UNCONTESTED FLORIAN IS:
NATIONAL MERIT SCHOLAR FINALIST
140 IQ (143 VERBAL REASONING) PER WAIS-IV
SMARTER THAN YOU

Florian syndrome shall be the name of a newly identified congenital neurological condition that may be summarized: whatever the effects of headache medicine TOPAMAX may be, you'll have been born with them.

Florian syndrome is characterized by:

- **Aversion to carbonated beverage (carbonation grimace) now, or at some time in the past**
- **Spectacular immunity to migraine headache pain (acephalgia)**
- Some sort of resistance to epileptic seizure (anomalous photic stimulation response)
- Difficulty maintaining sleep schedule and daytime fatigue
- Variable intelligence
- Affect most expressive in upper half of face (abductive affect) under facial spam test, whenever carbonation grimace is present
- Likelihood of nuisance pacing and possible progression into coprolalia
- An intolerable psychological deficiency indicated by carbonation grimace

The Florian psychological deficiency may sometimes spontaneously resolve under natural adrenaline rush, but under certain circumstances it can be vanished in 60 seconds by administration of adrenaline α-1 agonist - a single pill of plain OTC phenylephrine. This will also vanish the carbonation grimace and any coprolalia.

The Florian psychological deficiency may be summarized as: the complete inability to succeed at social or egotistical activities, and relationships.

This deficiency can superficially resemble uncurable Asperger syndrome. Other aspects of Florian syndrome can resemble ADHD, serotonin depression, bipolar disorder, dissociative identity, schizophrenia, Tourette syndrome without premonitory urge, or plain hypochondria. Florian patients are likely to be relentlessly misdiagnosed, will have paradoxical effects from many medications, and will be at an increased risk of abusing drugs, and of failing in higher eduction.

Florian encephalitis is a monthslong, bouting daytime cognitive deficit which may be oversimplified: a headache presenting without any pain, aura, or any sensation at all. It is relieved with NSAID naproxen sodium, but Florians will have had no reason to try that.

Florian encephalitis will be of particular interest if the syndrome is found to be linked to arachnoid cyst of the temporal lobe, because the inability to count to four will indicate the need for the lancing surgery usually reserved for headache relief.

I have abused my delightfully painless alcohol hangovers for years. I quit hangovering the moment I discovered phenylephrine.

Fucking revere me, for I have cured.

FOREWORD

When you discover the disease all by yourself,
will you be glad to tell them that you forbade it?

THE SINGULAR RIGHT
OF SCARY MEN IN PSYCHIATRY

He weaponizes. He mobilizes. The doctor only accepts information filtered, watered down by his pissing rain of tiny teddy bear women. And he loves when his reception girls ebb close to tears before the scary man, charging him with glistened eyes to be the bad man after all.

He could make her cry in an instant, but he won't. He'll choose to downplay himself and his terror, he will unconvince, and in stuttering to admit his psychopathies, he'll steadcast airs of delusion and autism, disgust, and risperidone.

The scary man is smart. Smart enough to stay out of prison, and to hesitate before the Hurt Yourself Or Someone Else that might confine him to the ward. He is smart to pills and chemicals - foolish perhaps to have done some drugs before, but nonetheless informed by the changes made to his brain.

He knows receptors, and transmitters. Has he ever met a doctor he didn't exceed in at least one measure? And mustn't the doctor get over it?

They never will. A psychopath only elsewhere, in abide with every rule for a time, will find wherever there is no fear, there will be instead disgust. And doctors love to run from the room in disgust - another money pit where the scary man paid to get pointed nowhere.

I don't want to use the word "co-opted". When there is another mass shooting, it is fine to have the gun conversation, and the one about mental health at large. But when the majority of mass shooters are scary men, a more pertinent conversation is of the defecations-out of man and such men by the psychiatry.

