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Faith Healing in Charismatic Christianity: Problematizing Miracle Claims from the Perspective of Suggestive Psychology and Public Health Ethics

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Abstract
The phenomenon of faith healing within Charismatic Christianity is gaining traction across religious contexts and creating tensions with evidence-based medical standards, particularly when claims of miraculous healings could influence therapeutic decisions. Although widely discussed in theology and the sociology of religion, interdisciplinary studies that systematically integrate the perspectives of suggestion psychology and public health ethics remain limited. This study aims to identify the psychological mechanisms that shape subjective experiences of healing and evaluate their epistemological legitimacy and ethical implications for public health practice. This study was designed as a critical integrative literature review with a constructivist-critical paradigm that combines discourse analysis and normative bioethics analysis. Data were obtained from clinical psychology journal articles, Charismatic theology studies, and public health ethics documents, which were analyzed using interdisciplinary thematic analysis techniques with selection criteria of conceptual relevance and academic authority. The results indicate that the legitimacy of healing claims is constructed performatively through testimonial narratives, the strengthening of charismatic authority, and the intensification of collective emotions, thereby creating therapeutic expectations. Suggestion mechanisms—including the placebo effect, affective regulation, social confirmation, and attribution bias—contribute

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significantly to perceived improvement, although they do not always correlate with objective clinical indicators. The analysis also highlights the epistemic risks of causal misattribution and the ethical risks of delaying medical intervention, reproducing misinformation, and exploiting patient vulnerability. It concludes that faith-healing claims serve more as constructions of religious meaning than as clinical verification, necessitating institutional dialogue between religious communities and health authorities to protect public health interests without neglecting the spiritual dimension.

Keywords: Faith Healing; Charismatic Christianity; Suggestive Psychology; Public Health; Medical Rationality

Abstrak

Fenomena *faith healing* dalam Kekristenan Karismatik semakin menguat di berbagai konteks masyarakat religius dan memunculkan ketegangan dengan standar kedokteran berbasis evidensi, khususnya ketika klaim mukjizat kesembuhan berpotensi memengaruhi keputusan terapeutik. Meskipun telah banyak dibahas dalam studi teologi dan sosiologi agama, kajian interdisipliner yang secara sistematis mengintegrasikan perspektif psikologi sugesti dan etika kesehatan publik masih terbatas. Penelitian ini bertujuan mengidentifikasi mekanisme psikologis yang membentuk pengalaman subjektif kesembuhan serta mengevaluasi legitimasi epistemologis dan implikasi etisnya terhadap praktik kesehatan publik. Penelitian ini dirancang sebagai *critical integrative literature review* berparadigma konstruktivis-kritis yang menggabungkan analisis wacana dan analisis normatif bioetika. Data diperoleh melalui artikel jurnal psikologi klinis, kajian teologi Karismatik, dan dokumen etika kesehatan publik, yang dianalisis melalui teknik analisis tematik interdisipliner dengan kriteria seleksi relevansi konseptual dan otoritas akademik. Hasil menunjukkan bahwa legitimasi klaim kesembuhan dibangun secara performatif melalui narasi kesaksian, penguatan otoritas karismatik, dan intensifikasi emosi kolektif yang menciptakan ekspektasi terapeutik. Mekanisme sugesti—termasuk efek *placebo*, regulasi afektif, konfirmasi sosial, dan bias atribusi—berkontribusi signifikan terhadap persepsi perbaikan kondisi, meskipun tidak selalu berkorelasi dengan indikator klinis objektif. Analisis juga menegaskan risiko epistemik berupa misatribusi sebab-akibat dan risiko etis berupa penundaan intervensi medis, reproduksi misinformasi, serta eksploitasi kerentanan pasien. Disimpulkan bahwa klaim *faith healing* lebih berfungsi sebagai konstruksi makna religius daripada verifikasi klinis, sehingga diperlukan dialog institusional antara komunitas religius dan otoritas kesehatan guna melindungi kepentingan kesehatan publik tanpa mengabaikan dimensi spiritualitas.

