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Research Article

Addiction Medicine: Z Syndrome and Pathological Substance Use: A Medical Tautochronous Study

Furlanetto ML*

Department of Medicine of Faculty of Medicine of Marilia, Aurora Borealis Support Center, Brazil

Introduction

According to the American Society of Addiction Medicine (ASAM) and the World Health Organization (WHO), chemical dependency is a chronic and progressive disease. But without understanding the etiopathogenic basis of the chronic hypodopaminergic brain state. This state generates restlessness, hedonism, boredom and irritability, and it is as a result of it that, unconsciously, the individual begins to live with dopamine-generating habits.

This condition is present in all human beings, being responsible, with little or very significant effect on neurobehavior, caused by genes, disorders of child neurodevelopment, family synchrony and attachment, in addition to enzymatic deficits that impact emotional regulation, inhibitory controls and social skills (dependent behaviors). Deprived of affective skills, the individual, in the family environment, causes friction, causing harmful or pathological family schemas to be produced, which we group in the Z syndrome(Sd).

Syndrome Z can be considered a "missing link", given that most addictions are secondary, evolving into pathologies (situations of biological damage and other damage) and other clinical diseases such as metabolic syndrome, neglected so far, that share Common neuronal pathways: impulsivity, sexuality, sugar and carbohydrate intake, substance use, and monetary gains. Addictions to sugar (diabetes mellitus), carbohydrates (obesity) and power (corruption and immediate pleasure) present the same clinical picture and the same pathophysiology as some psychosomatic diseases and conversion crises. Zoe syndrome (named in honor of Brazilian Indians) is projected in the professional field due to the unconscious activation of mirror neurons, amygdala systems and parietofrontal systems, which cause brain dysfunctions such as alexithymia and anosognosia, empathy deficit and, in serious, irrationality.

The Sd Z and Zoe syndromes maintain a clinical stakehold with several areas responsible for the human mind, such as neurology, psychiatry, psychology, cardiology, vascular surgery, obstetrics, genetics, endocrinology, plastic surgery, pediatric surgery, anesthesiology, intensive care unit, internal medicine, pediatrics, dermatology and immunology. Its etiopathogenesis can begin during pregnancy and progress to old age, such as Alzheimer's disease.

Chronic Hypodopaminergic State Newborn (Rn) Child or Adult

- Speech delay up to four years of age Irritability
- Hypoactivity in seeking breastfeeding Frequent crying
- Eczema
- Persistent fever with no known cause (emotional fever) Empathy and fluid intelligence
- Sudden and exaggerated excitation of the sympathetic autonomic nervous system
- Elevated heart rate Slight pupil enlargement
- Subitization in geometric readings Difficulty in mathematics

***Correspondence to**: Mario Luiz Furlanetto Junior, Department of Medicine of Faculty of Medicine of Marilia, Aurora Borealis Support Center, 17519-060, Marilia, SP, Brazil, Tel: +55 14 3306-4354; E-mail: furlanettojr@hotmail.com

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- 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 Deficit of hygienic control
- Sensory habits, such as exploring smell and touch, when calm
- Trichotillomania, onychophagia and other compulsions during anxiety episodes Constant duality
- Constant insecurity Boredom
- Intensity
- Explicit kindness Irritability in routines Eve disorganization
- Deficit of the executive function Emotional instability
- Anxiety
- Attention deficit and concentration Accelerated pace of thinking Indisposition
- Nocturnal fatigue after activities involving automatism Pragmatism
- Organizational indiscipline Excesses
- Habits that use dopamine Impulsivity
- Sugar and carbohydrate affinity Exaggerations at night Procrastination Hyperactivity/hyperkinesis Constant search for news
- Hypersensitivity and pain intolerance Alexithymia
- Shyness Social isolation
- Fluid intelligence
- Hyperfocus on preferred activities
- Multiple relationships or difficulty in marital bonding Early passion addiction
- Need for validation Hypersexuality Survival manipulation Perfectionism
- Concern for others, not self
- Initiation of several activities or projects simultaneously Affinity to caffeine and energy drinks
- Sensory stimuli
- Inability to deny assistance
- Adrenaline dependent habits
- Attraction to extreme sports and complex and challenging activities Excessive work
- Insomnia
- High risk of developing pathological substance use and depression (60%)

Keywords: Etiopathogenic; Hypodopaminergic; Neurobehavior

Objectives

Main Purpose

The main objective of this study is to evaluate the impairment in the autonomy of a patient who is at risk of death, due to associated and neglected pathological mental states.

