DEFENSE MECHANISMS AND COUNTER-REFERENTIAL ASPECTS OF THE CAREGIVER: CONTRIBUTIONS FROM PSYCHOANALYSIS AND HEALTH PASTORAL CARE

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Abstract: This article investigates the defense mechanisms and countertransference processes inherent in the caregiver's experience in hospital and pastoral settings. Drawing on classical and contemporary psychoanalytic frameworks (Freud, Anna Freud, Melanie Klein, Winnicott, and Vaillant) and the dialogue with Catholic spirituality (Koenig and the Pastoral Care of Health documents), the study aims to understand how these psychic defenses, although initially protective, may undermine the authenticity, mental health, and spiritual well-being of those who care. The paper offers theoretical and practical contributions to help caregivers recognize their own vulnerabilities, integrate their psychic and spiritual dimensions, and sustain an ethical, compassionate, and humanized approach to care. This study originates from pastoral and clinical experiences at the Hospital Federal de Bonsucesso and a lecture delivered at the Health Pastoral Care Meeting of the Archdiocese of Rio de Janeiro.

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Keywords: Psychoanalysis. Defense mechanisms. Countertransference. Catholic spirituality. Pastoral Care of Health. Mental health.

INTRODUCTION

Care, especially in the hospital and pastoral context, constitutes a privileged space for the encounter between human frailties and ethical, emotional and spiritual demands. Caregivers — health professionals, pastoral workers and volunteers — not only watch physical suffering, but are also challenged by deep, symbolic and existential anguish that crosses the scene of care. In this scenario, it is inevitable that complex psychic mechanisms of protection and elaboration come into play, demanding from the caregiver not only technical skills, but a mature and continuous reflection on himself and on the bonds he establishes with those he serves.

This article emerges from the pastoral and clinical experience accumulated in formative activities in the Chapel of Our Lady of Graces, at the Federal Hospital of Bonsucesso, and from the homonymous lecture given to the Pastoral da Saúde of the Archdiocese of Rio de Janeiro, revealing itself as an attempt at rigorous articulation between two knowledges that are sometimes presented as antagonistic: psychoanalysis and Catholic spirituality. Contrary to this supposed opposition, we start here from the premise that such knowledge complements each other in the integral care of the human person, promoting a deeper understanding of both the subjectivity of the caregiver and the ethical-spiritual requirements of the mission of care.

The proposal of this study is, therefore, multiple and integrated: to analyze the main defense mechanisms that emerge in the caregiver — understanding how they operate both as protection and as psychic traps —; to explore the countertransferential aspects that inevitably cross the care relationship and that, when unconscious, distort the bond and compromise the emotional health of those who care; and to draw fruitful bridges between psychoanalytic experience and Christian spirituality, considering that the act of caring is also an interior itinerary, a path of self-knowledge, openness to grace and renewal of meaning.

Finally, the objective is to offer theoretical and practical subsidies that enable caregivers to remain whole, present and human in the exercise of their mission, rescuing care as a radically humanizing and spiritual experience. In a time marked by fragmentation and emotional overload, this reflection contributes to the development of a more lucid, ethical and compassionate Health Pastoral, capable of welcoming not only the pain of the sick, but also the vulnerabilities and needs of those who care.

DEFENSE MECHANISMS, SPIRITUALITY AND MENTAL HEALTH: PERSPECTIVES FOR CONTEMPORARY CARE

The complexity of the human experience in suffering and care demands a look that transcends simplistic explanations and integrates psychic, spiritual and social dimensions. In the contemporary field of mental health, the dialogue between psychoanalysis and spirituality is not only opportune, but epistemologically fruitful: it allows us to unveil both the unconscious defenses that structure subjectivity and the symbolic and transcendental instances that sustain the desire for meaning (Freud, 1926/1974; Klein, 1957).

Starting from the Freudian heritage — which situated defense mechanisms as strategies of the Ego in the face of intrapsychic conflicts (Freud, 1926/1974) — this chapter proposes to examine the conceptual evolution of these mechanisms, from classical psychoanalysis to the contemporary rereadings of Anna Freud (1936) and Vaillant (1993), who systematized and hierarchized such mechanisms, contributing to their clinical and ethical understanding.

Next, we will expand the analysis by articulating such mechanisms with the field of Catholic spirituality and with recent findings in the area of religion and mental health, as emphasized by Koenig (2001) and Moreira-Almeida et al. (2020), which demonstrate that intrinsic religious practices can contribute to greater emotional resilience and healthy coping with situations of suffering.

This critical-analytical itinerary is premised on the premise that the modes of defense do

not operate in isolation in the psyche: they are intertwined with cultural representations, spiritual narratives and care practices that directly impact emotional health, especially in the hospital and home context, where Health Pastoral agents work (CNBB, 2010; Puchalski et al., 2009).

By problematizing excessive medicalization and the risk of psychopathological reductionism, our reflection seeks to restore the centrality of singular listening — the one that recognizes, in the subject's discourse, both defensive movements and their search for recognition and transcendence (Winnicott, 1965; Puchalski et al., 2014). It is, in the final analysis, a matter of sustaining care as an ethical space, where the unconscious, otherness and spirituality meet so that suffering can be welcomed and, eventually, symbolized.

Classical Psychoanalysis

The emergence of the concept of defense mechanisms constitutes one of Sigmund Freud's most original and decisive contributions to the understanding of psychic dynamics. Since his first writings (Freud, 1896/2012; 1905/2010, 2023), Freud has identified that the Ego — a mediating psychic instance — needs to protect itself from conflicting pressures arising from unconscious drive impulses (Id), internalized normative demands (Superego), and the demands imposed by external reality. This triple tension forces the Ego to resort to commitment strategies that do not aim to eliminate the conflict, but to attenuate its conscious effects, guaranteeing a minimum of functional balance to the subject.

The systematization of these mechanisms was deepened by Anna Freud, whose work The Ego and the Defense Mechanisms (1936/1991), became a fundamental reference for the clinical field. Anna Freud describes and exemplifies defensive modes such as denial — unconscious refusal to recognize a painful reality; projection — attribution to the other of unacceptable internal contents; and rationalization — elaboration of plausible justifications for behaviors motivated by unconscious impulses. In his perspective, these mechanisms are not pathological in themselves: their adequacy or

maladjustment depends on the flexibility and capacity of the Ego to mobilize them in an integrated and adaptive way (Anna Freud, 1936/1991; Vaillant, 1993).