Kata Kunci: *Faith Healing*; Kekristenan Karismatik; Psikologi Sugesti; Kesehatan Publik; Rasionalitas Medis

Introduction

The practice of faith healing in Charismatic Christianity refers to healing acts based on prayer, the laying on of hands, anointing, or declarations of faith believed to represent divine intervention without clinical medical procedures (Ayivor, 2025). This practice is positioned as a manifestation of the gifts of the Holy Spirit and as a legitimation of the spiritual leader's authority. Claims of healing are often perceived as proof of the truth of faith and the efficacy of the ministry, although they are generally not subject to independent diagnostic verification (Shoib et al., 2023). This situation raises epistemological and ethical problems when subjective experiences of healing are treated as objective facts that determine therapeutic decisions. The

psychology of suggestion perspective explains that expectations, symbolic authority, group dynamics, and the placebo effect can influence perceptions of symptom improvement without measurable pathological changes (Bingel, 2020). Tensions between religious beliefs and bioethical principles—particularly nonmaleficence, beneficence, autonomy, and informed consent—emerge when claims of miracles encourage the rejection or postponement of evidence-based therapies. This issue is not simply a theological debate but a public health issue concerning patient safety and the social accountability of religious communities.

Empirical evidence demonstrates the real consequences of faith-healing practices for public health. The World Health Organization (2024) reported that the rejection of evidence-based medical interventions significantly contributes to increased morbidity and mortality from infectious diseases and chronic illnesses that could otherwise be managed clinically, particularly in vulnerable populations. A (2016) report by the United Nations Children's Fund documented numerous child deaths resulting from the delay of essential care due to an exclusive reliance on religious healing. The World Medical Association (2005) emphasized that claims of healing without a scientific basis may violate the principles of nonmaleficence and informed consent when patients are not adequately informed of the risks. The Pew Research Center (2011) estimated that more than a quarter of global Christians identify as part of the Charismatic or Pentecostal movements, with the fastest growth occurring in the Global South; miraculous healings are a key attraction of this expansion. This quantitative growth extends faith healing practices across social contexts and national health systems, making the risk of refusing medical therapy no longer sporadic but rather having structural implications for public health policy.

Previous literature demonstrates a fragmented spectrum of approaches. Marimbe (2024) interprets charismatic healing as embodied healing mediated by religious meaning and community rituals; her contribution enriches the experiential dimension of faith but does not evaluate objective medical impact. Petrie and Rief (2019) demonstrate that suggestion, expectation, and the therapeutic relationship play a significant role in symptom improvement through a placebo mechanism; this study explains the psychological mechanisms but does not link them to a specific religious context. Narbona Cárceles (2023) highlights miracles as symbolic capital that strengthens the authority of charismatic leaders; her analysis is sociologically astute, but fails to assess the ethical implications for patient safety.

Javid et al. (2024) criticized the replacement of medical therapy with faith healing as a violation of the principles of beneficence and autonomy; the study was normative-bioethical, but failed to consider the dynamics of suggestion and socio-religious pressure. Borges, Malagris, and de Freitas (2022) found a correlation between refusal of faith-based treatment and an increased risk of chronic disease complications; this study was based on public health but did not integrate theological analysis or the construction of miracle experiences. A critical synthesis

of these five studies reveals the absence of an integrative analytical model that explains how the mechanisms of psychological suggestion, the symbolic construction of miracles, and bioethical principles interact in the context of Charismatic Christianity. The research gap lies in the lack of a conceptual framework that simultaneously reads healing claims as socio-psychological constructs and evaluates them through public health ethics standards.

The research problem is formulated as follows: how can faith-healing claims in Charismatic Christianity be explained through the psychological mechanisms of suggestion, including expectations, the placebo effect, and the dynamics of power relations, and what are the implications of these mechanisms for the principles of public health ethics and medical decision-making? The research objectives include: conceptually explaining the psychological mechanisms that shape perceptions of miracles; evaluating faith-healing practices through a bioethical framework; and analyzing their impact on individual and community health decisions. The initial argument of the research states that many healing claims cannot be separated from the processes of suggestion, collective expectations, and socio-religious pressures that operate within the structure of symbolic authority, thus requiring a critical reading informed by health psychology and public ethics without negating the meaning of faith for its adherents. The theoretical contribution of the research lies in the development of an integrative model that connects the psychology of suggestion, the sociology of religion, and bioethics in the analysis of faith healing. Its practical contribution includes providing an evaluative framework for health policymakers, medical personnel, and religious leaders to formulate guidelines for faith-medicine dialogue that respect religious freedom while ensuring patient safety and public accountability.