Secondary Objectives

The secondary objectives are:

a) Promote the real free will of each human being, which still prevails the cerebral influence;

b) To provoke reflection from the medical, scientific, legal, family, political, religious and world communities on what is common to every human being, regardless of ethnicity, since this depends on child neurodevelopment and maternal relationships;

c) Carry out psychoeducation for the collective diagnosis of Zoe syndrome;

d) Evidencing that all the knowledge presented was acquired during the journey of truth and life and the search for learning, love and the Gospel;

e) Humbly request the opening of the addiction medicine specialty in Brazil.

Materials and Methods

The construction and scientific development of this work took place through clinical observation in a practical field precisely, the Aurora Boreal Therapeutic Center, a philanthropic organization located in the city of Marília, in São Paulo, during a period of one year, combined with the study intensive scientific articles. Although it was not the initial objective, this work evolved as the first tautochronous scientific study, with ethnographic scientific methodology, literature review, case report and medical report, with the professional force of a medical act.

An active search was carried out for scientific articles, especially 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. The search returned 45,432 studies for the first, 177 studies for the second, and 31,544 for the latter. An active search for studies on attention deficit hyperactivity disorder (ADHD), consciousness, genetics and epigenetics, relapse to substance use, neurobiology of addiction, neurodevelopment, neurobiology of sensitivity, simultanagnosia, dopamine, neuroadaptations, pregnancy and use was also carried out. substance abuse, obesity, autism spectrum, smoking, neuroscience of automatisms, alexithymia, Cannabis, methamphetamine, cocaine, anosognosia and substance use disorder (SUD).

We carried out the description of the clinic of relapse throughout that year, associating the current studies of neuroimaging, behav-

iors, genetics and epigenetics of the TUS and discarding theories and philosophies without any biological nexus. We also describe the technique of evaluating the peripheral mind, without invading the individual's intimate forum, through the concealment of clinical and semiological techniques based on neurosciences of automatisms, technical skills for evaluating the unconscious and the conscious of psychoanalysis, dialectical behavioral therapy (dialectical behavior therapy [DBT]), Young's schema therapy, human neurodevelopment, clinical medicine and neurology and semiology of neurological systems allied to the semiology of eye, pupillary, saccadic and anti-saccade movements .

Pathogenesis

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

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

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

Pathological substance use or substance addiction: psychological or biological addiction to the use of psychoactive and/or psychedelic substances, with tissue damage and secondary complications added to the inability to stop the habit and prioritization of substance use, consciously or not, in the absence of Z syndrome.

a) Primary pathological substance use: substance use addiction or pathological substance use secondary to syndrome Z, in the presence of allele genes and/or polymorphisms that cause specific clinical states and significant alterations in psychic functions and behaviors of variable duration. It has several mechanisms: production of dysfunctional histone enzymatic complexes; dopamine transporter dysfunction (dopamine transporter [DAT]); lasting molecules produced by genes in the presence of substance use; chronic abstinence; pathological demotivation; relapse neurogenetic processes; fissure; compulsion for enzymatic deficit of inhibitory control; emotional dysregulation; allostatic cycles; morphological changes in dopaminergic receptors, mainly D2; neuronal migration; hypodopaminergic neuroadaptation; dysfunction of synaptic connectivity, which can decompensate for previous disease or bring about secondary complications; and specific conditions of substance use, such as depression induced by epigenetic mechanisms such as opioids and alcoholics.

b) Secondary pathological substance use: substance addiction in the presence of Z syndrome and absence of genes, without specific clinics. It is easier to treat with abstinence. It presents common tissue adaptation, such as enzymatic alterations of hepatic clearance, dosage intolerance, acute withdrawal syndrome, use of substances unaware of their relieving function in the family scheme and escape from reality.

Hepatotoxic injury: cirrhosis, steatosis, hepatocarcinoma.

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

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

Acute and chronic cardiovascular injuries: cardiac arrhythmias, dilated cardiomyopathy (a case to be reported), excess alcohol that impairs myocardial contractility leading to systolic dysfunction and ventricular dilatation, due to mitochondrial damage to the myocyte, and alcoholic cardiomyopathy.

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

GENETICS + ADDITION = PATHOLOGY

- Addition with tissue sequelae
- Addiction with social-family damages
- Addition with criminal implications
- Unconscious addition of syndrome Z

Zoe syndrome is severe, having massive pathological effect.