At the same time, Melanie Klein proposed a decisive theoretical advance by exploring the primitive defenses that have operated since the dawn of psychic life. In his study of the paranoid and depressive schizophrenic positions, Klein (1946-1963/1957) describes the central role of projective identification, a mechanism by which the subject expels intolerable parts of the self from himself, projecting them onto the object, and then controls or reintegrates them in a partial and distressing way. This conception allowed us to understand that defenses are not exclusive to the mature Ego, but are present from the first relational and affective experiences, implying both unconscious fantasies and intersubjective dynamics.

In the hospital context — and similarly in the pastoral sphere, especially in visiting the sick at home — these primitive defenses gain singular relevance. In the face of disease, pain and the threat of finitude, both patients and caregivers can intensely mobilize mechanisms such as denial or projection, producing complex transferential dynamics (Koenig, 2001; CNBB, 2010). The Health Pastoral agent, in turn, when inserted in this scene, becomes an interlocutor privileged of contents that go beyond the field of the rational and are inscribed in the territory of the unconscious.

Classical psychoanalysis, therefore, offers the caregiver and the contemporary analyst a robust conceptual map to understand the defensive manifestations that permeate care: from the denial of the seriousness of a diagnosis to the aggressiveness projected onto the professional or pastoral agent. More than categorizing them as dysfunctions, it is necessary to welcome these defenses as legitimate expressions of a psyche confronted with suffering, unveiling in the heart of these strategies an attempt to — sometimes desperate — of preserving the subject in the face of the unbearable (Winnicott, 1965; Puchalski et al., 2009).

Contemporary Psychoanalysis

Contemporary psychoanalysis, without abandoning the Freudian core that structures the theory of defense mechanisms, has significantly expanded and refined its understanding, incorporating clinical and empirical contributions that respond to the complexities of the modern subject (Winnicott, 1965; Mezzomo, 2010).

A notable example of this movement is the work of George Vaillant (1993), whose proposal to classify defense mechanisms into hierarchical levels — from the most immature to the most mature — conferred an important heuristic value for contemporary clinical practice and for interdisciplinary dialogues with psychiatry and developmental psychology.

For Vaillant, the so-called mature mechanisms, such as sublimation and altruism, favor not only intrapsychic balance, but also creative and ethical social adaptation, and are often observed in individuals who achieve resilience in the face of adversity. Immature mechanisms, such as denial and projection, when predominant, tend to weaken psychic functioning, making it difficult to relate to reality and to the other, in addition to compromising subjective authenticity.

Donald Winnicott (1965), in turn, offers a qualitative and paradigmatic shift in the contemporary reading of defenses by introducing the concept of false self. For the author, it is a defensive structure that is constituted from environmental inadequacy, especially in early relationships with primary caregivers, leading the subject to build a persona adjusted to external expectations to the detriment of its spontaneity and authenticity. This adaptive, though often effective, mask to survive the pressures of the environment, it operates as a pathological defense when crystallized, distancing the subject from his true self, his true and creative core.

In the field of care and Health Pastoral, the concept of false self acquires particular relevance. Professional and volunteer caregivers, pressured by institutional, religious, or cultural demands, may develop an apparently impeccable behavior, but dissociated from their inner truth, wearing out emotionally and, ultimately, compromising the relational quality of their work (CNBB, 2010;

Francisco, 2019). From this perspective, recognizing the emergence of the false self in the caregiver is an ethical and clinical task of the first order, as the authenticity of the caregiver is an essential condition for the care offered to be truly humanized and welcoming.

In this way, contemporary psychoanalysis not only broadens the theoretical repertoire on unconscious defenses, but also deepens the understanding of their function in the subjective constitution and in the intersubjective bond (Anna Freud, 1936; Koenig, 2001). By articulating the concepts of Vaillant and Winnicott, this chapter suggests that the health caregiver and the pastoral agent need a permanent reflective work on themselves: the conscious management of defensive mechanisms — both their own and those of those they care for — is, therefore, an inseparable part of comprehensive, mature and ethical care (Ramos, 2025).

Spirituality in Health Pastoral Care

Spirituality is a structuring axis of the Pastoral of Health and is configured as an essential dimension in comprehensive care, as understood by the Catholic tradition (CNBB, 2010). From her origins, the Church has taken on the mission of promoting not only the alleviation of physical suffering, but also the restoration of dignity and hope, recognizing in the sick the presence of the suffering Christ (cf. Mt 25:36b). Thus, spiritual care cannot be reduced to a mere ethical supplement or a complementary plus to biomedical care; it is constitutive of an integral anthropology, which values the inseparable unity of body, psyche and spirit (Catechism of the Catholic Church, 1999).

The Pontifical Council for Pastoral Assistance to Health Care (1985-2017) has reiterated, over the last decades, this commitment to holistic care, recalling that the health of human beings transcends clinical and statistical indicators and involves their existential and transcendent horizon. The institution of World Wildlife Day Sick, in 1992, through the prophetic initiative of St. John Paul II, he was a milestone of this commitment, proposing to the Church and to the world a constant reflection on the value of human life in all its stages and conditions.

In this horizon, spirituality in the Pastoral of Health finds its deepest meaning: not as an escape or religious compensation in the face of illness, but as a way of inhabiting suffering with meaning and offering the sick a space of recognition and listening, where the mystery of pain can be welcomed and symbolized (Rocha, 2015; Congregation for the Doctrine of the Faith, 2016). Sacramental actions — anointing of the sick, confession, Eucharistic communion — become, therefore, concrete mediations of spiritual care, allowing suffering not only to be endured, but to be re-signified in the light of faith and ecclesial communion (Ferreira et al., 1982; Sacred Congregation for the Doctrine of the Faith, 1981; Sacred Congregation for Divine Worship, 1984; Maggioni et al., 1974).

From the psychoanalytic point of view, this spiritual approach also assumes a restorative function: in the face of the unconscious defenses activated by the impact of illness, the pastoral encounter offers a symbolic continent capable of welcoming primary anxieties, fears of fragmentation and regressive experiences that often emerge in the context of illness and hospitalization (Winnicott, 1965).

The pastoral agent, therefore, not only provides a religious service, but occupies a place that intersects with the maternal functions of care and holding described by Winnicott, being called to sustain, through presence and listening, the radical fragility of the sick subject (Mezzomo, 2010; Ramos, 2024).