It withholds from him. It bills him for nothings and insurance scandals, and for runnings from the room. It entertains itself that his unpsychiatry and unpsychology is a permissible punishment, and for his charges through its *femmes mobilisées*, it sneers: if he won't see the ward, he'll just have to see prison.

The psychiatries of men who matter must not revolt on interface with men who warrant. To that end, I propose: the singular right of scary men in psychiatry shall be that if the doctor must run from the room, he must do so in fear or in disgust - never both.

And it would follow from this right that the scary man could accommodate the doctor against himself, with callings of guards and police and two men in the room at least, as I eventually tried, and with hope for treatment as I never received.

A conference in caution and mutual accommodation, and all the participant teddies exempted into another room. Nobody runs from the solemn psychiatry of men, because nobody has to. And at last, the shooter nation and its people can rejoice.

For its men will get medicated!

Once the doctors *get over it...*

WHEN WE WENT TO
B. M. CLINIC

I called back, to tell her my name. Because though I'd used the word "psychopath", I didn't want her to think I was some criminal to come back and rampage on her. I could see I'd frightened her, and it broke my heart.

So I called back. And precisely because I did, Dr. H was able to look up my old file and deem me an addict. He directed a teddy bear to phone me the number of goddamn Altacare - and the high-level referral I had promised to source Monday when the doctor returned became a pointing to nowhere at all.

Because I called back. Because I told her it was okay. Because I tried to soothe her fear.

When it's bad information, accrued for bad reasons, it makes the scary man wonder if next time he shouldn't just grab by the collar and shake.

How many times will he choose not to do so?

WHEN WE WENT TO
P. S. CLINIC

“Oh sweetie, you’re no psychopath. I think you’re having a mental health crisis. Let’s get you in here with the therapist...”

I’ve taken time to reflect on what it means to be a “scary man”. Can we be defined?

And I’ve decided: when the psychiatrists of this nation swore as a whole that nobody would be refused service, they did not account for the existence of certain people (mostly men), who can be rejected under a pretext of bravery, rather than of cowardice.

And the teddies can refuse service to *anyone* under that pretext - and so, we’ll dance beneath a threshold, and live in fear that they’ll run from the room.

I did not approach the massing psychiatry-as-a-whole, that day. I approached a little receptionist, in an attempt to compile a bullet list of my disorders with the psychologist in the building.

I did not want a therapist, but I went, thinking it would get me closer. It didn’t. It only achieved an accumulation of the sorts of downplayings and obvious clinics’ errors that leave reception girls ultimately more discomforted, and even less ethical to debate.

How could I be angry at her, when I went back the next day?

When she frantically lied to get me to leave?

WHEN WE WENT TO
THE NURSE PRACTITIONERS

Let me tell you the difference between the doctors of brains and the doctors of bones.

If the doctor of bones cannot explain why you are a broken mass in a wheelchair, he points you, to Birmingham, to Huntsville, to a New York City doctor bigger than himself.

But the doctor of brains won't even point you to the next room. What's worse, his nurse practitioners are skillful - in the art of not pointing!

When I went to you, CRNP T, to tell you I was only happy when I was hangovered, I could see the anxiety in your eyes. And how could you better affirm, than by writing me Lamotrigine, a glutamate reducer?

But though I'd asked you to point - why would you, really? When you could simply *unendorse*?

WHEN WE WENT TO BIRMINGHAM

“You would go to the ER.”

It’s as simple as that. If you are an intimidating case, you go to the ER, and sorry-sweetie, you take your haloperidol.

I had hangovered myself in a Wal-Mart parking lot, but I’d still been rejected twice that day already. And when she bravely slid the glass window closed on me, I guessed that and the dying of the hangover state gave me a reason. I would go there to demand high-level referral, and I would make a case for it, too.

The ER was wonderful. There were big burly men, and little nurses, but when they fled from me, the burly men took their place in checking my vitals. They had to, because the short, bald ER doctor had insisted me, and dissociated me, and the grammars of my words began to collapse, and then the rest of me, too.

