

Can Faith Heal the Mind?

Supernatural Healing, Mental Illness, and the Research Question of Faith

Alisha Bradley, M.A.

October 2026 | Version 1.0

Independent working paper. This paper presents developing hypotheses, research questions, and interdisciplinary inquiry. It has not undergone peer review.

Abstract

Christian Scripture contains unusually strong claims about healing. Psalm 103:3 describes God as the one who forgives iniquity and heals disease. The Gospels repeatedly portray Jesus healing illness and, in several accounts, telling a healed person that faith has made them well. Second Timothy 1:7 contrasts fear with power, love, and a 'sound mind' in the King James rendering. Christians also continue to report recoveries they understand as supernatural healing, including recoveries from psychiatric diagnoses. These claims create a difficult research question. If a person experiences an abrupt and durable disappearance of clinically significant symptoms in temporal relationship to prayer, faith, conversion, deliverance, or another religious event, how should that recovery be studied? This paper proposes a research agenda that neither assumes divine causation nor excludes it in advance. It distinguishes biblical theology from clinical outcome, testimony from verification, faith as a possible psychosocial mechanism from faith as a theological condition, and remission from the stronger claim of miraculous healing. The central question is not whether science can place God inside an experiment. It is whether reported extraordinary recoveries can be documented rigorously enough to determine what happened, when it happened, how durable it was, what conventional explanations remain plausible, and where empirical explanation reaches its limits.

Author's Note

I am not approaching this question only as an observer. I have personally understood my own recovery from diagnoses of borderline personality disorder, bipolar II disorder, clinical anxiety, and clinical depression as supernatural healing. That testimony is one reason I believe this subject deserves serious investigation. It is not, by itself, scientific proof of divine causation. My personal account belongs in the phenomenological record: what I experienced, what changed, how quickly it changed, what treatment or other factors were present, and whether the change endured. The research task is to build methods capable of examining testimonies like mine without either dismissing them because they are religious or accepting their causal interpretation without investigation.

This paper also continues the larger convergence framework of this working paper series: mind, soul, physical body, and spirit are treated as distinguishable domains of inquiry. Psychiatric and

medical care should not be abandoned on the basis of a healing claim. The purpose is to investigate recovery more completely, not to create a theological substitute for clinical assessment.

The Biblical Claim Is Stronger Than General Wellness

The biblical material does not merely say that religious belief can make people feel better. It contains claims about healing, restoration, deliverance, and wholeness. Psalm 103:3 describes God as the one 'who forgives all your iniquities' and 'heals all your diseases.' This is a statement from the Psalms, not a direct quotation of Jesus. The Gospels, however, portray Jesus as a healer throughout his ministry and repeatedly connect healing with faith. In Mark 5:34, Luke 8:48, Luke 17:19, and related passages, the person is told that faith has made them well or saved them, depending on translation and context.

Second Timothy 1:7 adds another text frequently used in Christian discussions of mental health: 'God hath not given us the spirit of fear; but of power, and of love, and of a sound mind' in the King James Version. The Greek term translated 'sound mind' is *sophronismos*, carrying the sense of self-control, sound judgment, or disciplined thinking. The verse should not simply be converted into a modern psychiatric proposition that Christians cannot experience mental illness. But it does establish a theological vocabulary in which fear is not presented as God's gift and disciplined, ordered mental life is associated with what God gives.

Taken together, these texts create a legitimate theological question for Christian mental-health research: if healing is part of the biblical witness, if faith is repeatedly connected to healing in the Gospels, and if ordered mental life is part of New Testament moral and spiritual language, what role - if any - might faith play in recoveries from conditions now classified as psychiatric disorders?

Faith Could Mean More Than One Thing

The word faith has to be operationalized before it can be researched. A study that merely asks whether someone is 'religious' will not answer the question posed here. Faith may function at several levels that should be separated rather than collapsed.

- Faith as belief or expectancy: the person strongly expects healing to occur.
- Faith as trust: the person experiences confidence in God that changes fear, hopelessness, vigilance, or perceived threat.
- Faith as practice: prayer, worship, Scripture meditation, confession, fasting, church participation, or other repeated behaviors alter attention, emotion, social support, sleep, stress, and behavior.
- Faith as identity and meaning: the person reorganizes the interpretation of self, suffering, trauma, guilt, future, and possibility.
- Faith as theological condition: within the believer's own ontology, faith is not merely a psychological variable but a mode of receiving or responding to divine action.