Method

This study was designed as a critical integrative literature review with a constructivist-critical paradigm that combines discourse analysis and normative bioethics analysis to model the relationship between miracle claims, psychological suggestion mechanisms, and public health implications. Data were systematically obtained from Scopus, Web of Science, PubMed, and JSTOR databases with a publication range of 2000–2025 using a structured selection protocol based on the PRISMA flow, accompanied by inclusion criteria such as peer-reviewed articles, empirical studies on the placebo/nosebo effect, mainstream Charismatic theological works, and public health ethics documents. Non-academic sources such as digital sermon archives and miracle testimonies were used only if documented in official channels and triangulated. Data collection was carried out through cross-disciplinary keyword identification, methodological quality screening, and stepwise thematic coding (open–axial–selective coding) using an integrative conceptual matrix. Discourse analysis follows Norman Fairclough's three-dimensional model to evaluate the construction of healing claims. At the same time, ethical evaluation uses

Tom L. Beauchamp and James F. Childress's principlism framework to assess compliance with the principles of nonmaleficence, beneficence, and justice. Conceptual synthesis produces a public health risk model grounded in the religious suggestion of integrating psychological and theological findings. Validity is maintained through theoretical triangulation, analytical trail audits, and the researcher's epistemological reflexivity to mitigate interpretive bias.

Results and Discussion

Miracles in Charismatic Faith Healing Practice

Healing miracles in Charismatic Faith Healing practices are understood as religious claims produced through a process of collective meaning construction, rather than as neutral accounts of biological events (Ayivor, 2025). This analysis departs from a social constructivist framework that positions religious reality as the institutionalized outcome of intersubjectively negotiated experiences (Lisovskaya, 2021). Miracles are conceptually differentiated between empirical events, performative claims, and theological meanings attached to them by the community. This distinction allows for an epistemological assessment of the status of truth operating internally within the community without assuming ontological validation. This framework positions miracles as narratives of faith that articulate the experience of divine presence through a narrative structure of suffering, intervention, and transformation. This construction produces a theological horizon that limits the possibility of alternative interpretations, thus maintaining internal coherence through symbolic repetition and collective reinforcement. The truth status of miracles is contextual and rooted in their conformity to institutionalized meaning schemes.

Public testimony serves as a primary mechanism for producing miracle claims through performative practices that create religious reality rather than represent it. The concept of performativity is understood as a tradition of speech acts that holds that certain utterances produce ontological consequences within a community's symbolic space (Krifka, 2024). The repetition of healing narratives constructs standards of truth based on emotional resonance and theological conformity, rather than empirical verification. The narrative selection process occurs through implicit regulation that filters out failed or ambivalent testimonies, so that only stories that meet normative expectations gain legitimacy. This mechanism creates symbolic pressure for individual experiences to align with collective narrative patterns. The production of testimony also demonstrates power relations, as spiritual authority plays a role in determining the validity of the story. This structure establishes a closed epistemic system that maintains miracle claims through repeated narrative reproduction and communitarian control of meaning (Varela, 2023).

The theological legitimacy of miracle claims rests on a selective hermeneutic that interprets biblical texts as promises of continued healing power. The analysis distinguishes between classical Charismatic theology, the Word of Faith tradition,

and variants of the prosperity gospel, each of which emphasizes the relationship between faith and healing. Hermeneutic selectivity is evident in the emphasis on verses that emphasize divine power and the neglect of narratives of failure or ongoing suffering. This model represents a revelational epistemology that positions the experience of faith as the authoritative source of religious truth. Failure to heal is interpreted through the categories of mystery or lack of faith, reducing empirical refutation to spiritual problems (Mees-Buss, Welch, & Piekkari, 2022). This scheme shifts the focus from medical evaluation to theological coherence. This hermeneutic system strengthens the internal consistency of miracle claims while limiting the scope for external criticism because the domain of truth has been redefined within the framework of faith.

The symbolic and ritual dimensions deepen the internalization of miracle claims of fostering a religious imagination that is incorporated within the congregation. Ritual theory asserts that symbols are not merely representations of meaning but rather tools that shape the dispositions and affective orientations of participants (Belorusets, 2020). The acts of laying on of hands, anointing with oil, and verbal declarations of divine power function as embodied practices that connect collective suggestion with sensory experience (Austad, Nygaard, & Kleiven, 2020). Liturgical repetition produces habituation, so that claims of healing are perceived as a natural and expected possibility (Stöckigt et al., 2021). This process creates cognitive predispositions that facilitate the interpretation of bodily experiences within a framework of faith. Symbols serve as mediators between theological expectations and subjective sensations, thereby making the experience of physical improvement readily interpreted as divine intervention (Amsikan, 2025). The integration of symbols and the body demonstrates how the construction of miracles is not merely discursive but is realized through the formation of a stable religious habitus.

