

Article

John Wesley's Holistic Healing and Contemporary Cognitive Behavioral Therapy: Toward a Differentiated Integration

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Abstract

This study argues that contemporary CBT/RCBT and John Wesley's theology of holistic healing reveal significant structural analogies despite their fundamental differences in agency, practices, and the goal of healing. This study first examines how each tradition understands the possibility and process of human change, as it compares CBT/RCBT's views of therapeutic learning, cognitive reorientation, core-belief transformation, and individualized development with Wesley's ideas of prevenient grace, repentance, faith and new birth, and sanctification. It then turns to the behavioral and relational practices for achieving transformation, as it delves into the analogical relation between CBT/RCBT's emphasis on behavioral experiments and therapeutic collaboration and Wesley's concern for the means of grace and social holiness. Finally, it considers the goal and scope of healing, as it relates adaptive functioning and whole-person flourishing in CBT/RCBT to Wesley's vision of restoration in the image of God, holy love, and happiness in God. In that respect, the study proposes a model of differentiated integration, which suggests that Wesley's theology harmonizes with CBT/RCBT's therapeutic approaches for their structural similarities despite their different visions of agency, practices, and the goal of healing.

Keywords: John Wesley; cognitive behavioral therapy; religiously integrated cognitive behavioral therapy; holistic healing; sanctification; human flourishing; differentiated integration

1. Introduction

Existing studies in Wesley scholarship have examined how Wesley's theology can relate to psychotherapy. Maddox argues that Wesley's understanding of human transformation was driven by his affectional moral psychology, which is directed toward holy character on account of divine grace (Maddox 2004, pp. 101–8). Kilian and Parker and Holeman develop these insights clinically. They relate prevenient grace, sanctification, religious affections, and holy love to human agency, relational change, and therapeutic practice, while distinguishing between theological and clinical transformation (Kilian and Parker 2001, pp. 74–78; Holeman 2014, pp. 370–75). Studies of Wesley's health practices further broaden this perspective. Ott emphasizes the interdependence of body and soul, while Madden and Hughes show that Wesley brought faith, empirical medicine, and care for body, mind, spirit, and community into a holistic framework without reducing one dimension to another (Ott 1991, pp. 43–44; Madden 2004, pp. 741–58; Madden 2006, pp. 162–72; Hughes 2008, pp. 240–47). Although previous studies have explored the relationship between Wesleyan theology and psychotherapy or counseling, the structural



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relationship between Wesley's account of holistic healing and contemporary CBT, particularly RCBT, has not been much explored. This study addresses this gap by comparing their accounts of transformative process, therapeutic practices and relationships, and the goal of healing. Taken together, this study suggests a model of differentiated integration, which relates CBT and RCBT as clinical approaches to the psychological dimension of healing within Wesley's broader theological vision. The task of suggesting this model needs to admit its methodological cautions. This project aims at reinterpreting and reconstructing Wesley's theology in light of the contemporary theoretical frameworks of CBT/RCBT, as it selectively focuses on certain theological elements in Wesley agreeable with CBT/RCBT. In that respect, this project does not go so far as to interpret CBT/RCBT and other religious approaches in RCBT in light of Wesley's theology. In addition, though it embarks on relating Wesley's theology to CBT/RCBT, it does not make any value judgment on any other religious options in RCBT.

Cognitive behavioral therapy (CBT) is an evolving family of empirically oriented approaches rather than a single technique of cognitive disputation. Classical cognitive therapy emphasized the role of interpretations and beliefs in emotional and behavioral disturbance and sought to help clients identify and modify maladaptive patterns of thinking (A. T. Beck 1976; Dobson and Dozois 2019). Beck's later Generic Cognitive Model broadened this approach, as it locates beliefs within deep-rooted schemas and modes involving cognitive, affective, motivational, and behavioral processes and treats maladaptation as continuous with ordinarily adaptive functioning (Beck and Haigh 2014). Contemporary CBT combines individualized case conceptions of different cases with cognitive, behavioral, and experiential interventions (J. S. Beck 2021). Behavioral experiments allow therapists and clients collaboratively to test beliefs through action and reflection, which, as a form of experiential learning, can engage different dimensions of meaning not readily changed through verbal thought records alone (Bennett-Levy 2003; Bennett-Levy et al. 2004). The therapeutic relationship has been conceived as a shared process of identifying problems and testing beliefs, although its specific mechanisms are empirically underexplored (Tee and Kazantzis 2011). Meanwhile, studies of treatment components and mediation have examined whether direct cognitive challenging alone can account for therapeutic change (Longmore and Worrell 2007). Third-wave approaches expanded attention toward acceptance, mindfulness, emotion, relationships, values, goals, and metacognition (Hayes and Hofmann 2017), while process-based therapy has moved further toward individualized, context-sensitive biopsychosocial processes of change rather than fixed disorder-specific protocols (Hofmann and Hayes 2019). This process-oriented development has also led evidence-based therapy to pay more attention to the investigation of spiritual traditions and holistic flourishing, as it provides a conceptual context—though not a direct genealogy—for the emergence of religiously integrated CBT (Hayes and Hofmann 2017).

Religiously integrated cognitive behavioral therapy (RCBT) emerged through adaptations of CBT to clients whose religious commitments shape their interpretive world. Early studies retained well-established standard cognitive-behavioral procedures while incorporating religious content into cognitive restructuring, imagery, and homework (Pecher and Edwards 1984; Propst et al. 1992). Later work broadened this approach from specifically Christian content to clients' wider religious resources, including prayer, scripture, gratitude, forgiveness, altruism, behavioral activation, and religious community involvement (Koenig 2012; Pearce et al. 2015). Costa and Moreira-Almeida (2022) describe RCBT as a culturally sensitive, client-centered adaptation in which religious beliefs and practices may function either as therapeutic resources or, when contributing to suffering, as targets of intervention. RCBT thus provides an important clinical bridge to Wesley by extending cognitive and behavioral change into religious practice, meaning, and com-

munity, while leaving decisive differences concerning the agency, practices, and telos of transformation.

This study argues that contemporary CBT/RCBT and Wesley's theology of holistic healing reveal significant structural analogies in their views of therapeutic change, behavioral and relational practices, and the concern for holistic healing as their goal, while revealing differences in defining what they are. Both CBT/RCBT and Wesley concur in the possibility of therapeutic change, the need for repetitive, social practices, and the importance of the holistic goal of healing, while they differ in attributing change to divine grace, its effects irreducible to practices, and the goal transcending clinical concerns. The appropriate relation between them is therefore one of differentiated integration, in which clinical healing is affirmed as a genuine but differentiated dimension within a broader theological vision of holistic restoration.