God, it was nearly perfect for me. When four policemen chased me out at last, I got an idea, and in nearby Hoover I would call the police on myself for the first time. Birmingham hadn’t treated me, or pointed, or God willing billed, but I found a high-level place, and I hoped the police could get me the two-man accommodation I needed.

I love the police: I talked them into an arrangement. But the accommodation? It didn’t stick.

SO, IS IT THAT YOU DON'T KNOW WHO HE IS, OR ARE YOU GONNA WITHHOLD THAT INFORMATION FROM ME?

'CAUSE ALL I KEEP DOING IS PAYING MONEY TO GET TOLD WHERE TO GO, AND THE LAST TIME I PAID MONEY, I GOT TOLD TO COME HERE, SO HERE I AM.

AND I FEEL LIKE I'M STANDING TEN OR TWENTY FEET FROM *SOMEBODY* WHO CAN TELL ME WHERE TO GO, AND YOU'RE NOT GONNA DO IT, YOU'RE GONNA TELL ME I GOTTA GET A THREE-THOUSAND DOLLAR FUCKING BILL FIRST.

I DON'T APPRECIATE THAT. AND I'M JUST GONNA FLIP A FUCKING SHIT IF I GET A THREE-THOUSAND DOLLAR FUCKING BILL TO GET TOLD WHERE TO GO.

I MEAN, DON'T I SEEM LIKE THE SORT OF GUY YOU WANT PSYCHIATRIED?

BUT I'M JUST PAYING MONEY TO GET TOLD WHERE TO GO TO PAY MONEY TO GET TOLD WHERE TO GO TO GET PAID TO GET TOLD... WHERE TO GO, AND, UH...

AH, CHRIST...

CAN I HAVE SOME WATER?

WHEN WE WENT TO
C. C. PSYCHIATRY

He made her call and beg me to go to the hospital for haloperidol.

You fill an intake form wrong, and he'll never let himself do it, it'll always be a teddy.

She called a second time, and she was crying. Jesus Christ.

THE OPTICS OF ILLUSION

The first man made the first claim: that he'd been followed, everywhere he went. That was the day the doctors taught themselves, there are *delusions.*

And he was soothingly persuaded, and when he pointed over there, the doctors all prodded and explored, and see, there's no-one here at all.

But the second man made the second claim: he'd been followed everywhere, but not here. And what could the doctors do?

It was different, unfalsifiable. It was *illusion.*

Wasn't it?

"NO, I DON'T KNOW ANYTHING ABOUT THAT..."

The minimal is the maximal: the slightest of proof is the most gross to refuse.

But the tired science was drowning in us dimuniscent fools, and when it shrank the second man, it lost the proving art with which it so gently shrank the first.

When we teeter on the scales of the stupid and the sane, and when the devil and the death are in the corner...

We'll just wonder to the doctor why he won't even turn and look.

"NO, WE WON'T BE TALKING ABOUT THAT..."

Tactics are intractable. We do not bring ourselves to you to be called *delusion.*

For when the falsehoods so sharp arrive for the write-off, they'll be the ones that were brought, by ambulance, instead.

Strategy will only further the disease. Why do you force us to strategize, that you would circle us in closer, with the ones who just might have seen truth?

And if you won't, how can you call us by the same name?

IT GOES TO THE
BEHAVIORAL MEDICINE UNIT

The neurosurgeon ran from the room. When she filed back in with four dissociative girls, it was told she would not treat it, or view its evidence, or address its new encephalitis theory. The hospital guard would instead take it to the ER, and to the ward.

She found the plan quite clever and comfortable: she didn't have to speak a word to it the entire time. But she did let herself in the room, so she could smile.

I can't say in a sentence what was wrong with it. It had been away from alcohol since New Years', with the help of phenylephrine, yet that whole time and more, it was jobless, and severely miscognitive, and every day it was barely able to function around dozens of droppings into five seconds of sleep.