The charismatic authority of spiritual leaders becomes the center of the circulation of legitimacy for miracle claims through collective recognition of special spiritual capacities. The concept of charismatic authority explains that legitimacy rests on the congregation's perception of the leader's exclusive access to divine power (Rozumny, 2025). This routinization is evident through the institutionalization of healing services, digital media, and repeated narratives of success that reinforce reputations. Power relations are manifested when leaders determine the criteria for legitimate healing and interpret failure within a framework of faith (Nygaard et al., 2020). This monopolization of interpretation limits pluralistic evaluations and reinforces closed epistemic structures. The circularity of legitimacy occurs when miracle claims affirm authority, while authority validates claims. This mechanism demonstrates epistemic control that integrates theological discourse, symbolic rituals, and public testimony into a

cohesive system. This structure effectively maintains the stability of belief despite challenges from external medical rationality.

Meta-theoretical analysis places the overall construction of miracles within a critical-constructivist paradigm that distinguishes between phenomenological understanding and ontological justification. This approach acknowledges the internal rationality of the community without affirming claims of empirical factuality. Internal coherence serves as a sufficient criterion of immanent truth for religious communities, but it is not automatically compatible with public verification standards. A closed epistemic system resists falsification because any dissonance is reinterpreted through the categories of faith. These epistemological implications are relevant for dialogue with medical rationality, which demands objective evidence. Tensions arise not simply from value conflicts, but from differences in knowledge structures and validating authorities. This explanation emphasizes that healing miracles are the product of a complex interaction between narrative, symbol, theology, and power that shapes a consistent yet problematic religious reality in the public sphere.

The Psychological Mechanism of Suggestion in Healing Experiences

Healing experiences in charismatic faith-healing practices can be analyzed within a naturalistic framework grounded in experimental psychology, which treats subjective reports as phenomenological data rather than directly converting them into evidence of pathological change (Kyzar & Denfield, 2023). The epistemological position adopted is methodologically agnostic: experiences are accepted as psychological facts, while claims of biological change require measurable clinical verification. The predictive processing model explains how religious beliefs function as prior beliefs that shape bodily inferences through Bayesian brain mechanisms. Healing expectations act as powerful predictors that modulate sensory signals, thus reducing the perception of pain, fatigue, or functional impairment without eliminating structural pathology (Assadi, 2025). The neuroimaging-based literature on placebo analgesia demonstrates activation of the endogenous opioid system and modulation of the prefrontal cortex when therapeutic expectations are instilled (Huneke et al., 2022). This framework emphasizes a clear distinction between symptom modulation and disease modification, preventing claims of miracles from being inferred solely from experiential data.

Expectancy occupies a central position in the mechanism of suggestion through response expectancy theory, which explains how beliefs about therapeutic outcomes trigger predictable psychophysiological responses (Huneke et al., 2025). Experiments on the manipulation of expectations in chronic pain studies have shown that verbal suggestions can reduce pain intensity through a top-down pathway involving the dorsolateral prefrontal cortex, anterior cingulate cortex, and the release of endogenous dopamine and opioids (Zaworski et al., 2025). Charismatic faith healing builds high expectations through the symbolic authority of

religious leaders, public testimonies, and repetitive ritual structures, thereby enhancing the credibility of the context (Varela, 2023). Credibility functions as an epistemic cue that strengthens the formation of prior beliefs. These effects depend on moderators such as dispositional optimism, religious belief, and the perceived legitimacy of the authoritative figure. Expectancy produces real neurobiological changes, but is limited to symptom regulation, not tissue regeneration or the elimination of degenerative disease. This etiological boundary requires a conceptual separation between experiences of improvement and permanent pathological transformation.

