

Dialectical Medicine: Z Syndrome and Use of Pathological Substances

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ABSTRACT

Since the beginning of humanity man develops without stimulation for internal consciousness, although technological evolution grows in a linear sense, the human mind remains stagnant, exchanging the ancient human slavery for the mental slavery of money and fear. Z Syndrome was described in September 2022 as a family neuroadaptation disease, dearly childhood, as central dysfunction to biological family asynchrony, with multiple neuroendocrine, neuro epigenetic alterations, associated with chronic filial hypodopaminergic state, all unconscious, in which family disease is harmful among family members. This is a dysfunction common to every human being, and Z Syndrome has initial dopaminergic pathophysiology, and is connected to other medical areas. The dialectic function of the reality of the religious, of the doctor, of the legal professional, of a political leader, who now has the choice between the biological truth of his diagnoses, of his families, and of his countries, whether a disease, disorder or just dysfunction, directly influences the collective future. All children to this day, are growing and developing neuro adapted, without biological family synchrony, and without real free will. Statistics will hardly solve studies of the human mind, which is always limited to linearity without clinical coding in the field of medicine. Dissecting intimately the love of attachment, the sublimation of charity and gaining fluid intelligence, is the result of the unique and REAL CHANGE, which is the treatment of Z Syndrome. The reflection and evaluation of the work performed to any addition should be reevaluated, as many are being harmed. With a lot of love and joy that I dedicate this work to all professional specialists, scientists and my parents, because without you, this diagnosis would not be possible.

Keywords: Z Syndrome, Metabolic Syndrome, Hypodopaminergic, Addiction, Dopamine

Introduction

According to the *American Society of Addiction Medicine* (ASAM) and the World Health Organization (WHO), chemical dependence is a chronic and progressive disease. But without organized etiopathogenesis, we perform in clinical practice, description of specific neurological states, based on brain physiology, human neurodevelopment, neuro behavior of

fear adaptation, neurogenetic behavior and neurobiological psychodynamics, and resulted in chronic hypodopaminergic neurological state, associated with subtle family disease of family asynchrony, which is visible worldwide, as several studies have already evidenced the family finding [1-19].

The state of chronic dopamine deficit, since the first days of life, generates restlessness, hedonism, boredom and irritability,

and unconsciously with growth, the individual begins to live from dopamine-generating habits, in addition to pleasure, which is where everyone focuses on the look [19-28].

The Syndrome(Sd) Z, is the association of chronic and oscillatory hypodopaminergic state, with neuroadaptive family disease due to family asynchrony, of neurobehavioral biological nature of survival adaptation, acquired in the first inactivity, which produce desadaptative, relieving, elusive or similar behaviors the family schemes² (Young), associated with alexithymia (inability to observe effectively), anosognosia (inability to effectively observe the family member), and there is still unconscious repetition, of the reality of psychodynamics inherited by parents, mirror neurons, and tonsillar systems [29-39].

This condition is present in all human beings, being responsible, with little effect being only a dysfunction, a disorder when moderate, without biological damage, but with loss of time in a family relationship [40-50]. Significant or pathological effects are evident-based neuro-behavior of chronic hypodopaminergic status, caused by specific genes (GARS) described by BLUM et al., inherited genes of Family asynchrony, gestational disorders, disorders of child neurodevelopment, family synchrony and attachment, Traumas and abuses such as (PTSD), association with other genes from other diseases such as Attention Deficit Disorders (ADHD) and Autistic Spectrum(AU), in addition to enzymatic deficits that cause impacts on emotional regulation, inhibitory controls and social skills and ESPECIALLY on FAMILY AFFECTIVE SKILLS (biology-dependent behaviors [40-69].

The human being devoid of affective abilities, in the family environment, causes frictions, is the neuroadaptation is automatically activated, which produces different behaviors, within the family in relation to other environments. Family schemes can be harmful or pathological, useful and neglected to this day, because escape, denial, aversion, elusiveness, is unconscious, and then as unconscious secondary gain, reproduces family asynchrony, evidenced by the incoherence of verbal discourse, behavior and individual reality. In the presence of activated scheme the individual can not reflect, does not control the immediate behavior, the judgment, because it did not train the control to closely inhibit the adaptive neuroadaptive automatic response. The inability to observe oneself in fact is different from self-knowledge [70-88].

Sd Z is ‘‘O missing link’’, given that most addictions are secondary, evolving to pathologies (situations of biological lesions and other damage) and other clinical diseases such as metabolic syndrome, addictions, not observed clinically to date, which share common neuronal pathways of the reward system: impulsivity, sexuality, intake of sugar and carbohydrates, substance use and monetary gains [89-104].

Addictions or additions in sugar (*diabetes mellitus*), carbohydrates (obesity) and power (corruption and immediate pleasure) present the same clinical picture, the same

² It is the clinical model of family schemes by american psychologist Jeffrey Young. These schemes produce psychic suffering, which is associated with alexithymia (inability to self-observe) and anosognosia (inability to observe others). Then, the activation of activating, elusive, aversive and punitive behaviors occurs, resulting in toxic relationships between parents and children.

pathophysiology as some psychosomatic diseases and conversive crises. Its etiopathogenesis may begin in pregnancy and evolve into old age, such as the elderly hypodopaminergic and in some subtypes of Alzheimer’s disease [105-159].

This is not a hypothesis to be tested, it is a clinical description associated with neurobiology and neurogenetics. Every human being unconsciously reproduces what mirror neurons captured from their parents during early childhood. Then it unconsciously reproduces the same psychodynamic profile, until it learns to observe itself in fact. If any human being, however much knowledge he has, has not identified this neurophysiological mechanism intimately, his diagnosis that does not have the ability to self-observe, is a fact [160-177].

Sd Z was silent passed on for years between family generations. If every human being learns self-observation, a movement that must be taught, evidenced by neuroimaging tests, that the movement of effective self-observation, of the internal reality mindfulness without judgment, without rationalization, activates the occipital cortex and automatically disables all automatic amigdalian neurological systems, adaptation, learning and still produces dopamine [161-179].

An example in the clinical area of vascular surgery is the smoking 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 other cardiovascular event (CVS). Science has few studies of the effects of basal dopamine in relation to arterial hypertension, but most risk factors for atherosclerosis are secondary to Sd Z. In pediatrics, the newly hypodopaminergic Sd Z (has hypodopaminergic genes + family asynchrony genes) makes differential diagnosis with Autism Spectrum (As), Attention Disorder and Attention Deficit (ADHD), can generate Secondary Childhood Obesity [161-179].

Sd Z provides ‘‘stakehold’’ clinical, with several areas that produce harmful effect, the human mind, and free will, which will be necessary the integration still invisible the areas of neurology, psychiatry, psychology, cardiology, vascular surgery, obstetrics, genetics, endocrinology, plastic surgery, pediatric surgery, anesthesiology, intensive care unit, medical clinic, pediatrics, dermatology, immunology, immunology, and law sciences, pedagogy and education [1-150].

Table 1: Boron Content of Some Foods/Food Groups and Beverages (µg/100g). Rainey, et al.1999 [11].

