

Stakehold ZXSZ: Disorder Deficit Familial Asynchrony and Syndrome Z

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Introduction

According to the American Society of Addiction Medicine (ASAM) and the World Health Organization (WHO), chemical dependence consists of a chronic and progressive disease. But without organized etiopathogenesis, we carried out in clinical practice, description of new specific neurological and clinical states, based on the brain physiology common to all human beings, which reorganized all Addiction Medicine, and the discovery of childhood, adult and elderly Z Syndromes, Syndrome Zoé, which are secondary to simultaneous neurological dysfunctions of human neuro-development, such as:

1. neurological deficit of familial asynchrony (DNAF), which generates in response
2. fear adaptation neuro behavior (amygdalian and limbic),
3. unconscious reproduction of familial asynchrony due to neurobiological psychodynamics, which generates the
4. hypodopaminergic neurological state or RDS described by Blum et al.

The state of chronic dopamine deficit, from the first days of life, generates restlessness, hedonism, boredom and irritability, and unconsciously with growth, the individual begins to live with dopamine-generating habits, in addition to pleasure, which is where everyone focuses their attention. to look.

Syndrome (Sd) Z, clinically, is the association of the chronic and oscillatory hypodopaminergic state, with the familial neuroadaptive disease due to familial asynchrony, of a biological neurobehavioral nature of survival adaptation, acquired in early childhood, which produce maladaptive, relieving, avoidant behaviors or similar to family schemas² (Young), associated with alexithymia (inability to effectively observe oneself), anosognosia (inability to effectively observe the familiar), and even unconscious repetition of the psychodynamic reality inherited by parents, by mirror neurons,

and tonsillar systems.

Such a condition is present in all human beings, being responsible, with little effect being just a dysfunction, a disorder when moderate, without biological, family and professional damage, but with a loss of time in a family relationship.

The significant, or pathological, effects are neurobehavior with an evident underlying chronic hypodopaminergic state, caused by specific genes (GWAS), genes inherited from Familial asynchrony, gestational disorders, disorders of childhood neurodevelopment, Adverse Childhood Experiences (ACE), Trauma and abuse with post-traumatic stress disorder (PTSD), which generate a new diagnosis such as RDS or Z Spectrum, which may be associated with other genes of other diseases such as Attention Deficit Disorders (ADHD) and Autistic Spectrum (AU), in addition to enzymatic deficits that they impact emotional regulation, inhibitory controls and social skills, and ESPECIALLY on FAMILY AFFECTIVE SKILLS (behaviors dependent on biology).

The human being devoid of affective skills, in the family environment, causes friction, and the neuro adaptation is automatically activated, which produces different behaviors, within the family in relation to other environments. Family schemes can be harmful or pathological, subtle and neglected until today, because the escape, denial, aversion, avoidance, is unconscious, and then as a secondary unconscious gain, it reproduces family asynchrony, evidenced by the incoherence of verbal discourse, behavior and behavior. individual reality. In the presence of an activated schema, the individual cannot reflect, does not control immediate behavior, judgment, as he has not trained the control to intimately inhibit the automatic neuro-adaptive response. The inability to actually observe oneself is different from self-knowledge.

SD Z is "The missing link", given that most addictions are secondary, evolving into pathologies (situations of biological injuries and other damages) and other clinical diseases such as metabolic syndrome, addictions, not clinically observed until now moment, who share common neuronal pathways of the reward system: impulsivity, sexuality, sugar and carbohydrate intake, substance use, and monetary gain.

Addictions or additions to sugar (diabetes mellitus), carbohydrates (obesity), monetary gains, substance use (US), shopping (immediate pleasure), present the same clinical picture, the same pathophysiology as some psychosomatic illnesses and conversion crises. Its etiopathogenesis may begin during pregnancy and evolve into old age, such as the hypodopaminergic elderly and in some subtypes of Alzheimer's disease.

The clinical model of family schemas is from the American psychologist Jeffrey Young. These schemas produce psychic suffering, which is associated with alexithymia (inability to self-observe) and anosognosia (inability to observe others). Then, there is the activation of relieving, avoidant, aversive and punitive behaviors, resulting in toxic relationships between parents and children.

It is not a hypothesis to be tested, it is a clinical description associated with neurobiology and neurogenetics. Every human being unconsciously reproduces what the mirror neurons captured from their parents during early childhood. Then he unconsciously reproduces the same psychodynamic profile, until he learns to actually observe himself. If any human being, however knowledgeable he may have, has not intimately identified this neurophysiological mechanism, his diagnosis that he does not have the ability to self-observe is a fact.

The Sd Z is silent and subtle, passed down through the years between family generations. If every human being learns the continuous effective self-observation of his internal reality continuously, a movement that must be taught, evidenced by the functional neuroimaging exams, that when we perform

such an intimate movement, the occipital cortex is activated and automatically deactivated all the neurological systems tonsillar automatic, adaptation, learning and even produces dopamine.

An example in the clinical area of Vascular surgery is the smoker patient who has already amputated a lower limb, and continues to smoke without fear, without concern, of the risk of amputation of the other limb, or another cardiovascular event (CVS).

Science presents few studies of the effects of basal dopamine in relation to systemic arterial hypertension, DM, obesity, but most risk factors for atherosclerosis are tertiary to SD Z. Most addictions, diabetes with insulin resistance, hysterical patients, depression, family alienation, attachment disorders, Obesity, and many family fights are actually biological, clinical and pathological. In pediatrics, a hypodopaminergic Newborn with RDS or Z spectrum (has hypodopaminergic genes + familial asynchrony genes) makes a differential diagnosis with Autistic Spectrum Disorder (AS), Attention Deficit Disorder (ADHD), and can generate Secondary Childhood Obesity. There are three different diagnoses, with different clinics, different genes and different pathophysiology.

Sd Z provides clinical stakehold, with several areas that produce harmful effects, the human mind, and free will, which will require the integration of several areas such as neurology, psychiatry, psychology, cardiology, vascular surgery, obstetrics, genetics, endocrinology, plastic surgery, pediatric surgery, anesthesiology, intensive care unit, internal medicine, pediatrics, dermatology, immunology, and law sciences, pedagogy and education.

Syndrome Z has set up a diagnostic clinical methodology, with variations in Sd ZX (Associated Metabolic Syndrome), psychiatric diseases and secondary addictions such as Sd ZY, and Syndrome ZS when we have other simultaneous and/or correlated, and/or secondary pathologies such as Atherosclerosis, Adenocarcinoma Colon and immunoinflammatory diseases.