In short, spirituality in the Pastoral of Health reaffirms that care is not only a technical action, but a profoundly human and ethical act, in which the suffering of the other is welcomed as a space of encounter, transcendence and transformation. In this sense, it is articulated with psychoanalysis in the search to offer care that respects subjective singularity, recognizing that, beyond the symptom, the patient has a desire for meaning that needs to be heard, welcomed and accompanied (Puchalski et al., 2009; Koenig, 2001).

Religion and Mental Health

The areas of intersection between religion and mental health have been consolidated in recent decades as a relevant and interdisciplinary field of research, overcoming reductionist prejudices that have sometimes relegated religious experience to the sphere of irrationality or escapism (Moreira-Almeida et al., 2020).

Consistent studies, such as those carried out by Koenig (2001) et al., empirically demonstrate that religiosity — especially when lived in an intrinsic and communal way — works as an important protective factor for mental health. The evidence points to the association between religious practices and lower rates of depression, lower risk of suicide, greater resilience and the use of more effective coping strategies in situations of suffering.

But the contribution of religiosity is not limited to epidemiological indicators. From the subjective point of view, religion offers a complex and shared symbolic structure, which allows the elaboration of suffering, the attribution of meaning to pain and the integration of limit-experiences, such as illness and finitude (John Paul II, 1984; Congregation for the Doctrine of the Faith, 2016; Ramos, 2025).

Rituals, narratives and community spaces provide not only social support, but also psychic continence for primordial anxieties, often not symbolized. In other words, religiosity constitutes a cultural and psychic resource that facilitates the passage through critical emotional states, enabling the subject not only to resist, but also to transform himself (Oliveira, 2020).

On the other hand, psychoanalysis — even while maintaining a critical stance regarding the illusion and the risks of religious alienation — recognizes that religious experience mobilizes deep unconscious dimensions, linked to the first experiences of care, dependence, and otherness (Freud, 1926/1974).

In certain cases, religious discourse can reinforce defensive mechanisms—such as denial or idealization—that need to be carefully considered in the clinical context (Winnicott, 1965). In

other cases, however, faith can open paths for the symbolization and reinvention of desire, serving as legitimate existential support.

In the specific context of Health Pastoral Care, this relationship becomes even more significant: when visiting the sick, the pastoral agent daily witnesses the impact that the religious dimension has on mental health, whether as a source of comfort and hope, or as a terrain of conflict and ambivalence (Francisco, 2015).

Therefore, understanding religion as a multidimensional phenomenon — capable of operating both as a defense and as a resource for elaboration — requires the caregiver to an attentive and ethical listening, which respects the uniqueness of each story of faith, avoiding generalizations and instrumentalizations.

It is concluded that religion, far from being a simple cultural adornment, constitutes a structuring pillar of subjectivity and mental health for a large part of the world's population (Moreira-Almeida et al., 2020). Integrating it in a critical and respectful way into psychic and pastoral care is, therefore, a contemporary requirement, capable of enriching both clinical practice and pastoral action in favor of truly integral and humanized care (Oliveira, 2020; Puchalski et al., 2014).

CONTEXTUALIZATION OF CARING AND BEING CARED FOR

The act of caring is, by definition, relational: it involves an encounter between weaknesses and strengths, between the suffering of the other and the limits and internal resources of those who are willing to welcome it. In this sense, caring and being cared for constitute profoundly human experiences and, therefore, crossed by the complexity of affections, by the subjective structuring and by the sociocultural conditions in which they are inserted.

If, in the Christian tradition, care has always been understood as an expression of charity and mercy — a concrete reflection of Christ's presence with those who suffer — in the contemporary context it is increasingly presented as a demanding and paradoxical challenge: we are called to care

in a time that often dehumanizes care and reduces it to technical procedures or measurable results.

Caring today: challenges and the caregiver in contemporary times

Contemporaneity imposes on caregivers — whether health professionals, volunteers or pastoral agents — an unprecedented accumulation of roles and emotional demands. In the daily exercise of care, there is a permanent tension between compassionate listening and the speed of protocols; between affective presence and the pressure for productivity; between singularized care and the standardization imposed by health systems (Mezzomo, 2010).

This multiplicity of demands — physical, emotional, spiritual and ethical — exposes the caregiver to extreme situations, making him vulnerable to insidious processes of exhaustion. Accumulated fatigue, scarcity of resources and emotional overload favor psychic illness, often silent and neglected. Burnout, somatizations, emotional cynicism, and spiritual exhaustion become symptoms of a that challenges not only individuals, but also the care institutions themselves.

Psychoanalysis offers precious contributions here, allowing us to understand the unconscious mechanisms that may be at play in this scenario: projective identification with the pain of the other, tendency to idealize the role of caregiver, compulsion to repair, and, not rarely, the mobilization of narcissistic defenses to bear the emotional weight of extreme situations (Winnicott, 1965; Freud, 1926).

From this perspective, caring requires from the caregiver not only technical competence and good will, but also a permanent commitment to self-knowledge and to the management of their own anxieties and fragilities — a challenge that, as Winnicott (1965) emphasizes, can only be faced through continuous reflection on oneself and on the other in contexts of vulnerability.

Spiritual perspective: care as sacramental service

In the horizon of the Catholic faith, the act of caring transcends the professional dimension and acquires a particular spiritual density: it is configured as a sacramental service, an extension of the compassion of Christ and the maternal tenderness of Mary (Boff, 1973; 2007; CNBB, 1977). Every compassionate gesture — from touching to silent listening, from visiting the sick to simply offering one's presence — becomes a visible sign of divine mercy that is close to human suffering (Catechism of the Catholic Church, 1999; Eliade, 1996; Didoné, 1986).

However, this spirituality of care is not without its pitfalls. Barreto (2005) and Barchifontaine (1996) warn of the risk of care driven by an excessive altruistic idealism, which can lead to self-sacrifice and psychic exhaustion. This "false altruism" — when not permeated by spiritual grace — transforms care into an alienating burden, to the detriment of the caregiver and the care offered (Vaillant, 1977/1993; Winnicott, 1965).