Hierarchical Nosology of Syndrome Z

1. Maternal causes/hostile pregnancy (maternal hypoxia, placental dysfunction, intrauterine growth restrictions, prematurity, substance use, etc. → Intrautero

and/or

2. Genes specific for hypodopaminergic states (Genome Wide Association Studies [GWAS]) → hypodopaminergic NB (differential diagnosis with ADHD and AS)

and/or

3. Adverse Childhood Emotions (with or without genetics) (NB to 3 years)

and/or

4. Childhood adversity and post-traumatic stress disorder (PTSD) (abandonment, trauma, abuse, grief, rape, surgery, etc.)

and/or

5. Concomitant psychiatric disorders (concurrent specific genetics): bipolar depression, ADHD, AS, anorexia, obsessive-compulsive disorder.

and/or

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. Addition to sugar or work (workaholic), internet, games of chance, power, etc.

and/or

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 lesions of neuronal immune complexes.

and/or

9. Chronic hypodopaminergic elderly: family schemas, trauma, frontotemporal cerebrovascular accident (CVA), grief, senility, dementia, Alzheimer's disease, irritability, post-retirement depression or after the family member returns for care.

Z Syndrome

Currently, there are several concepts. We chose to group the disorders of family relationship, family alienation, attachment disorder, pathological love, emotional dependence and Münchhausen syndrome into just one. The sciences of law need this new conception to adjust the true justice.

Syndrome Z presents a significant distortion in the clinical pictures of fear, which are rich in slips, differing from behaviors and reality.

This work clinically corroborates the findings of the Canadian study of "Hostile and Useless" (HH) mental states, carried out at the Université du Québec à Trois-Rivières, as well as other meta-analyses. Lyons-Ruth et al. (1999) 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) a bad sense of self. fMRI studies show that maternal love (thalamus, substantia nigra, and left putamen regions) and romantic passion, attachment, and marital relationship (bilateral ventral tegmental area) present common neurodevelopmental disorders. Such disorders are orchestrated by oxytocin, vasopressin, and cortisol-dependent neuronal pathways, in conjunction with the brain's reward system. They show important neuronal activity in the cognitive-affective regulation of attachment, along with the desire to combine interests in love behaviors.

Neurobiology of Family Synchrony

Familial affective synchrony develops in human beings in the first three years of life. It begins with the stimulation of 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 until the age of three, according to the explicit and implicit reality of the parents, due to cortical, frontal, inferior and left mirror neurons (Broca's area) and to the arcuate fasciculus (Korsakoff's 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 reception. The brains of newborn boys block pain, disaffection, absences and trauma from the mother, and the brains of girls operate the same in relation to the father.

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

FMRI studies in adults with stimulation showed increased activations of neuroadaptation in the thalamus, brainstem, amygdala, hippocampus, anterior cingulate cortex (anterior cingulate cortex [ACC]), insula and temporal cortex.

These are the same regions of parenteral and infant attachment. These studies also showed parallel neuronal activities in the anterior paracingulate cortex and 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 unable to effectively stimulate her child, as her (biologically dependent) abilities were not neurodeveloped by her absent and unconscious parents.

At the same time, 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 in an intergenerational way, in a zigzag format (Z syndrome), since the beginning of time.

Diagnosis of Syndrome Z

Through clinical anamnesis, family tautochronous assessment or simple observations of already produced acts, we assess the neuroadaptive behavior common to every human being, without invading the intimate forum. This is how the diagnosis of syndrome Z is carried out in up to three generations, with observations and simple questions, as in the following case. These observations are exempt from the judgment of the conscious and the unconscious, verifying if the speech equates to behavior and reality (effect).

We compare the reality of family affection for three generations, simultaneously observing the unconscious and the conscious, body and verbal languages and behaviors. Then, we identify if there is a synchrony of family affection or if, unconsciously, the family members reproduce the same realities as their ancestors, with secondary gain.

5.3. Child Z Syndrome

The hypodopaminergic newborn (NB) has always been neglected, without protocols and attention to their clinical characteristics, such as few reactions, variations of the sympathetic nervous system, with high heart rates, reaction to light, facial expressions, crying, and lack of identification. child genius clinic. Children who show maturations only of the amygdala brain systems, with survival learning, develop only dense intelligence, as they are not taught emotional intelligence, and do not explore internal reality. The imagination

that has a function, of creative development, is exterminated by normopathic parents.

The clinic is sovereign in neuropsychological assessment in relation to psychometric instruments. We are in a period when it is easy to identify irrationality. Professionals dependent on these exams are evaluating brains with a predominance of egoic mind, of survival, taught by parents, by society, or due to trauma neuroadaptation, with a predominance of dense intelligence. Another problem to reflect on are children with severe neuropathies, which the prevention of seizures has only been a medical concern in many cases, and we remember that it 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 Syndrome Z, with hypersensitivity, for several hospitalizations, child surgeries, chronic states of pain, discomfort, and sadness, which do not express the suffering of unspoken sequelae, and observed.

