and disgust toward them.

Pride. Pride is often perceived as feelings of arrogance or superiority. However, in psychology, pride is understood differently. Pride is defined as an emotion "generated by appraisals that one is responsible for a socially valued outcome or for being a socially valued person" (Mascolo & Fischer, 1995, p. 66). Pride is centered on the sense of accomplishment that is felt after performing a difficult task; there is recognition of the hard work performed in order to reach a specific goal. An individual who experiences pride may have the thought, "I am really pleased with myself for how I scored on that test after having studied so hard." Pride has the capacity to be a positive emotion because it can enhance "people's self-worth and [encourage] future behavior that conforms to social standards of worth or merit" (Tangney, 2002).

Researchers investigated how self-conscious emotions are related to perfectionism (Tangney, 2002; Fedewa et al., 2005; Kohki, 2001; Tangney & Dearing, 2002). A person who has a "dispositional tendency to experience shame" is more likely to experience negative (maladaptive, unhealthy) forms of perfectionism (Tangney, 2002, p. 210). Guilt, on the other hand, leads to adaptive perfectionism (Fedewa et al., 2005; Kohki, 2001; Tangney & Dearing, 2002) because guilt is related to the experience of empathy. Empathy causes an individual to try to repair a breach through offering an apology or making amends after an offense to another (Tangney, 2002). This act repairs the relationship with the other and provides the self with the ability to acknowledge mistakes without feeling inferior. In contrast, a person who experiences shame is much more motivated to hide their insecurities or mistakes from others to promote an image of perfection. Therefore, shame perpetuates the feelings of being "less than ideal" and "never good enough," while at the same time causing individuals to withdraw and distance themselves from others.

In a follow-up study, Fedewa et al. (2005) investigated types of perfectionism in relation to shame, guilt, and pride. Their findings supported previous findings that state-shame and shame-proneness are associated with maladaptive perfectionism. In addition, they found that pride was negatively correlated with anxiety, hostility, shame-proneness, and unhealthy perfectionism. Therefore, pride is an adaptive emotion. Stoeber, Harris, and Moon (2007) performed a study where they compared healthy perfectionists, unhealthy perfectionists, and nonperfectionists with their experiences of shame, guilt, and pride. Healthy perfectionists were operationalized as individuals with high perfectionistic strivings but low perfectionistic concerns, whereas unhealthy perfectionists had both high perfectionistic strivings and high perfectionistic concerns. The results found that healthy perfectionists "[experienced] more pride and less shame and guilt than unhealthy perfectionists" (p. 139). Further, healthy perfectionists rated lower than unhealthy perfectionists and nonperfectionists on their proneness to shame. Unhealthy perfectionists were found to experience significantly higher levels of shame than healthy perfectionists and nonperfectionists. Both healthy and unhealthy perfectionists had higher proneness to pride than did nonperfectionists. While healthy perfectionists experienced less guilt than unhealthy perfectionists, these two groups did not differ in their proneness to guilt. In conclusion, experience and proneness to shame is the primary moderating variable in what makes an individual a healthy versus an unhealthy perfectionist within self-conscious emotions.

Shame and pride are self-conscious emotions that are highly relevant when treating clients who are members of the Church of Jesus Christ. Shame is often experienced by clients who are members of the Church of Jesus Christ when they fail to keep religious commandments or standards (Peer & McGraw, 2017). Helping these clients distinguish between guilt and shame, where individuals realize that they performed a bad behavior but are not bad people, is an important goal in therapy. Guilt enables the individual to feel sorry, make amends if needed, and even repent. These are often components to a religious lifestyle. Shame prompts the individual to often experience feelings of self-hatred and to avoid making amends. These feelings are not common components to a religious lifestyle. Many LDS clients have come to believe that shame brings about repentance and change. However, research demonstrates that shame causes an individual to avoid repentance and change and to hold feelings of hatred toward the self. Therefore, helping clients understand that shame will not lead clients to their desired outcomes is a vital component in treatment.

Therapists should also encourage clients who are members of the Church of Jesus Christ to experience

higher levels of pride. This intervention requires a therapist to reframe how pride is defined. Within the culture of the Church of Jesus Christ, the emotion of pride is often perceived negatively due to teachings by LDS prophets and within the Book of Mormon (Benson, 1989). In these instances, pride is defined as a sense of superiority. Therapists can help LDS clients discriminate between religious pride (a sense of superiority or arrogance) and psychological pride (a positive feeling of personal accomplishment). Helping LDS clients realize that taking a moment to enjoy and appreciate their accomplishments (psychological definition of pride) after they have put in hard work is not only appropriate, it also leads to reaching their religious goals.