Individual suggestibility determines the degree of internalization of expectations and the intensity of perceptual changes. Experimental hypnosis literature uses instruments such as the Harvard Group Scale of Hypnotic Susceptibility to measure responses to structured suggestions (Zahedi & Sommer, 2022). The construct of suggestibility correlates with traits such as absorption, dissociative tendencies, and high imaginative capacity. Individuals with high levels of absorption are more susceptible to modulation of sensation through selective attentional focus and vivid imagery (Cabbai et al., 2023). Emotional ritual environments enhance directed attentional states, thus facilitating suggestive responses (Xygalatas et al., 2024). Keller et al. (2025) demonstrated that suggestion can modulate heart rate, heart rate variability, and galvanic skin response, although these changes are regulatory rather than curative. Intraindividual variation also occurs because suggestibility is influenced by emotional context, fatigue, and social expectations. This explanation avoids reducing the phenomenon to cognitive weakness and rejects the generalization that all participants experience identical effects.

Social and religious pressures reinforce suggestions through mechanisms of normative and informational conformity, as demonstrated by classic social psychology experiments (Thiruchselvam et al., 2017). Normative conformity encourages individuals to adjust their expressions of experiences to align with group identity, while informational influences alter internal interpretations of ambiguous sensations (Huang, Li, & Jiang, 2023). Social identity theory explains that religious affiliation shapes a collective evaluative framework that assesses healing as an indicator of faith (Balamir & Yılmaz, 2025). A distinction must be made between genuine altered perception, reporting bias, and retrospective reinterpretation to avoid equating experiential changes with self-presentational strategies. Pizarro et al.'s (2022) study of social contagion and collective effervescence demonstrated that group resonance increases the intensity of emotions and shared beliefs. A public context with authoritative figures strengthens the credibility of healing narratives, allowing personal reports to be integrated into collective memory. Such analysis positions testimony as a narrative construction influenced by social interactions, rather than as a direct reflection of biological conditions.

Intense collective emotions modulate pain perception thresholds and vitality through neuroaffective mechanisms. Research by Werner et al. (2023) on ritual synchrony demonstrated that coordinated movement, music, and communal singing increased pain tolerance and endorphin release. The broaden-and-build theory explains how positive emotions expand cognitive repertoires and enhance perceptions of self-control (Roth et al., 2024). High arousal also increases suggestibility because the attentional focus narrows to authoritative cues and symbolic meanings (Zsidó, 2024). Activation of the limbic system and engagement with the prefrontal cortex facilitate the reinterpretation of bodily sensations as signs of recovery. These effects are generally temporary and depend on the continuity of the emotional context. A longitudinal study of religious rituals by Chen, Kim, and Weele (2021) showed that improvements in well-being often decline after the collective stimulus ends. When symptoms recur, religious attributions can maintain healing beliefs through cognitive mechanisms of dissonance and reinterpretation of previous experiences. This neuroaffective framework strengthens the integration of suggestions, expectations, and group dynamics.

Psychosomatic effects provide an empirical bridge between mental processes and limited physiological regulation. Kumar and Vallabhaneni (2025) demonstrated that stress and anxiety exacerbate symptoms of irritable bowel syndrome, musculoskeletal pain, and other functional disorders without clear biological markers. Neuroimaging-based placebo analgesia demonstrated modulation of pain pathways through activation of the endogenous opioid system without specific pharmacological intervention (Neyama et al., 2025). Open-label placebos even demonstrated symptom improvement despite participants being aware of the inert nature of the intervention, suggesting a causal role for therapeutic significance (von Wernsdorff et al., 2021). However, this evidence does not support claims of tissue regeneration or remission of advanced cancer. The nocebo effect suggests that negative expectations can exacerbate symptoms, suggesting that psychological mechanisms are bidirectional (Colloca, 2024). The distinction between symptom modulation and structural pathology must be maintained to avoid reducing the experience to illusion or affirming medical change without clinical data. Charismatic faith healing may facilitate symptom regulation, but etiological limitations remain significant.

An integrative model can be formulated through a mutually reinforcing psychological causal chain: the induction of expectations through religious authority shapes prior beliefs; individual suggestibility moderates the internalization of predictions; collective emotions and ritual synchrony increase arousal and attentional focus; social pressure reinforces narrative consolidation; the result is symptom modulation and the experience of intense well-being. The model operates at four levels of analysis: neurobiological, cognitive, affective, and social. Each level has empirical boundaries and measurable indicators such as stress biomarkers,

functional imaging, or suggestibility scales. This approach avoids the logical leap between transformative experiences and permanent pathological changes. Claims of miracles involve the domain of disease modification, which requires controlled clinical trials, longitudinal medical documentation, and independent verification. Without such evidence, scientific psychology maintains an agnostic position toward supernatural attributions.