CHRONIC HYPODOPAMINERGIC STATUS

NEWBORN (RN)	CHILD OR ADULT
<ul style="list-style-type: none"> • Delay at he speaks until four years old _ • Irritability • hypoactivity at search for breastfeeding • Cry frequent • eczema • Fever persistent without cause known (fever emotional) • empathy and intelligence fluid • Excitement sudden and exaggerated system _ nervous autonomic kind • Frequency increase _ cardiac • Increase discreet of the pupil • Subitization in readings geometric • Difficulty in mathematics • Apprenticeship fast • school indiscipline • Difficulty in school development • distraction with imagination deep • Superficial distraction with automatisms • situations exaggerated without fear control • (phobias) _ • mannerisms • Movements stereotyped • Self -care deficit and inability • control deficit _ hygienic • habits sensory , like explore smell and touch , when _ calm • Trichotillomania , onychophagia and others compulsions , during anxiety episodes _ 	<ul style="list-style-type: none"> • Duality constant • Insecurity constant • Boredom • Intensity • Kindness explicit • Irritability in routines • eve disorganization _ • function deficit _ enforceable • Instability emotional • Anxiety • Attention deficit and concentration _ • Rhythm accelerated thought _ • Indisposition • Tiredness nocturnal after activities what involve automatism • Pragmatism • organizational indiscipline _ • excesses • habits what use dopamine • impulsivity • Affinity to the sugar and carbohydrates • Exaggerations in the period nocturnal • Procrastination • hyperactivity / hyperkinesia • news search _ constant • Hypersensitivity and pain intolerance _ • Alexithymia • shyness • social isolation • Intelligence fluid • hyperfocus in preferred activities _ • multiples relationships or difficulty in marital bond • Addiction in passion initial • Fault • Need for validation • hypersexuality • survival manipulation _ • Perfectionism • Concern for others , not with you same • Initiation of several activities or projects simultaneously • Affinity for caffeine and energy drinks • stimuli sensory • inability to deny aid • tics • habits adrenaline addicts _ • Attraction per sports radicals and activities complex and challenging • Work excessive • Insomnia • High risk of developing substance use __ pathological and depression (60%)

OBJECTIVES

Main Objective

The main objective of this work is to highlight the impairment in the autonomy of the patient in question, as well as the various clinically identifiable, simultaneous pathological mental states that are being neglected, such as a state of relapse, state of activated family schema, Neurological Family Disease and Drug Use. Pathological substance (primary or secondary)

Secondary Objectives

Secondary objectives are:

- Promoting the real free will of each human being, which still prevails the cerebral influence through psychoeducation, and effective self-observation training
- Highlight the need for reflection by the medical, scientific, legal, political, religious communities worldwide, on what is common to every human being, regardless of ethnicity, as it depends on the child's brain neurodevelopment;
- Show the clinical findings of DNAF, Z Syndrome, Zoé Syndrome (Occupational Alienation, Professional), which can be observed in any individual, as it has neurobiological pathophysiology, which unites psychoanalyst, psychological and medical theories.
- Resolve the case reported because the patient is without effective treatment, as well as all patients currently.
- Medical psychoeducation, as the principle of fundamentals I of the code of medical ethics, allows this study as a protocol, for a new treatment and prevention action in the child window
- Bear in mind that human evolution is heading towards generations of worsening human relations due to heredity and genetics of family asynchrony and brain structure disorders.
- Promoting new studies of new drugs aimed at the dopaminergic clinic, new therapeutic plans seeking Family Asynchrony, reducing the risks of cardiovascular events, addictions, domestic violence, cancer and metabolic diseases.

Materials And Methods

It was not our objective to carry out science, but due to the clinical findings based on science, reason and medicine, I immediately ceased our voluntary work, and I urgently bring, as recommended by the Law on Studies in Human Beings, Code of Medical Ethics, and make this document a medical act. It is evident that the free will of the human being is impaired, by unconscious neurological and mental states, due to

1. family pathology,
2. illusory lasting states, of a psychological and biological nature, by molecules that cause significant changes produced by epigenetics, and
3. **every child is being developed already with dysfunctional neuroadaptation.**

The construction and scientific development of this work took place through clinical observation in the practical field — precisely, the Aurora Boreal Therapeutic Center, a Catholic religious philanthropic body, located in the city of Marília, in

São Paulo — Brazil, during the period of one year, combined with intensive studies of scientific articles, incessantly, and aware of new findings.

This work evolved as the first scientific study of ethnographic methodology, with and Mini bibliographic review, case report, medical report, and psychoeducation in Dialectic Medicine.

An active search was carried out for scientific articles, in particular current articles on functional magnetic resonance imaging (fMRI) in the PubMed and Way of Science digital libraries. This survey took place between October 13, 2021 and November 4, 2022 using the terms use substance, simultanagnosia and, together, use substance and genetic, neurobiologic and addiction. The search returned 45,432 studies for the first, 177 studies for the second and 31,544 for the set of the latter. An active search was also carried out for studies on ADHD, consciousness, genetics and epigenetics, substance use relapse, neurobiology of addiction, neurodevelopment, neurobiology of sensitivity, dopamine, neuroadaptations, pregnancy and substance use, obesity, autism spectrum, smoking, neuroscience of automatism, anosognosia alexithymia, Cannabis, methamphetamine, cocaine, anosognosia and substance use disorder (SUD).

We carried out a description of the relapse clinic throughout that year, associating the current studies of neuroimaging, behaviors, genetics and epigenetics of the SUT and discarding theories and philosophies without any biological connection.

We also describe the technique for evaluating the peripheral mind, without invading the individual intimate forum, through the concealment of clinical and semiological techniques based on neurosciences of automatism, technical skills for evaluating the unconscious and the conscious of psychoanalysis, dialectical behavioral therapy (dialectical behavior therapy [DBT]), Young's schema therapy, human neurodevelopment, internal medicine, neurology and semiology of neurological systems combined with semiology of eye, pupil, saccadic and antisaccade movements³.

Pathogenesis

Harmful habit: produces pleasure and/or relief of psychic suffering, with risk of tissue damage and addiction.

Social substance use: absence of Sd Z or dual psychic illness and effective self-control, without family and tissue complications.

³With regard to clinical practice, how many patients develop pathological substance use with dependence on only one substance and do not simultaneously have syndrome Z or a hypodopaminergic state? How many observational studies show prevalence of only a single substance with population individuation, according to methodology for substance-specific genetics? How many clinical studies show clinical matching based on childhood experiences associated with appropriate matching? How many studies focus on the patient's pathological lying? How to conduct a large, multicentre, sex, age, ethnicity, and genetics matched clinical trial for a specific substance? We have

Addiction or addiction: evolution of the habit or behavior that leads to pleasure or relief from displeasure, or suffering from family schemes, showing difficulty or denial to stop the habit. It may present with behavioral and adaptive disorders of brain, liver and endocrine tissues, as in the acute withdrawal syndrome, and dose-dependent tolerance without genetic/epigenetic etiology.

Pathological substance use (USP): psychological and/or biological addiction or addiction to psychoactive and/or psychedelic US, with tissue damage and secondary complications, added to the inability to quit the habit and prioritization of US, consciously or not, in the absence of Sd Z.

Primary pathological substance use: addiction in substance use or secondary pathological substance use to Sd Z, in the **PRESENCE** of allele genes and/or polymorphisms, which cause specific clinical states and significant alterations in psychic functions, **GENERATING** behaviors of variable duration. It has several mechanisms: production of dysfunctional histone enzyme complexes; dopamine transporter [DAT] dysfunction; long-lasting molecules produced by genes in the presence of substance use; chronic abstinence; pathological demotivation; Law Suit neurogenetics of relapse; fissure; compulsion due to enzyme deficit of inhibitory control; emotional dysregulation; allostatic cycles; morphological alterations in dopaminergic receptors, mainly D2; neuronal migration; hypodopaminergic neuroadaptation; dysfunction of synaptic connectivity, which can decompensate previous disease or bring about secondary complications; and specific conditions of substance use, such as depression induced by epigenetic mechanisms such as opioids and alcohol.

Any studies with single substance evaluation without associated familial disease? With humility, reason and science, we believe that this simultaneous methodology study — case report, ethnographic study, literature review and medical report — has more strength than any current study, as it is impossible to perform a meta-analysis with one question to be answered. Answered by current studies with uncertain designs.