The Catholic spiritual tradition offers valuable criteria to face this challenge: personal prayer as a space for interior recomposition; the sacraments as sources of grace and restoration (Ferreira et al., 1982; Congregation for Divine Worship, 1984); community discernment as an antidote to caregiver loneliness and isolation. In short, it is a matter of recognizing that in order to care authentically, it is also necessary to allow oneself to be cared for — by God, by the community and by one's own interior rhythm.

In this time marked by the acceleration and multiplication of demands, the Health Ministry is called upon to assume a double responsibility: to care for the sick and to care for the caregiver, promoting spaces for listening, training and support that make it possible to sustain care as a humanizing and spiritual act (Costa, 2018; Congregation for the Doctrine of the Faith, 1986). After all, as the Gospel recalls: "I was sick and you visited me" (Mt 25:36) — but this call to visit and to be present presupposes that the caregiver himself is whole, pacified and available — body, soul and spirit — under penalty of transferring his own shortcomings in pastoral service (Boff, 2007; Catechism of

the Catholic Church, 1999).

DEFENSE MECHANISMS IN THE CAREGIVER

The experience of caring, with its intense load of emotional, ethical and practical demands, inevitably confronts the caregiver with his own and others' limits. In the face of this limit-experience, it is natural that psychic mechanisms emerge aimed at protecting the Ego from excess suffering. Psychoanalysis teaches that defense mechanisms are unconscious strategies whose main function is to modulate and attenuate anguish, preventing threatening content from invading consciousness in a disorganizing way. However, if mobilized in a rigid and repeated way, these mechanisms, which should sustain psychic balance, can imprison the subject in a pathological defensive dynamic, distorting reality, hindering self-care and emotionally saturating the caregiver.

The theoretical origin of these concepts goes back to Freud, as we saw in section 1.1, who described defenses as internal devices activated in the tension between Id, Ego and Superego — a dynamic in which irreconcilable instinctual desires and conflicting moral demands threaten psychic stability (Freud, 1894, 1926). Anna Freud (1936) deepened this understanding, systematizing defense mechanisms and attributing them a fundamental adaptive role, as long as they are used flexibly. Melanie Klein, in turn, highlighted the primitive mechanisms, present since childhood, which assume particular relevance in regressive situations associated with suffering and dependence, as occurs in the hospital and pastoral environment.

Among the classic mechanisms, denial, projection, reactive training and rationalization stand out, all of which are frequently identifiable in the practice of care. The caregiver, by mobilizing them unconsciously, can preserve their psychic health and — if you exaggerate them — compromise your capacity for genuine presence, empathy, and discernment.

Extreme Idealization ("saint without limits")

Extreme idealization often manifests itself in the field of care as the unconscious belief that the caregiver must be perfect, always available, and immune to fatigue. This position may be rooted in a mechanism of reactive formation, in which the subject reacts in the opposite way to what he really feels — masking fragility, fear or insecurity through rigid perfectionism (Freud, 1926/1974; Anna Freud, 1936/1991).

In addition, a partial denial operates here: by refusing to admit human limitations, the caregiver builds an "infallible" self-image, which quickly becomes a source of guilt and frustration when the inevitable error or fatigue arises, as Vaillant (1977/1993) points out. This "merciless internal judger" is fueled by idealized demands and unrealistic expectations: "If I failed once, I failed completely", as Winnicott (1965) observes, when he describes the false self as an adaptive mask molded to correspond to external demands, but which distorts genuine spontaneity and stifles the caregiver's individuality.

Psychoanalysis warns that, by adopting this position, the caregiver not only moves away from his authenticity, but compromises the relational quality of his service, as he becomes less sensitive to the complexity and ambivalence of the human experience – including his own.

The Catholic spiritual tradition also warns of this trap: according to Boff (2007), true holiness is not to be confused with perfectionism, but is made up of reconciled humanity, aware of its own limits and vulnerabilities. Therefore, the adoption of this idealized position implies not only the distancing of personal authenticity, but also the compromise of the relational quality of the service provided, as it reduces the caregiver's sensitivity to the complexity and ambivalence of the human condition — including his or her own (CNBB, 2010; Oliveira, 2020).

Vulnerability Denial

Another prevalent mechanism is the denial of vulnerability: refusing to recognize signs

of physical fatigue, emotional exhaustion or psychological suffering, sustaining the illusion of invulnerability. According to Vaillant's classification (1977/1993), it is an intermediate-level defense mechanism: adaptive in certain circumstances, but harmful when chronically triggered.

Expressions such as "everything is fine" or "I can handle it" hide the imminent collapse, creating a psychic shield that prevents the caregiver from seeking help and practicing the self-care necessary for their emotional and spiritual health. This form of defense is often reinforced by the institutional and religious culture that, paradoxically, as Benedict XVI (2007) observes, idealizes the caregiver as a "tireless servant", without considering his concrete humanity and his own needs.

In addition, from the psychoanalytic point of view, Freud (1926/1974) already pointed out that denial operates as an attempt by the ego to protect itself from painful realities, even at the cost of a departure from psychic authenticity. In the Pastoral of Health, this tendency can be aggravated by institutional expectations and by a spiritual conception that values extreme sacrifice, but which, without discernment, risks promoting a dehumanizing ideal (CNBB, 2010; Francisco, 2015).

Therefore, recognizing denial as a legitimate but insufficient defense is an essential step to rescue the caregiver's emotional balance, integrating human limits and spirituality in a healthy way (Cantalamessa, 1993; Mezzomo, 2010).

Blame Displacements and Rationalization

In situations of high emotional tension, the caregiver may resort to blame shifting, transferring their frustration to patients, family members, or colleagues. This defense, according to Freud (1926/1974), emerges as an unconscious strategy for protecting the ego in the face of unbearable intrapsychic conflicts. In other words, this unconscious defense temporarily relieves internal anguish, but compromises the interpersonal bond, establishing relationships marked by veiled hostility and resentment.

Rationalization, in turn, makes it possible to justify decisions and behaviors that, deep down,

stem from exhaustion or emotional disconnection: “It’s my mission, no matter the cost,” says the caregiver, hiding the suffering that such an attitude causes him. Although this defense offers a logical and coherent narrative, it prevents the caregiver from recognizing the true psychic impact of the work and makes it difficult to exercise reflection on their own limits.

This reflection is reinforced by the Pastoral of Health, which recognizes, according to the CNBB (2010), that true care requires conscious presence and not just compliance uncritical of duties, preventing rationalization from becoming a trap that dehumanizes both those who care and those who are cared for.