Problematizing Miracle Claims Against Medical Rationality

The problematization of charismatic faith-healing miracle claims against evidence-based medical rationality must be framed as a normative epistemological issue that concerns the demarcation of knowledge, not merely differences in therapeutic methods. Modern medical rationality operates through methodological naturalism, which limits causal explanations to empirically testable, correctable, and replicable mechanisms (Pirintsos et al., 2022). This framework aligns with Popper's (1963) principle of falsifiability and the demarcation problem, which demands a clear distinction between scientific and nonscientific claims (Hafid et al., 2025). Evidence-based medicine relies not only on observation but also on a hierarchy of evidence, randomized clinical trials, clinical expertise, and patient values as components of the legitimacy of medical knowledge (Subbiah, 2023). Miracle claims that affirm personal divine intervention embody a transcendent ontological commitment that is not subject to empirical falsification. Epistemological tensions arise when these claims are presented as factual propositions about biological change, thus entering the same domain of evaluation as evidence-based medicine.

Contemporary philosophy of science literature shows that conflicts between religion and science are not always ontological but often center on the boundaries of epistemic jurisdiction (Marin & Lindeman, 2021). The non-overlapping model of magisteria suggests a separation of domains, but claims of miraculous cures alleging tumor regression, restoration of organ function, or normalization of clinical parameters propose verifiable empirical propositions. This situation shifts the relationship into a cognitive competition over the authority to interpret bodily reality. Social epistemology helps explain this dynamic through the concept of epistemic authority and the distribution of collective belief. Scientific authority gains legitimacy through institutional correction mechanisms such as peer review, clinical audits, and research replication. Charismatic authority gains legitimacy through testimony, religious experience, and community recognition. The problem arises not from the existence of transcendental beliefs, but from the affirmation of empirical claims without correction procedures equivalent to medical verification standards.

Medical anthropology studies on medical pluralism show that many religious communities do not reject biomedicine but rather integrate spiritual and clinical practices (Malviya, 2023). The typology of the relationship between religion and medicine includes coexistence, complementarity, subordination, and epistemic exclusivism. This problematization is particularly relevant to forms of epistemic

exclusivism or supersessionism, namely, the position that treats divine intervention as a substitute for or final correction of medical diagnoses. Narratives of physician failure are often presented as confirmation of the superiority of faith. In contrast, within the framework of scientific epistemology, failure is an integral part of the process of correcting knowledge (Yu & Petkov, 2024). Without typological clarification, critics of faith healing risk overgeneralizing. This analysis focuses on situations in which claims of miracles shift the hierarchy of medical evidence and deny the need for clinical verification, rather than on spiritual practices that operate in parallel with medical therapy.

Evidence-based medical rationality has a specific normative structure, namely a hierarchy of evidence that places randomized clinical trials and meta-analyses as the gold standard for claims of therapeutic causality (de Alencar, Rego, & Nunes, 2025). This structure is not absolute but is revisable through data accumulation and collective evaluation. Knowledge correction mechanisms operate through open publication, replication, and institutional oversight (J. Chen et al., 2022). Miracle claims alleging biological cures without diagnostic documentation before and after intervention fail to distinguish between measurable physiological changes and subjective interpretations of symptoms. The absence of external audit mechanisms increases epistemic risk, namely the risk of falsely accepting claims due to the absence of verification procedures. This critique does not reject the possibility of changes in health conditions after prayer, but rather emphasizes that factual claims about the body require independently verifiable evidence to avoid blurring the line between religious experience and biological fact.

Social epistemological analysis deepens the problem through the concepts of epistemic injustice and the distribution of credibility. When spiritual leaders are positioned as the primary interpreters of bodily conditions, a redistribution of authority occurs that can marginalize the voices of healthcare professionals. This delegitimization is not always explicit but manifests in a horizon of meaning that positions medical diagnoses as partial knowledge, subject to divine will. This situation has the potential to produce unbalanced epistemic dependence, as communities accept claims of healing based on charisma without access to corrective mechanisms. Research by Religioni et al. (2025) on trust in healthcare shows that institutional trust plays a significant role in therapy adherence and clinical outcomes. The erosion of trust due to supersessionist narratives can result in treatment delays or discontinuation; thus, epistemic issues have measurable practical implications.