CHRONIC HYPODOPAMINERGIC STATUS	
NEWBORN (RN)	CHILD OR ADULT
<ul style="list-style-type: none"> • Speech delay up to four years of age • Irritability • Hypoactivity in the search for breastfeeding Frequent crying • Eczema • Persistent fever with no known cause (emotional fever) • Empathy and fluid intelligence • Sudden and exaggerated arousal of the sympathetic autonomic nervous system • Heart rate rise • Discrete pupil augmentation • Subitization in geometric readings 	<ul style="list-style-type: none"> • Constant duality • Constant insecurity • Boredom • Intensity • Explicit goodness • Irritability in routines • Disorganization of the day before • Deficit of enforceability • Emotional instability • Anxiety • Attention deficit and concentration • Fast pace of thinking • Malaise • Night weariness after activities involving automatism • Pragmatism • Indiscipline of organization • Excesses • Habits that use dopamine

<ul style="list-style-type: none"> • Difficulty in mathematics • Fast learning • School indiscipline • Difficulty in school development • Distraction with deep imagination • Superficial distraction with automatisms • Exaggerated situations without fear control (phobias) • Mannerisms • Stereotyped movements • Deficit and inability to self-care • Hygienic control deficit • Sensory habits, such as exploring smell and touch, when calm • <i>T r i c h o t i l l o m a n i a</i>, onychophagy and other compulsions during anxiety episodes 	<ul style="list-style-type: none"> • Impulsiveness • Affinity to sugar and carbohydrates • Gula's night • Procrastination • Hyperactivity/hyperkinesia • Constant search for news • Hypersensitivity and intolerance to pain • Alexitimic • Shyness • Social isolation • Fluid intelligence • Hyperfocus on preferred activities • Multiple relationships or difficulty in marital bonding • Addiction to early passion • Blame • Need for validation • Hypersexuality • Survival manipulation • Perfectionism • Concern for others, and I don't even • Initiation of multiple activities or projects simultaneously • Affinity to caffeine and energy drinks • Sensory stimuli • Inability to deny aid • Ticks • Adrenaline-dependent habits • Attraction to extreme sports and complex and challenging activities • Excessive work • Insomnia • High risk of developing use of pathological substances and depression (60%)
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Objectives

Main Objective

The main objective of this study is to highlight the impairment in the autonomy of the patient in question, as well as the various clinically identifiable pathological mental states, simultaneous that are being neglected, such as a state of relapse, state of activated family scheme, neurological family disease and use of pathological substance (primary or secondary)

Secondary Objectives

There are secondary objectives:

- Promote **the real** free will of every human being, which still prevails brain influence through psychoeducation.
- To highlight the need for reflection of the medical, scientific, legal, political, religious communities worldwide, in what is common to every human being, regardless of ethnicity, because it depends on the brain child neurodevelopment;
- To evidence the clinical finding of Z Syndrome, a family asynchrony disorder, which can be observed in any individual, because it has neurobiological pathophysiology, which unites psychoanalyst, psychological and medical theories.
- Solve the case reported because the patient is without effective treatment, as well as all patients today.
- Medical psychoeducation of Dialectical Medicine, as the principle of the foundation sofa I of the code of medical ethics, allows this study as a protocol, for new treatment action and prevention in the child window

Watch that human evolution is moving towards generations of worsening human relationships by heredity and genetics of family asynchrony and brain structure disorders.

Material and Methods

It was not our goal to carry out science, but by the clinical findings based on science, reason and medicine, I immediately ceased our voluntary work, and I bring in urgency, as recommended by the Law of studies in human beings, Code of medical ethics, and I 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, psychological and biological long-lasting states, by molecules that cause significant alterations produced by epigenetics, and (3) every child is already being developed 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 Community (CT) in use of substance, a Catholic religious philanthropic organ, located in the city of Marilia, in São Paulo —Brazil, during the period of one year, allied to intensive studies of scientific articles, incessantly, and aware of the new findings. Today are the first CT specialized in Relapse in Use Substance and Treatment of Sd Z.

This study 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 of scientific articles was performed, especially *from current functional magnetic resonance imaging (fMRI) articles*, 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 with 45,432 studies for the first, 177 studies for the second and 31,544 for the latter. An active search was conducted for studies on ADHD, consciousness, genetics and epigenetics, relapse in substance use, neurobiology of addition, neurodevelopment, neurobiology of sensitivity, dopamine, neuro-adaptations, pregnancy and substance use, obesity, autistic spectrum, smoking, neuroscience of automatisms, anosognosia alexitimic, *Cannabis*, methamphetamine, cocaine, anosognosia and substance use disorder (TUS).

We performed the description of the relapse clinic throughout this year, associating the current studies of neuroimaging, behaviors, genetics and epigenetics of TUS and discarding the theories and philosophies without any biological link.

We also performed the description of the technique of evaluation of the peripheral mind, without invading the individual intimate forum, through the concealment of clinical and semiological techniques based on neurosciences of automatisms, technical skills of evaluation of the unconscious and the conscious of psychoanalysis, *dialectical behavior therapy (DBT)*, therapy of young schemes, human neurodevelopment, clinical clinic, neurology and semiology of neurological systems combined with the semiology of eye, pupillary, saccadic and anti-saccadic movements, simpatics autonomic nervous [3].

3 With regard to clinical practice, how many patients develop use of pathological substances with dependence on only one substance and do not present, simultaneously, Z syndrome or hypodopaminergic state? How many observational studies have prevalence of only a single substance with population individuation, according to methodology for specific genetics of the substance? How many clinical studies have clinical pairing based on childhood experiences associated with proper pairing? How many studies aim at the pathological lie of the patient? How to conduct a large,

Pathogeneis

Harmful habit: produces pleasure and/or relief of psychic suffering, with risk of tissue injury and addiction [1—117].

Social substance use: absence of Sd Z or dual psychic disease and effective self-control, without family and tissue complications [1-119].

Addiction: evolution of habit or behavior that leads to pleasure or relief of displeasure, or suffering of family schemes, presenting difficulty or denial to cease the habit. It may present behavioral and adaptation dysfunctions of brain, hepatic and endocrine tissues, such as acute abstinence syndrome, and dose-dependent tolerance without genetic/epigenetic etiology [1-120].

Use of pathological substances (USP): psychological and/or biological addiction or addition in psychoactive and/or psychedelic US, with tissue damage and secondary complications, added to the inability to cease habit and prioritization of US, consciously or not, in the absence of Sd Z [1-121].

Use of primary pathological substances: addiction in substance use or use of pathological substances **secondary to Sd Z**, in the **PRESENCE** of allusive genes and/or polymorphisms, which cause specific clinical states and significant changes in psychic functions, **GENERATING** behaviors of variable duration. It has several mechanisms: production of dysfunctional enzyme complexes of histonas; dopamine transporter dysfunction (*dopamine transporter* [DAT]); molecules produced by genes in the presence of substance use; chronic abstinence; pathological demotivation; neurogenetic relapse processes; fissure; compulsion for enzymatic deficit of inhibitory control; emotional dysregulation; allostatic cycles; morphological changes in dopaminergic receptors, especially D2; neuronal migration;

hypodopaminergic neuroadaptation; synaptic connectivity dysfunction, which may decompensate previous disease or bring secondary complications; and specific conditions of substance use, such as depression induced by epigenetic mechanisms such as opioids and alcohol [1-121].