The diagnostic suspicion of Autism Spectrum (AS), Attention Deficit Hyperactivity Disorder (ADHD), Hypodopaminergic State and childhood obesity secondary to Z syndrome, is a new reality to reassess, seeking to improve the assertiveness of diagnoses, which can be harmful to health. parents' mentality. The immunological drops that cause repeated infections, and the exacerbated responses of the immune systems, with hyper inflammatory reactions, such as bronchitis, atopic dermatitis, emotional fevers, can be simultaneous in Syndrome Z, and severe neuropathies.

The hypodopaminergic child evolves with depression of the neurological state, conversion syndromes, speech delays, hypersensitivity, as etiological factors are added, such as affective absence of parents, bullying, psychological capacity of family, professionals and society, generating aggression, introspection, and shame. Innate genius has less suffering from emotional dysregulation, as it has dopamine-producing neuronal networks, and allows for the development of fluid intelligence, in the right cerebral hemisphere.

I humbly request the Societies of Pediatrics, Neurology and Child Psychiatry, to evaluate the current diagnosis, in the face of the diseases of severe Chronic Degenerative Encephalopathies, ADHD, AS, emotional fevers, conversion crises (with discreet lip cyanosis), and situations of genius and empathy, to collaborate in Addiction Medicine, as the window is often in early childhood.

Professional Disease or Zoe Syndrome

In the professional field, we honor the Zoé indigenous tribe of the Brazilian past, which went through a situation similar to that of the Zoe syndrome. The neuroadaptive activation of mirror neurons and amygdala systems occurs by identifying situations, objects and people, such as doctors, therapists, teachers, religious leaders and political leaders, concomitantly with the neuropsychological mechanisms of transference and countertransference.

With all professions and positions that symbolize roles of paternal or maternal authority, there is some intensity of transference, always unconscious, and this leads to the activation of family-like schemas, which can generate pathological, negligent and abusive professional acts, which must be diagnosed first, before character is judged.

Zoe syndrome is the projection of familial schemas associated with simultanagnosia (inability to identify multiple objects at the same time), alexithymia (inability to observe oneself) and anosognosia (inability to effectively observe others). It characterizes neurological blindness and, when evidenced, produces avoidance, denial and aversion, causing the individual not to perceive the disease itself.

Without ophthalmologic deficit, but with functional attention deficit, subjects who suffer from this condition do not identify the "thief in the room", which is caused by dysfunctional frontoparietal hemineglect or, in other words, diabolic work, in honor of the Holy Bible.

It has been described, in a more severe form, by frontoparietal ischemic brain lesions, in Hanton syndrome, or in lobectomy brain surgeries of the same lobes. Presents clinical prejudgments, denial of the problem, predominance of rational illusion and inability to self-care or empathy. In the angiology clinic, it occurs when the patient has a lower limb amputation due to peripheral arterial disease and smoking. Even so, he does not stop using this drug, without fear of suffering a new amputation.

Pathology, in science, religion, medicine, law, politics, culture and religion, is diagnosed. Under reason, science and unshakable faith, we arrive at the irrationality of science, like many redundant scientific studies on the topic of addition.

Pathogeny

Dopamine has several functions in clinical practice, being fundamental in assertive behaviors. Only self-reflection and self-knowledge do not allow real individuation. In order to really know oneself, 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 their initiation, and they themselves produce dopamine during their performance.

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

The right hemisphere participates in the perception of emotion, and functional disturbances are due to interhemispheric transfer 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 folly with professional responsibility.

We call attention, with humility and love and without judgment, to the direction that occupational disease, religious disease, judicial disease, cultural disease and spiritual disease are taking. They are on the opposite path of everything that is preached, spoken and promised, especially considering those who abuse power, who make the diagnosis of the disease explicit and, secondarily, denounce the crime automatically.

A fair and real trial should only be carried out after excluding the pathology, with the help of forensic psychiatry, religion, culture, politics, human rights and the laws of law. The State has an obligation to provide the treatment.

Emotional and fluid intelligence is a constant and active training in self- observation and in habits that produce dopamine. These stimulate dopaminergic neuronal growth, bringing interaction between the cerebral hemispheres. Dense intelligence is rigid specific knowledge, which, however, produces irrationality after long periods.