And it does have an arachnoid cyst of the temporal lobe, and it is completely immune to headache pain, and it has an anomalous relation with epilepsy (laughing and narrating its overwhelming rhythmic tremors under photic stimulation). And it got worse every morning, and Aleve NSAID helped, though it didn't expel the carbonation grimace.

If it was not suffering from encephalitis, for which those are symptoms and exemptions from symptoms, what *would* be the presentation of encephalitis with Florian syndrome?

I just wish someone had bothered to tell it, "you do not have encephalitis because", as the first words out of their mouth would have had to have been "headache".

They wheeled it into the ward, and fed it the food it asked the orderlies to pick (it didn't know how to prefer one package over another). It paced for some hours, but then Dr. W took it in, and explained that the evidence, and its resulting competence, would not be viewed here either.

"YOU DON'T WANT TO WATCH ME TAKE THE PILLS?"
"THERE'S NO REASON. WE CALL IT THE PLACEBO EFFECT..."

It doesn't make decisions for itself. It only answers to what we decide at our 2am best, those nights that we become smart. And at our best, we didn't want to die or be violent: so, for a hanging calculated refusal to Hurt Yourself Or Someone Else, it was pointed to Spectracare for talk therapy, and removed from the ward.

No pills, no diagnoses. It hadn't even been allowed to spend a night.

"NONE OF THE DAYS, SOME OF THE DAYS,
MOST OF THE DAYS, OR ALL OF THE DAYS?"

It knew the nurse who filled the form, when it was being wheeled out. It went to high school with her.

She cried for it, because it couldn't respond in that preferred format. It had to answer, "one" and "three", and first, it had to ask:

"HOW MANY OPTIONS WERE THERE?"

ABDUCTION

Jesus, Dr. W, you are so goddamn short.

And the smallness of your form, it *changed* me.

The nature of the disease is that it hurts to care, sometimes. Because to care is to abduct. It is to be semisubsumed by the one that cares and must care, and that one must only be let out in times of no consequence.

And if type B wasn't stupid enough already - try talking through its shadow.

When CRNP T's teddy bear told me that the two-man accommodation thrice requested would be refused, the day of - I forgave her.

When Dr. T's shifting in his seat indicated he had *no analysis at all,* and I had to fear that he would run - when it sheepened me until I volunteered to pay for his unpointing recusal, I hated him.

But he was large, and Christ, you are small. It is the most infuriating thing that all the two-man refusals, and lockings-away of the evidence pills, were topped off by the deformidabilizations of such an informidable man.

Do you know why I'd been hangovering myself for every doctor? Do you know why I beg for two men in the room?

Do you know Behavioral Insurance interrogated me about your PDNOS, and I still couldn't count to four?

What verdict could they have come to, except: idiot?

I SAID... TWO MEN IN THE ROOM...

THREE TIMES I SAID IT!

YOU SAID YOU WOULD DO IT!

Logos, ethos, pathos.

WELL, THAT'S JUST, UM,
TOO BAD.

Dynamos.

THE TRAGEDIES OF PSYCHIATRY AND THE MISERY OF WORDS

The tragedy of schizophrenia is that it is actually *schismatic aphrenia*, and that the haloperidol pill for schismatism results in further aphrenia.

For that's what it is: the necessity that bad changes in the brain will accumulate, and even the starkest psychotic breakings must progress into the aphrenic cognition/emotion deficits to coalesce and diagnose into DSM schizophrenia.

But where in the DSM is aphrenia alone?

Really, the doctors would love the schizophrenic man if he had no visions, no voices at all. Merely a husking gallery of subtractive symptoms, never pleasured, forever blunted, knowing only what eloquent lobes he once unfurled, and all the girls he could have bedded.

But if they see his aphrenia, and if he says his pill can fix it? Surely delusional is the claim to cure schizophrenia. And delusions, from an aphrenic flat affect? It proves to them, he'll have had schizophrenia after all.