The first section examines the process of therapeutic change by tracing its four dimensions: its possibility, the recognition and reorientation of problematic patterns, deeper transformation, and continuing individualized formation. It compares changes through therapeutic learning with changes through prevenient grace, cognitive reorientation with repentance, core-belief change with faith and new birth, and individualized therapeutic development with sanctification, as it argues that the strongest parallels concern patterns of transformation. The second section addresses the behavioral, relational practices that facilitate the process of transformation. It compares behavioral experiments and repeated therapeutic practices with Wesley's means of grace, and therapeutic collaboration with social holiness, while showing that both traditions understand change as enacted and relational while differing decisively in the source and character of their efficacy. The third section considers the goal and scope of healing. It compares adaptive functioning and holistic flourishing in CBT/RCBT with Wesley's restoration of the image of God, while showing that both traditions grapple with cognitive, affective, behavioral, relational, bodily, and spiritual dimensions of human well-being despite their different goals of therapy.

2. Therapeutic Change as a Transformative Process

The first section examines therapeutic change as a process of transformation by comparing contemporary CBT and Wesleyan soteriology. Both traditions understand change as involving more than isolated thoughts or behaviors, as they attend to the possibility of change, the recognition of deeply rooted problematic patterns, the reorganization of those patterns, and the continuing formation of new patterns over time.

2.1. *The Possibility of Therapeutic Change: Transformative Learning and Prevenient Grace*

A basic point of contact between CBT/RCBT and Wesley lies in their affirmation that there is the possibility of therapeutic change that can be attained through the process of transformation. In contemporary CBT, this possibility is understood primarily in terms of learning and the modification of cognitive and behavioral patterns. Case-formulation approaches emphasize that CBT should “flexibly meet[] the unique needs of the patient at hand” and develop an individualized formulation that guides treatment (Persons 2008, pp. 1–2). Behavioral experiments make this process especially concrete. They are individually designed to test beliefs through prediction, action, observation, and reflection, and repeated experiences may be necessary when dysfunctional patterns are deeply entrenched (Bennett-Levy et al. 2004, pp. 21–22, 44). In this sense, CBT works with a clinically observable capacity to learn from experience and to develop new cognitive, affective, and behavioral patterns. RCBT also preserves this learning-based account of change while extending it into the client's religious world. Costa and Moreira-Almeida describe psychoeducation as central to CBT because it enables clients to develop abilities to

modify cognition, emotion, and behavior so that they can “become their own therapist,” which, according to RCBT, is supplemented by religious rationales, values, and practices (Costa and Moreira-Almeida 2022, pp. 453–54). Pearce and colleagues similarly integrate repeated religious practices—such as contemplative prayer, scripture memorization, and prayer for others—into daily therapeutic activity, and argue that such practices strengthen psychological skills and support spiritual growth (Pearce et al. 2015, pp. 58–59). RCBT therefore retains the CBT assumption that human patterns can be learned, practiced, and modified throughout the therapeutic process of transformation, while locating part of that learning within the client’s own religious beliefs and practices.

In light of RCBT’s shared assumption of therapeutic change with CBT and its distinctive emphasis on religious beliefs and practices, Wesley’s theological account of prevenient grace can be reframed as the condition of possible therapeutic change. Wesley also affirms the possibility of therapeutic change, as he grounds it in prevenient divine grace, which is not reducible to an autonomous human capacity. In *On Working Out Our Own Salvation*, he writes: “Salvation begins with what is usually termed (and very properly) preventing grace; including the first wish to please God, the first dawn of light concerning his will, and the first slight transient conviction of having sinned against him” (Wesley 1872f, p. 509). Prevenient grace thus marks “the beginning of a deliverance from a blind, unfeeling heart” and initiates the possibility of further response. Yet this divine priority does not eliminate human activity. Wesley begins the same section: “If God worketh in you, then work out your own salvation,” adding that “you yourselves must do this, or it will be left undone for ever” (Wesley 1872f, p. 509). The structure is therefore neither autonomous self-transformation nor passive reception, but grace-enabled response. Wesleyan scholarship has emphasized this point. Maddox describes salvation as grounded in the prevenience and indispensability of divine grace while also stressing its “co-operant” character: grace can be resisted and must be “put to work” if it is to achieve its intended effect (Maddox 1994, p. 147). Collins likewise interprets prevenient grace as the priority of divine action that elicits genuine human response and makes cooperation possible, rather than as a natural human capacity independent of grace (Collins 2007, pp. 73–75).

The comparison therefore addresses the possibility of therapeutic change through the transformative process of learning and response as the first aspect of the structural analogy between CBT/RCBT and Wesley, though revealing their differences in conceptualizing therapeutic agency. CBT describes psychological capacities for learning and change as conditions of therapeutic change, with RCBT incorporating religious rationales, values, and practices into this therapeutic process, whereas Wesley understands human responsiveness itself as enabled by the prior and continuing agency of divine grace. Therapeutic learning and prevenient grace are thus structurally comparable but conceptually distinct: the former explains mechanisms of psychological change, whereas the latter gives a theological account of the prevenient grace that defines it as the condition of human responsiveness.

2.2. Recognizing and Reorienting Deep Patterns: Core Beliefs and Repentance

In addition to suggesting the possibility of therapeutic change, another point to consider is the recognition of one’s problematic condition of life and the demand for re-orientation, whether it is a matter of one’s core beliefs or repentance. In CBT, automatic thoughts emerge out of deeper intermediate and core beliefs that shape how situations are interpreted and how persons think, feel, and act (J. S. Beck 2021, pp. 35–37). One aim of treatment is to identify dysfunctional beliefs about clients’ situations and themselves and develop more reality-based and adaptive alternatives. Beck therefore emphasizes that dysfunctional beliefs can be “unlearned” and replaced or strengthened through new learning and therapeutic work (J. S. Beck 2021, p. 36). The therapeutic task is thus not

merely to suppress negative thoughts, but to make underlying patterns available for critical examination and gradual reorientation. RCBT extends this same process by treating religious beliefs and practices as part of the client's interpretive framework and as potential resources for reorientation. Rather than replacing standard cognitive restructuring, RCBT uses the client's own religious values, teachings, scriptures, and practices to examine and challenge dysfunctional thoughts and beliefs, thereby placing cognitive change within a religiously meaningful framework (Costa and Moreira-Almeida 2022, pp. 458–61; Pearce et al. 2015, pp. 58–59). In this sense, religious belief does not simply add new content to CBT. It can provide an additional normative and motivational context for clients' reassessment of how they understand themselves, their circumstances, and their future. At the same time, RCBT does not assume that all religious cognitions are therapeutically constructive. Beliefs associated with spiritual struggle—such as perceiving illness or suffering as divine punishment or abandonment—may themselves become objects of critical examination and restructuring (Costa and Moreira-Almeida 2022, pp. 460–61). RCBT therefore deepens the CBT process of reorientation by bringing the client's lived religious world into both the diagnosis of dysfunctional interpretation and the formation of alternative patterns of thought and practice.