These are habits that 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. childish.

The diagnosis of Zoe syndrome is performed in the same way as the tautochronous family assessment, but with a projection to professional neurobehaviours, without invasion of the intimate forum.

Zoe Syndrome and Psychopathy

In psychopathy, the patient has response modulation dysfunction. Your attention plays a crucial role in moderating fear and self-regulation deficits. Response modulation involves the temporary suspension of the dominant response set and produces rapid change, simultaneously, in the organization's attention and in the implementation of the response of interest, playing the victim. In coherent response modulation dysfunction, the patient ignores, does not accept, avoids or retaliates and manipulates people or systems in his favor.

Contextual information already performs crucial diagnosis in your behavioral assessment.

Psychopaths are arrogant and consider themselves superior; they despise the world and the people around them, displaying antisocial behavior. They show hatred when they are deceived or defeated, especially when others use their own grandiosity and egos against them.

Psychopaths do not feel anxiety and do not show empathy and a sense of premonition and consequences in the future. They abuse with pathological "manipulative truths". Unconsciously, they always leave clues or traces in pathological crimes.

In the hypodopaminergic state, they present an inverse clinic: they are anxious, empathetic, intense, kind and intelligent, and the pathological lie is told for survival, according to the dysfunctional formation of attachment in the childhood phase.

The big difference between psychopathy and Zoe syndrome is the genius of dense intelligence in psychopathy, which brings harm to others, like any personality disorder. Zoe syndrome presents genius of dense and fluid intelligence.

Treatment

Individual, Family and/or Systemic Psychoeducation

Teaching skills is different from mentoring and psychoeducation. It can be harmful, producing domestic quarrels, as is currently the case. Affective family skills must be trained, ensuring their effectiveness with psychoeducation. The treatment of schemas ingroup is important to show family members and patients the situations of activated schemas, with denial or avoidance being an automatic response (adaptive brain mastery over its essence).

Schema therapy and DBT, combined with neurodevelopmental psychoeducation and the unconscious reality of the reproduction of 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.

The 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 thinking is a fundamental movement, identifying only the emotions, felt in the same second. We have 187 emotions per second; we can't even name four of them. This requires training and persistence, until the movement is automated.

In functional neuroimaging studies, self-observation movement deactivates the automatic amygdala systems and activates the system in the occipital lobe. It is the literal moment of encounter with our essence.

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 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 perform effective treatment are easily observed in the clinical diagnosis, with denial, aversion, avoidance, criticism or lack of consideration of the disease, not fully identifying their behaviors, Cicling Alostatic.

Psychointervention

Dopaminergic Motivational Psychointervention

We ensure the effectiveness of self-observation with self-observation

training, teaching, guiding and clinically showing the moment when the brain survival system invades essence (or spirit). Whenever there is rationalization, taxation or avoidance before self-observation, it can be said that there is an automatic neuroadaptive behavior, with duality, uncertainty, denial and aversion.

When we ask what emotion you feel in the current second, the quick answer, in the third person, leads to the use of a verb or a justification from the past, future or knowledge, and you can also automatically respond with another question (avoidance). Responding with "nothing" is evidence that the skill of observing has not been learned; is the clinical diagnosis of alexithymia and, consequently, simultanagnosia.

Memory Reconsolidation Psychointervention

"As with all surgery, the surgeon should not perform it if he does not understand the anatomy and physiology of the organ or if he does not know how to treat its complication."

In the sensitivity arising from the empathic professional bond, and with the patient's permission, we indicate the psychointervention of memory reconsolidation. It is about the continuity of motivational psychointervention.

Continuing the motivational psychoeducation, combined with 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, destabilization initially occurs, if it is remembered with the therapist, due to the transference of the father or mother. When the patient presents relaxation and empathic bonding, we begin the process of reconsolidation through guided intervention, which can last for weeks, until the therapist works through the entire resignification, performing reconsolidation instead of extinction.

Pathological Use of Substances

According to the National Institute on Drug Abuse [NIDA] and the ASAM, there is genetic vulnerability to drug use responsible for 50% of cases, with the remaining vulnerabilities being the sum of social factors. , psychological, environmental, family and psychological. There are specific genes for specific substances, thus totaling more than seven thousand genes. Pathological substance use may be primary, in the presence of those genes that produced clinically identifiable pathological mental states. Secondary pathological substance use is a consequence of the Z syndrome.

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

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 long-lasting molecules.