The first four levels are at least partly accessible to psychological, behavioral, and neurobiological research. The fifth is a metaphysical and theological claim. A rigorous research program should not confuse them. Finding that expectancy, community, meaning, or nervous-system regulation mediates improvement would explain something important. It would not logically prove that God

did not act. Conversely, a person's conviction that God acted does not establish that no psychological or biological mechanism participated in the recovery.

What Existing Science Already Allows Us to Say

Religion and spirituality are already legitimate subjects of mental-health research. Reviews have found meaningful relationships between spirituality or religiousness and depression, anxiety, suicidality, substance use, PTSD, psychosis, and other outcomes. A 2023 multilevel meta-analysis of randomized trials found that, among patients with strong religious or spiritual affiliation, explicitly religious or spiritually integrated psychotherapies were moderately more effective than comparison treatments at post-treatment and follow-up. A 2026 systematic review likewise reported that spiritual well-being was generally associated with lower depression and anxiety symptoms, while also noting that spiritual conflict can be associated with greater distress.

Neuroscience has also begun examining religious and spiritual experience alongside mental health, but the literature remains limited and does not establish a single biological pathway by which 'faith heals.' That is important. There is evidence that religious and spiritual variables can matter clinically. There is not a settled scientific model showing that faith, as such, supernaturally cures psychiatric disease.

Intercessory-prayer research is similarly mixed and methodologically difficult. Systematic reviews and controlled trials have not produced a consistent demonstration that distant prayer causes improved medical outcomes. Even the Cochrane review explicitly notes the conceptual limit: trials can study measurable outcomes associated with prayer, but they cannot straightforwardly prove or disprove God's response to prayer. That limitation should be acknowledged rather than hidden.

Recovery Is Real - But Recovery Is Not Automatically a Miracle

Psychiatric diagnoses do not all imply permanent, unchanging illness. This matters enormously for miracle research. Longitudinal studies show that many people with borderline personality disorder eventually achieve diagnostic remission. In one 10-year prospective study, 93% attained at least a two-year symptomatic remission, although full psychosocial recovery was harder to achieve and recurrence remained possible. Major depression can also remit without formal treatment; estimates vary by population, severity, and time window. Bipolar disorders can enter remission as well, although recurrence is common and durable functional recovery may lag behind symptom improvement.

Therefore, the disappearance of a diagnosis cannot, by itself, establish miraculous healing. Any serious study must compare the reported event with the known natural history of the condition. Was the recovery unusually rapid? Did it occur after years of chronic impairment? Was it complete rather than partial? Did medications change before or after the event? Was the original diagnosis well documented? Did independent clinicians observe the change? Did functioning change along with symptoms? Has the recovery persisted for years? These questions do not diminish testimony. They are what make testimony researchable.

The Phenomenon That Needs Its Own Name

The most interesting cases are not simply people who become more spiritual and gradually improve. The research target is a narrower phenomenon: a reported abrupt or unusually rapid, clinically meaningful, durable recovery that the person attributes to divine intervention and that occurs in close temporal relationship to a religious event such as prayer, a faith experience, conversion, deliverance, worship, or a perceived encounter with God.

For research purposes, I would provisionally call this a reported spiritually attributed extraordinary recovery, or SAER. The term does not declare the recovery miraculous. It identifies the phenomenon to be investigated.

A SAER registry could allow researchers to collect cases prospectively and retrospectively using the same standards. That would move the conversation beyond isolated testimony videos and beyond the equally inadequate response of dismissing every report as anecdote.

What Would Count as Stronger Evidence?

No single case can force a metaphysical conclusion. But cases can vary dramatically in evidentiary quality. A stronger case would include contemporaneous diagnostic records, clear pre-event severity, documented treatment history, a defined religious event, a short and well-described time course of change, standardized symptom measures, medication records, clinician observations, collateral reports from family or coworkers, objective evidence of restored functioning, and long-term follow-up.

Researchers should also document disconfirming evidence. If symptoms recur, that matters. If medication continued, that matters. If a diagnosis was later judged inaccurate, that matters. If the person had already been improving before the religious event, that matters. If the testimony changes over time, that matters.

The aim should not be to manufacture a miracle. The aim should be to describe the recovery so precisely that competing explanations can be compared.

Core Research Questions

- Among people who report supernatural healing from a psychiatric disorder, what proportion have verifiable pre-healing diagnoses and longitudinal clinical records?
- What is the temporal pattern of reported healing: instantaneous, hours, days, weeks, or gradual change retrospectively interpreted as miraculous?
- Which symptom domains change first, and do functional outcomes improve at the same time as subjective symptoms?
- How durable are reported recoveries at 6 months, 1 year, 5 years, and 10 years?
- How do SAER cases compare with expected remission and recurrence rates for the same diagnosis, severity, duration, treatment history, and demographic profile?
- Does the intensity or character of faith before the event predict outcome, or does faith increase after the recovery?
- Are there measurable changes in fear, expectancy, meaning, self-concept, autonomic regulation, sleep, stress physiology, social connection, or behavior that mediate improvement?