In a similar vein, Wesley articulates a doctrine of repentance when he addresses the recognition of a deeper disorder and a demand for reorientation, though its framework is explicitly more theological and moral than psychological. Repentance is not simply awareness of error or the correction of mistaken judgment. In *The Principles of a Methodist Farther Explained*, Wesley responds to the objection that his account reduces repentance to conviction of sin by recalling his earlier definition of repentance as “conviction of sin, producing real desires and sincere resolutions of amendment,” thereby insisting that repentance includes not only recognition of deep-seated sin and immediately responsive desires but also a genuine purpose of amendment and obedience (Wesley 1872m, pp. 428–29). Repentance therefore involves a theological recognition of one's sinful condition before God and a reorientation of desire, purpose, and conduct toward obedience. This reorientation also reaches beyond cognition into desire, will, and conduct. In *A Farther Appeal to Men of Reason and Religion*, Wesley specifies what repentance is in his account of “fruits meet for repentance,” which include “forgiving our brother; ceasing from evil, doing good; using the ordinances of God,” and obedience “according to the measure of grace which we have received” (Wesley 1872a, p. 47). Repentance is therefore not merely a revised recognition of one's problematic condition but a grace-enabled change in one's practical re-orientation. It involves recognizing one's disorder, abandoning patterns judged contrary to God's will, and adopting new patterns of desire and action ordered toward God and neighbor. The comparison with CBT and RCBT is therefore strongest at the level of deep reorientation: both seek to bring underlying interpretive patterns into critical awareness and redirect them, but Wesley judges those patterns not primarily by therapeutic functionality or religious meaningfulness, but by their relation to sin, grace, obedience, and holy love.

The structural similarity lies in the movement from unexamined deep patterns toward conscious recognition and practical reorientation. Both CBT and Wesley refuse to treat surface reactions apart from more enduring patterns that shape their habits of interpretation, their circumstances, and their possible responses. In CBT and RCBT, these patterns are examined in terms of their accuracy, functionality, psychological consequences, and their relation to the client's religious framework. In Wesley, however, they are judged in terms of one's relation to God, which involves the conviction of sin and reorientation in their changed desire, obedience, forgiveness, ceasing from evil, doing good, and the use of the ordinances of God.

2.3. Deep Therapeutic Change: Core-Belief Change and New Birth

After considering the possibility of therapeutic change and the demand for recognizing one's problems and reorienting one's life, it is necessary to examine the deeper moral–psychological structures that sustain recurring patterns of thought, emotion, and action. In CBT, core beliefs are relatively deep-seated, fundamental beliefs about the self, others, and the world that organize the interpretation of experience and influence the formation of automatic thoughts, emotional responses, and behavioral tendencies. Because such beliefs often operate as enduring assumptions rather than as isolated conscious judgments, dysfunctional core beliefs can repeatedly shape how new situations are perceived and can reinforce characteristic patterns of distress and maladaptive behavior. Therapy therefore seeks not merely to challenge particular negative thoughts but to identify deeper beliefs from which these thoughts arise, weaken dysfunctional beliefs, and strengthen more realistic and functional alternatives through cognitive and experiential work (J. S. Beck 2021, pp. 30–36, 303–5). In this respect, substantial therapeutic change involves a reorganization of the cognitive structures of one's habitual interpretation of experience, as changes in core beliefs gradually affect cognition, emotion, behavior, and the person's broader pattern of responding to one's situation. This therapeutic change can be gradual as well as sudden, depending on whether and how reorganization of the cognitive structures takes place at the level of one's core belief. Although CBT generally understands change as a gradual process of cognitive and behavioral learning, research on sudden gains demonstrates that substantial improvement can also occur abruptly within an ongoing course of treatment. Such changes may be preceded by cognitive reorientation and followed by further improvement, suggesting an interaction between gradual development and sudden transformation (Tang and DeRubeis 1999, pp. 894–904; Tang et al. 2005, pp. 168–72). RCBT recognizes that, for religious clients, some of these enduring interpretive structures of core beliefs are embedded within a broader religious worldview. Religious beliefs, values, teachings, and practices provide resources for challenging dysfunctional interpretations and constructing alternative ways of understanding the self, the world, suffering, and the future (Costa and Moreira-Almeida 2022, pp. 458–60; Pearce et al. 2015, pp. 59–61). In addition, when religious interpretations intensify distress—such as beliefs that God has abandoned or is punishing the person—they may be examined and restructured as part of treatment (Costa and Moreira-Almeida 2022, pp. 460–61). RCBT broadens the cognitive model by locating belief change within the client's lived religious meaning system, as it allows cognitive, emotional, behavioral, and spiritual patterns to be addressed together without abandoning the basic CBT mechanism of identifying and modifying dysfunctional beliefs. CBT and RCBT provide a useful framework for asking whether Wesley's account of transformation likewise reaches beneath particular acts or judgments to more enduring orientations that organize the moral and religious life of the person.

In addition, Wesley also affirms that there is an instantaneous aspect of therapeutic change within its gradual process of sanctification. For Wesley, there is an ongoing process of sanctification as therapeutic change, which begins with an initial moment of justification and ends with a final, instantaneous moment of change. “It is both the one and the other. From the moment we are justified, there may be a gradual sanctification, a growing in grace, a daily advance in the knowledge and love of God. And if sin cease before death, there must, in the nature of the thing, be an instantaneous change; there must be a last moment wherein it does exist, and a first moment wherein it does not” (Wesley 1872d, p. 329). Wesley likewise understands sanctification as involving both gradual growth and instantaneous transformation. Wesley suggests that there can be an extraordinary instantaneous moment of change that involves a sudden leap of therapeutic change. God may accomplish “the usual work of many years in a moment,” while gradual transformation

continues before and after that moment (Wesley 1872b, p. 423). Wesley's instantaneous dimension of sanctification is grounded not simply in temporal abruptness but in the conviction that sanctification is received by faith rather than achieved through prior human accomplishment. As Wesley puts it, "If you seek it by faith, you may expect it as you are: and if as you are, then expect it now" (Wesley 1872n, 53). Maddox interprets this instantaneous dimension as an expression of entire sanctification as "as unmerited gifts of God, rather than human achievements," while situating such moments within the broader process of gradual transformation (Maddox 1994, pp. 153–54). Collins further distinguishes gradual sanctification as a process from entire sanctification itself as the instantaneous actualization of grace, which marks "a threshold transformation" (Collins 2007, p. 295). Sanctification is therefore not a static condition but a continuing formation toward greater maturity, which involves an instantaneous threshold moment of transformation triggered directly by God's grace as well as by faith.