The Acceptance Model of Perfectionism

Lundh (2004) affirmed that the key determinate of whether an individual was an adaptive or a maladaptive perfectionist was the concept of acceptance. When an individual is unable to accept anything performed "less than perfect," the result is dysfunction or maladaptive behavior in the pursuit of perfection. The expectation to be perfect becomes a demand rather than a desire or aspiration. This expectation leads to maladaptive perfectionism. Positive perfectionism is made up of two key components: first, the desire to strive for perfection (perfectionistic striving), and second, the ability to accept nonperfection in an individual's behavior or task performance (acceptance). The primary differentiating factor between adaptive and maladaptive perfection is the ability to accept a less-than-perfect performance on a task.

Three different forms of acceptance are outlined within this model (Lundh, 2004): *self-acceptance*, where an individual is able to accept one's self as is; *other-acceptance*, the ability to accept other people within their social environment as they are; and *experiential acceptance*, the ability to accept one's own internal "experiences [thoughts, feelings, body sensations, behavioral interpretations, etc.] and allow them to have their way, without trying to suppress or control them" (p. 257).

Lundh's model of acceptance in understanding perfectionism helps clients differentiate healthy versus unhealthy ways to engage in religious perfectionism. The core finding indicates that religious striving should come from a personal desire to improve oneself rather than from a demand to be flawless. If individuals believe the only way they can be morally good or acceptable to God is through perfection, perfectionistic striving becomes a demand in their life. This will lead to poor mental health outcomes, such as depression, anxiety, low self-esteem, etc. Healthy perfectionists can accept less-than-perfect performance and adjust their perfectionistic standards for the short-term in order to reach their long-term goals.

The "Big Five Personality Traits" Model of Perfectionism

Researchers have investigated how perfectionism is related to personality factors using the Big Five personality assessment instruments (Dunkley, Blankstein, Zuroff, Lecce, & Hui, 2006; Hewitt, Flett, & Blankstein, 1991; Hill, McIntire, & Bacharach, 1997; Parker & Stumpf, 1995; Stumpf & Parker, 2000). The five personality traits are *extraversion*, *agreeableness*, *conscientiousness*, *neuroticism*, and *openness to experience*. *Extraversion* comprises personality traits such as sociability, talkativeness, energy, activity, assertiveness, stimulation when being with others, and positive emotionality. *Agreeableness* represents being cooperative, trustful, tender-minded, well-tempered, compassionate, altruistic, and modest. *Conscientiousness* describes an individual's tendency to be organized, show self-discipline, prioritize tasks, and be careful in planning (as opposed to being highly spontaneous or impulsive). *Neuroticism* describes an individual's propensity to experience unpleasant emotions easily, such as feelings of anger, nervousness, sadness, and tension. Neuroticism also refers to an individual's degree of emotional stability. *Openness to experience* involves traits such as creativeness, adventure, uniqueness, curiosity, appreciation of art, originality, and imagination (Ulu & Tezer, 2010).

Research comparing perfectionism with personality traits has found that neuroticism was significantly associated with socially prescribed perfectionism in males and females and was also significantly associated with self-oriented perfectionism in females (Hewitt et al., 1991). Hill et al. (1997) found that self-oriented perfectionism was strongly associated with conscientiousness and personal striving, while socially prescribed perfectionism was associated with neuroticism, and other-oriented perfectionism was inversely associated with agreeableness. Self-oriented

perfectionism was found to be more adaptive, whereas socially prescribed and other-oriented perfectionism are maladaptive. Self-critical perfectionism (negative perceptions of the self and a defensive interpersonal orientation) was positively associated with neuroticism in another study (Dunkley et al., 2006). In conclusion, the replicated finding is that the trait of neuroticism is a component of maladaptive perfectionism, whereas adaptive perfectionism is significantly predicted by conscientiousness, openness, and extraversion (Ulu & Tezer, 2010).

These findings direct clinicians toward mechanisms that are most efficacious in treatment with perfectionists. The therapist will be most effective by helping clients in "developing a new set of beliefs about oneself and developing new relationships with more affirming others" (Ulu & Tezer, 2010, p. 336). Intrapersonal and interpersonal factors allow the client to gain more stability in the frequency and intensity of emotions such as anger, sadness, tension, and nervousness (neuroticism). In addition, researchers advise utilizing the therapeutic relationship as a secure attachment base. This secure base enables clients to reach their goal of gaining a more positive view of the self, having more secure and trusting relationships, and increasing in interpersonal competencies (Ulu & Tezer, 2010).

In particular, therapists can highlight with clients who are members of the Church of Jesus Christ that the components that promote an adaptive form of perfectionism—agreeableness and conscientiousness—are endorsed within the beliefs of religious teachings of the Church of Jesus Christ. For example, the traits of being cooperative, trustful, well-tempered, compassionate, modest, and altruistic (agreeableness) are often virtues that an individual is counseled to strive for within the religious faith of the Church of Jesus Christ. Showing reasonable self-discipline, being careful in planning, prioritizing what is important, and being well-organized (conscientiousness) are also values endorsed within the Church's faith. Therefore, personality components that promote adaptive perfectionism are endorsed within the teachings of the Church's faith.