Projective Identification

From the Kleinian reading (1957), it is understood that the caregiver can project unwanted feelings onto the patient or family — fear, anger, impotence — and then act on them in the care relationship. Projective identification not only discharges intolerable affects on the other, but also shapes the other’s behavior, reinforcing a dysfunctional relational cycle. Thus, a caregiver who projects his unconscious anger on the patient may interpret his reactions as hostile, responding defensively and confirming his initial expectation. As Winnicott (1965) warns, these transferential and countertransferential dynamics are not only inevitable in the care field, but also require emotional maturity and reflective capacity from the caregiver to recognize and manage them.

This insidious dynamic demonstrates how the field of care is also an intersubjective space permeated by transferences and countertransferences, requiring from the caregiver psychic maturity and reflective availability to identify and manage the unconscious projections that arise in the interaction with the suffering of others.

From the pastoral point of view, this psychoanalytic awareness is fundamental to prevent care from losing its dimension of authentic and compassionate acceptance. The caregiver needs to realize when he is distancing himself from genuine listening, as Francisco (2015) proposes, so that the

care relationship remains in an ethical and humanizing space.

Reactive training: overzealousness as a defense

Finally, reactive training can lead caregivers to act excessively zealously, controllingly, or intrusively as a way of masking their own fragility. By caring "with excess", the caregiver, paradoxically, moves away from the real need of the other, replacing genuine empathy with a defensive performance that reassures his own internal insecurity (Anna Freud, 1936).

Although this behavior is often socially valued—being interpreted as dedication or generosity—it betrays a distancing from the true self and produces, in the long run, emotional exhaustion and difficulty in authentic listening (Winnicott, 1965).

In the context of the Pastoral of Health, this logic is equally dangerous. As the CNBB (2010) advises, caring with integrity requires that the caregiver be aware of his own limits and needs, preserving his psychic and spiritual health so that his presence with the patient is, in fact, humanizing and ethical.

In summary, psychoanalysis offers caregivers valuable tools to recognize their own defense mechanisms, generating self-awareness and psychic flexibility (Vaillant, 1977/1993). When not identified, such mechanisms become true emotional traps: they distort the perception of reality, prevent self-care and weaken the capacity for loving presence. In order for caring to be a source of life and not exhaustion, the caregiver needs, first of all, to accept to be a caregiver of himself as well – a principle that Christian spirituality equally values, remembering that it is necessary to "love one's neighbor as oneself" (Mk 12:31), which includes taking care of oneself in order to take better care.

ASPECTS COUNTER TRANSFERENTIALS: Or SIDE DARK CARE

Countertransference is the inevitable shadow of the caregiver — and only those who

illuminate their own shadows can offer the other a truly free and compassionate presence.

Countertransference is, so to speak, the inevitable penumbra in the territory of the caregiver: it insinuates itself in a subtle way, arises without asking permission and, when ignored, distorts what should be free, ethical and compassionate care. Countertransference is the mirror where the caregiver sees, not the patient, but himself—even if often without realizing it.

Psychoanalysis gives us the key to understanding this phenomenon: transference is when the patient projects on the caregiver the old, unconscious affects coming from his own history — unresolved emotional memories, needs, idealizations, rejections. Countertransference, in turn, is the caregiver's unconscious emotional response to this projected material.

In other words: while transference is the emotional baggage that the patient brings, countertransference is the baggage that the caregiver carries – and that he often inadvertently deposits in the field of the relationship.

Definition and distinction: transference and countertransference

The encounter between caregiver and patient can be understood, in the light of psychoanalytic theory, as an "invisible stage" on which unconscious emotional contents are staged (Freud, 1920). Transference corresponds to the patient's projection of affections, expectations and conflicts arising from his past relational history on the figure of the caregiver. Thus, the patient begins to perceive the caregiver as if he or she were someone significant from his or her past (Winnicott, 1965).

In turn, countertransference represents the set of unconscious emotional reactions that the caregiver experiences in the face of these transferential projections. As Martin (1993) explains, it is a response that mixes elements of the caregiver's emotional history with the affective requests that the patient mobilizes in him/her, and is, therefore, inevitable and, at the same time, potentially productive or harmful to the care bond.

Positive and negative countertransference

Countertransference manifests itself in two main aspects. Positive countertransference arises when the caregiver feels a strong affective identification with the patient, which can lead to excessive dedication, loss of professional boundaries and confusion between care and emotional fusion (Vaillant, 1977/1993). This movement, although initially it seems "generous", tends to compromise the objectivity of care, weakening both the caregiver and the patient.

Negative countertransference, on the other hand, occurs when feelings of irritation, disinterest or repulsion emerge in the caregiver without him understanding exactly their origin. Koenig (2001) observes that, if not recognized, these reactions make care mechanical and distant, emptying the relationship of empathy and compromising the quality of care.

Both forms, positive or negative, when not elaborated, generate emotional exhaustion and can transform care practice into a space of suffering not only for those who are cared for, but for those who care (Mezzomo, 2010). As Winnicott (1965) reminds us, caring presupposes a caregiver who is sufficiently present and capable of distinguishing what belongs to him or her and what belongs to the other – an essential condition to preserve the potential space of the therapeutic and pastoral encounter.

A common example in pastoral and hospital work

Scenes such as the one in which a hospitalized patient evokes in the caregiver the memory of significant figures in his own history — a distant father, a fragile mother or a lost child — are emblematic of the complexity of countertransference (Winnicott, 1965). As Bertechini and Pessini (2011) point out, such processes act in the caregiver's unconscious and often escape immediate perception, becoming hidden determinants of the way they get involved in care.

This phenomenon not only interferes with the quality of the presence offered, but also tends to be reinforced by the emotional intensity typical of hospital and pastoral contexts (Martin, 1993).

In view of this, authors such as Vaillant (1977/1993) recommend the constant practice of supervision and clinical reflection as indispensable instruments to help the caregiver recognize and elaborate the emotions aroused by the care relationship.

When the caregiver takes on the existential weight of the other

The challenge deepens when the caregiver goes beyond the ethical and emotional limits of his function, assuming the responsibility of relieving not only the physical pain, but also the deep existential suffering of the patient. According to John Paul II (1984), the Christian mission in care consists of walking with the other, and not in replacing him in the crossing of his pain.