Wesley's language of spiritual senses can be related to the deeper moral–psychological structures of therapeutic change, although his emphasis on spiritual senses should not be identified directly with the CBT's concept of core beliefs. In *The Great Privilege of Those That Are Born of God*, Wesley describes the unregenerate person as one who is "not sensible of any of the things of God; they make no impression upon his soul," because "the eyes of his understanding" are "closed" and he has "no spiritual senses capable of discerning spiritual objects" (Wesley 1872i, pp. 225–26). After the new birth, however, "all the senses of the soul" are "awake," and "the eyes of his understanding" are "now open," enabling a new perception of God and spiritual good and evil (Wesley 1872i, p. 226). This perceptual renewal can be connected with Wesley's account of holy tempers, since he also argues that "wrong opinions in religion naturally lead to wrong tempers, or wrong practices," while faith, "through the energy of God," produces love toward God and humanity, which evokes "every holy and heavenly temper," including "lowliness, meekness, gentleness, temperance, and longsuffering" (Wesley 1872e, pp. 316–17). Wesley distinguishes justification, "that great work which God does for us, in forgiving our sins," from new birth, "the great work which God does in us, in renewing our fallen nature" (Wesley 1872l, p. 66). Maddox accordingly describes new birth as a restoration of responsive participation in God and a regeneration of human faculties that opens the way for continuing transformation in holiness (Maddox 1994, pp. 169–70). While spiritual senses function as a foundational capacity for spiritual perception, which is interwoven with faith and love and affects one's cognition, holy tempers can be understood as a cognitive-affective structure established by spiritual senses that affect and influence other personal traits. Maddox similarly explains that Wesley's holy tempers are not transient emotions but habituated affections and relatively stable "orienting dispositions" from which holy thoughts, words, and actions proceed (Maddox 1994, p. 132). The Wesleyan analogue to deep cognitive organization should not be reduced either to *belief* or to *temper* alone. Spiritual senses may therefore be understood as a grace-enabled capacity for perceiving God and spiritual reality, while holy tempers describe the enduring affective and dispositional orientation of the renewed person. The two belong to Wesley's broader account of transformed perception, faith, love, and character, although Wesley does not identify them as a single cognitive structure.

The structural similarity between CBT/RCBT and Wesley lies in their shared recognition that the therapeutic change must reach beneath isolated thoughts and behaviors to deeper patterns that organize perception, emotion, and action. CBT locates these patterns primarily in core beliefs and schemas, while RCBT extends the same logic into the client's religious meaning system by using religious beliefs and practices both as resources for restructuring and, when maladaptive, as objects of critical examination. Wesley similarly recognizes that spiritual senses shape cognitive understanding and holy tempers, yet he

refuses to reduce transformation to correct cognition alone. For Wesley, deeper change involves the renewal of senses together with faith and love and enduring holy tempers, which consists of the new birth as God's work of renewing fallen nature. The comparison therefore concerns depth and organizing function rather than conceptual identity. CBT/RCBT explains deep change through modifiable cognitive and religious meaning structures shaped through therapeutic learning, whereas Wesley grounds the renewal of judgment, affection, disposition, and conduct in divine grace, faith, and new birth.

2.4. Ongoing Formation: Individualized Change and Sanctification

A fourth point of comparison concerns therapeutic change as an ongoing, individualized process. Although early CBT was organized around disorder-specific models and treatment protocols, the tradition has increasingly emphasized individualized formulation and flexible adaptation to the processes tailored to a particular person's difficulties. Persons describes case-formulation-driven CBT as an approach that "flexibly meets the unique needs of the patient at hand," beginning with an individualized formulation and using it to guide treatment planning, progress monitoring, and subsequent modification of therapy (Persons 2008, pp. 1–2). This individualized orientation has been further developed in contemporary process-based approaches, which shift attention from standardized protocols for diagnostic syndromes toward context-sensitive, modifiable biopsychosocial processes, while asking which processes should be targeted for "this client given this goal in this situation" (Hofmann and Hayes 2019, p. 38). Third-wave and process-based developments have not simply replaced earlier cognitive and behavioral methods but widened the range of processes—cognitive, affective, behavioral, relational, and contextual—that may become therapeutically relevant (Hayes and Hofmann 2017, pp. 245–46). RCBT extends this individualized logic into the religious domain. Costa and Moreira-Almeida argue that religious adaptation must be "client-centered," taking into account not only a client's religious affiliation but also "the way he/she understands and practices the religion," while emphasizing that the results of such integration should be evaluated "for each client throughout the treatment" (Costa and Moreira-Almeida 2022, p. 462). Pearce and colleagues likewise underscore that RCBT manuals should function as guides rather than prescriptions, since religious beliefs and practices differ substantially within the same tradition. They also acknowledge that some clients may require more than the standard ten sessions or additional time for particular problems, with a longer-term follow-up, depending on how deep-seated those problems are (Pearce et al. 2015, pp. 59, 65). RCBT preserves a structured treatment model while allowing treatments and sessions to be differentiated according to clients' particular situations.

In a similar vein, Wesley likewise understands sanctification as an ongoing process of growth after the new birth that each individual must undergo under differing conditions. In *The New Birth*, he writes that "a child is born of God in a short time, if not in a moment. But it is by slow degrees that he afterward grows up to the measure of the full stature of Christ," adding that the relation between new birth and sanctification corresponds to that between natural birth and subsequent growth (Wesley 1872l, p. 75). He makes the continuing character of this growth equally clear in *A Plain Account of Christian Perfection*: "There is no perfection of degrees, none which does not admit of a continual increase" (Wesley 1872b, p. 374). This growth does not erase particular conditions in different trajectories of diverse persons. Wesley repeatedly allows for differing infirmities, needs, and degrees of progress within the common movement toward holiness, which are to be understood in a moral, religious sense. In the preface to *An Extract from the Journal of Elizabeth Harper*, he defines Christian perfection as "giving God all our heart; loving Him with all our heart, and our neighbour as ourselves," while insisting that this is "well

consistent with a thousand infirmities” (Wesley 1872h, pp. 261–62). He can therefore say that Harper was “a real witness of Christian perfection, but only in a low degree,” while acknowledging that others may be delivered from such infirmities “in a far greater measure” (Wesley 1872h, p. 262). Wesley’s language elsewhere suggests that pastoral care is responsive to diverse human conditions: Christians are to “instruct, rebuke, exhort, and pray with them, and for them, according to their several necessities” (Wesley 1872c, p. 251). Christian fellowship involves instruction, rebuke, exhortation, and prayer according to differing needs of particular persons. The common process of sanctification is thus neither mechanically uniform nor psychologically homogeneous. Yet this diversity of degree, infirmity, and need does not dissolve the common telos, which Wesley identifies as “that never-failing love of God and man” and the pursuit of “the entire image of God” (Wesley 1872h, p. 262). Sanctification therefore holds together a shared theological end with diverse personal trajectories: human particularity is not simply erased by holiness but is progressively formed within a common movement toward holy love and restoration in the image of God.

The comparison with CBT/RCBT therefore concerns more than gradual change alone. Both traditions understand transformation as an ongoing process that must take account of each individual’s concrete condition rather than imposing a completely uniform path of change. CBT individualizes case formulation, treatment targets, pacing, and interventions according to each patient’s particular history, maintaining mechanisms, goals, and therapeutic response, while RCBT extends this individualized structure into the religious domain by adapting treatment to the client’s own religious beliefs, practices, values. Wesley allows for differing infirmities, present needs, degrees of growth, and trajectories of sanctification within the common life of grace. The decisive difference is that Wesley’s differentiated process is ordered toward a shared theological telos: personal conditions and rates of growth may vary, but the goal remains holy love, Christlikeness, and renewal in the image of God. Wesleyan sanctification therefore holds together diversity of condition, need, and degree with unity of telos, whereas CBT/RCBT individualization is primarily organized around the clinically defined needs, goals, mechanisms, and, in RCBT, the particular religious world of the patient.