Use of secondary pathological substances: addiction by substances **in the presence of Z** syndrome 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 alterations of liver clearance, dosage intolerance, acute abstinence syndrome, use of unconscious substances of its function relieving the family scheme and escape from reality [1-121].

Hepatotoxic lesion: cirrhosis, steatosis, hepatocarcinoma [1-121].

Acute neurological injury: acute psychoses due to excess dopamine, decompensation of bipolar depression, schizophrenia, advance Alzheimer’s disease, overdoses, suicide and crime [1-121].

Recurrent neurological injury: sequelae such as neuronal loss psychosis, *Cannabis*, peripheral alcohol neuropathy, cognitive deficit such as ADHD and dementias [1-121].

Acute and chronic cardiovascular lesions: cardiac arrhythmias, dilated cardiomyopathy (case to be reported), excess alcohol that impairs myocardial contractility leading to systolic dysfunction and dilation of the ventricles, mitochondrial injury in myocyte, and alcoholic cardiomyopathy [1-122].

Lesions due to hypertensive crises: multiple episodes of AsAA that produce hypertensive crisis and hyperglycemia, causing organ damage and high dosages of simpatomimetic substances [1-122].

multicenter, paired clinical study in sex, age, ethnicity and genetics for specific substance?? Do we have any single-substance evaluation studies without associated family disease? With humility, reason and science, we believe that this study of simultaneous methodology — case report, ethnographic study, literature review and medical report — is stronger than any study today, because it is impossible to perform meta-analysis with a question to be answered by current studies with uncertain designs.

GENETICS + ADDICTION	
<ul style="list-style-type: none"> Addiction with tissue sequelae Addiction with social-family losses Addiction with criminal implications Unconscious addiction of Z syndrome 	= PATHOLOGY

HIERARCHICAL NOSOLOGY OF Z SYNDROME	
1	Maternal causes/hostile pregnancy (maternal hypoxia, placental dysfunction, intrauterine growth restrictions, prematurity, substance use, etc) → Intrauterine
and/or	
2	([Specific genes of hypodopaminergic states (<i>Genome Wide Association Studies</i> [GARS → Hypodopaminergic NB (differential diagnosis with ADHD and AS
and/or	
3	(Adverse Childhood Emotions (with or without genetics) → (RN to 3 years)
and/or	
4	(Child adversity and post-traumatic stress disorder (PTSD) (abandonment, trauma, abuse, bereavement, rape, surgeries, etc
and/or	
5	Concomitant psychiatric diseases (concomitant specific genetics): bipolar depression, ADHD, AS, anorexia, obsessive-compulsive disorder
and/or	
6	Head trauma (TBI)/Frontal lobe tumor
SECONDARY ADDICTIONS TO Z SYNDROME	
7	Use of pathological substances or addiction in use of substances: primary or secondary. Addition in sugar or at work (<i>workaholic</i>), <i>internet</i> , lucky games, power etc
and/or	
8	Psychological effect of the COVID-19 pandemic (PTSD): currently, previous hypodopaminergic status worsens, with no correlation with cerebral arterial microthrombotic effects and neuronal immune complex lesions
and/or	
9	Elderly chronic hypodopaminergic: family regimens, traumas, frontotemporal stroke, grief, senility, dementia, Alzheimer’s disease, irritability, post-retirement depression or after the family’s return to care

Syndrome Z

Currently, there are several similar concepts. We chose to group in only one the disorders of family relationship, family alienation, attachment disorder, pathological love, emotional dependence and Münchhausen syndrome. Central dysfunction is Family Asynchrony or Absence of Affective Family Skills due to neurohormonal deficit [121-189].

The sciences of law, forensic psychiatry, occupational medicine and need this “new” medicine with organized etiopathogenesis, without theories, ideas, which should be reflected in reformulations still theoretical or philosophical, because it is a clear disease, which presents professional responsibility as any disease, as well as the current legal sciences and judicialization of medicine, should be reevaluated [121-189].

Sd Z presents significant distortions in clinical conditions of fear, which are rich in flawed acts, differing from behaviors and reality. The flawed act in the psicanalise is a language of the unconscious, when very sick presents verbal discourse, and inverse behavior of reality, without perception of it [121-189].

This work clinically corroborates the findings of the Canadian study of mental states “Hostile and Useless” (HH), conducted at the *Université du Québec à Trois-Rivières*, as well as other meta-analyses. Similar of Schemas Familiar of Young, highlight the severity of childhood trauma associated with four indicators of HH: (1) identification with a hostile caregiver; (2) laughter in pain; (3) global devaluation of a caregiver; and (4) bad sense of yourself. FMRI studies show that maternal love (thalamus regions, black substance and left putamen) and romantic passion, attachment and marital relationship (bilateral ventral tegmental area) present common neuronal neurodevelopmental disorders [121-171].

Such disorders are orchestrated by the neuronal pathways dependent on oxytocins, vasopressins, cortisol and melatonin, together with dopaminergic hyperstimulation of the cerebral reward system. They present important neuronal activity in the cognitive-affective regulations of attachment, fear, insecurity, and duality, along with the unconscious need to reproduce the affective relationships similar to the family role experienced in loving behaviors [121-166].

Neurobiology of Family Synchrony

Family affective synchrony develops in humans in the first three years of life. It begins by stimulating maternal touch and other physical senses, with reaction effect on newborns [121-189].

The human brain, from the time of primates, is programmed to develop the familiar role up to the three age, according to the explicit and implicit reality of the parents, due to cortical, frontal, lower and left mirror neurons (Broca area) and the arched fascicle (Korsakoff area) [121-189].

During the intrauterine and the first three years of life, maturation takes place automatically. The expectation is that the father will be dominant, with real control of the limits, and the mother will produce the welcome. The brains of newborn boys block pain, disaffection, absences and trauma stemming from the mother, and the girls’ brains operate the same in relation to their father [121-219].

When there are intense or repetitive traumas or pains, due to the unconscious brain mechanism of fear, an unconscious inversion

occurs in the functional role, by the neurobiology of attachment formation. This inversion influences the neurotransmission of gender choice around 10–12 years [121-200].

FMRI studies in adults with stimulation showed greater activations of neuroadaptation in the regions of the thalamus, brainstem, amygdala, hippocampus, anterior *cingulate cortex* (ACC), insula and temporal cortex. These are the same regions of parenteral and infantile attachment. These studies also showed parallel neuronal activities in the anterior paracingulate cortex and posterior superior temporal groove, as well as in limbic and tonsil emotional networks, which remain until old age [121-199].

The mother who does not have affective synchrony with her parents is unable to effectively stimulate her child, because her abilities (biological dependent) were not neuro developed by her absent and unconscious parents. These skills, therefore, must be taught [102-177].