In addition to (1) dose-effect amount tolerance and (2) acute withdrawal syndrome, there are mechanisms that conform to the amount of inherited genes, such as (3) craving, (4) loss of inhibition of control after rampant substance use, (5) chronic withdrawal (hypodopaminergic, depressive, and anxious states), (6) pathological demotivation caused by molecules produced in repetitive substance use, which cause a sudden motivational drop for the contemplator, (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 to psychological processes, behaviors there, travelers, limiting beliefs, thought distortions and negative emotions that are potentiated in the first 30 days by the acute withdrawal syndrome.

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 cross-activation of cocaine genes, causing immediate and relapse states. until ten years later.

Chronic Abstinence and Sequelae

Chronic abstinence is the 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 sequela by 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 a neuropsychic and genetic state, more precisely a classic and momentary pathological complex, which aims at substance use, orchestrated by 4% of global sensitized neurons. It

can be activated in minutes or weeks before actual use. It presents rich signs of the unconscious, such as slips that always end in use. It can 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.

From a previous mental state (Z syndrome), it can be said that there are several triggers that activate the relapse process. This has as an unconscious objective the use of substances, by which the patient forgets some values and narrows the limits of morality; ambivalence becomes predominant, with loss of 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. If substance use leads to a "neurotoxic mind" and activates sensitized dopaminergic hypermodulatory systems, it causes 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 familiar schemas and 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 D2 receptors of low density.

In prolonged abstinence, there is a slow and gradual decline 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 from this period, there are no more neuroepigenetic processes and adaptations, and the patient returns to the state prior to substance use, with remission or maintenance phase occurring.

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

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

Attention to care with medications and situations that activate shared neuronal pathways in common serve to prevent reactivation of the relapse process. Trauma, monetary gain, 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 the demands of survival, 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 schemas for health professionals and friends, with the activation of the relapse process.

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

Clinically, in the first cycle, right after substance use, central nervous system (CNS) depression occurs, causing frustration, guilt, promises and illusory acceptance. In the second phase, mild excitation of the CNS 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, craving, risky substance use behaviors, hypersexuality and exaggerated intake of sweet foods, ending in abusive use, psychosis or aggression. Generally, it is divided into three periods of 30 days, with ten days each cycle or variations of periods always divided into three.

Pathological Demotivation

Pathological demotivation may occur slowly or suddenly after repetitive substance use, with production of neural substrates. These are molecules with significantly altered 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 tone, leading to the gradual loss of the sense of self- care, premonition and urgency with alexithymia. Then, forgetfulness, the anesthesia of guilt, 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 uses substances and behaves as if nothing has happened, with pathological lies and an illusory state of false-positive self-sufficiency.

In patients who are trying to abstain, but continue to use substances, whether tobacco, cannabis, or 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 stems from the expectation of the possibility of substance use and, thus, incubates such a silent motivation by the neurons responsible for orchestrating the relapse complex and the dopaminergics. At one point, they explode explosively with intense, uncontrollable desire—the urge itself. In moments of negative mental quality, pathological surges of dopaminergics are fatal, in addi-

tion to the effects of acute withdrawals 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 performs crimes, robberies and pathological professional acts.

Motivation

The pathological basis is motivational: individual motivation, which dictates the progress of severity as well as disease control. There are many patients, who do not finish the treatment or stop 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 the readiness to respond to external stimuli. Although rewards and punishments activate responses independently of emotional state, it is the reward stimulators that 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. It does not follow the stages in a linear-causal fashion. When achieving a change, this 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 ordering. We adapted this classification according to the neurochemical pathology of motivation, because, in precontemplation or contemplation itself, the patient has no motivation, which means that it is useless to undergo intensive treatment, as this can worsen the situation. In the action and relapse phase, the patient may try abstinence, without, however, being successful, but returning motivated. This is the time to seize the moment.

After repetitive use, the patient is intoxicated with epigenetic molecules and, in the face of this, pathological demotivation occurs, returning to the state of chronic contemplator.

Clinical Case

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

E. N. L. C. S., 34 years old, married, pathological user of crack, cocaine, Cannabis and, eventually, tobacco, without drug treatment. denies depression, as refers to impulsivity 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.

Search for the use of crack after 21 days of discharge from the traditional TC, where he stayed for eight months in abstinence and traditional treatment in pairs. She says she does not understand the reason for using substances on the fifth day of abstinence. In the initial assessment, we observed motivation to change action and easy therapeutic attachment, with little parent-therapist transference in its conscious and unconscious expressions.

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

Current diagnosis: Z syndrome 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 wife, whom he has not seen since he was welcomed eight months and 24 days ago.