In the psychoanalytic field, Winnicott (1965) clarifies that the confusion of psychic boundaries between caregiver and patient prevents the constitution of a safe environment and favors the emotional exhaustion of the caregiver. In addition, Koenig (2001) warns that when the caregiver identifies excessively with the suffering of others, he loses the objectivity necessary to offer balanced and compassionate care.

Therefore, the ethics of care, both pastoral and clinical, requires that the caregiver recognize his own limits and accept that his role is that of a lucid and supportive companion, and not that of an "absolute savior". It is in this humble recognition that the possibility of comprehensive care resides, which respects the patient's otherness and protects the emotional and spiritual health of those who care (CNBB, 2010; Mezzomo, 2010).

PROFANE AND SACRED IN THE ACT OF CARING

To care is to walk on the invisible line that joins the ground and the sky; The Christian caregiver doesn't just touch wounds—he celebrates, with every gesture, the liturgy of encounter.

In fact, care is a threshold, a thin line where the everyday and the transcendent meet. He is

at the same time ground and sky, gesture and sacrament, sweat and grace. The caregiver inhabits this border barefoot on the hard ground of reality and eyes raised to the height of mystery.

In the hospital, in the home or in the pastoral care, the scene is repeated: hands that clean wounds, words that welcome groans, silences that endure tears. All this belongs to the "profane", in the sense of being everyday, concrete, subject to contingency and imperfection. But at the same time, each of these gestures is potentially "sacred" — because it touches what is most vulnerable and precious in the other: their wounded dignity, their exposed soul, their naked humanity.

Here a truth that unites psychoanalysis and spirituality is revealed: all true care is also a space for humanization. The hospital, with its rigorous routines and sophisticated technology, can become an arid and impersonal environment. And it is the caregiver — with his attentive gaze, his delicate touch, his entire presence — who returns human warmth to that space.

As Winnicott said, sufficiently good care is not just technical action; he is environment, presence and continence. And when this care is illuminated by Christian spirituality, it becomes even more: a silent and concrete extension of the Eucharistic liturgy itself.

Care as a space for humanization

The contemporary hospital environment, due to its technical and accelerated nature, tends to obscure the subjective and relational dimension of care. As Mezzomo (2010) points out, hospital humanization requires the caregiver to return warmth and dignity to the institutional space, making it a place of welcome and respect for the patient's vulnerability. It is in this context that Winnicott (1965) contributes with the idea of sufficiently good care: a holding environment where the subject can exist without invasions, recognized in its entirety and particularity.

The Christian spiritual tradition, according to John Paul II (1984), complements this understanding by stating that care is not only a technical function, but a response to the presence of Christ in the sufferer, demanding from the caregiver a look that recognizes in the other a brother,

a sacred body, worthy of listening and tenderness. The Catechism of the Catholic Church (1999) reinforces that the human being must be welcomed integrally, in his unity of body, psyche and spirit.

Thus, to welcome pain is to welcome the subject who suffers; and welcoming the subject is, ultimately, humanizing the hospital space, transforming it from a cold and functional place into a space of encounter and authentic care.

Care as a sacramental gesture

In the face of suffering, the Catholic Christian caregiver recognizes that not only a wounded body is in front of him, but a subject with a history and a unique interiority (CNBB, 1977; CNBB, 2010). Psychoanalytic listening, as Winnicott (1965) shows, invites the caregiver to perceive these hidden and subjective layers, while the Catholic faith calls to welcome them with reverence, transforming care into a sacramental gesture.

Bertechini and Pessini (2011) point out that each gesture of care in the hospital context — from personal hygiene to the simple act of silent presence — can acquire transcendent meaning, becoming an expression of divine compassion. The Catechism (1999) and the pastoral reflection of the CNBB (2010) point to the sacramentality of the compassionate presence, where assistance to the sick becomes an extension of the Eucharist and a concrete manifestation of Christ's mercy.

Therefore, when the caregiver becomes close with tenderness and availability, he not only performs a technical service: he participates in a discreet liturgical act, where chronological time is transformed into kairotic time, that is, God's time, in which the encounter with the suffering of others acquires salvific meaning (Clément, 1998; John Paul II, 1984).

Humanizing the environment and taking care of those who care for it

The caregiver, by occupying the symbolic space between the profane and the sacred, is always

exposed to the risk of losing himself, as Winnicott (1965) warns, when describing the dangers of the false self: the one who, in order to correspond to external expectations, sacrifices his authenticity and inner spontaneity. This tendency becomes even more pronounced in the pastoral and hospital context, where the ideal of selfless service can obscure the caregiver's own needs.

As Francisco (2015) observes, taking care of the other requires taking care of oneself as well, in a necessary balance between availability and inner preservation. The Catholic spiritual tradition, reflected in the Catechism of the Catholic Church (1999) and in the Guidelines of the Pastoral of Health of the CNBB (2010), emphasizes the importance of spaces of silence, contemplation and community sharing so that the caregiver can recompose himself, avoiding becoming an "empty vessel", present in the gesture, but absent in the heart.

Bertechini and Pessini (2011) also emphasize that there is no ethical and compassionate care that can be sustained without the caregiver himself being the target of comprehensive care — physical, emotional and spiritual. For this reason, practices such as personal prayer, sacramental life and fraternal support become indispensable for the integral health of those who serve.

Caring, therefore, is art and vocation: the art of sustaining humanity in the other without losing one's own, and the vocation to walk in the in-between place of the human and the divine, recognizing that it is in this liminal space that God himself becomes a living presence (Clément, 1998; John Paul II, 1984). In short, caring is walking on the thin line that separates and unites the profane and the sacred, knowing that it is there, in this in-between-place, that God makes himself present.

PSYCHIC AND SPIRITUAL STRUCTURES OF THE CAREGIVER

The false self makes the caregiver a tired actor; the cared heart makes him a living instrument of God.

The caregiver is, by vocation, the one who offers himself: his hands, his time, his listening, his compassion. But there is a subtle danger that lurks precisely around those who give too much: the

temptation to put on an emotional armor, hide behind a mask of invulnerability, and thereby silence their own inner needs.

This mask was masterfully conceptualized by Winnicott as the "false self": it is not just a protection, but a psychic structure built to correspond to external expectations, at the cost of suffocating the true Self. This occurs when the caregiver begins to function more in his role as a caregiver than as a caregiver.