At the same time, there are unconscious secondary gains in many cases. In them, there is the reproduction of family roles (psychodynamics), as perceived in the practical reality of their parents, captured by mirror neurons, which are passed on intergenerationally, in zigzag format (Sd Z), since the beginning of time [11-219].

Diagnosis of Z Syndrome

Through clinical anamnesis, dialectical neurobehavioral evaluation with technical interview, or with simple observations of acts already produced, we evaluate dweller behaviors common to every human being, without invading the intimate forum, which present conscious and unconscious effects [101-219].

It is clinically that Sd Z is diagnosed in up to three generations, as I describe in the following case. These observations are exempt from judgments, and from the subjectivity of the patient’s conscious and unconscious, verifying whether the discourse is equivalent to behavior and reality (effect). Always observing your sense of motivation and notion of your inner reality [121-189].

We compared the reality of the EFFECTIVENESS of the family affection of three generations, observing simultaneously the unconscious and the conscious, the body and verbal languages and the behaviors. Then, we identify whether there is synchrony of family affection or whether, unconsciously, the components of the family reproduce the same realities of their ancestors, with secondary gain or not [121-189].

Infant Z Syndrome

The Newborn (NB) hypodopaminergic, has always been neglected, without protocols and clinical attention in its hypodopaminergic characteristics, such as variations of the sympathetic nervous system, high heart rate, hyper or hypo reactional to light, typical facial expressions, usually have infantile genius. They always occur simultaneously or in isolation, as in adults. Children are currently growing neuro adapted, as there are no collective or singular strategic plans for training family skills, and emotional intelligence, without presentation of internal consciousness (Emotional Intelligence, Thoughts, Body, Interoceptives, Intuitive, and external stimuli sensitivity) prevailing only the tonsillan brain systems responsible for learning survival, develop only dense intelligence (specific knowledge, life experience and beliefs) [121-189].

The imagination that has a function of creative development, momentarily interrupting the development of human genius, and later can become misunderstood genius children, or pathological leaders, or evil genius [121-189]. The clinic is sovereign in the neuropsychological evaluation in relation to psychometric instruments. We are in a maximum period of identification of the pathological irrationality produced by the disease, in the family environment and in the occupational environment [121-189].

Another problem to be reflected, are children with severe neuropathies, that the prevention of seizures, has been only the medical concern in many cases, and we remember that it is a child, without effective presence of family affection [121-189]. How many children with cerebral palsy, degenerative lesions, present simultaneously hypodopaminergic state and/or Z syndrome, with hypersensitivity, for various hospitalizations, childhood surgeries, chronic states of pain, discomfort, introspection, which do not express the suffering of unspoken sequelae, only observed [121-189]. The diagnostic suspicion of the different conditions: AE, 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 parents' mental health [121-189]. Immune falls that cause repeat infections, and exacerbated responses of immune systems, with hyperinflammatory reactions such as bronchitis, atopic dermatitis, emotional fevers, can be simultaneous in Sd Z, and severe neuropathies [121-189]. The hypodopaminergic child evolves with depression of the neurological state, convergent syndromes, speech delays, hypersensitivity, as it adds etiological factors, such as affective absence of parents, bullying, psychological capacitive of family members, taxing of professionals and society, generating aggressiveness, introspection, and shame [121-189].

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 behaviors. Only self-reflection and self-knowledge do not allow real individuation. To really know, it is necessary direct, sustained and effective self-observation, through deep and intimate movements, with the aim of gaining dexterity in emotions and broadening the consciousness of internal reality (awareness of emotions, thoughts, body interception and intuition). Such exercises require dopamine to start, and they themselves produce dopamine during their execution [121-189]. The fMRI studies in alexithymics have demonstrated poor states of feelings, few affective responses, and emotional reactivity deficit. They are dysfunctions of neuronal connection between limbic and neocortical areas. The persistence of tonsil neuronal activity, responsible for defense behaviors, rationality and rigid reason, produces long-term dopaminergic deficit, with brain dysfunction and decreased cephalic mass [121-189]. The right hemisphere participates in the perception of emotion, and functional disorders are due to the dysfunction of interhemispheric interconnection (functional commissurotomy model [121-189].

Every emotion is a reaction. Emotions are reflexes of stimuli, which respond with physical effect, such as hunger, seed and fear, and are necessary for our survival. Judging neglecting this **truth** worsens the disease and produces folly with professional responsibility [121-189]. Emotional and fluid intelligence is a constant and active training of self-observation and habits that

produce dopamine, balancing the patient, observing the REAL CHANGE, RESULT OF Effective Treatment of Sd Z, These stimulate dopaminergic neuronal growth, bringing interaction between the cerebral hemispheres. Dense intelligence is rigid specific knowledge, which, however, produces irrationality after long periods [121-189]. Are 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 stimulation of the child's imagination, manual works such as painting [121-189].

"Fluid Intelligence = Superconsciousness, Free Thinker, Unadapted Mind, Mental Mastery,"

To be achieved after reflection and self-observation that has fluid intelligence, which can happen "insights" the superconsciousness in which there is no more predominance of neuroadaptations, with loss of Functional Alexithymia, Simultanagnosia and Anosognosia.

The light of Engle and Tsukahara's works scientific has been the effect of dopamine on the brain loci of this wonderful work:

"The potentially important relationship to understand the biological basis of intelligence: the relationship between fluid intelligence and the locus coeruleus-norepinephrine system. This is largely motivated by our findings that the size of the base pupil is related to fluid intelligence, the larger the pupils, the greater the intelligence of the fluids.

Modern thinking about intelligence is strongly influenced by the discovery that individual differences in working memory capacity are highly correlated with fluid intelligence.

The connection with the locus coeruleus is based on research showing that pupil size can be used as an indicator of locus coeruleus activity A large body of research on the locus coeruleus-norepinephrine system in animal and human studies has shown how critical this system is for an impressively wide range of cognitive behaviors and processes, from the regulation of sleep/wake cycles, to sensation and perception, attention, learning and memory, decision-making and more. The locus coeruleus-norepinephrine system achieves this primarily through its generalized projection system throughout the cortex, strong connections with the prefrontal cortex, and the effect of norepinephrine on many levels of brain function Given the broad role of this system in behavior, cognition and brain function, we propose that the locus coeruleus-norepinephrine system is essential to understand the biological basis of intelligence. The ability to regulate perception, cognition and behavior is a fundamental characteristic of any complex organism that allows them to navigate and successfully adapt to changing and uncertain environments, it is when self-safety, fear is controlled, and not anesthetized." [121-219].

Zoe Syndrome

The right hemisphere is responsible for an improvement in the perception of emotion, such as dexterity in feelings, experiences rich in detail, fantasies, imagination, creations engage in a real or playful dream, feel them are affective responses when we have healthy limbic and neocortical neural connections, like a normal child [159-219].

The term alexithymia, "absence of words for emotion", usually in patients in automatic states, Chronic and Acute

Abstinence, Fissure, Relapse Processes, Acute Neurointoxication, psychosomatic diseases with restricted affective life, absence of social and family skills, in which intensity depends on dopaminergic deficit, can be a permanent or momentary state, as in family schemes [160-219]. Alexithymic individuals suffer in interpersonal relationships because of a deficit of expressing themselves, feeling, perceiving, communicating, in front of 'normal' people who also do not realize, the real alexithymic problem [160-219].

