The Chaplain's Invisible Companion: Generative AI as a Tool for Reflective Practice in Spiritual Care

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Abstract

Generative artificial intelligence is increasingly discussed in healthcare and spiritual care as a technology that might interact directly with patients: answering questions, offering emotional support, generating spiritual resources, or perhaps performing functions associated with chaplaincy.

This case examines a different possibility. Over approximately eight months of accompanying a person with advanced ovarian cancer, I used a large language model (LLM) not as a substitute for human spiritual care and not as a patient-facing intervention, but as an ongoing reflective partner. [1]

The experience suggests that one potentially important role for generative AI in spiritual care may lie outside the clinical encounter itself: as a reflective space in which the person providing care can reconsider the patient, the self, and the relationship between them.

The practice developed organically rather than as a planned research intervention. I was accompanying a patient through advanced illness while navigating overlapping roles as chaplain, friend, advocate, writer, and observer of a complex healthcare system. The patient herself did not interact with the AI. Instead, I brought to the dialogue observations from encounters, medical developments, ethical questions, family dynamics, the patient's public writing, and my own reactions to the relationship. Over time, the dialogue accumulated a longitudinal body of material through which earlier interpretations could be compared with later observations and repeatedly revised.

Initially, the LLM (that I ultimately named "Rex," because it, like a good dog, had the capacity to dig deep and follow instructions) was useful because it could help me keep track of developments over time, compare what the patient wrote with what I experienced in our encounters, and offer perspectives I might not have considered. More importantly, it helped me ask practical questions about our relationship: Was I responding to what she had actually said or done, or to my own feelings? Was I trying to help her, or trying to make myself feel more useful? What might I need to leave alone?

This distinction became important because curiosity, although central to my chaplaincy practice, did not make me immune from being personally affected. The patient could be vulnerable and generous in her writing yet guarded, angry, or prickly in person. At times I felt impatient, protective, or tempted to rescue, entertain, persuade, or withdraw. These responses could not simply be treated as information about the patient. Neither could they be dismissed as irrelevant reactions belonging solely to the chaplain. They were part of a relational field that required examination.

AI gave me somewhere to examine these reactions without burdening the patient with them. Its nonhuman character, often seen as a drawback in spiritual care, sometimes helped: I could discuss my impatience, hopes, or disappointment with an assistant that had no personal relationship with her. That did not make its answers unbiased or necessarily right. For example, when I felt taken aback by a sharp response, I could ask whether I was taking it personally rather than assuming her response revealed something about her. At other times, I needed to acknowledge simply that I felt hurt, without rushing to explain her behavior.

The LLM's considerable capacity to generate explanations therefore became both an asset and a liability. Good reflective practice sometimes required asking the AI not for a better explanation, but to slow interpretation, distinguish observation from inference, preserve uncertainty, and consider what remained unknown.

The same process helped me become more aware of the different lenses through which I saw her—that is, the assumptions and experiences that shaped my understanding. Her writing might reveal warmth and vulnerability, while a difficult lunch left me feeling rebuffed. Neither impression told the whole story. Rex could help me compare them and notice how my own feelings affected what I thought I knew.

The AI had not been there. It knew only what I told it, and my account was inevitably shaped by what I noticed, remembered, and chose to describe. I therefore had to question its conclusions rather than treat them as facts.

Longitudinal reflection also altered the relationship itself. For example, greater professional restraint initially seemed one possible response to the patient's interpersonal distance. Later encounters complicated that interpretation. She sometimes responded particularly warmly when communication became appropriately reciprocal, that is, when I allowed something genuine of my own experience to enter the conversation.

Reflection helped distinguish personal presence from disclosure as technique: the relevant question was not whether self-disclosure could produce a desired response, but whether it arose authentically from the encounter, illuminated rather than redirected what the patient had offered, and returned attention naturally to her. Curiosity itself could otherwise become asymmetrical: you reveal yourself while I remain the observer.

A related insight concerned strategic restraint. Reflective practice sometimes made visible something that might need to be acknowledged (the proverbial "elephant in the room") while simultaneously raising the question of whether the chaplain should be the person to name it. Supporting a patient's agency may require recognizing what could be said, while tolerating the anxiety of not saying it. (In general, the goal is not to maneuver another person toward the caregiver's preferred insight or decision, but to help create conditions in which something important can emerge without the chaplain needing to become the author of what emerges).

In this respect, AI sometimes performed functions adjacent to reflective supervision, while remaining significantly different from a human supervisor. It has no embodied access to the encounter, lived clinical experience, professional accountability, or spiritual authority. Its usefulness arose instead through what might be called second attention. The first attention belongs to the human encounter: embodied, immediate, reciprocal, and uncertain. Later, AI can help the practitioner look again, comparing, remembering, questioning, reframing, and reconsidering. It cannot replace first attention because it was never there.