The distinction between ontological, epistemological, institutional, and practical levels clarifies the structure of the problematization. The ontological level concerns commitment to the existence of divine intervention; the epistemological level concerns how claims are validated; the institutional level concerns the distribution of authority; and the practical level concerns the consequences of health

behaviors. Criticism focuses on the epistemological and institutional levels when miracle claims enter the empirical realm without falsification procedures. A critical realism approach can offer a theoretical bridge by acknowledging a reality that may transcend direct observation, while still requiring evidence-based inference to support causal claims. This framework prevents positivistic reductionism while avoiding epistemic relativism. Faith healing can be understood as a meaningful religious practice, but its biological claims remain within the realm of scientific evaluation if they allege measurable changes in the body.

This debate also relates to the limits of methodological naturalism, the foundation of modern science. Methodological naturalism does not deny the possibility of transcendent reality, but rather limits scientific explanatory procedures to testable causes (Boucher, 2020). When miracles are claimed to be the direct cause of biological healing, such claims cannot be tested through standard experimental protocols because they presuppose an uncontrolled, transcendent agent. Consequently, the claims fall outside the causal inference structures used by medicine. Awareness of this limit enables the formulation of non-competitive relationships, provided that religious claims do not supersede medical evaluation. Epistemological conflict arises only when religious propositions are put forward as a substitute for empirical verification procedures and reject the possibility of data-based correction.

A Public Health Ethics Analysis of Faith Healing Practices

The public health ethics analysis of charismatic faith healing practices is based on a synthesis of the harm principle as formulated by John Stuart Mill (1999) and the stewardship model developed by the Nuffield Council on Bioethics (Tulchinsky, 2018). This framework places the prevention of serious harm and the protection of vulnerable groups as the primary justification for normative interventions without negating religious freedom. The harm principle limits freedom when actions result in significant risks to others, while the stewardship model affirms institutional obligations to maintain conditions that enable populations to achieve optimal health. This synthesis provides an explicit theoretical foundation that religious practices gain moral legitimacy to the extent that they do not result in foreseeable health harm and do not erode the capacity of vulnerable agents to make informed choices. This framework avoids abstract moralism by testing claims of miracles through parameters of risk, probability of harm, and population impact.

The concept of vulnerability is understood through the layered vulnerability approach developed in contemporary bioethics literature, which views vulnerability not as an essential attribute but as a result of social, economic, and relational configurations (Mergen & Akpınar, 2021). Children, the elderly, people with disabilities, and individuals with limited health literacy experience layers of vulnerability reinforced by symbolic power relations between charismatic leaders and followers. This analysis aligns with Iris Marion Young's (1990) social connection

model of responsibility, which places moral responsibility on the collective structures that generate injustice, not solely on individual choices. Charismatic faith healing becomes problematic when religious authority creates a closed epistemic horizon, allowing claims of healing to displace rational medical considerations. This situation transcends private preferences because asymmetrical relations diminish the capacity for autonomous consent and create normative dependencies that limit the substantive freedoms of vulnerable groups.

The justification for extending moral evaluation to the public sphere is based on John Rawls' (1999) theory of public reason and an analysis of population health externalities. Communal practices that normalize the rejection of evidence-based therapies result in collective consequences such as increased morbidity, delayed diagnosis, and burden on the health system (Iwuji et al., 2020). Childress's framework emphasizes the principles of proportionality, least infringement, and reciprocity as standards for legitimizing restrictions on freedom (Melekh & Melekh, 2025). These parameters require proof that the risks are serious, that interventions are designed to be minimally intrusive, and that affected communities receive equitable support. Faith healing cannot be treated privately when healing narratives shape social norms that influence the health decisions of others, including children who lack the capacity to consent. Externality analysis demonstrates that risks do not stop with the perpetrator but rather spread through family and community networks, entering the realm of legitimate public interest.

Religious freedom remains recognized as a fundamental moral right, as Martha Nussbaum (1997) argued. However, this freedom is not absolute when it could result in serious harm to life and health. The distinction between soft and hard paternalism clarifies the limits of intervention; restrictions are justified when individuals lack adequate information capacity or are in situations of structural oppression. The balancing test assesses the severity of the harm, the probability of occurrence, the reversibility of the impact, and the degree of vulnerability of the exposed party. This approach prevents state overreach and rejects relativism that allows risky practices in the name of faith. Proportionality does not imply a dogmatic hierarchy of values, but rather a contextual evaluation based on epidemiological evidence and risk analysis. Religious freedom maintains ethical legitimacy as long as its practices do not undermine the fundamental rights of others to adequate health protection.