Disorders in the functioning of the right hemisphere, interhemispheric transfer deficit, or excessive activity of the left hemisphere by automatism neuroadaptation, such as Z Syndrome or perhaps the ex "normal", or functional commissurotomy model, when the emotional material is cut from the left hemisphere by an expressive verbal act, which activates automatic movement processing s. It can be when a mother tries to correct the normal and disables the normal development of the child, or when the Teacher cuts the genius student [160-219]. In alexithymia, thinking oriented to external reality and difficulties to identify feelings, deficits of facial expressions automatic the states of neuroadaptation. Alexithymic individuals manifest low reactivity to negative emotional stimuli, in which less work the brain regions responsible for evaluation, coding and affective response, such as occipitotemporal, tonsilla and insula areas, and is characterized simultaneously with anosognosia with the same deficits in perceiving the next, by automatic activation again of the circuits alexithymics [160-219].

A family scheme can be activated by mirror neurons, in the occupational environment, by a professional who unconsciously can activate a similar family scheme in a professional and patient and vice versa, that we have several neuronal networks and theories such as "shared representations" of empathy, postulating that the neural networks involved by the experience of pain in the first person also support the sharing of pain of others, or the theory of the collective unconscious [160-219]. The Z Syndrome in the professional scope we call It Zoe Syndrome (named after the indigenous tribe of the Brazilian past that presented similar sodium), which is characterized by alexithymia, anosognosia and simultanagnosia [160-219]. When activated by the family scheme, the therapist also limits consciousness, compromises his therapeutic bond, evidencing an asynchronous care, and totally without guilt, because the problem of the automatic functioning of the schemes and the psychodynamics received were never presented and treated. Simultanagnosia was initially defined by the inability to perceive the individual elements at a time, without synthesizing the general meaning of the scene, which results from bilateral parieto-occipital damage, the intraparietal sulco of the white matter. The functional attention deficit that patients have "neurological blindness," or functional tempoparietal hemineglect, described by tempoparietal ischemic brain lesions in Anton syndrome, leads to early judgments, denial of the problem, predominance of illusion of their intimate reality, because it loses the real notion of the problem, self-care or care to others, in an intense way, in Z or Zoe Syndrome is discreet, subtle and chronic [160-219]. The research of three or more lines referring to interconnected research, related to the main mechanisms of the nervous and mental and spiritual system, should be the current challenge, to correct the limitation of current scientific studies, such as the current one that proves the disordered realities, which will be the deepest explorations of the mind, or "Stakekold ZXY" [160-219].

Treatment

Individual, Family and/or Systemic Psychoeducation

The teaching of skills is different from orientation and psychoeducation. It can be harmful, producing domestic quarrels, as it currently does. Affective family skills should be trained, ensuring their effectiveness with psychoeducation. The treatment of group regimens is important to show family members and patients the situations of activated regimens, with denial or dodging an automatic response (adaptive brain domain over its essence [160-219].

Schemetherapy and DBT, combined with the psychoeducation of neurodevelopment and the unconscious reality of the reproduction of the reality of parents, related to family affection and family synchrony, are fundamental objectives. The first step is to learn self-observation by identifying current deficits and harmful automatic schemes [160-219]. The evaluation of four characteristics, at the same time, is trained and acquired by the current treatment of the use of pathological substances. Self-observation without judgment, rationalization, reflection or thought is a fundamental movement, identifying only emotions, felt in the same second. The human being has 37 emotions per second, and we do not know how to name even four of them, without rationalizing [160-219].

The goal is to help parents 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 *parent and child therapy* (PACT) (CHAMBERS *et al.* 2006), which have been shown to be effective in high-risk populations [160-219]. Patients, family members and professionals who have not undergone effective treatment are easily observed in the clinical diagnosis, with denial, aversion, elusiveness, criticism or non-consideration of the disease, not fully identifying their behaviors [160-219]. Digital applications can aid in treatment and prevention by stimulating emotional intelligence [160-219].

Dopaminergic Motivational Psycho intervention

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 brain survival system invades the essence or self. Whenever there is rationalization, taxation before self-observation, it can be said that there is an automatic neuroadaptive behavior, with duality, uncertainty, denial and aversion, so it is brain interference [160-219].

When we ask what emotion feelings 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 can also answer automatically with another question (dodge). Responding with a "nothing" is evidence that the ability to observe has not been learned; it is the clinical diagnosis of alexithymia and anosognosia [160-219].

Psycho Memory Reconsolidation Intervention

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

the motivational psycho intervention [160-219].

In continuity with motivational psychoeducation, combined with the patient's imagination in going back in time, to another experiential moment, with memories of parents and childhood, the therapist assists in resignification, leading to the conception that no one is to blame. The pain of the absence of parents brings a brilliant mind, a current consciousness, in addition to providing life, a special moment [160-219].

The memory of childhood memory is consolidated, and in the presence of dopamine, initially destabilization occurs, if it is remembered with the therapist, due to the transfer of father or mother. When the patient presents relaxation and empathic bonding, we begin the process of reconsolidation by guided intervention, which can last for weeks, until the therapist works all the resignification, performing the reconsolidation, instead of extinction [160-219].

8. Use of Pathological Substances (USP)

According to the *National Institute on Drug Abuse* (NIDA) and ASAM, there is genetic vulnerability to substance use (US) responsible for 50% of cases, with the remainder of the vulnerabilities being the sums of social, psychological, environmental, family and psychological factors [160-219].

There are specific genes for specific substances, thus totaling more than 7,000 genes, according to the Japanese genomic library [160-219].

USP may be primary in the presence of these genes that produced clinically identifiable and specific pathological mental states. Secondary USP, on the other, is a consequence of Sd Z [160-219].

We performed clinical description of behaviors in the presence of genes common to all substances. Repetitive US produces long-lasting molecules, as well as migrations and sensitizations by epigenetic mechanism when the substance comes into contact with the specific gene, generating epigenetic mutations by alterations of chromatin, serotonergic receptor genes-2A (5-HTT2a and 5HTTLLR), dopamine receptors (DAD2 [DRD2], DAD1 [DRD1], DAD3 [DRD3] and DAD4 [DRD4]), catechol-O-methyltransferase (COMT) monoamine genes, monoamine oxidase-A (MOA-A), glutamatergic system genes, AMPAR, wt-GluR1, pd-GluR1, GABA, opioids, histone modification, acetylation and methylation of non-coding DNA and RNA, dopamine carrier enzyme (DAT1) dysfunctions, interleukin-6 gene expressions and Delta-FOs transcription, leading to lasting behavioral changes and reactivation in the future, of new behaviors, in addition to producing genetic changes altering sperm and egg [160-219].

Severity depends on the intensity of the family disease and the amount of inherited genes that have more neuronal and clinical mechanisms, making treatment difficult [160-219].