- Do people who report healing discontinue medication before the event, after the event, or not at all, and what are the outcomes of each pattern?
- Can blinded independent clinicians reviewing de-identified records identify a subset of cases as unusually rapid or otherwise atypical without knowing that the person attributes the recovery to God?
- What features, if any, distinguish spiritually attributed extraordinary recovery from spontaneous remission, placebo or expectancy effects, treatment response, diagnostic error, regression to the mean, natural developmental change, or retrospective reconstruction?

The Specific Question of Faith

The Gospels make the role of faith impossible to ignore as a theological variable, but the phrase 'your faith has made you well' should generate research questions rather than a simplistic formula. Did faith precede healing? Was it confidence that healing was possible, trust in the healer, willingness to act, persistence in seeking help, or something else? Are there biblical healing accounts in which the recipient's faith is not foregrounded? Yes. That variation matters for theology as well as research.

A Christian research program should therefore resist turning faith into blame. If healing does not occur, the absence of healing cannot automatically be used as proof that the sufferer lacked sufficient faith. Such a conclusion exceeds what the clinical data can establish and can produce spiritual harm. Research should investigate whether measurable dimensions of faith predict particular outcomes while leaving theological judgments about divine action appropriately distinct.

The Question of the Sound Mind

Second Timothy 1:7 deserves a separate research track because it is frequently used as though it were a diagnostic statement. It is not a DSM category and should not be treated as one. Yet the verse raises potentially testable questions about fear, self-regulation, cognition, agency, and perceived spiritual identity.

Researchers could examine whether internalizing a 'sound mind' identity changes metacognition, catastrophic interpretation, emotion regulation, attentional control, self-efficacy, or symptom-related identity. They could compare the effects of a biblically grounded cognitive intervention with a structurally similar secular intervention. They could also investigate when this language helps and when it produces shame or symptom suppression. The theological claim and the psychological mechanism can be studied side by side without pretending they are identical.

Forgiveness, Iniquity, and Healing

Psalms 103 places forgiveness and healing in the same poetic movement: God forgives iniquity and heals disease. That juxtaposition does not establish a medical rule that disease is caused by personal sin. The Bible itself resists that simplistic equation in other passages. But the relationship between forgiveness, guilt, shame, moral injury, reconciliation, and mental health is empirically researchable.

One line of inquiry could examine whether experiences of divine forgiveness produce changes in shame, rumination, threat perception, self-condemnation, interpersonal functioning, and depressive or anxiety symptoms. Another could investigate interpersonal forgiveness and acceptance, which longitudinal research has already associated with recovery status in borderline personality disorder. These mechanisms would not exhaust the theological meaning of forgiveness, but they would help identify pathways through which a religious experience might become embodied psychologically and behaviorally.

A Research Design for Extraordinary Healing Claims

A serious program could proceed in stages. First, build a case registry with strict inclusion criteria and standardized documentation. Second, conduct deep longitudinal case studies using clinical records, structured diagnostic interviews, symptom measures, functioning measures, collateral interviews, treatment timelines, and detailed phenomenology of the religious event. Third, create matched comparison groups of people with the same diagnosis and severity who recovered through conventional treatment, natural remission, or other pathways. Fourth, where ethically and clinically appropriate, study prospective faith-integrated interventions without asking participants to stop standard care. Fifth, establish long-term follow-up so that temporary relief is not mislabeled as cure.

The strongest design would also use independent adjudication. Reviewers who do not know whether a case is religious could rate the probability of diagnostic validity, magnitude of change, speed of change, durability, and how unusual the course is relative to the disorder's known natural history. Only after those ratings are completed would the spiritually attributed event be disclosed for theological and phenomenological analysis.

What Science Could Establish - and What It Could Not

Science could potentially establish that a person had a well-documented disorder, that symptoms and impairment changed dramatically, that the change occurred at a particular time, that the recovery endured, and that common alternative explanations fit the case poorly. It could identify psychological, social, behavioral, and biological correlates of the recovery. It could determine whether a class of such cases occurs more often than expected under specified conditions.

What science cannot directly do is measure God as an experimental variable. Even an extraordinary recovery with no currently adequate medical explanation would be an unexplained recovery, not laboratory proof of divine action. 'Unexplained' and 'supernatural' are not synonyms.