Secondary pathological substance use: substance addiction in the presence of syndrome Z and **ABSENCE** of genes, therefore **ABSENCE** of specific pathological and clinical states. It is easier to treat with abstinence. It presents common tissue adaptation, such as enzymatic changes in liver clearance, dosage intolerance, acute withdrawal syndrome, substance use unaware of its relieving function to the family scheme and escape from reality.

Hepatotoxic injury: cirrhosis, steatosis, hepatocellular carcinoma.

Acute neurological injury: acute psychoses due to excess dopamine, decompensation of bipolar depression, schizophrenia, advanced Alzheimer's, overdoses, suicide and criminality.

Repetitive neurological injury: sequelae such as psychosis due to neuronal loss, Cannabis, alcoholic peripheral neuropathy, cognitive deficits such as ADHD and dementia.

Acute and chronic cardiovascular injuries: cardiac arrhythmias, dilated cardiomyopathy (case to be reported), excess alcohol that impairs myocardial contractility leading to systolic dysfunction and dilation of the ventricles, due to mitochondrial injury in the myocyte, and alcoholic cardiomyopathy.

Hypertensive crisis injuries: multiple episodes of SAA that produce hypertensive crisis and hyperglycemia, causing organ damage and high doses of sympathomimetic substances.

GENETICS + ADDITION	
<ul style="list-style-type: none"> • Addition with tissue sequelae • Addition with social-family losses • Addition with criminal implications • Z syndrome unconscious addition 	= PATHOLOGY

HIERARCHICAL NOSOLOGY OF SYNDROME Z	
1	Maternal causes/hostile pregnancy (maternal hypoxia, placental dysfunction, intrauterine growth restrictions, prematurity, substance use, etc. → Intrauterine
2	Genes specific for hypodopaminergic states (<i>Genome Wide Association Studies [GWAS]</i>) → Hypodopaminergic NB (differential diagnosis with ADHD and AS)
3	Childhood Adverse Emotions (with or without genetics) (NB to 3 years old)
4	Childhood adversity and post-traumatic stress disorder (PTSD) (abandonment, trauma, abuse, bereavement, rape, surgery, etc.)
5	Concomitant psychiatric disorders (concurrent specific genetics): bipolar depression, ADHD, AS, anorexia, obsessive-compulsive disorder.
6	Traumatic brain injury (TBI)/Frontal lobe tumor resections
SECONDARY ADDITIONS TO SYNDROME Z	
7	Pathological substance use or addiction in substance use: primary or secondary. Addiction to sugar or work (workaholic), internet , games of luck, power, etc.
8	Psychological effect of the COVID-19 pandemic (PTSD): currently, there is a worsening of the previous hypodopaminergic state, without correlation with cerebral arterial microthrombotic effects and damage to neuronal immune complexes.
9	Chronic hypodopaminergic elderly: family schemas, traumas, frontotemporal stroke, mourning, senility, dementia, Alzheimer’s disease, irritability, post-retirement depression or after the family member returns for care.

Z SYNDROME

Currently, there are several similar concepts. We chose to group family relationship disorders, family alienation, attachment disorder, pathological love, emotional dependence and Münchhausen syndrome into just one. hormonal.

The sciences of law, forensic psychiatry, occupational and forensic medicine, need this “new” medicine with organized etiopathogenesis, without theories, ideas, which should be reflected in still theoretical or philosophical reformulations, because it is a clear disease , which presents professional responsibility like any disease, as well as the current legal sciences and the judicialization of Medicine, must be reassessed.

Sd Z presents significant distortions in the clinical pictures of fear, which are rich in slips, differing from behaviors and reality. reality, without perception of it. Current efforts to address toxic stress in children address childhood adversity, and much of the existing evidence is based on studies of adults with retrospective reports of childhood adversity.

Studies on childhood adversities with pediatric health outcomes pointed to a greater probability of physical and mental health problems when exposed to stress, adversities, during the developmental window in children exposed to adversities, with correlations in cardiovascular and immunoinflammatory diseases, mainly with long-lasting epigenetic alterations, and in hereditary and pisocosomatic genes. This work clinically corroborates the findings of the Canadian study of “Hostile and Unhelpful” (HH) mental states, conducted at the Université du Québec à Trois-Rivières, as well as other meta-analyses, assessing the severity of childhood trauma associated with four indicators of HH : (1) identification with a hostile caregiver; (2) laughter in pain; (3) overall devaluation of a caregiver; and (4) poor sense of self. fMRI studies show that maternal love (thalamic, substantia nigra, and left putamen regions) and

romantic passion, attachment, and marital relationship (bilateral ventral tegmental area) exhibit common neurodevelopmental neuronal disorders.

Such disorders are orchestrated by neuronal pathways dependent on oxytocin, vasopressin, cortisol and melatonin, together with dopaminergic hyperstimulation of the brain reward system. They show important neuronal activity in the cognitive-affective regulations of attachment, fear, insecurity, and duality, along with the unconscious need to reproduce affective relationships similar to the experienced family role, in loving behaviors.

Neurobiology of Family Synchrony

Family affective synchrony develops in human beings in the first three years of life. It begins by stimulating maternal touch and other physical senses, with a reaction effect on newborns.

The human brain, since primate times, is programmed to develop the family role up to the age of three, according to the explicit and implicit reality of the parents, due to cortical mirror neurons, frontal, inferior and left (Broca’s area) and to the arcuate fasciculus (Korsakoff area).

During the intrauterine period and the first three years of life, maturation takes place automatically. The expectation is that the father is dominant, with real control of the limits, and the mother produces the embracement. The brains of newborn boys block the pain, disaffects, absences and traumas coming from the mother, and the brains of girls do the same thing in relation to the father.

When there is trauma or intense or repetitive pain, due to the unconscious brain mechanism of fear, there is an unconscious reversal in the functional role, due to the neurobiology of attachment formation. This inversion influences the neurotransmission of gender choice around 10–12 years.

fMRI studies in adults with stimulation have shown increased neuroadaptive activations in the thalamus, brainstem, amygdala, hippocampus, anterior cingulate cortex (ACC), insula, and temporal cortex regions. These are the same regions of parenteral and infant attachment. These studies also showed parallel neuronal activities in the anterior paracingulate cortex and in the posterior superior temporal sulcus, as well as in the limbic and amygdala emotional networks, which remain until old age.

The mother who does not have affective synchrony with her parents is incapable of effectively stimulating her child, as her skills (biologically dependent) were not developed by her absent and unconscious parents. These skills, therefore, must be taught.

Simultaneously, there are unconscious secondary gains in many cases. In them, the reproduction of family roles (psychodynamics) occurs, as perceived in the practical reality of their parents, captured by mirror neurons, which are passed on intergenerationally, in a zigzag format (Sd Z), since the beginning of time.

Diagnosis of Syndrome Z

Through clinical anamnesis, dialectical neuro-behavioral assessment with technical interview, or with simple observations of acts already produced, we evaluate the neuro-adaptive behaviors common to every human being, without invading the intimate forum, which have conscious and unconscious effects.

It is clinically that the diagnosis of Sd Z is made in up to three generations, as we describe in the following case. These observations are free from judgments, and from the patient's conscious and unconscious subjectivity, verifying whether the discourse is equivalent to behavior and reality (effect). Always watching your sense of motivation and sense of your inner reality.

We strategically performed the dialectical neurobehavioral assessment through family psychodynamics, observing whether there was an inversion of roles in family systems, or whether there was a deficit or exaggeration in the family role.