The presence of concomitant comorbidities (dual), mainly anxiety disorders, bipolar depression, impulsive disorders, ADHD and secondary states, are sequelae by neuro adaptations or long-lasting molecules [160-219].

In addition to (1) tolerance of the dose-effect amount and (2) acute abstinence syndrome, there are mechanisms that present compliance with the amount of inherited genes, such as (3) *craving*, (4) loss of control inhibition after the use of

rampant substances, (5) chronic abstinence (hypodopaminergic, depressive and anxious states), (6) pathological demotivation caused by molecules produced in the use of repetitive substances, that cause sudden motivational drop for the contemplator, (7) alostatic cycles and (8) relapse processes, which are crucial in treatment [160-219].

Simultaneously occur all these pathological mechanisms, together with tired and sick subjectivity, with no way out of psychological processes, relieving behaviors, limiting beliefs, distortions of negative thoughts and emotions that are enhanced in the first 30 days by acute abstinence syndrome [160-219].

Several animal and neuroimaging studies in humans show that *previous exposure to Cannabis, synthetic cannabidiol CP-55940*, as well as cannabidiol itself produces brain changes in adolescence, inducing the cross-activation of cocaine genes, causing states of immediate relapse and up to ten years later, in addition to Cannabidiol Reactivating a relapse process [160-219].

8.2 Chronic Abstinence and Sequelae

Chronic abstinence is the long-term potentiation with strengthened neural connections over time and with increased stimuli, causing hedonism, bipolar depression, or long-term or perennial ADHD, as a sequel to neuronal injury. Of epigenetic effect, there is molecular production in the first 24 hours after the use of substances, mainly anesthetics, sedatives and benzodiazepines [160-219].

8.3 Relapse Process

The process of relapse, is not the act of US, is a neurological, psychic and genetic state that aims to end in US, more precisely a classical and momentary pathological complex, orchestrated by 4% of globally sensitized neurons. It can be activated in minutes or weeks before use itself. It presents rich signs of the unconscious, such as flawed acts that always end in use. It can start with motivational loss of treatment, behavior change, and memory loss. Usually these are the initial changes. However, it has 11 phases and 83 signs and symptoms, according to Gorski's studies [160-219].

They are complexes activated by long-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 [160-219].

From a previous mental state (Sd Z), it can be said that there are several triggers that activate the relapse process. This objective is unconscious the use of substances, by which the patient forgets some values and narrows the limits of morality; ambivalence becomes predominant, with prejudice to critical sense and loss of ability to predict possible complications. Treatment is no longer a priority, as it decreases the motivational state of the disease [160-219].

If substance use leads to a "neurointoxicated mind" and activates sensitized dopaminergic hypermodulator systems, it causes loss of reason, sense of morality, self-care and 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 [160-219].

In most cases, the acceptance of cessation of the use of substances is camouflaged, because self-deception is frequent. Automatic survival systems prevent self-observation, and relapse processes are activated by harmful family schemes and in the presence of triggers [160-219].

Several studies of genetics and epigenetics show high molecular production, which leads to lasting changes in cognition, behavior and emotional state, ranging from two to three years, with enzymatic changes in histones and low density D2 receptors [160-219].

In prolonged abstinence, there is slow and gradual fall after the last day of substance use. When molecular levels drop suddenly, 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 decreased intensity during a variable period, but with an average of two years. After abstinence from this period, there are no more neuro epigenetic processes and adaptations, and the patient returns to the state prior to substance use, with remission or maintenance phase [160-219].

Patients who progress from the early stage to maintenance easily lack genetics for relapse [160-219].

In the process of spontaneous (automatic) relapse, 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 other genes, are responsible for specific genetic mechanisms [160-219].

Attention to care for medications and situations that activate the neuronal pathways shared in common serve to prevent the reactivation of the relapse process. Traumas, monetary gains, gambling, candy abuse, pornography and other medications that bring false sense of pleasure (psychological addiction) produce escape from *reality like Cannabis and psychedelics* [200-219].

These are moments that require more attention to the demands of survival pressures at work, meetings with family members, changes in environments and commemorative dates, such as the end of years and birthday, because they activate unconscious schemes for health professionals and friends, with activation of the relapse process [200-219].

Allostatic Mechanisms

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

Clinically, in the first cycle, just after US, central nervous system depression (CNS) occurs, causing frustration, guilt, promises and illusory acceptance. In the second phase, mild CNS arousal occurs, with anxiety, insomnia, irritability, egocentrism, and loss of empathy. In the third stage, there is greater neurological arousal, promoting a state similar to that of hypomania, impulsivity, fissure, risk behaviors of HYPERSEXUALITY US and exaggerated intake of sweet foods, ending in abusive use, psychosis or aggressiveness. Generally, it is divided into three periods of 30 days, having ten days each cycle or variations of periods always divided into three [160-219].

Pathological Demotivation

Pathological demotivation can occur slowly or suddenly after repetitive US, with production of neural substrates. These are molecules with significant behavior change and subtle distortions of internal reality. They present a driving force in the disease, being components of the main neurocircuits that govern motivational tone, leading to the gradual loss of the sense of self-care, premonition and urgency with alexithymia. Then, forgetfulness, anesthesia of guilt, shame and frustration occur, triggering demotivation by intoxication of epigenetic molecules [160-219].

Elusive movements occur in consultations, disinterest in psychoeducation and withdrawal from treatment, causing alexithymia. The moment the patient gains control of the treatment, he also does US and behaves as if nothing had happened, with pathological lies and illusory state of false-positive self-sufficiency [160-219].

In patients who are trying abstinence, but continue to use substances, *be it tobacco, cannabis* or alcohol, demotivation and motivational fall occur. For pre-contemplator or contemplator status, these elements have been largely neglected in the clinic, and in the development of new treatments [160-219].

Fissure

The fissure **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 dopaminergics. At one point, they fire explosively with intense and uncontrollable desire—the fissure itself. In moments of negative mental quality, pathological dopaminergic shots are fatal added to the effects of acute abstinence at the end of the allostatic cycle—a moment of monetary gain and mourning [160-219].

In the fissure, the patient has no sense of consequence and performs crimes, robberies and pathological professional acts [160-219].

Motivation

The pathological basis is motivational: individual motivation, which dictates the progress of gravity, as well as disease control. There are many patients, who do not complete treatment or cease 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 out of shame or by demotivation caused by the substance itself [160-219]. Motivational excitation is a variable that regulates readiness to respond to external stimuli. Although rewards and punishments activate responses regardless of emotional state, reward stimulators are the determinants, making dysfunctional programming of punishments dependent on dopaminergic arousal [160-219].

The motivational classification of Prochaska, DiClemente and Norcross articulates the indication of treatment of the patient. This does not follow the stages in a linear-causal way. When achieving a change, it does not mean that it 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 ordering. We adapt this classification according to the neurochemical pathology of motivation, because, in the precontemplation or in the contemplation itself, the patient does not present motivation, which means that there is no point in

performing an intensive treatment, because this can worsen the situation. In the phase of action and relapse, the patient can try abstinence, without, however, succeeding, but returning motivated. This is the time to seize the moment [160-219].