3. Practices and Relationships of Therapeutic Change

This section examines therapeutic change as a practice-mediated process rather than a matter of insight alone. CBT and RCBT both emphasize repeated, enacted practices that shape beliefs, emotions, and behaviors, while Wesley locates repeated practices within the means of grace as divinely appointed occasions of God’s transforming agency.

3.1. *Therapeutic Practice: Behavioral Experiments, Repetition, and the Means of Grace*

A first point of comparison concerns the role of concrete practice in transformation. In CBT, behavioral experiments are planned in order to test beliefs and to generate new learning. Longmore and Worrell define behavioral experiments as “planned, experiential activities designed to test the validity of beliefs” and describe them as a form of collaborative empiricism aimed at cognitive change (Longmore and Worrell 2007, p. 180). Behavioral experiments therefore move beyond verbal reflection by placing clients in situations where they can test their own expectations and learn experientially alternative interpretations. RCBT extends this practical dimension by integrating religious practices into the behavioral work of therapy. Pearce and colleagues include contemplative prayer, scripture memorization, prayer for others, gratitude, forgiveness, altruism, and participation in religious community as repeated practices that enable and facilitate therapeutic skills (Pearce et al. 2015, pp. 58–59). In this respect, RCBT does not merely add religious content

to cognitive reflection. It incorporates religiously meaningful action into the process of learning, while reshaping beliefs, emotions, and behaviors through repeated practice within the client's own faith tradition.

Though Wesley likewise assigns a central role to concrete practices, he interprets their function theologically. In *The Means of Grace*, he defines the means of grace as “outward signs, words, or actions, ordained of God, and appointed for this end, to be the ordinary channels whereby he might convey to men, preventing, justifying, or sanctifying grace” (Wesley 1872j, pp. 187–88). He identifies among the chief means “prayer, whether in secret or with the great congregation; searching the Scriptures,” including reading, hearing, and meditation, and “receiving the Lord's supper” (Wesley 1872j, p. 188). These practices are therefore regular forms of Christian participation which make believers seek and receive grace. Wesley also describes transformation as being deepened through repeated engagement with these practices. Speaking of a person being awakened through Scripture, he writes: “The more he hears and reads, the more convinced he is; and the more he meditates thereon day and night.” He continues, “And by all these means, the arrows of conviction sink deeper into his soul” (Wesley 1872j, pp. 198–99). This passage is particularly important because it shows that Wesley does not treat the means merely as isolated religious acts. Repeated hearing, reading, and meditation deepen conviction and increasingly influence the person's understanding, affections, and response.

At the same time, Wesley rejects any understanding that repetition or practice itself automatically produces therapeutic change. He states that “the whole value of the means depends on their actual subservience to the end of religion,” while adding that, when separated from that end, they are “less than nothing and vanity” (Wesley 1872j, p. 188). He further insists that “all outward means whatever, if separate from the Spirit of God, cannot profit at all” and that “there is no inherent power” in prayer, Scripture, or the Lord's Supper, since “it is God alone who is the Giver of every good gift, the Author of all grace” (Wesley 1872j, pp. 188–89). Though repeated practice is significant, its efficacy is not mechanical. Therapeutic change remains dependent upon divine grace. This does not make the believer passive. Wesley explicitly argues that “all who desire the grace of God are to wait for it in the means which he hath ordained; in using, not in laying them aside” (Wesley 1872j, p. 190). Maddox similarly interprets Wesley's mature account of the means of grace as combining divine agency with human participation: the means function as channels of empowering grace and practices of nurturing Christian character (Maddox 1994, pp. 199–201). The means of grace therefore involve both receptive dependence and sustained participation.

The structural similarity between CBT/RCBT and Wesley lies in the conviction that enduring transformation requires the ongoing process of enactment and repetition rather than insight alone. Behavioral experiments expose beliefs to experiential testing and generate new learning, while RCBT extends this practice-based logic by incorporating repeated religious activities—such as contemplative prayer, scripture memorization, gratitude, forgiveness, altruism, and participation in religious community—into the therapeutic process, so that cognitive and behavioral change is reinforced within the client's own faith tradition. Wesley's means of grace involve repeated practices deepened by conviction, faith, and Christian formation. Yet the difference remains decisive. Behavioral and religiously integrated therapeutic practices are designed to produce learning, coping, and behavioral change through structured experience, whereas the means of grace are divinely appointed practices whose efficacy depends upon the Spirit and the gracious action of God. The comparison is therefore best understood as one of repeated, practice-mediated transformation, while preserving the distinction between therapeutic practice and the means of grace.

3.2. Relationally Mediated Change: Therapeutic Alliance and Social Holiness

A second point of comparison concerns the relational mediation of transformation. In CBT, the therapeutic relationship is not merely a supportive background for the application of techniques. Tee and Kazantzis describe collaborative empiricism as a process in which clients and therapists “actively collaborate to identify problem situations, and to design, implement, and evaluate empirical tests of the client’s beliefs” (Tee and Kazantzis 2011, p. 48). They further characterize this relationship as a “collaborative sharing of the work,” emphasizing joint participation rather than passive compliance (Tee and Kazantzis 2011, pp. 48–49). The therapeutic relationship becomes one context for clients’ active participation in their own change. RCBT incorporates this relational dimension by requiring therapists to engage the clients’ own religious world rather than impose the therapists’ beliefs. Costa and Moreira-Almeida emphasize that therapists employing RCBT should use the clients’ own “religious beliefs, values, teachings, and practices,” while they need not share those beliefs and should avoid any attempt to proselytize (Costa and Moreira-Almeida 2022, pp. 447, 462). Pearce and colleagues broaden the relational field beyond the therapist–client dyad by encouraging involvement in religious community and support for others, so that change is mediated not only through therapeutic collaboration but also through reciprocal social and religious participation (Pearce et al. 2015, p. 59).

Wesley gives relationship an even more constitutive place in Christian formation. In *Upon Our Lord’s Sermon on the Mount, Discourse IV*, he states that “Christianity is essentially a social religion; and that to turn it into a solitary one is to destroy it” (Wesley 1872p, pp. 296–97). He immediately explains that Christianity “cannot subsist at all, without society,—without living and conversing with other men” (Wesley 1872p, pp. 296–97). The reason is not merely that fellowship assists an otherwise individual process of holiness. Wesley argues that dispositions such as meekness, understood as “mildness, gentleness, and long-suffering,” “cannot possibly have a being” without “an intercourse with other men” (Wesley 1872p, p. 297). Holiness is therefore relational at the level of its actual formation and embodiment. This relational structure was institutionalized in the Methodist societies and classes. Wesley defines a society as persons “united in order to pray together, to receive the word of exhortation, and to watch over one another in love, that they may help each other to work out their salvation” (Wesley 1872k, p. 269). The class leader was expected “to inquire how their souls prosper; to advise, reprove, comfort, or exhort, as occasion may require” (Wesley 1872k, pp. 269–70). In *A Plain Account of the People Called Methodists*, Wesley describes the difference made by such relationships: those who were not united with others often “grew faint in their minds, and fell back into what they were before” (Wesley 1872c, pp. 250–51). He then asks, “Who watched over them in love? Who marked their growth in grace? Who advised and exhorted them from time to time? Who prayed with them and for them, as they had need?” and concludes, “This, and this alone, is Christian fellowship” (Wesley 1872c, p. 251). Relationship therefore functions as a concrete medium of encouragement, correction, accountability, prayer, and continuing growth. This is also the proper context for Wesley’s language of social holiness. Maddox interprets Wesley’s claim that there is “no holiness but social holiness” primarily in terms of the corporate character of discipleship and the role of mutual accountability and communal support in sanctification (Maddox 1994, pp. 208–10). Holeman develops this dimension explicitly for counseling, as she describes Wesleyan social holiness as “spiritual-accountability-in-community” and argues that “Transformation requires relationality” (Holeman 2014, pp. 375–76). In a similar vein, it has been argued that the main cause of the success of the Wesleyan movement consists more in bands and classes that provide a sense of belonging and a communal system of support than in public preaching (Kirby 2021). Wesley’s class meetings formed a hierarchy of interconnected groups that fostered behavioral change,