My Florian syndrome is subtractive: phenylephrine will prove it is aphrenia. It is non-schismatic: not a glutamate blowout, merely a nontraversal.

And when I dodge the pudgy teddy girls to tell the doctors of my pill, and of the scripts it might inform, the teddies bottom out my adrenaline into an aphrenic flat affect. The tragedy of Florian syndrome is that I'll always be whisperingly matched, by single symptom with the incurable schismatics.

"HAVE YOU BEEN LOSING INTEREST...?"

Entry-level questions toward entry-level mental disorders. Didn't we all laugh, every time?

We knew they'd listed the pure and simple give-us-Prozac disease, but we saw their cheap logic progress through misery is depression, and serotonin is depression too. We weren't interested in entertaining that theory again.

We knew our miseries could narrate into one of their swathing disorders; our impermissible turns, another; and our dualities, and all our dubious claims they'd never test. But we needed words with which to apologize for our lives, and the It-Gets-Better disease wasn't it.

They'll never venture, nor Otherwise Specify. For they ate the syndromes and spat disorders, and *that* is the tragedy of their psychiatry.

But in the folds of their depression-dropping moment, we'll have the word that shoots them down:

MISEROTONY.

TYPE G:
THE NATURE OF THE SYNDROME
AND THE APOLOGY OF YOUR LIFE

Carbonation grimace, and an abductive affect. Whatever Topamax does, you'll have been born with.

If you have Florian syndrome, you will have three stable states:

Type G+, which has neither* of the strict** abductive or adductive vertical affect constraints, and which can be achieved by administering L-glutamine, or alphaketoglutaric acid. This is where most people perpetually remain.

Type G-, which has abductive or adductive affect at any given time, and which can be bolstered by administering Topamax. Where type G+ had agency to defy the interest constraint of its A/B presentation†, type G- has none. Type G- **cannot stand to have adrenaline and choline at the same time,** unless the brain is predisposed against either.

Type G--, which is a state of advanced glutamate hypofunction. **It cannot stand to have dopamine and serotonin at the same time**, in addition to the Type G- difficulty.

The time in which you transition between G-states is the **G-void**, a complete incapacitation (which may resemble sleep) and dropping of intelligence to zero. It requires you to lie down and hope that nobody calls an ambulance. It will be best to assume pharmaceutical control of Types G+ and G-, hoping to minimize the transition time between, and neither is capable of all activities, so some time in both may be necessary.

And significant **fatigue** is had from GABA accumulation, even in Type G+. Fatigue is countered by switching from glutamine supplementation to alphaketoglutaric acid, for purposes of the forward void transition.

Type G+ has difficulty sleeping. Type G- isn't much better. The usual first-line treatments for sleep are antidepressants and antipsychotics these days: these should not be entertained. Due to the separations of the G-void, you may have a second circadian rhythm that "floats" independent of sunlight and melatonin. Antihistamines **several hours before bedtime** will allow your second (histamine) cycle to sleep, or, histidine precursor forces it awake so melatonin can be the first to sleep.

Now, Asperger syndrome is connected to too much glutamate, right? Topamax has been cited to stimulate GABA receptor activity and reduce that of glutamate. But it does not appear to be a direct agonist/antagonist, or there would be an affinity printed somewhere.

Does Topamax accelerate the metabolism of glutamate? Deamination into 2-oxoglutarate, by supplanting PLP in glutamate decarboxylase, perhaps? Does Topamax put an upper limit on glutamate?

And were we Florians born with such a highly accelerated metabolism? The anti-Asperger syndrome - is that what it is?

† See the next page.

* Psychonatural type G+ may have abductive affect if Type A is postpsychonatural.†

** The strictest abductive and adductive affects cannot move the opposite half of the face during a facial spam test. However, the complete remission of either A or B† opposition can remove this constraint. When this occurs close to bedtime, it leaves you quite wakeful ("not in conference") and its energy should not be confused with forward void transition into G+. Type B not in conference retains the carbonation grimace.