After repetitive use, the patient is intoxicated with epigenetic molecules and, in view of this, pathological demotivation occurs, returning to the state of chronic contemplator [160-219].

Clinical Case

This is a real clinical case. Currently, the patient is welcomed in traditional CT.

E. N. L. C. S., 34 years old, *married, pathological user of crack, cocaine, cannabis* and, eventually, tobacco, without drug treatment. He denies depression, but refers to impulsiveness and moderate anxiety.

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

It seeks the use of *crack* after 21 days of discharge from traditional CT, where he was welcomed for eight months in abstinence and traditional peer treatment. He says he doesn't 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 linkage, with little father-therapist transference in its conscious and unconscious expressions.

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

Current diagnosis: Z syndrome and primary substance use.

Reports greater affinity with grandparents. The father was absent because he died when he was three years old, and with his mother he had little contact because he worked hard. He reports longing for his son and wife, whom he has not re-found since his reception eight months and 24 days ago.

He reports that his 3-year-old son S. R. C.S., has a similar behavioral condition, leading to the suspicion of autistic spectrum, although he did not perform the investigation. Evaluating its 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.

It does not yet present self-observation ability, but deficit of empathic perception and sensitivity and rapid response with response time conditioned by rigid ratio.

Without knowing it previously, it is possible to diagnose expected mental status of epigenetic molecular neurointoxication of the use of substances, because it was on the fifth day of abstinence.

We identified a functional family neurobehavioral reality unconsciously similar to that of his father, replicating an absent father and husband. We perform psychoeducation of the disease and its egoic states - family, addition and relapse - as well as its possible complications (accidents, mortality, crime, secondary

diseases, chronic abstinence, suicides and neurological sequelae and chronic disease). It is the duty of the doctor and the patient's right to clarify the disease.

Psychoeducation to patients and their families aims to clarify the disease with its family etiopathogenesis, genetic and related to neurodevelopment, 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 performed psychoeducation and identification of their 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 have 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 perform self-observation training, because he would forget the learning.

After psychoeducation, he felt hopeful, excited by the new knowledge, and effortlessly accepted the reception.

We welcomed 12 days of abstinence, and was already discreetly anxious. We started dopaminergic motivational psycho intervention with slow and deep diaphragmatic breathing, *guided by mindfulness with an exercise* in presenting consciousness of internal reality (emotional and thoughts interoception). We slowly perform an experiential moment with happy children's imagination or remembrance.

After being instructed to observe their child (experiential moment), the patient was moved, reporting feeling a lot of joy. At that time, there was a dopaminergic discharge that increased the motivation for treatment (dopaminergic motivational psycho intervention).

Motivational diagnosis: relapse.

Evaluated by the fact that his speech is equivalent to behavior, by the voluntary action of requesting help and by the real desire diagnosed clinically, allied to the complaint of his lack of understanding of the use of substances suddenly, has no control, despite his efforts. It reports that the search action lasted an average of five minutes until the use of substances, because it saw an individual performing it.

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

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

In the first three weeks, the patient presented difficulty in self-observation, using rationalization and limiting beliefs. In the fourth week, anxiety worsened. He triggered us, and we helped him with DBT skills. It was successful.

The following week, he presented a classic episode of relapse, with change in behavior and internal reality, with verbal aggressions and increased egocentrism. He left without communication.

We can not oblige, but we combine exit only with therapeutic companion or after 30 days.

Relapsed. We conduct orientation of urgent skills. After several attempts won by denial, he returned to the previous state.

It evolved with improvement after performing self-observation movement. You've achieved success again. After 35 days of abstinence, the clinical course of the behavioral evolution of the three alostatic cycles was evident. There was no response to the episode of automatic relapse at the third month after the last day of substance use. Like every neurological relapse process, it ended in substance use.

After the use of substances, he depressed, promising not to err again, repeating the alostatic cycles. We've reset the count of days since the last day of substance use. On the fourteenth day of abstinence, he tended to reduce his assistance in hygiene services and garden workshops, with a predominance of conversations with old friends, egocentrism, 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 rental prices, to plan the coming of his wife and son, with no certain date. On the way out of the reception, he used *crack* for three uninterrupted days.

He returned again to CT taken by frustration and guilt, requesting help again. We've reset the relapse calendar count once again.

In the first three days, he presented neurointoxication with slow cognitive processing and light working memory loss. In the evaluation of the pre-use period of substances, he reported anxiety and referred to the need for employment and purchase of the trip of his wife and child.

In the treatment, we showed him the behaviors of the cycles and evidenced when he started the relapse process, from his reports, such as the fissure before the use of substances.

Started the previous day presenting insomnia; planned the new housing, forgetting that we do not think about its exit 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 working with 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 happy, motivated, completing three months of abstinence. We observed, however, the difficulty in managing liability pressures. He requested housing in another environment with wife and child.

We performed clinical and motivational family evaluation and identified Sd Z, since the wife has a reality similar to that of the patient's mother, being absent for the patient and his/her child unconsciously.

The patient also presented asynchrony, with affective absence (unconscious) similar to that of his father. She reported being a father present in the speech, but absent in reality, which

is similar to the father of his wife, who was always at work, according to her own account, clinically confirming her paternal absence.

We performed psychoeducation of both and pointed to the need for treatment of the wife, to assist in the harmful states within the family, prevent the reactivation of the relapse process and prevent the use of substances. We introduced the sense of disease at risk of complication. We deal with the difficulty of successful treatment if the family member does not treat Z syndrome concomitantly. In this follow-up, the patient does not perform treatment and presents recurrence.

The disease is unconscious, underpinating 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 real risk of fatalities, sudden death, accidents, aggressive crimes.

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

It resurfaced with the discourse of resuming treatment, but with the desire to partially perform it (treatment control = contemplator) and describing the whole relapse process, from the choice of bus driving to the purchase of the drug. He consciously chose to use substances after observing the whole process, and finally realized that he did not actually accept to cease use.

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

He continued outpatient treatment and, after 30 days, again used substances, always with the same clinic. His wife hasn't introduced herself since day one.

The patient was able to observe his relapse process, identified after observing co-workers who performed substance use after work. That wasn't reported from the start. He lost his job after us.

He maintained irregular outpatient treatment and started daily smoking, which we contradicted the possibility of pathological demotivation. Even so, he maintained the use of substances. In two weeks, she presented absences in consultations and distancing from treatment. His wife started a job in the same environment, again presenting easy access to the substance.

We had no further contact with both of them. 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 of the local hospital.

He was diagnosed with acute pulmonary edema, with progression to acute respiratory failure, requiring orotracheal intubation. At that time, he presented alcohol breath and orotracheal secretion, according to medical records. He was hospitalized in the Intensive Care Unit with sedation, vasoactive drug use, aspiration pneumonia antibiotic therapy and cardiogenic shock.

He underwent echocardiogram on August 5, 2022, with dilated hypertrophy and moderate left ventricular function. It presented satisfactory evolution. He was discharged from the hospital on the same day, diagnosed with Systemic Arterial Hypertension, being referred to the outpatient service, with a prescription of Hydrochlorothiazide 25mg added to Losartana 50mg, Quetiapina 25mg and Citalopram 40mg.