spiritual growth, and rehabilitation. Governed by established rules, they organized members by readiness, required active participation through structured activities, enforced accountability through membership tickets, and provided individualized pastoral care (Henderson 1997, pp. 139–44). Social holiness should not be reduced either to private spirituality or to social activism alone. It is a form of holiness to be cultivated and enacted within relations of mutual responsibility.

The parallel with CBT/RCBT can thus be framed in terms of the relational conditions of therapeutic change. Neither approach treats transformation as something generated by private reflection in isolation. In CBT, therapists and clients work together within a structured clinical relationship to identify difficulties and test new ways of understanding and responding, while RCBT broadens this relational setting by engaging clients' own religious framework and, where appropriate, connecting change with participation in a faith community and care for others. In contrast, Wesley places spiritual formation within enduring practices of fellowship, mutual correction, prayer, and love that compel believers to accompany one another in the life of holiness. The two models therefore share a relational dimension without being equivalent: the therapeutic relationship and religiously integrated support serve clinical change, whereas Wesleyan social holiness belongs to a continuing communal form of sanctified life.

4. The Goal and Scope of Healing

This section compares the goal and scope of healing in CBT/RCBT and Wesley. In terms of goal, CBT/RCBT seeks reduced dysfunction, adaptive functioning, and holistic flourishing, whereas Wesley directs restoration toward holiness, happiness in God, and renewal in the image of God. In terms of scope, both address multiple dimensions of human life, including cognitive, affective, behavioral, relational, bodily, and spiritual well-being. The comparison therefore concerns both the breadth of healing and the different telos that gives that healing its final orientation.

4.1. *The Goal of Healing: Functional Recovery and the Restoration of the Image of God*

A first point of comparison centers on the goal of healing. In contemporary CBT, improvement is generally understood as movement from maladaptive toward more adaptive cognitive, affective, motivational, and behavioral functioning. Beck and Haigh describe adaptive functioning as a condition in which “our ability to function in our various roles is not impaired by errors in thinking,” emotional responses remain proportionate to actual problems, and behavior facilitates rather than obstructs the attainment of goals (Beck and Haigh 2014, p. 3). RCBT retains this functional aim while broadening it through religious resources and outcomes such as spiritual growth, positive emotion, gratitude, forgiveness, altruism, and participation in religious community (Pearce et al. 2015, pp. 58–63).

Wesley also describes salvation as restoration, but according to a more explicitly theological norm. In *Original Sin*, Christianity is God’s “method of healing a soul which is thus diseased,” through which “the great Physician of souls applies medicines to heal this sickness; to restore human nature, totally corrupted in all its faculties”; its “great end” is “to renew our hearts in the image of God” and restore “righteousness and true holiness” (Wesley 1872g, p. 64). *The New Birth* similarly defines regeneration as “the change wrought in the whole soul by the almighty Spirit of God,” through which persons are “renewed after the image of God, in righteousness and true holiness” (Wesley 1872l, p. 71). Maddox accordingly describes Wesleyan salvation as “a restoration of the soul to its primitive health,” while Runyon identifies renewal of the divine image as central to Wesley’s understanding of Christianity (Maddox 1994, p. 145; Runyon 1998, pp. 8, 224).

The structural similarity lies in the movement from disordered or maladaptive functioning toward restored forms of human functioning, even though the normative horizons differ. CBT/RCBT evaluates change primarily through reduced dysfunction, adaptive functioning, and broader psychological and spiritual well-being, whereas Wesley evaluates change in light of the deeper telos of renewal in the image of God, righteousness, holiness, and Christlike love.

4.2. *The Scope of Healing: Biopsychosocial Processes and Bodily Spiritual Health*

The comparison becomes broader when healing is reframed in terms of flourishing rather than symptom reduction alone. Process-based CBT increasingly approaches therapeutic change by tackling cognitive, affective, behavioral, motivational, relational, and broader biopsychosocial processes, as it asks how “core biopsychosocial processes” should be targeted for “this client given this goal in this situation,” which is not confined to mere problem resolutions but directed to the “prosperity of particular people” (Hofmann and Hayes 2019, p. 38). Hayes and Hofmann similarly emphasize “human psychological prosperity and the thriving of whole persons, not merely psychopathology” (Hayes and Hofmann 2017, p. 245). This development makes contemporary CBT increasingly multidimensional: cognition is understood in interaction with emotion, motivation, behavior, interpersonal context, bodily condition, and personally meaningful goals rather than as an isolated mental process. RCBT relates this multidimensional orientation to the religious and spiritual dimensions of the person. Developed for clients facing chronic physical illness, RCBT explicitly addresses the interaction of bodily suffering, depressive symptoms, cognitive interpretation, relationships, religious coping, spiritual struggle, and meaning-making (Koenig 2012; Pearce et al. 2015, pp. 56–63). Its interventions include not only cognitive restructuring and behavioral activation but also prayer, scripture, gratitude, forgiveness, altruism, religious community participation, and spiritual growth; its manualized treatment further explores positive changes in relationships, character, abilities, meaning, and purpose through “stress-related and spiritual growth” (Pearce et al. 2015, pp. 58–63; Ciarrocchi et al. 2014, pp. 75–76). CBT/RCBT can therefore be understood as oriented toward holistic healing at the clinical level, as it integrates psychological, behavioral, relational, bodily, existential, and spiritual dimensions of distress and recovery, even though it does not provide a single comprehensive theological account of what human wholeness is.

Wesley’s account is broader than the healing of the soul. In *A Farther Appeal*, salvation is “a restoration of the soul to its primitive health” and renewal “after the image of God in righteousness and true holiness” (Wesley 1872a, p. 47), while *Primitive Physick* and Wesley’s wider medical practice show a sustained concern for bodily health, regimen, prevention, and accessible treatment. Ott interprets Wesley’s understanding of health through the “symbiotic relation between body and spirit,” while Malony reads *Primitive Physick*’s emphasis on healthy living, hygiene, prevention, and treatment (Ott 1991, p. 43; Malony 1996, pp. 147–59). Madden situates Wesley’s medical work within a broader program of practical piety that links physical and spiritual health with care for the poor (Madden 2004, pp. 742, 757–58). Yet Wesley’s holistic vision is not merely an accumulation of bodily, psychological, social, and spiritual goods. These dimensions address a theological account of human flourishing. In *The Unity of the Divine Being*, he declares, “You are made to be happy in God” and insists that God “made you to be happy in him; and nothing else can make you happy” (Wesley 1872o, pp. 266–67). He can therefore identify religion and happiness directly: “This is religion, and this is happiness; the happiness for which we were made” (Wesley 1872o, p. 267). Wesleyan healing culminates in a form of flourishing in which bodily well-being, restored faculties, holy love, Christlike character, and happiness in God belong together within the renewal of the image of God.