The Mindfulness Model of Perfectionism

Mindfulness has been demonstrated to be an operative component of several theoretical models (see Harris & Hayes, 2009; Hayes & Smith, 2005; Kabat-Zinn, 2011; Linehan, 1993; Neff, 2011). Researchers have explored how mindfulness may impact perfectionism. Two primary components of socially prescribed perfectionism and maladaptive perfectionism are chronic worrying and rumination. Chronic worry is when individuals consistently and continually hold on to thoughts about the uncertain outcome of a future event, which results in experiencing negative emotions. Rumination occurs when individuals continually review a past event over and over in their minds while linking that event with negative affect. Chronic worry focuses on an unknown future, whereas rumination focuses on the past; neither allows individuals to be present with their experiences. Because of the impact of rumination and chronic worry, practicing mindfulness (being present in the moment) can lead to a reduction of maladaptive perfectionism or socially prescribed perfectionism.

Mindfulness is a process whereby individuals are able to bring their complete attention to what they are experiencing in the present moment without judgment. Mindfulness has been found to be both a dispositional factor in some people and a skill that can be gained through practice. The construct of mindfulness is made up of five skills. First, individuals are able to observe within their social environment both external and internal stimuli in the form of thoughts, sensations, and feelings. Second, these sensations, thoughts, or feelings are observed without judgment. Third, individuals remain and act with awareness, rather than focusing their attention elsewhere. Fourth, as individuals experience internal and external occurrences, continuous nonjudgment is exhibited toward their thoughts and feelings. Lastly, individuals are nonreactive to internal experience, allowing thoughts and feelings to come and go freely. The integration of mindfulness in therapeutic work with LDS clients is highly warranted for reducing chronic worry and rumination. Mindfulness teaches an individual to avoid judgment and reactivity, the two primary components of worry and rumination, resulting in a lowering of negative affect (Short & Mazmanian, 2013).

Short and Mazmanian (2013) postulated that it is harder for perfectionists to accept moments of failure; that is why it is hard for them to extricate themselves from rumination. The researchers devised a study with 213 university-student participants and

found that both chronic worry and rumination "underlie the relationship between socially prescribed perfectionism and negative affect" (p. 720). When an individual acts with greater awareness and nonjudgment toward his or her inner experience (thoughts, feelings, body sensations), a reduction of maladaptive perfectionism occurs. Those who ranked higher in mindfulness had lower levels of socially prescribed perfectionism, negative thoughts, and distress. However, higher levels of mindfulness were not found to have a mediating effect on rumination. Therefore, Short and Mazmanian's hypothesis was partially supported. These findings demonstrate that mindfulness functions as a protective factor when it comes to rumination, but not as a mediating effect.

Both chronic worry and rumination can be common components in a religious individual's life, particularly among members of the Church of Jesus Christ. A strong component of the Church's theology is the belief that family relationships continue into the next life for eternity (Family Proclamation, para. 1) and that everyone will be judged for their actions on earth to determine their eternal destination in the afterlife. Religious individuals tend to worry chronically about the salvation of not only themselves but others in their lives (Exline, 2002; Ellison et al., 2009). This chronic worry is often heightened in clients who are members of the Church of Jesus Christ because if a family member stops practicing the Church's faith, family relationships could be incomplete in the hereafter. Members of the Church of Jesus Christ are highly invested and tend to ruminate about not only their personal salvation but the salvation of all of their family members going generations back in their ancestral line. In addition, another component of the Church's theology is that repentance requires an individual to feel sorrow for past sins. Some members of the Church of Jesus Christ interpret this belief to mean that ruminating about past sins, to an unhealthy degree, is the only way to fulfill the requirements of the repentance process. Mindfulness is an effective intervention strategy to help clients who are members of the Church reduce worry and rumination.

Conclusion

While religiousness often serves as a protective factor against many mental health concerns, at times it can lead to religious perfectionism that is associated with poor mental health outcomes (i.e., depression, anxiety, eating disorders, OCD, and scrupulosity). Clinicians can feel perplexed by how to ethically support the client's autonomy in his or her religion (self-determination) while at the same time promoting mental healing and wellness. The theoretical models reviewed in this paper—the six facets, the three facets, behavioral, attachment, self-conscious emotions, acceptance, Big Five personality traits, and mindfulness—have been shown to be effective and successful in the conceptualization and treatment of clients who are members of the Church of Jesus Christ and who present with maladaptive religious perfectionism. Further, these models help therapists uncover a methodology to support clients engaging in the standards and teachings of their faith, while at the same time alleviating their suffering and promoting their healing. All of these models help clients embrace their desire for perfectionistic striving (a central component of their religious faith) while moving away from maladaptive forms of religious perfectionism.

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