She reports that her 3-year-old son S.R.C.S. has a similar behavioral picture, leading to the suspicion of autism spectrum, although she did not carry out 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 speech (self-deception), which diverges from behavior and reality.

He still lacks self-observation skills, but deficits in empathic perception and sensitivity and rapid response with a response time conditioned to rigid reason.

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

We identified a familial functional neurobehavioral reality unconsciously similar to that of her father, replicating an absent father and husband. We carry out psychoeducation on the disease and its ego states family, addiction and relapse as well as its possible complications (accidents, mortality, criminality, secondary diseases, chronic withdrawal, suicides and neurological sequelae and disease chronification). It is the physician'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 have significant effects on self-care perceptions.

and empathy. In the different pathological neurobehavioral states or 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 the 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 didn't do self- observation training, as he would forget about learning.

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

We welcomed him with 12 days of abstinence, and he was already discreetly 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 carry out an experiential moment with imagination or a happy childhood memory.

After being instructed to observe his child (experiential moment), the patient became emotional, reporting feeling very happy. At that time, there was a dopaminergic discharge that increased motivation for treatment (dopaminergic motivational psychointervention).

Motivational diagnosis: relapse.

Assessed by the fact that his speech is equivalent to the behavior, by the voluntary action of asking for help and by the clinically diagnosed real desire, allied to the complaint of his sudden lack of understanding of substance use, he has no control, despite his efforts. He reports that the search action lasted an average of five minutes until substance use, as he saw an individual performing 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 for the psychological one. These goals would be evaluated by negativity of passivity.

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

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

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

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

He had a relapse. We carry out urgent skills orientation. After several unsuccessful attempts by denial, he returned to his previous state.

He evolved with improvement after performing a self-observation movement. He was successful again. After 35 days of abstinence, the clinical behavior evolution of the three allostatic cycles was evident. He was not aware of the automatic relapse episode in the third month after the last day of substance use. Like all neurological relapse processes, it ended up in substance use.

After substance use, he became depressed, vowing not to make mistakes again, repeating the allostatic cycles. We have restarted counting the days since the last day of substance use. On the fourteenth day of abstinence, he tended to reduce his assistance in the hygiene service and in the vegetable garden

workshops, with a predominance of conversations with old friends, egocentrism, preference for more extravagant clothes, insomnia and daytime sleepiness.

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

He returned to the CT again in frustration and guilt, again asking for help.

We restarted the relapse calendar count once again.

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

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

He started the previous day with insomnia; he planned the new home, forgetting that we do not consider their 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 relapse specialist therapeutic agent monitoring.

In November, the wife and son arrived, and she stated that treatment would be a priority (26 November 2021). He evolved happy, motivated, completing three months of abstinence. We observe, 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 syndrome Z, since the wife has a similar reality to the patient's mother, being unconsciously absent for the patient and her child.

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 her paternal absence.

We carried out psychoeducation for both and pointed to the need for treatment for the wife, to help with harmful states within the family, prevent the reactivation of the relapse process and prevent substance use. We introduced the sense of illness with risk of com-

plication. We deal with the difficulty of successful treatment, if the family member does not perform the treatment of syndrome Z concomitantly. At this follow-up, the patient does not undergo treatment and has 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 death, accidents, aggressiveness and crimes.

After four months, he referred to a return to the relapsed state for two moments identified after small domestic disputes. After completing six months of abstinence, he relapsed and uses crack for three consecutive days.

He resurfaced with the speech of resuming treatment, but with the desire to carry it out partially (treatment control = contemplator) and describing the entire relapse process, from choosing to drive the bus to buying the drug. He consciously chose to use substances, after observing the entire process, and finally realized that he did not actually accept to stop using it.

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 entire process. This is his real chance of choosing will. The will, however, was not being evaluated, prevailing the will of those who "treat" him.

The outpatient treatment continued and, after 30 days, he used substances again, always with the same clinic. The wife has not introduced herself 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 reported from the beginning. He lost his job after substance use.

He maintained the irregular outpatient treatment and started daily smoking, which we contraindicated due to the possibility of pathological demotivation. Even so, he continued to use substances. In two weeks, he showed absences in consultations and detachment from treatment. His wife started working 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 of 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 medical records. 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 showed satisfactory evolution. He was discharged from hospital on the same day, with a diagnosis of Systemic Arterial Hypertension, being referred to the CAPS (outpatient service), with a prescription of Hydrochlorothiazide 25mg plus Losartan 50mg, Quetiapine 25mg and Citalopram 40mg.

Family Tautochrone Assessment of Z Syndrome (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.