On August 6th, he came to us on the phone. I was afraid of the certificate and the benefit of the INSS, because I had no desire to return to the outpatient service of the state health system. We indicated treatment with reception in the same week, but did not attend.

On August 8, he came to us via telephone, justifying the lack of his mother's visit, which he would return to his 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, he informed that he was unable to work, because he started work at 2:00 p.m. with an end at 8:00 p.m. At 8:00 a.m. daily, he had a commitment to take his son to school. We advise on the need to return to treatment quickly and reassess the workplace and family treatment, as it almost lost its life in US.

He reported that he had seen the importance of life due to "fright", but said that the current work was important with his wife. His wife works at times inverted by his. He said that he would rest, that he had been able to remain abstinent since July 29, and that the work was important for his control. We requested a return to our service, but he didn't show up. The team sought psychological care at alternative times. After 14 days, he returned with headache and hypersexuality. We asked you to return to CT again, but we had no further contact. There were only two meetings with his wife.

Discussion

The patient presents mechanisms such as staggering allostatic cycles, exhibiting states of classical relapses, in which he ends up choosing the use of substances. However, it presents awareness and real chance of change, demonstrating its difficulty of emotional regulation and its real denial, only perceived in the moment before the substance. In the presence of the family, he presented more difficulty and currently demonstrates elusive behavior. It seems paradoxical, but the unconscious inability to remain peaceful in the family environment is a subtle reality, like that of your parents and many [167-219].

In the case reported, the patient is not effective as a parent (unconsciously), because he is always absent, reproducing the absence of his own father, in the synchronicity present physically or not. His wife also repeats the pattern of his parents [181-219].

The wife has an absent husband, like her father, and she is also asynchronous with her son, who already has hypodopaminergic symptoms. He is intelligent, empathetic, pragmatic and objective, suffering in the absence of his father.¹⁸¹⁻²¹⁹

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

he still chose not to choose and thus, in human reality, to be free is to make choices, but choices in situation, as a field of possibilities to be, for the subject to transform his reality of life" (SCHNEIDER, 2006; 2013). It would be true if he had chosen conscious or semiconscious (intoxicated) [178-219].

The wife's motivation for treatment is nil. Even after being oriented about the need, there was dodging on her part [179-219].

The patient relapsed and used *crack on the* fourteenth day of discharge, after almost losing his life. He was neurointoxicated by 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 CVS in the use of compulsive substances [190-219].

Without freedom of mind, the real autonomy of the child and the patient is hidden in the unconscious, impairing treatment, presenting risk of death, which seems to be neglected by psychologists and religious [160-219].

Currently, we do not have a health policy with an objective medical protocol, and a minimum medical hospitalization of 30 days is necessary, because the neurotoxic patient presented neurological deficit with alexithymia and a real loss of sense of premonition and urgency [160-219].

Their human dignity is not being evaluated, as the patient's will is also not properly evaluated due to Zoe syndrome. The will has different origins: pathological (epigenetic), psychological (in beliefs) and secondary, for relief and pleasure (addition) [160-219].

If we ask the neurointoxicated patient, in which there is pathological demotivation by molecules and "deficiency" in some cases of the sense of gravity, premonition, self-care, the also biological origin, we are not offering the real chance of change, moment when he is most conscious possible, as the family disease that hinders and discourages the patient, in which we must reorganize the entire treatment strategy, because they are difficult, subtle and symbiotic diseases [160-219].

The importance for initial family evaluation, in an organized way, without compromising ethics and morals, is a point for reflection, because returning to the memory of the past and "neuro rights" issues should be reevaluated [160-219].

After reviewing brain functioning, current psychotherapies, with no therapeutic objective based on origin, can neglect and chronicle the conditions of the family and the patient [160-219]. Social reintegration, physical activities and welcoming are fundamental, but they are not the treatment of fact, but accessories. Without the therapeutic process aimed at etiopathogenesis, we do not treat the disease [160-219].

The current evidence-based medicine presented a gap of errors in methodologies without correct matching of different genetic factors for each substance, in the presence of polymorphisms, poly substances, associated psychiatric diseases, neurodevelopment and traumas. We question whether it is the best study, as Jasper and others have suggested, because we still have spiritual issues [189-219].

Studies of psychometric questionnaires in patients that require the sensitivity of the evaluator, diagnoses of motivation and situations of great social stigma, with dysfunction of expectation, and presence of pathological lie make it difficult

to collect information. Without treatment, the patient returns to substance use, suffering from emotional dysregulation due to overwork, sweets or addiction migration, very common work or workaholic [189-219].

Digital Medicine and therapeutic companions are excellent allies in the identification of relapse, assisting with urgent skills to stop relapse, because it is certain the use of substances, if it does not stop. The familiarization of the family and the patient is not simple, as they are afraid of relapse. At first, they suspect all the time, they get scared, until they make the habit [189-219].

New objective strategies for prevention and treatment of mental health professionals are allowed. The best indication is the reduction of damage, as well as the hypothesis of studies of new dopaminergic drugs of specific receptors, according to pharmacogenetics [111-219].

Clinical studies individualize the necessary factors in conscious phases, without inducing relapse processes, preventing complications in their areas.¹⁶⁰⁻²¹⁹

The counting and orientation of the psychopathological calendar and relapse of the cycles of the disease, together with specialized therapeutic companions, are essential factors [144-219].

Abstinence is fundamental, and purify the mind of all these accumulative and mechanisms-dependent effects, ethiopathogenic factors, added together, which is the union of psychological, biomedical and personalized concepts [144-219].

It is a disease with real risk of sudden death by CVS, deficit of the sense of reality (overdose), risk of contracting severe infections by needles and sexual intercourse, loss and damage to property and legal problems [151-219].

Conclusion

The notion of the individual limit of internal and external reality, if the individual presents observation of the cerebral domain is easily observed clinically, shows that the experience and knowledge accumulated, linearly, at that moment, has no effect for those who acquired the fluid intelligence of the treatment of Sd Z [118-219]

The Clinical Evaluation of Evidence-Based Medicine is being lost by the excess of linear thinking that limits clinical reasoning, because only correlating, theorizing, without biological causal link, unconsciously impairs the technological, scientific and human biological evolution advances, which certainly already involute, and genetically the children Z generations of the Internet, will have more difficulty in family relationship [160-219].

This Document proves that all human pain at first is due to neuroadaptation of absence of family synchrony and the dopamine deficit that generates discomfort, hedonism, and no one is to blame, because it was only possible to identify through new studies of family neuroscience, that there was an increase in family quarrels in home confinement, decompensation of dependents, panic syndromes [160-219].

They are two diseases of professional responsibility to human rights. It does not present a record of CEP, we voluntarily work in a humble therapeutic center of 21 years of existence, regulate the Sanitary Surveillance, and does not present a bond and academic yet [154-219].

Conflict of Interest

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, and I described USP disease in May 2022, Z and Zoe Syndrome in September 2022.

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