The Christian spiritual tradition, however, offers a precious counterpoint: it reminds us that the human heart is a dwelling place, not a mask. It is a place of encounter with God, not a space of staging.

The caregiver's ego and the "false self"

In the face of constant emotional pressures — institutional demands, the suffering of others, the social gaze that expects "strength and selflessness" — the caregiver can, without realizing it, build a false self: a character who knows how to smile even when exhausted, who attends without complaining even when injured, who remains available even when he is empty.

This defensive structure, which, at first sight, seems to ensure efficiency and emotional stability, reveals itself, in the long run, as an emotional prison: the caregiver becomes a "compassionate robot", absent from himself while performing his function (Vaillant, 1993). The Catechism of the Catholic Church (1999) and Francis (2015) remind us that this risk is aggravated in contexts where the altruistic ideal is overvalued without due attention to the limit and human frailty.

Recognizing and welcoming one's own vulnerability becomes, therefore, not only an ethical imperative, but a clinical and spiritual requirement. As Bertechini and Pessini (2011) argue, accepting that it is not possible to attend to everyone, admitting one's own fatigue and anguish, far from weakening the caregiver, humanizes their practice and strengthens their presence with the other.

The caregiver's soul as a place of encounter with God

If, as psychoanalysis reveals, the experience of the false self imprisons the caregiver in a rigid and dehumanized role, the Catholic spiritual tradition offers a path of return: to turn to the heart as a space of encounter with God, as St. Augustine teaches — "Return to your heart... there is God" (cf. Catechism of the Catholic Church, 1999).

This perspective is reiterated by the Health Pastoral, which understands that the caregiver needs time and interior space to replenish himself spiritually and find renewed meaning for the service he provides (CNBB, 2010). Taking care of oneself psychically and spiritually is not a luxury or vanity, but an essential condition to sustain ethical and compassionate care in the long term (Mezzomo, 2010).

By recognizing their vulnerability and allowing themselves to be cared for, the caregiver becomes more compassionate and present, preventing zeal from turning into silent exhaustion. As Benedict XVI (2007) recalls, only those who allow themselves to be cared for by grace and community can remain whole in the service of life and human dignity.

STRATEGIES FROM SELF-CARE: ONE ACT FROM COURAGE AND WISDOM

Taking care of oneself is the first act of pastoral love: without interior silence, the gesture tires; without prayer, the presence empties; without limits, love gets sick. Therefore, taking care of yourself is the first step to taking good care of the other.

Self-care is not selfishness — it is fidelity to the mission. After all, no one can offer fresh water with an empty pitcher. The caregiver needs to nourish himself internally in order to be a full, free and compassionate presence.

Clinical and spiritual wisdom converge here: the caregiver is called to recognize his or her own limits and needs in order to sustain care with authenticity.

Psychoanalytic practices for the caregiver

Psychoanalysis, as a method of listening and inner elaboration, offers valuable tools for the caregiver to develop self-knowledge and emotional maturity (Freud, 1926; Winnicott, 1965). Supervision and personal analysis constitute essential spaces, allowing the examination of deep emotions, defense mechanisms and countertransferences that permeate their practice – in an environment of freedom and acceptance (Vaillant, 1993).

Reflecting on one's own limits is indispensable. The caregiver who assumes an omnipotent posture, believing that he must attend to everything and everyone without rest, risks falling into emotional exhaustion and resentment (Mezzomo, 2010). Acknowledging that "no one can give what they do not have" is a principle that protects both the caregiver and those he serves, preserving the quality of the care relationship (Koenig, 2001). The identification of countertransferential patterns is also a necessary practice: learning to recognize when certain emotions arise not only from the other, but from the emotional impact he causes, allows the caregiver to remain lucid and present, without distorting the bond (Klein, 1957). As stated by scholars of mental health and spirituality, emotional balance is a condition for offering comprehensive and compassionate (Puchalski et al., 2009).

Catholic spiritual practices

Spirituality is not an accessory, but a source of meaning and deep support in the life of the Christian caregiver (CNBB, 2010). Daily prayer offers nourishment and inner rest, allowing the caregiver to breathe and reconnect with the God who inhabits his own history (Benedict XVI, 2007).

Participation in the Eucharist nourishes spiritually, renewing the call to mission with vigor and authenticity (Ferreira et al., 1982). The prayerful reading of the Word of God proves to be a source of inspiration and discernment in the face of the complexities of human suffering (Catechism of the Catholic Church, 1999).

The Sacrament of Reconciliation has a central place as a space of purification and interior liberation, restoring the caretaker from the ill-elaborated faults that arise when his humanity is faced with insurmountable limits (John Paul II, 1984). As Francis (2015) emphasizes, taking care of oneself spiritually allows the caregiver to act with true mercy, not from heroic demands, but with authenticity, simplicity and inner freedom.

Community and affective support

The caregiver needs brothers and sisters in the faith and community spaces to share their pains and joys without masks, being welcomed with genuine hospitality (CNBB, 2010). Community life is not a mere context, but a true source of emotional and spiritual strengthening (Romer, 1973). Practices such as pastoral groups, fraternal sharing circles and initiatives such as community therapy — as proposed by Barreto (2005) — offer affective support that is indispensable to the emotional and spiritual health of those who care, preventing isolation and silent exhaustion.

From a pastoral perspective, these spaces also promote discernment and co-responsibility, allowing caregivers to recognize their own limits and welcome their vulnerability without guilt (Moreira-Almeida et al., 2020). As Catholic spirituality emphasizes, fraternity is a gift that transforms the mission of care into a shared and solidary experience (Ferreira et al., 1982).

Integral self-care: suggested practices

The practice of integral self-care requires articulation between mental health, spirituality and community (Puchalski et al., 2009). Psychoanalysis and clinical supervision are tools to continuously reflect on defenses and countertransference, helping the caregiver to remain aware of his motivations and emotional reactions (Freud, 1926/1974; Winnicott, 1965).

Awareness of limits and the cultivation of self-compassion are also fundamental: accepting

oneself as human, imperfect and vulnerable without excessive guilt is a gesture of wisdom and emotional maturity (Vaillant, 1993).

Spiritual practices—prayer, participation in the Eucharist, confession, and prayerful reading—offer nourishment for the soul and inner renewal, allowing the caregiver not only to act with dedication, but to serve with joy and freedom (Catechism of the Catholic Church, 1999; Francisco, 2015).