But the reverse error should also be avoided. If science cannot directly test divine agency, it cannot legitimately convert that methodological limitation into proof that divine agency is impossible. The empirical question is what happened. The theological question is what ultimately caused or meant what happened. The two questions can inform one another without being collapsed.

Why Testimony Still Matters

Testimony is often treated as the weakest possible evidence because a testimony cannot control for alternative explanations. That criticism is valid if testimony is being offered as a clinical trial. But testimony is also how new phenomena enter research. Case reports, patient narratives, adverse-

event reports, unusual recoveries, and unexpected clinical observations have historically generated research questions.

The right response to a credible healing testimony is neither 'therefore miracle' nor 'therefore meaningless.' It is: document it. Retrieve the records. Establish the timeline. Define the diagnosis. Measure the change. Follow the person. Look for recurrence. Ask what else changed. Compare the course with what is known about the condition. Then state clearly what the evidence supports and what remains interpretation.

The Question I Am Carrying Forward

I am carrying forward a question that is both personal and scholarly: What do we do with people who say, with seriousness and sustained evidence of changed life, 'I was mentally ill, I encountered God, and I was healed'?

Christian theology already has a category for that claim. Psychiatry has categories for remission, recovery, recurrence, treatment response, diagnostic revision, and spontaneous improvement. Psychology has categories for expectancy, meaning, identity, cognitive change, attachment, social support, and behavior. Neuroscience can ask what changed in the embodied brain and nervous system. None of these categories, by itself, settles the whole question.

My hypothesis is not that every psychiatric recovery is miraculous, that faith replaces treatment, or that failure to recover demonstrates weak faith. My proposal is narrower: reports of supernatural mental-health healing are a legitimate phenomenon for disciplined study, and faith should be investigated as both a measurable human variable and, within Christian theology, a claimed point of relationship to divine healing.

If the biblical healing claims are true, serious research should not be feared. If conventional mechanisms explain many reports, we should want to know that. If a subset of cases remains unusually abrupt, durable, well-documented, and resistant to ordinary explanation, we should want to know that too.

The research question is not served by credulity. It is also not served by an a priori refusal to look.

References

- Benson, H., Dusek, J. A., Sherwood, J. B., et al. (2006). Study of the Therapeutic Effects of Intercessory Prayer (STEP) in cardiac bypass patients: A multicenter randomized trial of uncertainty and certainty of receiving intercessory prayer. *American Heart Journal*, 151(4), 934-942. <https://doi.org/10.1016/j.ahj.2005.05.028>
- Braam, A. W., et al. (2023). The evaluation of religious and spirituality-based therapy compared to standard treatment in mental health care: A multi-level meta-analysis of randomized controlled trials. [PubMed PMID: 37615090].
- Lucchetti, G., Koenig, H. G., & Lucchetti, A. L. G. (2021). Spirituality, religiousness, and mental health: A review of the current scientific evidence. *World Journal of Clinical Cases*. [PubMed PMID: 34621814].
- Mekonen, T., Ford, S., Chan, G. C. K., Hides, L., Connor, J. P., & Leung, J. (2022). What is the short-term remission rate for people with untreated depression? A systematic review and meta-analysis. *Journal of Affective Disorders*, 296, 17-25. <https://doi.org/10.1016/j.jad.2021.09.046>
- Roberts, L., Ahmed, I., & Hall, S. (2007). Intercessory prayer for the alleviation of ill health. *Cochrane Database of Systematic Reviews*, (1), CD000368. <https://doi.org/10.1002/14651858.CD000368.pub2>

- Rim, J. I., et al. (2022). The neuroscience of spirituality, religion, and mental health: A systematic review and synthesis. *Journal of Psychiatric Research*. <https://doi.org/10.1016/j.jpsychires.2022.10.003>
- Whiteford, H. A., Harris, M. G., McKeon, G., et al. (2013). Estimating remission from untreated major depression: A systematic review and meta-analysis. *Psychological Medicine*, 43(8), 1569-1585. <https://doi.org/10.1017/S0033291712001717>
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). Time to attainment of recovery from borderline personality disorder and stability of recovery: A 10-year prospective follow-up study. *American Journal of Psychiatry*, 167(6), 663-667. <https://doi.org/10.1176/appi.ajp.2009.09081130>
- Zanarini, M. C., et al. (2019). Levels of acceptance and forgiveness reported by patients with BPD and personality-disordered comparison subjects over 20 years of prospective follow-up. *Journal of Personality Disorders*. [PubMed PMID: 30649991].
- The Holy Bible. Psalm 103:1-5; Mark 5:25-34; Luke 8:43-48; Luke 17:11-19; 2 Timothy 1:7; James 5:13-16.