The distribution of moral responsibility requires differentiation of actors and levels of causal contribution. Religious leaders bear epistemic responsibility for producing healing claims and influencing collective belief structures. Communities play a role in maintaining norms and imposing symbolic sanctions against medical deviations. The state holds a stewardship obligation to ensure regulatory frameworks protect vulnerable individuals without discriminating based on beliefs. This collective analysis avoids reducing morality to individual good intentions and emphasizes the structural dimension of faith healing practices. Responsibility is not

merely retrospective but prospective through the obligation to prevent recurring patterns of harm. This model aligns with collective agency theory, which views communities as capable of acting as moral subjects when they have clear decision-making mechanisms and role distributions, so that health consequences cannot be separated from the normative structures that produce them (Wang & Stokhof, 2022).

The principle of nonmaleficence fosters a reinterpretation of populations of preventing predictable harm based on empirical data. Tom Beauchamp and James Childress's (2013) principlism framework provides a normative foundation, but public health ethics expands its scope to the structural level and risk distribution. The literature shows a correlation between delays in faith-healing-based medical therapy and increased mortality among treatable diseases (Anwar et al., 2025). The precautionary principle requires restrictions on practices when the potential for serious harm cannot be eliminated, even if the perpetrator's intentions are altruistic. Moral evaluation does not negate spiritual significance, but demands transparency of risks and a prohibition on misleading therapeutic claims. When consistent patterns of harm are identified, the moral legitimacy of collective practices is called into question on the grounds of the obligation to prevent avoidable suffering at the population level.

Policy implications require a multilevel approach that respects democratic pluralism while maintaining public safety. Regulation could take the form of mandatory disclosure that spiritual practices are not a substitute for medical therapy, documentation of informed refusal for competent adult patients, and child protection interventions when guardians refuse essential treatment. The least restrictive alternative strategy prioritizes collaborative health education with religious communities before applying coercive sanctions. The principle of reciprocity requires the state to provide equitable access to health services so that individuals are not driven to seek risky alternatives due to structural barriers. The framework emphasizes that restrictions are directed at harmful therapeutic claims, not expressions of faith. Normative evaluation produces an analytical model based on four parameters: level of vulnerability, probability and severity of harm, reversibility of impact, and capacity for autonomous consent.

Conclusion

Charismatic faith healing constructs miracle claims through the interplay of narrative authority, ritual performativity, and community validation, resulting in the reinforcement of collective suggestion. Key findings suggest that healing experiences emerge through mechanisms of expectancy, meaning response, emotional regulation, and social cohesion, triggering changes in pain perception, improved subjective functioning, and symptom reinterpretation, despite the frequent lack of clinical verification. Miracle claims become problematic when they are positioned as a substitute for evidence-based therapy, risking diagnostic delays and interfering

with safe healthcare decision-making. The theoretical contribution is a three-layered analytical model—narrative, ritual, and community—that extends the concept of individual suggestion to the dynamics of religious collectives and links it to the principles of beneficence, non-maleficence, autonomy, and justice. Practical implications include risk communication guidelines for religious leaders, collaborative health literacy education, and the involvement of charismatic communities in preventive promotion. Limitations include the interpretive qualitative design, reliance on narratives without medical verification, potential selection and interpretation biases, and limited generalizability of the cases. Further research agendas should include longitudinal studies, experiments on the effects of ritual suggestion, and evaluation of cross-disciplinary ethical communication models.

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Author Contribution Statement

RP contributed to the conceptualization of the study, the development of the theoretical framework, data analysis, the writing of the main draft, and correspondence, and finalization of the manuscript. AS contributed to data collection, literature search, and preparation of the methodology section. HG contributed to data validation, analysis of findings, and review of the manuscript's substance. LR contributed to the interpretation of the results, the development of academic arguments, and the editing of the manuscript's content. UC contributed to reference verification, alignment of writing format, checking for citation consistency, and final review of the manuscript.

Conflict of Interest

The authors declare that there are no conflicts of interest of any kind related to the research, writing, or publication of this manuscript. The authors have no financial, professional, institutional relationships, or personal interests that could affect the objectivity, interpretation of data, analysis, or conclusions presented in the article. The entire research process and preparation of the manuscript were conducted independently in accordance with the principles of academic integrity and applicable research ethics standards.

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interpretations, and conclusions presented in this manuscript are the author's own intellectual work.

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