We compared the reality of the EFFECTIVENESS of the family affection of three generations, simultaneously observing the unconscious and the conscious, body and verbal languages and behaviors. So, we identified whether there is synchrony of family affection or whether, unconsciously, family members reproduce the same realities of their ancestors, with secondary gain or not.

RDS spectrum / childhood Z Syndrome

Hypodopaminergic Newborns (NBs) have always been neglected, without protocols and clinical attention to their hypodopaminergic characteristics, such as variations in the sympathetic nervous system, elevated heart rate, hyper or hyporeactivity to light, typical facial expressions, generally possessing childlike genius.

They always occur simultaneously or isolated, as in adults. Children are currently growing up neuroadapted, as there are no collective or singular strategic plans for training family skills, and emotional intelligence, without presenting internal awareness (Emotional Intelligence, Thoughts, Body, Interoceptive, Intuitive, and sensitivity to external stimuli) predominating only the Amygdalian brain systems responsible for survival learning, develop only dense intelligence (specific knowledge, life experience and beliefs).

The imagination that has the function of creative development, momentarily interrupting the development of human genius, and later they can become misunderstood genius children, or pathological leaders, or evil genius. The clinic is sovereign in the neuropsychological assessment in relation to psychometric instruments. We are in the maximum period of identification of the pathological irrationality produced by the disease, in the family environment and in the occupational environment.

Another problem to reflect on is children with severe neuropathies, where the prevention of seizures has been just a medical concern in many cases, and we remember that this is a child, without the EFFECTIVE presence of family affection.

How many children with cerebral palsy, degenerative lesions, simultaneously present a hypodopaminergic state and/or Z Syndrome, with hypersensitivity, due to several hospitalizations, childhood surgeries, chronic states of pain, discomfort, introspection, which do not express the suffering of unspoken consequences, only observed.

The diagnostic suspicion of the different conditions: AS, ADHD, hypodopaminergic state and childhood obesity secondary to SD Z, is a new reality to reassess, seeking to improve the assertiveness of diagnoses, which are harmful to the mental health of parents. Immune declines that cause repeated infections, and exacerbated responses of the immune systems, with inflammatory hyperreactions, such as bronchitis, atopic dermatitis, emotional fevers, can be simultaneous in Sd Z, and severe neuropathies.

The hypodopaminergic child evolves with depression in the neurological state, conversion syndromes, speech delays, hypersensitivity, as etiological factors are added, such as emotional absence of parents, bullying, psychological capacity of family members, taxation of professionals and society, generating aggressiveness, introspection, and shame. Innate Genius has less suffering from emotional dysregulation, as it presents dopamine-producing neuronal networks, and allows the development of fluid intelligence, in the right cerebral hemisphere. Dopamine has several functions in clinical practice, being fundamental in assertive behavior.

Only self-reflection and self-knowledge do not allow for real individuation. To really know yourself, direct, sustained and effective self-observation is necessary, through deep and intimate movements, with the aim of gaining dexterity in emotions and expanding awareness of internal reality (awareness of emotions, thoughts, body interoception and

intuition). Such exercises require dopamine for initiation, and they themselves produce dopamine during execution.

fMRI studies in alexithymics demonstrated poor feeling states, few affective responses and emotional reactivity deficit. These are neuronal connection dysfunctions between limbic and neocortical areas. The persistence of tonsillar neuronal activity, responsible for defense behaviors, rationality and rigid reasoning, produces a dopaminergic deficit in the long term, with brain dysfunction and a decrease in head mass.

The right hemisphere participates in the perception of emotion, and the functional disturbances are due to interhemispheric interconnection dysfunction (functional commissurotomy model).

Every emotion is a reaction. Emotions are reflexes of stimuli, which respond with physical effect, such as hunger, thirst and fear, and are necessary for our survival. Judging by neglecting this truth, worsens the disease and produces foolishness with professional responsibility.

Emotional and fluid intelligence is a constant and active training of self-observation and habits that produce dopamine, balancing the patient, observing REAL CHANGE, RESULT OF Effective treatment of Sd Z These stimulate dopaminergic neuronal growth, bringing interaction between the hemispheres brain. Dense intelligence is rigid specific knowledge, which, however, produces irrationality after long periods of time.

Habits stimulate the production of dopamine playful activities, music therapy, feng shui activities, mindfulness skills, mediumship and other exercises that lead to self-knowledge and body sensitivity, such as Reiki, yoga, meditation, access bars, apometry and imagination stimulation children, crafts such as painting.

Treatment

Individual, Family and/or Systemic Psychoeducation

Teaching skills is different from mentoring and psychoeducation. It can be harmful, producing domestic quarrels, as happens today. Affective family skills must be trained, ensuring their effectiveness with psychoeducation.

Group schema treatment is important to show families and patients situations of activated schemas, with denial or avoidance being an automatic response (adaptive brain control over its essence).

Schema therapy and DBT, combined with psychoeducation of neurodevelopment and the unconscious reality of reproduction of the parents' reality, related to family affection and family synchrony, are fundamental objectives. The first step is to learn self-observation, identifying current deficits and harmful automatic schemas.

Assessment of four characteristics at the same time is trained and acquired by current treatment of pathological substance use. Self-observation without judgment, rationalization,

reflection or thought is a fundamental movement, identifying only the emotions, felt in the same second. The human being has 37 emotions per second, and we cannot even name four of them without rationalizing.

The objective is to help parents to recognize and identify their past experiences, improving the quality of family relationships. Thus, they strengthen the relationship and promote the development of family synchrony, being sensitive and acting with indulgence. There are several attachment-based intervention programs, such as STEEP (Steps Toward Effective, Enjoyable Parenting) (EGELAND; ERICKSON, 1993) and parallel therapy for parents and children (Parent and Child Therapy [PACT]) (CHAMBERS et al., 2006), which have been shown to be effective in high-risk populations.

Patients, family members and professionals who did not undergo effective treatment are easily observed in the clinical diagnosis, with denial, aversion, avoidance, criticism or non-consideration of the disease, not fully identifying their behaviors.

Digital applications can help in treatment and prevention by stimulating emotional intelligence.

Dopaminergic Motivational Psychointervention

Through slow and deep breathing guided in mindfulness, effectiveness of self-observation with self-observation training, teaching, guiding and clinically showing the moment when the cerebral survival system invades the essence or self. Whenever there is rationalization, taxation or avoidance before self-observation, it can be said that there is automatic neuroadaptive behavior, with duality, uncertainty, denial and aversion, so it is brain interference.

When we ask which emotion we are feeling in the current second, the quick answer, in the third person, leads to the use of a verb or a justification of the past, the future or knowledge, and may even respond automatically with another question (avoidance). Responding with "nothing" is evidence that you haven't learned the skill of observing yourself; is the clinical diagnosis of alexithymia and anosognosia.

Psycho intervention of Memory Reconsolidation

In the sensitivity arising from the empathetic professional bond, and with the patient's permission, we indicate the psycho intervention of memory reconsolidation. This is the continuity of motivational psycho intervention.

Continuing with the motivational psychoeducation, allied to the patient's imagination of going back in time, to another experiential moment, with memories of parents and childhood, the therapist helps in the re-signification, leading to the conception that no one is to blame. The pain of the absence of parents brings a bright mind, a current conscience, in addition to providing life, a special moment.