The comparison therefore concerns two increasingly holistic accounts of healing that still remain distinct. Contemporary CBT/RCBT moves beyond symptom reduction toward a multidimensional account of recovery involving cognitive, affective, behavioral, relational, bodily, and spiritual processes, with RCBT further incorporating religious meaning, practice, community, and spiritual growth. Likewise, Wesley understands healing in holistic terms, as it integrates bodily care, restoration of human faculties, practical piety, holy love, and the renewal of the image of God. The decisive difference lies in the overarching frame of telos. CBT/RCBT remains clinically oriented toward adaptive functioning and whole-person flourishing, whereas Wesley orders all dimensions of healing toward holiness and happiness in God. Wesleyan holistic healing can affirm psychological and spiritual flourishing as genuine dimensions of restoration without identifying them with the full meaning of salvation.

5. Conclusions

This study argues that John Wesley's theology of holistic healing and contemporary CBT/RCBT can enter into a constructive dialogue without being reduced to one another. Their strongest similarities lie in recurring patterns of human transformation. Both traditions attend to the possibility of therapeutic change, the recognition and reorientation of deeply rooted patterns, continuing formation, repeated practices, relationally mediated change, and the recovery of impaired human capacities. RCBT further strengthens this comparison by extending cognitive-behavioral treatment into religious meaning, spiritual practice, community, and spiritual growth.

These structural parallels, however, remain bounded by fundamental differences in agency, practices, and scope and goals. CBT/RCBT explains therapeutic change primarily through empirically accessible psychological and biopsychosocial processes, whereas Wesley understands therapeutic change as enabled by divine agency and directed toward holy love, Christlikeness, and renewal in the image of God. In addition to human or divine agency, CBT/RCBT and Wesley differ significantly in their conceptions of practices. Whereas CBT/RCBT and Wesley also concur that repetitive practices and relational aspects bolster the process of therapeutic change, they differ when Wesley emphasizes that practices and communities are the means of grace that are open to the direct influence of grace. Finally, after having addressed agency and practices, CBT/RCBT and Wesley disagree on defining the final goal of health. Contemporary CBT has developed beyond cognitive correction toward increasingly individualized, contextual, relational, and biopsychosocial models of flourishing, while RCBT includes bodily suffering, religious coping, meaning, spiritual struggle, religious practice, and community. Wesley's own vision is similarly holistic. His account of happiness in God brings psychological, relational, bodily and spiritual well-being within a wider vision of restored humanity, which culminates in holiness as the restoration of the divine image.

A model of differentiated integration therefore offers the most appropriate relation between these traditions. CBT and RCBT may be received as clinically grounded practices addressing differentiated dimensions of human suffering and recovery, while Wesleyan theology provides a wider anthropology of grace and a theological account of human restoration. Psychological, relational, bodily, and spiritual flourishing can thus be affirmed as genuine dimensions of holistic healing without being identified with salvation itself. Such an integration preserves the clinical integrity of CBT/RCBT while allowing Wesley's theology of holistic healing to provide a broader context for defining therapeutic recovery as one dimension of the restoration of the whole person. In that respect, it offers the most appropriate relation between these traditions and can be specified through four related principles. First, psychotherapy and Wesleyan soteriology address distinguishable levels of

human transformation. CBT/RCBT concerns clinically identifiable processes of suffering and recovery, whereas Wesleyan soteriology concerns the comprehensive restoration of the person within divine grace. Second, clinical mechanisms remain distinct from theological agency. Cognitive restructuring, behavioral practice, therapeutic collaboration, and other therapeutic processes can explain how particular forms of psychological change occur, but they do not replace Wesley's account of grace as the ultimate ground and agency of salvation. Third, psychological, relational, bodily, and spiritual flourishing may be affirmed as genuinely differentiated dimensions within Wesley's broader vision of human restoration, which also retain its unique theological and philosophical underpinning. Finally, integration must remain non-reductive in both directions. Wesleyan categories of grace, holiness, and the image of God cannot be translated into psychological mechanisms, while CBT/RCBT should retain their clinical and empirical integrity without being reduced to a theological account of change. Differentiated integration thus makes it possible to recognize therapeutic recovery as a genuine dimension of holistic healing while preserving Wesley's more comprehensive theological account of the goal and purpose of human restoration.

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References

- Beck, Aaron T. 1976. *Cognitive Therapy and the Emotional Disorders*. New York: International Universities Press.
- Beck, Aaron T., and Emily A. P. Haigh. 2014. Advances in Cognitive Theory and Therapy: The Generic Cognitive Model. *Annual Review of Clinical Psychology* 10: 1–24. [[CrossRef](#)] [[PubMed](#)]
- Beck, Judith S. 2021. *Cognitive Behavior Therapy: Basics and Beyond*, 3rd ed. New York: Guilford Press.
- Bennett-Levy, James. 2003. Mechanisms of Change in Cognitive Therapy: The Case of Automatic Thought Records and Behavioural Experiments. *Behavioural and Cognitive Psychotherapy* 31: 261–77. [[CrossRef](#)]
- Bennett-Levy, James, Gillian Butler, Melanie Fennell, Ann Hackmann, Martina Mueller, and David Westbrook, eds. 2004. *Oxford Guide to Behavioural Experiments in Cognitive Therapy*. Oxford: Oxford University Press.
- Ciarrocchi, Joseph W., Debbie Schechter, Michelle J. Pearce, and Harold G. Koenig. 2014. *Religious Cognitive Behavioral Therapy (Christian Version): 10-Session Treatment Manual for Depression in Clients with Chronic Physical Illness*. Durham: Duke University Center for Spirituality, Theology and Health.
- Collins, Kenneth J. 2007. *The Theology of John Wesley: Holy Love and the Shape of Grace*. Nashville: Abingdon Press.
- Costa, Marianna de Abreu, and Alexander Moreira-Almeida. 2022. Religion-Adapted Cognitive Behavioral Therapy: A Review and Description of Techniques. *Journal of Religion and Health* 61: 443–66. [[CrossRef](#)] [[PubMed](#)]
- Dobson, Keith S., and David J. A. Dozois, eds. 2019. *Handbook of Cognitive-Behavioral Therapies*, 4th ed. New York: Guilford Press.
- Hayes, Steven C., and Stefan G. Hofmann. 2017. The Third Wave of Cognitive Behavioral Therapy and the Rise of Process-Based Care. *World Psychiatry* 16: 245–46. [[CrossRef](#)] [[PubMed](#)]
- Henderson, D. Michael. 1997. *John Wesley's Class Meeting: A Model for Making Disciples*. Nappanee: Evangel Publishing House.
- Hofmann, Stefan G., and Steven C. Hayes. 2019. The Future of Intervention Science: Process-Based Therapy. *Clinical Psychological Science* 7: 37–50. [[CrossRef](#)] [[PubMed](#)]
- Holeman, Virginia T. 2014. Theology for Better Counseling: Help from Within the Wesleyan-Holiness Theological Tradition. *Journal of Psychology and Theology* 42: 369–78. [[CrossRef](#)]
- Hughes, Melanie Dobson. 2008. The Holistic Way: John Wesley's Practical Piety as a Resource for Integrated Healthcare. *Journal of Religion and Health* 47: 237–52. [[CrossRef](#)] [[PubMed](#)]
- Kilian, Marcus K., and Stephen Parker. 2001. A Wesleyan Spirituality: Implications for Clinical Practice. *Journal of Psychology and Theology* 29: 72–80. [[CrossRef](#)]