Finally, insertion in communities and spaces of sharing — such as pastoral groups and fraternal meetings — strengthens the caregiver's heart, helping him to remain whole and compassionate in the mission (CNBB, 2010). This integration between clinical, spiritual, and community practices makes it possible to sustain care as a profoundly humanizing and sanctifying service (Pew Research Center, 2025).

PSYCHOANALYSIS AND SPIRITUALITY AT THE SERVICE OF THE PASTORAL CARE OF HEALTH: INTEGRATION THAT LIBERATES

The integration between psychoanalysis and spirituality favors humanized and sustainable care. While defense mechanisms may temporarily protect the caregiver, without self-awareness, they become harmful. Similarly, faith strengthens resilience but requires the caregiver to take care of himself or herself in order to serve generously.

Here, we need to overcome false dichotomies: psychoanalysis and Catholic spirituality are not antagonistic, this is a mistake that must be definitively overcome. Both, when understood in their depth, share the same horizon: they help the caregiver to understand their humanity, recognize their limits, accept their weaknesses, vulnerabilities and, from there, offer freer, more genuine and compassionate care.

Indeed, psychoanalysis reveals the labyrinths of the soul; Christian spirituality, in turn, points to the presence of God in these same labyrinths. Together, they don't compete they complete

each other.

Humanize without losing the dimension of the sacred.

The pastoral care of health care must avoid two dangers: the cold technicality that dehumanizes and the alienated spirituality that denies the concrete reality of suffering. As the Pontifical Council for Health Care Workers (1985-2017) reminds us, integral care requires uniting technique and compassion, reason and faith. Catholic spirituality reaffirms that Christ is present in the sick, and that to care is also to recognize this presence, allowing Him Himself to take care of us in interior silence (CNBB, 1977; 1981; 1986; 2010; 2017). At the same time, psychoanalysis invites the caregiver to see the suffering of the other with lucidity, recognizing the psychic defenses involved in the encounter and remaining available, but without losing his own emotional integrity (Freud, 1926/1974; Winnicott, 1965).

The caregiver as a living icon of Mercy.

Psychoanalysis and spirituality do not compete: both point to complementary paths for the caregiver to recognize himself or herself as human and, from there, to provide care in a more truthful and compassionate way (Vaillant, 1993). As Pope Francis (2019) recalls, the Church is called to be a "field hospital", a place of unconditional welcome for all, especially for the most vulnerable. The caregiver, therefore, becomes an icon of mercy: he is a concrete presence of God's compassion, capable of restoring dignity to the one who suffers (Boff, 2007). But this mercy can only be sustained if the caregiver himself learns to care for himself and to receive care—spiritual, psychological, and communal — on a permanent basis (Puchalski et al., 2009).

Ten Recommendations for Caregiver Self-Care

Closing this chapter, I present ten practical recommendations — a true "decalogue" — for those who wish to sustain care as an integral, spiritual and human mission:

1. Set aside time daily for prayer and inner silence—breathe God before you breathe the world.
2. Take regular breaks for personal analysis or supervision — without self-awareness, the gesture becomes empty.
3. Recognize and accept your limitations with humility — limits are not failures, they are humanity's condition.
4. Practice body self-care: food, rest, healthy leisure — the body is temple and instrument.
5. Seek fraternal support in the community and in the Health Ministry — no one cares alone.
6. Celebrate the Eucharist as a source of strength and spiritual nourishment — altar and infirmary are not opposed, they complement each other.
7. Share your emotions with trusted people — who share lightens invisible burdens.
8. Learn to say "no" when necessary, without guilt—saying "no" can also be an act of love.
9. Face the right to be cared for naturally — those who care deserve to be cared for.
10. See yourself as an instrument, not as a savior — Christ is the one who saves, we only serve him.

FINAL CONSIDERATIONS

The caregiver is, above all, a silent alchemist: he transforms tiredness into presence, anguish into welcoming, and his own weaknesses into a safe space for the other to exist. But for this delicate

art to sustain itself, he needs to dive into himself, recognize the psychic backstage of his performance — the invisible defenses, the emotional reflexes that spring up in the relationship and the masks he often wears without realizing it.

Acknowledging your defenses is not an exercise in denunciation, but an act of lucid compassion with yourself. Negation, idealization, and rationalization are not moral weaknesses; they are ingenious attempts by the ego to protect itself in the face of pain and limits. But, as Freud would say, what we avoid comes back — and it comes back stronger, more demanding, and more confused.

Countertransference, this hidden mirror of the caregiver, when not recognized, acts as a ghost that occupies the relationship, distorting affections, weighing gestures, saturating bonds. It is like a fogged lens that prevents a clean look at the other and oneself.

Integrating psychoanalysis and Catholic spirituality is not a contradiction: it is complementarity. Both teach us that care is also an interior journey — an itinerary of self-knowledge and openness to God's grace. Being a caregiver, in this sense, is more than a technical practice or social service: it is a way of being, profoundly human and mystically rooted in the following of Christ.

Christ himself experienced fatigue, sorrow, and pain. The Gospel does not present him as an invulnerable hero, but as the Good Samaritan who had compassion (Lk 10:33) and who made himself a neighbor. He welcomed humanity in its fullness and teaches us, by his example, that allowing oneself to be cared for is also an expression of faith.

Therefore, taking care of those who care is not a luxury: it is an ethical and spiritual requirement. We are all fragile and in need of mercy, and this shared vulnerability does not diminish our vocation—on the contrary, it elevates and purifies it. Like a sculptor who must first touch the stone to reveal the hidden form, we must touch our own humanity in order to be able to care for the humanity of others.

Each caregiver carries, invisible to the eye, a psychic territory populated by anguish, desires and defenses. But it also carries an immense potential for renewal and holiness: there is no true care without taking care of oneself first. When we allow ourselves to being human, with limits and needs,

we become more authentic, free, and compassionate caregivers (Secretariat of State of the Holy See, 2020).

So, here is the invitation I launch to all caregivers: take care of yourselves! Do not neglect your own soul, your own body, your own time. God wants us to be whole, human and renewed for the service he has entrusted to us.

May our pastoral mission and our work with the sick and fragile be illuminated by the awareness that the Lord does not want tired heroes, but whole hearts and available hands — whole, human and holy in the act of caring.

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