She mentions that her pregnancy was troubled and that she was rejected by her father, according to her mother, because she was taking medicine to avoid getting pregnant.

Doctor: Can you remember two "good" traits of your father and two "bad" traits?

Patient: "Good": funny; do not remember. "Bad": irresponsible and lacking in 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

The youngest of four children, with an eight-year difference between her and her closest brother.

Doctor: Can you remember two "good" characteristics of your mother and two "bad" characteristics of you?

Wife: "Good": hardworking and faith. "Bad": suspicious and systematic.

Doctor: Can you remember two "good" characteristics of your father and two "bad" characteristics of you?

Wife: "Good": faith and hardworking. "Bad": stubbornness and recklessness. She reports that her father was present during her childhood.

Patient's Mother

First planned daughter. No problem during your pregnancy.

Doctor: Can you remember two "good" characteristics of your mother and two "bad" characteristics of you?

Patient's mother: "Good": hardworking and caring. "Bad": liar and victimist.

Doctor: Can you remember two "good" characteristics of your father and two "bad" characteristics of you?

Patient's mother: "Good": honest and companion. "Bad": very anxious and forgetful.

She reports that her father was present during her childhood.

On the 6th of August, he contacted us by phone. 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 (CAPS). We indicated treatment with reception in the same week, but he did not attend.

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

On August 9, he informed that he could not afford it, because he started work at 2 pm and ended at 8 pm. At 8 am, daily, she had a commitment to take her son to school. We advised him on the need to return to treatment quickly and reassess the work place and family treatment, as he almost lost his life due to substance use.

He reported that he had seen the importance of life due to the "scare", but said that the current job was important with his wife. The wife works off-hours had to his. He mentioned that he would rest, that he had been able to remain abstinent since July 29 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 sought psychological care at alternative times. After 14 days, he returned with headache and hypersexuality. We asked him to return to CT again, but we had no further contact. There were only two meetings with the wife.

Discussion

The patient presents mechanisms such as staggering allostatic cycles, exhibiting classic relapse states, in which he ends up choosing to use 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 had 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 case reported here, the patient is not effective as a father (unconsciously), as he is always absent, reproducing the absence of his own father, in synchrony, 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 builds himself and defines himself as a being. In the exercise of freedom, man becomes man in the action and responsibility 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 a situation, as a field of possibilities of being, for the subject. transform their reality of life" (SCHNEIDER, 2006; 2013). It would be true if he had chosen conscious or semi-conscious (intoxicated).

The wife's motivation for treatment is nil. Even after she was told 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 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 CVE from compulsive substance use.

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

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

Their human dignity is not being evaluated, as the patient's will is also not evaluated correctly because of 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 by molecules and "deficiency" in some cases of the sense of gravity, premonition, self-care, the biological origin, we are not offering the real chance of change, a moment when he was as 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 way, 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, with no therapeutic objective based on origin, can neglect and chronify the conditions of the family and the patient.

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

Current evidence-based medicine has 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, neurodevelopment and trauma.

Studies of psychometric questionnaires in patients that require the sensitivity of the evaluator, diagnoses of motivation and situations of a lot of social stigma, with dysfunction of expectation, and the presence of pathological lying 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.

Digital Medicine and therapeutic companions are great allies in the identification of relapse, helping with urgency skills to stop the relapse, as the use of substances is right, if it does not stop. Familiarizing the family and the patient is not simple, as they are afraid of relapse. In fact, at first they suspect all the time, until they create the habit.

It allows new objective prevention and treatment strategies to mental health professionals. The best indication is harm reduction, as well as the hypothesis of studies of new dopaminergic drugs of specific receptors, according to pharmacogenetics.

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

The counting and orientation of the psychopathological and relapse calendar of disease cycles, combined with specialized therapeutic companions, are essential factors.

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

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

Conclusion

I need worldwide help to solve the real problem, such as the aforementioned clinical case, and treatment of Pathologies in the spheres of Medicine, Culture, Religion, Law and Politics.

This scientific article has true and simultaneous interpretation, regardless of ethnicity, and it is a medical report, Medical ATO, Clarifying, for all human beings, as it does not depend on ethnicity, culture, or country exclusively. It refers directly to human rights, and its disobedience is a crime against humanity, and neglects human health with professional responsibility.

It is faithful to the Code of Ethics, oath of Medicine, Human Rights. This document makes an individual and collective pathological diagnosis, mainly of professional, political, religious, judicial and family pathologies, according to the individual reaction, which highlights the severity of the pathology and denounces the crime.

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