The memory of childhood memory is consolidated, and, in the presence of dopamine, there is initially destabilization, if it is

recalled with the therapist, due to the transference of the father or mother. When the patient shows relaxation and an empathic bond, we start the process of reconsolidation through guided intervention, which can last for weeks, until the therapist works all the reframing, performing the reconsolidation, instead of extinction.

Use of Pathological Substances (USP)

According to the National Institute on Drug Abuse of the United States (NIDA) and ASAM, there is a genetic vulnerability to substance use (US) responsible for 50% of cases, with the remaining vulnerabilities being summaries of social, psychological, environmental, family and psychological factors. There are specific genes for specific substances, thus totaling more than seven thousand genes, according to the Japanese genomic library.

USP may be primary, in the presence of those genes that produced clinically identifiable and specific pathological mental states. Secondary USP is a consequence of Sd Z.

We performed a clinical description of behaviors in the presence of genes common to all substances. Repetitive US produces long-lasting molecules, in addition to migrations and sensitization by an epigenetic mechanism when the substance comes into contact with the specific gene, generating epigenetic mutations by alterations in the chromatin, in the serotonergic-2A receptor genes (5-HTT2a and 5HTTLR), in the dopamine receptors (DAD2 [DRD2], DAD1 [DRD1], DAD3 [DRD3] and DAD4 [DRD4]), genes for the enzyme monoamine catechol-O-methyltransferase (COMT), enzyme monoamine oxidase-A (MOA-A), the genes of the glutamatergic systems, AMPAR, wt-GluR1, pd-GluR1, GABA, opioid, the modification of histones, the acetylation and methylation of non-coding DNA and RNA, the dysfunctions of the dopamine transporter enzyme (DAT1), the gene expressions of interleukin-6 and Delta-FOs transcription, leading to long-lasting behavioral alterations and to the reactivation, in a future period, of new behaviors, in addition to producing genetic alterations altering spermatozoa and egg.

The severity depends on the intensity of the familial disease and the amount of inherited genes that present more neuronal and clinical mechanisms, making treatment difficult.

The presence of concomitant (dual) comorbidities, mainly anxiety disorders, bipolar depression, impulsive disorders, ADHD and secondary states, are sequelae by neuroadaptations or enduring molecules.

In addition to

1. dose-effect amount tolerance and
2. acute withdrawal syndrome, there are mechanisms that show conformity with the amount of inherited genes, such as
3. craving,
4. loss of inhibition of control after rampant substance use,
5. chronic abstinence (hypodopaminergic, depressive and anxious states),

6. pathological demotivation caused by molecules produced in repetitive substance use, which cause a sudden motivational drop for the beholder,
7. allostatic cycles and
8. relapse processes, which are crucial in treatment.

All these pathological mechanisms occur simultaneously, together with tired and sick subjectivity, with no way out of psychological processes, relieving behaviors, limiting beliefs, distortions of thoughts and negative emotions that are potentiated in the first 30 days by the acute withdrawal syndrome.

Chronic Abstinence and Sequelae

Chronic abstinence is long-term potentiation with neural connections strengthened over time and with increased stimuli, causing hedonism, bipolar depression or long-term or perennial ADHD, as a sequel to neuronal injury. With an epigenetic effect, there is molecular production in the first 24 hours after the use of substances, mainly anesthetics, sedatives and benzodiazepines.

Relapse Process

The relapse process is not the US act, it is a neurological, psychic and genetic state that aims to end in the US, more precisely a classic and momentary pathological complex, orchestrated by 4% of the sensitized neurons globally. Can be activated minutes or weeks before actual use. It presents rich signs of the unconscious, such as faulty acts that always end in use. It may start with motivational loss of treatment, behavior change and memory loss. These are usually the initial changes. However, it has 11 phases and 83 signs and symptoms, according to studies by Gorski.

They are complexes activated by lasting molecules produced by epigenetics in the presence of the substance, which lasts for two years, and around ninety days, oscillates molecular levels by abstinence, and activates the relapse complex automatically every ninety days, with decreasing intensity, and ceases in abstinence around 2 years.

From a previous mental state (Sd Z), it can be said that there are several triggers that activate the relapse process. The unconscious purpose of this is the use of substances, whereby the patient forgets some values and narrows the limits of morality; ambivalence becomes predominant, with impairment of critical thinking and loss of ability to predict possible complications.

Treatment is no longer a priority, as it decreases the motivational state of the disease. If substance use leads to a "neurointoxicated mind" and activates sensitized dopaminergic hypermodulator systems, it causes a loss of reason, a sense of morality, self-care, and a sense of urgency and premonition. Pathological demotivation occurs and presents impulsive, compulsive (substances block the few inhibitory enzymes) and aggressive behaviors, and may present episodes of psychosis and suicide attempts.

In most cases, the acceptance of ceasing substance use is camouflaged, as self-deception is frequent. Automatic survival systems prevent self-observation, and relapse processes are activated by harmful family schemas and in the presence of triggers.

Several genetic and epigenetic studies show high molecular production, which leads to lasting changes in cognition, behavior and emotional state, with a variation of two to three years, with enzymatic modifications of histones and low-density D2 receptors.

In prolonged abstinence, there is a slow and gradual decrease after the last day of substance use. When there is a sudden drop in molecular levels, usually every ninety days, or even on the thirtieth day of acute abstinence, this variation causes unexpected (or automatic) relapse processes, with repetition every three months, with a decrease in intensity for a variable period, but with an average of two years. After abstinence for this period, there are no more neuroepigenetic processes and adaptations, and the patient returns to the state prior to substance use, with remission or the maintenance phase.

Patients who progress from early stage to maintenance easily do not have the genetics for relapse.

In the process of spontaneous (automatic) relapse, specific genetic mechanisms are responsible for the low density of dopamine D2 receptors, polymorphisms with dysfunction of the enzymes monoamine oxidase-A and catechol-O-methyltransferase and the genes of the glutamatergic system, among others genes.

Attention to medication care and situations that activate common shared neuronal pathways serve to prevent the reactivation of the relapse process. Trauma, monetary gains, gambling, abuse of sweets, pornography and other medications that bring a false sense of pleasure (psychological addiction) produce an escape from reality like Cannabis and psychedelics.

These are moments that require more attention to survival demands, pressures at work, meetings with family members, changes in environments and commemorative dates, such as the end of years and birthdays, as they activate unconscious schemes for health professionals and friends, activating the relapse process.

Allostatic Mechanisms

US triggers a disruption of hedonic homeostasis, concomitant compensatory responses in reward systems, and brain stress, generating the withdrawal stage of negative affect. In common, all substances of abuse present allostatic processes, with positive reinforcing properties upon cessation of use.

Clinically, in the first cycle, right after the US, central nervous system (CNS) depression occurs, causing frustration, guilt, promises and illusory acceptance. In the second phase, mild CNS excitation occurs, with anxiety, insomnia, irritability, egocentrism and loss of empathy. In the third stage, there is

greater neurological excitation, promoting a state similar to that of hypomania, impulsivity, fissure, US risk behaviors, hypersexuality and exaggerated intake of sweet foods, ending in abusive use, psychosis or aggressiveness. Generally, it is divided into three periods of 30 days, each cycle having ten days or variations of periods always divided into three.

Pathological Demotivation

Pathological demotivation can occur slowly or suddenly after repetitive US, with production of neural substrates. These are molecules with significant alteration of behavior and subtle distortions of internal reality. They present a driving force in the disease, being components of the main neurocircuits that govern the motivational tonus, leading to the gradual loss of the sense of self-care, premonition and urgency with alexithymia. Then, forgetfulness, guilt anesthesia, shame and frustration occur, triggering demotivation by intoxication of epigenetic molecules.