- Kirby, Eddie. 2021. *Band of Hope: How the Voice of the People in John Wesley's Classes and Bands Informs Today's Church*. Doctor of Ministry dissertation, Southern Methodist University, Dallas, TX, USA.
- Koenig, Harold G. 2012. Religious versus Conventional Psychotherapy for Major Depression in Patients with Chronic Medical Illness: Rationale, Methods, and Preliminary Results. *Depression Research and Treatment* 2012: 460419. [[CrossRef](#)] [[PubMed](#)]
- Longmore, Richard J., and Michael Worrell. 2007. Do We Need to Challenge Thoughts in Cognitive Behavior Therapy? *Clinical Psychology Review* 27: 173–87. [[CrossRef](#)] [[PubMed](#)]
- Madden, Deborah. 2004. Medicine and Moral Reform: The Place of Practical Piety in John Wesley's Art of Physic. *Church History* 73: 741–58. [[CrossRef](#)]
- Madden, Deborah. 2006. The Limitation of Human Knowledge: Faith and the Empirical Method in John Wesley's Medical Holism. *History of European Ideas* 32: 162–72. [[CrossRef](#)]
- Maddox, Randy L. 1994. *Responsible Grace: John Wesley's Practical Theology*. Nashville: Kingswood Books.
- Maddox, Randy L. 2004. Psychology and Wesleyan Theology: Precedents and Prospects for a Renewed Engagement. *Journal of Psychology and Christianity* 23: 101–9.
- Malony, H. Newton, Jr. 1996. John Wesley's *Primitive Physick*: An 18th-Century Health Psychology. *Journal of Health Psychology* 1: 147–59. [[PubMed](#)]
- Ott, Philip W. 1991. John Wesley on Health as Wholeness. *Journal of Religion and Health* 30: 43–57. [[CrossRef](#)] [[PubMed](#)]
- Pearce, Michelle J., Harold G. Koenig, Clive J. Robins, Bruce Nelson, Sally F. Shaw, Harvey J. Cohen, and Michael B. King. 2015. Religiously Integrated Cognitive Behavioral Therapy: A New Method of Treatment for Major Depression in Patients with Chronic Medical Illness. *Psychotherapy* 52: 56–66. [[CrossRef](#)] [[PubMed](#)]
- Pecheur, David Richard, and Keith J. Edwards. 1984. A Comparison of Secular and Religious Versions of Cognitive Therapy with Depressed Christian College Students. *Journal of Psychology and Theology* 12: 45–54. [[CrossRef](#)]
- Persons, Jacqueline B. 2008. *The Case Formulation Approach to Cognitive-Behavior Therapy*. New York: Guilford Press.
- Propst, L. Rebecca, Richard Ostrom, Philip Watkins, Terri Dean, and David Mashburn. 1992. Comparative Efficacy of Religious and Nonreligious Cognitive-Behavioral Therapy for the Treatment of Clinical Depression in Religious Individuals. *Journal of Consulting and Clinical Psychology* 60: 94–103. [[CrossRef](#)] [[PubMed](#)]
- Runyon, Theodore. 1998. *The New Creation: John Wesley's Theology Today*. Nashville: Abingdon Press.
- Tang, Tony Z., and Robert J. DeRubeis. 1999. Sudden Gains and Critical Sessions in Cognitive–Behavioral Therapy for Depression. *Journal of Consulting and Clinical Psychology* 67: 894–904. [[CrossRef](#)] [[PubMed](#)]
- Tang, Tony Z., Robert J. DeRubeis, Rachel Beberman, and Thu Pham. 2005. Cognitive Changes, Critical Sessions, and Sudden Gains in Cognitive–Behavioral Therapy for Depression. *Journal of Consulting and Clinical Psychology* 73: 168–172. [[CrossRef](#)] [[PubMed](#)]
- Tee, John, and Nikolaos Kazantzis. 2011. Collaborative Empiricism in Cognitive Therapy: A Definition and Theory for the Relationship Construct. *Clinical Psychology: Science and Practice* 18: 47–61. [[CrossRef](#)]
- Wesley, John. 1872a. A Farther Appeal to Men of Reason and Religion. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 8, pp. 46–247.
- Wesley, John. 1872b. A Plain Account of Christian Perfection. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 11, pp. 366–446.
- Wesley, John. 1872c. A Plain Account of the People Called Methodists. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 8, pp. 248–68.
- Wesley, John. 1872d. Minutes of Several Conversations between the Rev. Mr. Wesley and Others, from the Year 1744 to 1789. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 8, pp. 299–338.
- Wesley, John. 1872e. On the Wedding Garment. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 7, pp. 311–17.
- Wesley, John. 1872f. On Working Out Our Own Salvation. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 6, pp. 506–13.
- Wesley, John. 1872g. Original Sin. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 6, pp. 54–65.
- Wesley, John. 1872h. Preface to *An Extract from the Journal of Elizabeth Harper*. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 14, pp. 261–63.
- Wesley, John. 1872i. The Great Privilege of Those That Are Born of God. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 5, pp. 223–31.
- Wesley, John. 1872j. The Means of Grace. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 5, pp. 185–201.
- Wesley, John. 1872k. The Nature, Design, and General Rules of the United Societies. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 8, pp. 269–71.

- Wesley, John. 1872l. The New Birth. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 6, pp. 65–77.
- Wesley, John. 1872m. The Principles of a Methodist Farther Explained: Occasioned by the Rev. Mr. Church's Second Letter to Mr. Wesley; in a Second Letter to That Gentleman. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 8, pp. 414–80.
- Wesley, John. 1872n. The Scripture Way of Salvation. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 6, pp. 43–54.
- Wesley, John. 1872o. The Unity of the Divine Being. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 7, pp. 264–73.
- Wesley, John. 1872p. Upon Our Lord's Sermon on the Mount, Discourse IV. In *The Works of the Rev. John Wesley, M.A.*, 3rd ed. Edited by Thomas Jackson. London: Wesleyan Methodist Book Room, vol. 5, pp. 294–309.

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