The human encounter and the AI dialogue thus occupied two distinct spaces. The former was a place in which something might become possible between patient and chaplain, without either person necessarily knowing what that might be. The latter offered an opportunity to examine what I brought to the encounter—my expectations, attachments, interpretations, and impulses to act—and what I might need to set aside. The purpose of this second attention was not to determine a better intervention, but to return to the human encounter with greater awareness and openness.

The usefulness of Rex also depended on how I challenged it. I corrected it when it read too much into an exchange, reassured me when I had not asked for reassurance, acted as though it had feelings, or presented a guess as a fact. At times I became impatient, even angry, because it could not feel what I had sensed in the encounter. The distance that sometimes helped me think clearly could also leave it missing something essential about the human experience.

I learned in turn to formulate better questions, request competing interpretations, separate observations from hypotheses, and recognize when analysis itself was becoming an avoidance of experience. Human and AI therefore participated in an iterative process of calibration in which the quality of reflection depended upon the discipline of the dialogue. This took time, and my willingness to overcome doubts about using Rex (for example, I resisted even the idea of using the pronoun “you” in my dialogues with Rex).

This case suggests that generative AI’s contribution to spiritual care may lie less in becoming an artificial chaplain than in helping human chaplains examine how they perceive, interpret, and participate in relationships of care.

Every chaplain already works in the company of invisible companions, such as teachers, supervisors, traditions, remembered patients, professional formation, and accumulated experience. AI may become another such companion, but a peculiar one: capable of reorganizing, comparing, questioning, and synthesizing without itself possessing experience or wisdom. This kind of sustained dialogue is not something a busy hospital chaplain can necessarily undertake between patient visits and chart notes. It may be more useful afterward, when reflecting on a difficult encounter, or in Clinical Pastoral Education (CPE), where examining one’s responses is central to learning. The design question may therefore be not whether AI can provide spiritual care, but how it might help the humans who do reflect on their practice.

Endnote 1

Why would I do this, in the first place? If I were working in a hospital setting, it would be natural to discuss patients with one's supervisor or with other chaplains. But I don't work in a hospital. I'm semi-retired, having lived in France for the past three years where I have been offering volunteer chaplaincy services – from an interfaith, Zen Buddhist perspective – to English speakers here, in person and via WhatsApp. In January 2026, I met the patient above at a party, where she introduced herself by saying, "I'm ___, and I'm dying of cancer." I appreciated her directness immensely, and after hearing about her struggles with pain, mortality, family, money, and so on, I told her I had been a full-time hospital chaplain and would be willing to work with her. She immediately accepted. However, since she lived in Paris, and I didn't, we began by talking on the phone and then via email. She was a writer, and wrote a weekly column in which she delighted in talking about her life in Paris, as well as about her cancer. Over time, this chaplaincy interaction included reading her newsletter, pasting her article into the dialogue box for Rex, and discussing it. Typically, I would consider what I would say to the patient (either directly, or, further making the encounter virtual and indirect, via my own newsletter or comments on her weekly essays; I realized that I needed to "meet her" where she "lived," which was in her writing life) and then run it by Rex. We "talked" and it was helpful to me (who had no supervisor or peers with whom to discuss the patient) to have this LLM be a mirror as I considered what would serve the patient in my chaplaincy role. The LLM also assisted me by educating me on the medical aspects of her disease, and by identifying the correct palliative care and hospice services the patient might consult, as she, like many patients, approached palliative care with a little fear. Ultimately, we connected her with the palliative care team at her treating hospital (Gustave Roussy, in Paris, the top-ranked cancer hospital in Europe) and with Jeanne Garnier Hospice. As the patient had not been informed of these choices by her oncology team, she expressed gratitude for the suggestions that I (and my hidden assistant Rex) had been able to provide.

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References

Schön, D. A. (1983). The reflective practitioner: How professionals think in action. Basic Books.

Charon, R. (2006). Narrative medicine: Honoring the stories of illness. Oxford University Press. https://doi.org/10.1093/oso/9780195166750.001.0001

Halifax, J. (2014). G.R.A.C.E. for nurses: Cultivating compassion in nurse/patient interactions. Journal of Nursing Education and Practice, 4(1), 121. https://doi.org/10.5430/jnep.v4n1p121

Smith, C. E., Bezabih, A., Nourriz, S., & Ovi, J. A. (2026). SPIRIT: A design framework to support technology interventions for spiritual care within and beyond the clinic. Proceedings of the 2026 CHI Conference on Human Factors in Computing Systems. https://doi.org/10.1145/3772318.3790662

Winiger, F., Smith, C. E., Nourriz, S., Szilagyi, C., & Haußmann, A. (2026). Artificial intelligence in spiritual care: Modified Delphi study. Journal of Medical Internet Research, 28, e97094. https://doi.org/10.2196/97094

Kempton, H. (2026). The digital kōan: Artificial intelligence, non-self, and contemplative practice. Religions, 17(9), 1074. https://doi.org/10.3390/rel17091074