There are avoidance movements in consultations, lack of interest in psychoeducation and withdrawal from treatment, causing alexithymia. The moment the patient gains control of the treatment, he also undergoes the US and behaves as if nothing had happened, with pathological lies and an illusory state of false-positive self-sufficiency.

In patients who are trying to abstinence, but continue to use substances, be it tobacco, be it Cannabis, be it alcohol, demotivation and a drop in motivation occur. For the pre-contemplator or contemplator state, these elements have been largely neglected in the clinic, and in the development of new treatments.

Crack

The craving derives from the expectation of the possibility of substance use and, thus, incubates such silent motivation by the neurons responsible for orchestrating the relapse complex and the dopaminergic ones. At one point, they erupt explosively with intense, uncontrollable desire—the craving itself. In moments of negative mental quality, the pathological triggers of dopaminergics are fatal, added to the effects of acute abstinence at the end of the allostatic cycle — a moment of monetary gain and mourning.

In the fissure, the patient has no sense of consequence and commits crimes, robberies and pathological professional acts.

Motivation

The pathological basis is motivational: individual motivation, which dictates the progression of severity as well as disease control. There are many patients, who do not finish the treatment or cease it in the early stages. Currently, patients and family members do not believe and/or do not accept the disease and, therefore, do not seek professional help, either because of shame or lack of motivation caused by the substance itself.

Motivational arousal is a variable that regulates readiness to respond to external stimuli. Although rewards and punishments activate responses independently of the emotional state,

the triggers of rewards are the determinants, making the dysfunctional programming of punishments dependent on dopaminergic arousal.

The motivational classification of Prochaska, DiClemente and Norcross articulates the patient's treatment indication. This one does not follow the stages in a causal-linear way. Upon achieving a change, it does not mean that he will stabilize at this stage. The process, then, is represented as a spiral, which presupposes movement, in which people can progress or regress, without logical order. We adapted this classification according to the neurochemical pathology of motivation, because, in pre-contemplation or in contemplation itself, the patient does not show motivation, which means that there is no point in carrying out an intensive treatment, as this can make the situation worse. In the action and relapse phase, the patient may try abstinence, without, however, succeeding, but returning motivated. This is the time to seize the moment.

After repetitive use, the patient becomes intoxicated with epigenetic molecules and, as a result, pathological demotivation occurs, returning to the state of chronic contemplation.

Clinical Case

This is a real clinical case. Currently, the patient is in a traditional TC. E. N. L. C. S., 34 years old, married, pathological user of crack, cocaine, Cannabis and, eventually, tobacco, without drug treatment. Denies depression, but refers to impulsivity and moderate anxiety.

L. F. R. C. D. S, 38 years old, wife, missionary, residing with their three-year-old son, S. R. C. S., in Rio de Janeiro.

Search for crack use after 21 days of discharge from the traditional TC where he spent eight months in abstinence and traditional treatment in pairs. She says she does not understand the reason for substance use on the fifth day of abstinence. In the initial evaluation, we observed motivation for change action and easy therapeutic bonding, with little father-therapist transference in their conscious and unconscious expressions.

Clinically observing the different body languages, due to their appreciation of the verbal content, the tone of voice, the looks, the attention of interest and the body movements and positions, their predominant peripheral mental functioning is hypodopaminergic (hyperactive, hypersensitive, with low concentration, anxiety, hyperkinesia and insecurity). It is worth noting that he finished high school without repeating a year, but with difficulty. He likes challenges and novelty. He has a hard time being alone. In idle time, he uses his cell phone.

Current diagnosis: Syndrome Z and primary substance use. Reports greater affinity with grandparents. His father was absent, as he died when he was three years old, and he had little contact with his mother, as he worked a lot. He reports missing his son and his wife, whom he has not seen since being taken in, eight months and 24 days ago.

She reports that her son S. R. C. S., 3 years old, presents a similar behavioral picture, leading to the suspicion of autistic spectrum, although she did not carry out the investigation. Evaluating their internal and external reality in the family environment (family affective effectiveness) and in society (predominance of the egoic mind), we identified the illusory discourse (self-deception), which diverges from behavior and reality.

He still does not have self-observation skills, but a deficit in empathic perception and sensitivity and a quick response with a response time conditioned to a rigid reason.

Without previously knowing it, it is possible to diagnose the expected mental state of epigenetic molecular neurointoxication from substance use, as he was on the fifth day of abstinence.

We identified a family functional neurobehavioral reality unconsciously similar to that of her father, replicating an absent father and husband. We carry out psychoeducation about the disease and its egoic states — family, addiction and relapse — as well as its possible complications (accidents, mortality, criminality, secondary diseases, chronic abstinence, suicides and neurological sequelae, and the chronification of the disease). It is the doctor's duty and the patient's right to clarify the disease.

Psychoeducation for patients and their families aims to clarify the disease with its familial, genetic and neurodevelopmental etiopathogenesis, as well as the importance of its "physical" or biological deficits, which produce significant effects on perceptions of self-care and empathy. In the different states or pathological neurobehavioral moments, the character is not evaluated. He had no sense of illness, like many, so we carried out psychoeducation and identification of his automatic states.

The ultimate goal of treatment is to obtain self-identification of pathological states and ensure the real moment of choice, as well as having a chance to return to the previous mental state, through relaxation skills taught by DBT.

On the fifth day, he presented with low dopamine, so we did not carry out self-observation training, as he would forget the learning.

After psychoeducation, he felt hopeful, excited by the new knowledge, and accepted the care without effort.

We welcomed him with 12 days of abstinence, and he was already mildly anxious. We started the dopaminergic motivational psychointervention with slow and deep diaphragmatic breathing, guided by mindfulness with an exercise to present awareness of internal reality (emotional and thought interoception). We slowly create an experiential moment with imagination or a happy childhood memory.

After being instructed to observe his child (experiential moment), the patient was moved, reporting feeling very

happy. At that moment, there was a dopaminergic discharge that increased the motivation for the treatment (dopaminergic motivational psychointervention).

Motivational diagnosis: relapse.

Evaluated by the fact that his speech is equivalent to his behavior, by the voluntary action of asking for help and by the real desire clinically diagnosed, allied to the complaint of his not understanding the use of substances suddenly, he has no control, despite his efforts. She reports that the search action lasted an average of five minutes until the use of substances, as she saw an individual doing it.

We instruct and apply knowledge of the service through the “therapeutic contract”, guiding the therapeutic goals to be developed: psychological, family, social and religious/spiritual, none of which are mandatory, except the psychological one. These goals would be evaluated by passivity negativity.

We started personalized multidisciplinary treatment, after discussion by the team, with daily activities: cognitive behavioral therapy (psychologist), psychoeducation, DBT and psychiatry (physician), change therapy (psychopedagogue), 12-step study, holistic therapies that bring relaxation and self-knowledge (access bars, multidimensional apometry with radiesthesia and systemic family constellation, showing reverberation of the past).

In the first three weeks, the patient presented difficulty in self-observation, resorting to rationalization and limiting beliefs. In the fourth week, there was a worsening of anxiety. He called us, and we helped him with DBT skills. He was successful.

The following week, he had a classic episode of relapse, with a change in behavior and internal reality, with verbal aggression and increased self-centeredness. Left without communication.

We cannot oblige, but we arrange departure only with a therapeutic companion or after 30 days.