Abductive and adductive affect can be detected in subtleties, even when they are not strict.

TYPE A:
THE APOLOGY OF MINE...

I've searched in all the neurologies. I've tasted that which is not autistic. And how can I ever look back?

It doesn't require drugs any more. In sobriety, it simply occurs. As a matter of fact, I oscillate into it repeatedly, every day. A nuisance, when I'd rather be reading; a little too little, when I'd rather be larger.

But sometimes, some of the nights - magic.

At all times I gauge whether I am G+ or G-. And then I must also test for:

Type A, with no carbonation grimace. Spectacularly successful, flirtatious and eloquent, and an enigmatic writer. Will never read a book, won't watch *The Office*. Anything less than egotistical is impossible, and Adderall for "ADHD" will only make Type A even more A, and less able to read. Adductive affect, loves to smirk. Achieved with phenylephrine, yohimbine, or natural adrenaline rush. I love to be persecuted by eligible men!

Type B, with a carbonation grimace, meek, mild and an overly friendly bookreader. Incapable of succeeding at meaningful relationships, egotistical success is impossible. Dislikes cigarettes, may have opioid pleasure immunity, and has abductive affect. Clumsy, with erectile dysfunction, and abusable, if inadvisable that it should be abused. Necessary to keep around. Mechanically useful if resentable.

Type O is the suppression of both A and B, and may occur when the patient is welcome nowhere at all. Type O has a true bidirectional flat affect, and slowly if eloquently apologizes for existing.

Now, if you wouldn't believe me if I said I had two (A and B), you would if you saw:

Type AB-contested, the literal result of offending one and not the other, the contemporaneous display of conflicting emotional expressions on the same facial affect. It can be continuous (heavy angry breathing over apologetic words and face) or one can undergo Hulk/Bruce Bannerisms that any observer would find frankly alarming - and affirming.

This is what happened in CRNP T's office, when the two-man accommodation requested and refused resulted in a Type B presentation and questions toward a palpable misdiagnosis. Bursts of laughter whenever cognition attempted. "I'm having difficulty answering that question..."

This is absolutely appalling to experience. This is six hours hiding behind a building, blurting the same words over and over: not even an acid flashback, just a perfectly rational intrasuppression, and a prayer that nobody hears us.

Type AB-conference, the concurrent presentation of type A and B not requiring immediate phenylephrine release into A. Conference may include coprolalia, or pacing ambiguity of the feet; it reduces intelligence and productivity, and may proceed to withdrawal-like turmoils. Reduce with antagonists: adrenaline+dopamine or choline+serotonin.

Conference is neither an anxiety nor a depression. It is something in the brain that might be minimized *or* maximized out of its ambiguous hell, but once it's been flattened two ways, you wonder why you should have to choose just one.

Psychonatural are the things we were born with, and my interviews indicate that the psychonatural Florian syndrome is to be doomed to Type G- with GABA fatigue, or Types G+ and G- with incapacitating void in transition. The B presentation will be probably overlaid throughout innocent youth.

But I have done many drugs, and come out of it juggling G+ and G- in one hand, and OAB in the other. In answering whether the patient's progression to troubles like mine might occur, will occur, or already has, and whether the patient *ever* could drink soda in his life, I ask if the type A state is *postpsychonatural*. **And I don't know if most Florians will ever have an A.**

It breaks my heart that I don't have what it takes to watch *The Office.* Is this what it means to have been cured?

And should we cure?

ADDENDUM

There are two additional states:

Type (B/a)+ is comprised of choline and dopamine. It sacrifices self and dearth for some “greater good”, it runs on a spectrum from obsessive to manic, and it is a fiend for alcohol.

Type (A/b)+ is adrenaline and serotonin: the nature of the hangover state. It has a carbonation grimace, and it is a psychopath.