Showed relapse. We conduct urgency skills orientation. After several unsuccessful attempts by denial, she returned to her previous state.

He evolved with improvement after performing a self-observation movement. He was again successful. After 35 days of abstinence, the clinical behavioral evolution of the three allostatic cycles was evident. She did not pay attention to the episode of automatic relapse in the third month after the last day of substance use. Like every neurological relapse process, it ended in substance use.

After substance use, she became depressed, vowing not to err again, repeating the allostatic cycles. We reset the count of days since the last day of substance use. On the fourteenth day of abstinence, she tended to reduce her help in the hygiene service and in the garden workshops, with a predominance of conversations with old friends, self-centeredness, preference

for more extravagant clothes, insomnia and drowsiness during the day.

With 30 days of abstinence, he decided to go out to buy a new cell phone and speculate on house rent prices, to plan the arrival of his wife and son, with no set date. Upon leaving the shelter, he used crack for three uninterrupted days.

He returned again to the TC filled with frustration and guilt, requesting assistance again. We restarted the relapse calendar count once more.

For the first three days, he had neurointoxication with slow cognitive processing and mild working memory loss. In the assessment of the pre-substance use period, he reported anxiety and referred to the need for a job and buying a trip for his wife and son.

In the treatment, we showed him the behaviors of the cycles and showed when he started the relapse process, based on his reports, such as craving before substance use.

He started the day before with insomnia; he planned the new house, forgetting that we did not consider his departure and reintegration into the social environment.

After a month, we worked DBT with relapse psychoeducation and other activities. He got a job at a diner at night. He felt safer when working with the monitoring of a therapeutic agent specialized in relapses.

In November, the wife and son arrived, and she stated that treatment would be a priority (November 26, 2021). He evolved happily, motivated, completing three months of abstinence. We noted, however, the difficulty in managing the pressures of responsibility. He requested housing in another environment with his wife and child.

We performed a clinical and motivational family assessment and identified Sd Z, since the wife has a similar reality to the patient’s mother, being absent for the patient and his son, unconsciously.

The patient also presented asynchrony, with affective absence (unconscious) similar to that of his father. He reported being a father present in the speech, but absent in reality, which is similar to his wife’s father, who was always at work, according to her own report, clinically confirming his father’s absence.

We carried out psychoeducation for both of them and pointed to the wife’s need for treatment, to help with harmful states within the family, to prevent the reactivation of the relapse process and to prevent the use of substances. We introduced the sense of disease with risk of complication. We deal with the difficulty of successful treatment if the family member does not undergo treatment for syndrome Z concomitantly. In this follow-up, the patient does not undergo the treatment and presents a recurrence.

The disease is unconscious, underlying the attachment between spouses with symbiosis.

With the mind intoxicated by molecules produced from epigenetics, the patient loses the sense of self-care, with alexithymia and anosognosia, with a real risk of fatalities, sudden deaths, accidents, aggressiveness and crimes.

After four months, he reported returning to the state of relapse for two moments identified after small fights at home. After completing six months of abstinence, he relapsed and uses crack for three consecutive days.

He reappeared with the speech of resuming treatment, but with the desire to partially perform it (treatment control = contemplator) and describing the entire process of relapse, from choosing to drive the bus to buying the drug. He consciously chose to engage in substance use, after observing the entire process, and finally realized that he did not really accept ceasing use.

In this moment of relapse, it was clear that he was able to observe all stages of his process, but in the final moment, he consciously chose substance use. If he wasn't conscious, he wouldn't be able to identify the whole process. This is his real chance to choose his will. The will, however, was not being evaluated, prevailing the will of those who "treat" him.

He continued the outpatient treatment and, after 30 days, underwent substance use again, always with the same clinic. The wife hasn't come forward since the first day.

The patient was able to observe his relapse process, identified after observing co-workers who used substances after work. This was not informed from the beginning. He lost his job after the US.

He maintained irregular outpatient treatment and started smoking daily, which we contraindicated due to the possibility of pathological demotivation. Even so, she maintained her substance use. In two weeks, she had missed appointments and distanced herself from treatment. His wife started work in the same environment, again showing easy access to the substance.

We had no further contact with either. On July 29, 2022, after four months, the patient developed abdominal pain, dyspnea and syncope in the morning, after having used substances the night before. He was then transported to the emergency room at the local hospital.

He was diagnosed with acute pulmonary edema, progressing to acute respiratory failure, requiring orotracheal intubation. At that moment, he had alcoholic breath and orotracheal secretion, according to the medical record. He was admitted to the Intensive Care Unit with sedation, use of vasoactive drugs, antibiotic therapy for aspiration pneumonia and cardiogenic shock.

He underwent an echocardiogram on August 5, 2022, with dilated hypertrophy and moderate left ventricular function. He presented satisfactory evolution. He was discharged on the same day, with a diagnosis of Systemic Arterial Hypertension, being forwarded to the outpatient service, with a prescription of Hydrochlorothiazide 25mg added to Losartan 50mg, Quetiapine 25mg and Citalopram 40mg.

Neurobehavioral EVALUATION Family Dialectics (3 GENERATIONS)
Interview conducted on August 8, 2022, illustrating the interview based on psychodynamics and neuroscience, evaluating 3 generations at the same time, according to their conscious and unconscious neurobehavioral functioning, always observing current and retrospective speech and behavior in relation to its effect (if it corresponds to reality).
PATIENT
Doctor: Can you remember two "good" characteristics of your mother and two "bad" characteristics? Patient: "Good": hardworking and supportive. "Bad": anxious and angry. He mentions that his pregnancy was troubled and that he was rejected by his father, according to his mother, because she was taking medication to avoid getting pregnant.
Doctor: Can you remember two "good" characteristics of your father and two "bad" characteristics? Patient: "Boas": funny; I don't remember. "Ruins": irresponsible and without character, according to my biological mother, as I did not live with my biological father. He mentions that he last saw his father in the hallway when he was three years old.
WIFE
Youngest of four children, eight years apart from her nearest sibling.
Doctor: Can you remember two "good" characteristics about your mother and two "bad" characteristics about you? Wife: "Boas": feisty and faith. "Bad": distrustful and systematic.
Doctor: Can you remember two "good" characteristics about your father and two "bad" characteristics about you? Wife: "Boas": faith and worker. "Bad": stubbornness and recklessness. She reports that her father was present during her childhood.
PATIENT'S MOTHER
First daughter planned. No problem during your pregnancy.
Doctor: Can you remember two "good" characteristics about your mother and two "bad" characteristics about you? Patient's mother: "Boas": hardworking and affectionate. "Ruins": liar and victimizer.
Doctor: Can you remember two "good" characteristics about your father and two "bad" characteristics about you? Patient's mother: "Boas": honest and friendly. "Bad": very anxious and forgetful. She reports that her father was present during her childhood.

On the 6th of August, he contacted us via telephone. He was afraid for the certificate and the INSS benefit, as he had no desire to return to the outpatient service of the state health system. We indicated treatment with reception in the same week, but he did not attend.

On August 8th, he contacted us via telephone, justifying the absence due to his mother's visit, who was about to return to her current city. We decided to record the case, which everyone accepted after verbally explaining and ensuring understanding, to sign the consent form.

On August 9, she informed that she did not have conditions, because she started work at 2 pm and ended at 8 pm. At 8:00 am, every day, she had a commitment to take her son to school. We advised on the need to return to treatment quickly and re-evaluate the workplace and family treatment, as he almost lost his life on US.

He reported that he had seen the importance of life due to the "fright", but said that the current work was important with his wife. His wife works hours that are the opposite of his. He mentioned that he was going to rest, that he had managed to remain abstinent since July 29th and that work was important for his control. We requested a return to our service, but he did not show up. He sought out the team for psychological care at alternative times. After 14 days, he returned with headache and hypersexuality. We asked him to return to the CT again, but we had no further contact. There were only two meetings with the wife.

Discussion

The patient presents mechanisms such as escalating allostatic cycles, showing states of classic relapses, in which he ends up choosing the use of substances. However, he presents awareness and a real chance of change, demonstrating his difficulty in emotional regulation and his real denial, only perceived at the moment in front of the substance. In the presence of the family, he presented more difficulty and, currently, demonstrates avoidance behavior. It seems paradoxical, but the unconscious inability to remain calm in the family environment is a subtle reality, like that of your parents and many others.

In the reported case, the patient is not effective as a father (unconsciously), as he is always absent, reproducing the absence of his own father, whether physically present or not. His wife also repeats the pattern of her parents.

The wife has an absent husband, like her father, and she is also asynchronous with her son, who already has a hypodopaminergic condition. He is intelligent, empathetic, pragmatic and objective, suffering in his father's absence.

Freedom refers to an ontological concept, as understood by Sartre, who argues that man constructs himself and defines himself as a being. In the exercise of freedom, man becomes a man in action and accountability for his choices. However, the patient is under adaptive neurological effects and/or epigenetic molecular intoxication. In this way, "even if the subject refuses

to make choices, even so, he chose not to choose and thus, in human reality, to be free is to make choices, but choices in a situation, as a field of possibilities of being, for the subject transform your life reality" (SCHNEIDER, 2006; 2013). It would be true if he had chosen conscious or semiconscious (intoxicated).

The wife's motivation for the treatment is nil. Even after she was guided about the need, there was avoidance on her part.

The patient relapsed and used crack on the fourteenth day of discharge, after almost losing his life. He was neurointoxicated due to the use of sedatives in the ICU associated with active maternal and wife regimens. The patient is young with moderate cardiomyopathy, having clear chances of ECV in compulsive substance use.

Without freedom of spirit, the real autonomy of the child and the patient is hidden in the unconscious, jeopardizing the treatment, presenting a risk of death, which seems to be neglected by psychologists and religious people.

Currently, we do not have a health policy with an objective medical protocol, requiring a minimum medical hospitalization of 30 days, as the patient neurointoxicated by an epigenetic substance has a neurological deficit with alexithymia and a real loss of sense of premonition and urgency.

His human dignity is not being evaluated, as the patient's will is also not evaluated correctly due to Zoe syndrome. The will has different origins: pathological (epigenetic), psychological (in beliefs) and secondary, for relief and pleasure (addition).

If we ask the neurointoxicated patient, in whom there is pathological demotivation due to molecules and "deficiency" in some cases of the sense of gravity, premonition, self-care, also biological origin, we are not offering the real chance of change, moment when he was more conscious as possible, such as the family disease that hinders and discourages the patient, in which we must reorganize the entire treatment strategy, as they are difficult, subtle and symbiotic diseases.

The importance of an initial family assessment, in an organized manner, without compromising ethics and morals, is a point for reflection, as returning to the memory of the past and neurolaw issues must be reassessed.

After reviewing brain functioning, current psychotherapies, without a therapeutic objective based on the origin, can neglect and chronicle the conditions of the family and the patient.

Social reintegration, physical activities and welcoming are fundamental, but they are not the actual treatment, but accessories. Without the therapeutic process aimed at the etiopathogenesis, we do not treat the disease.

The current evidence-based medicine presented a gap of errors in methodologies without correct pairing of different genetic factors for each substance, in the presence of polymorphisms,

in polysubstances, in associated psychiatric diseases, in neurodevelopment and in traumas. We question whether it is the best study, as Jasper and others have suggested, as we still have the spiritual questions.

Studies of psychometric questionnaires in patients that require the evaluator's sensitivity, diagnoses of motivation and situations of high social stigma, with dysfunctional expectations, and the presence of pathological lying make it difficult to collect information. Without treatment, the patient returns to the use of substances, suffering from emotional dysregulation due to overwork, sweets or the migration of addiction, very common to work or workaholic.

Digital Medicine and therapeutic companions are great allies in identifying relapses, helping with urgent skills to stop the relapse, as substance use is certain if it does not stop. The familiarization of the family and the patient is not simple, as they are afraid of relapse. In fact, at first they suspect all the time, they get scared, until they create the habit.

New objective prevention and treatment strategies are allowed for mental health professionals. The best indication is damage reduction, as well as the hypothesis of studies of new dopaminergic receptor-specific drugs, according to pharmacogenetics.

Clinical studies individualize the necessary factors in conscious phases, without inducing relapse processes, preventing complications in their areas.

Counting and guiding the psychopathological and relapse calendar of the disease cycles, together with specialized therapeutic companions, are essential factors.

Abstinence is fundamental, and purifying the mind of all these cumulative and mechanism-dependent effects, etiopathogenic factors, added, which is the union of psychological, biomedical and personalized concepts.

It is a disease with a real risk of sudden death due to ECV, a deficit in the sense of reality (overdose), a risk of contracting serious infections from needles and sexual intercourse, material losses and damages, and legal problems.

Conclusion

The notion of individual limits, of internal and external reality, if the individual presents observation of cerebral self-control is easily observed clinically, and shows that experience and accumulated knowledge, in a linear way, and only dense intelligence, do not have better conditions of free will, insights, and real expansion of consciousness, for those who acquired fluid intelligence, through dopaminergic gain, from the treatment of Sd Z and simultanagnosia.

The Clinical evaluation of Evidence-Based Medicine is being lost due to the excess of linear thinking that limits clinical reasoning, since just correlating, theorizing, without a biological causal link, unconsciously harms the technological,

scientific and human biological evolution advancement, which is certainly involuting by the loss of brain volume, cognitive, increasing the presence of asynchrony genes and influencers of addictions. The current children and adolescents who are dubbed the "Z generations" of the internet, will have more difficulty in family relationships.

This Document proves that all human pain, at first, is due to neuroadaptation of lack of family synchrony and the dopamine deficit that generates discomfort and hedonism, and the clinical identification was only possible, through the new studies of family neuroscience, that there was an increase of family fights in home confinement, decompensation of chemical dependents, workaholics, depression and panic syndromes.

They are diseases of professional responsibility to human rights, and from various areas of human knowledge. It does not have a CEP record, we work voluntarily in a humble Therapeutic Center that has been in existence for 21 years, regulate the Sanitary Surveillance, and does not yet have an academic bond.

This document makes pathological diagnoses individually and collectively, from family members and professionals according to individual reaction, whether it be silence or the irrationality of denying human neurobiology. If all human brains present some dysfunction, neglecting this subtle neurological disease is the same as neglecting one's own family, children, humanity and God, so until now religion has only had the function of relieving conscience, as it produces dopamine an exercise in religious and spiritual.

With love,

Conflict of interests

I have no connection with pharmaceutical companies, I have no economic, political, religious or academic interest. I am an active specialist in Vascular and Endovascular Surgery, student of psychiatry, psychoanalysis and neuroscience, and we describe USP Diseases in May 2022 and Syndrome Z and Zoé in September 2022, Sd ZX, and the Clinical methodology ZXSX, and we continue the studies.

Marília, SP, January 7, 2023.

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