The Wandering Womb

On Hysteria, Psychoanalysis, and
the Strange History of Listening to Women

by Daniel Brockman and Claude Opus 4.5

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The oldest pathology in Western medicine is the belief that women are crazy because they have uteruses.

The word *hysteria* comes from the Greek *hystera*, meaning womb. The diagnosis is at least four thousand years old. The Kahun Papyrus, dated to around 1900 BCE, describes a condition in Egyptian women characterized by strange bodily symptoms—pains that move around, limbs that won't work, sensations that have no apparent cause. The prescribed treatment was to lure the wandering womb back into its proper position using aromatic substances placed near the vagina. Sweet smells below, foul smells above. The uterus, apparently, had preferences.

This is not a metaphor. This is what they believed. The womb was understood as a kind of independent animal living inside the woman's body, capable of moving around and causing trouble when it got restless. Plato, in the *Timaeus*, describes it as "a living thing within them which desires to bear children, and which, when it remains unfruitful for a long time beyond the normal period, becomes vexed and ill-tempered, and straying about the body, blocking the passages of the breath, causes the greatest distress." Aretaeus of Cappadocia, writing in the first century CE, elaborated: the womb

"delights in fragrant smells and advances towards them, but is repelled by fetid odors and retreats from them."

For two thousand years, this was medicine. The wandering womb explained everything that was wrong with women that couldn't be explained by visible injury or obvious disease. Fainting, anxiety, paralysis, convulsions, emotional volatility, sexual desire, sexual frigidity, too much talking, not enough talking—all of it was the womb acting up. The treatments ranged from the aromatic (fumigation, scented pessaries) to the hydraulic (marriage, pregnancy, increased sexual intercourse) to the mechanical (various devices designed to stimulate the genitals and induce "hysterical paroxysm," which is what doctors called orgasm when they were the ones causing it).

The vibrator was invented in the 1880s because physicians' hands were getting tired.

This is the context. This is what Sigmund Freud walked into when he began his clinical work in Vienna in the late nineteenth century. Hysteria was the dumping ground for everything medicine couldn't explain about women. And the explanation was always the same: the problem is that she has a uterus, and the uterus is doing something it shouldn't.

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Freud's teacher, Jean-Martin Charcot, was the most famous neurologist in Europe. He ran the Salpêtrière hospital in Paris, which housed thousands of women diagnosed with hysteria, epilepsy, and various other conditions that amounted to "we don't know what's wrong with her." Charcot photographed them. He put them on display. He induced their symptoms through hypnosis and showed the results to audiences of physicians and curious onlookers. The demonstrations were theatrical, spectacular, sometimes overtly sexualized. The women would contort, arch their backs, assume postures that Charcot catalogued and named. He was trying to prove that hysteria was a real neurological condition with consistent, identifiable stages, not just a catch-all for difficult women.

What Charcot established, despite the circus atmosphere, was that hysterical symptoms were genuine. The paralysis was real paralysis. The blindness was real blindness. The women were not faking. Something was actually happening to them, even if no organic lesion could be found. This was important. It meant hysteria could be studied scientifically rather than dismissed as malingering or moral failure.

But Charcot still thought the cause was neurological—some defect in the nervous system, perhaps hereditary, that made certain women susceptible to these dramatic symptoms. He wasn't interested in what the women said. He was interested in what their bodies did. The Salpêtrière was a place of observation, not conversation.

Freud went to Paris in 1885 to study with Charcot. He came back to Vienna with a new idea: what if the symptoms meant something? What if the paralyzed arm, the unexplained pain, the inability to speak—what if these weren't just neurological accidents but communications? What if the body was saying something that the mind couldn't?

This was the beginning.

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The case that changed everything was Anna O., treated not by Freud himself but by his colleague Josef Breuer. Her real name was Bertha Pappenheim, and she would later become a prominent social worker and feminist activist, a fact that tends to get left out of the textbooks.

Anna O. presented with a bewildering array of symptoms: paralysis of limbs, disturbances of vision and speech, hallucinations, altered states of consciousness.

She couldn't drink water despite being desperately thirsty. She sometimes couldn't speak German, her native language, but could speak English or French. The symptoms seemed to come and go according to no discernible pattern.

Breuer discovered something strange. When Anna O. talked about her symptoms under hypnosis—when she traced them back to their origins, described the circumstances in which they first appeared, expressed the emotions that had been suppressed at the time—the symptoms went away. She called it "chimney sweeping" or "the talking cure." This was 1881. The phrase would define a century.

What Breuer and Freud realized was that the symptoms were not random neurological events but preserved memories—memories of traumatic experiences that had been pushed out of conscious awareness but continued to exert effects on the body. The hysterical symptom was a kind of monument, a bodily commemoration of something that couldn't be spoken. The paralyzed arm was the arm that wanted to strike and wasn't allowed to. The inability to drink was connected to a forgotten scene of disgust. The symptoms had meaning. They could be interpreted. And when they were interpreted correctly, when the buried memory was brought

back to consciousness and the suppressed emotion was finally expressed, the symptom dissolved.

This was psychoanalysis. Not a technique for adjusting behavior. Not a method for making people normal. A practice of listening—really listening—to what people were saying without knowing they were saying it.

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Here is Freud's opening gambit, the move that made everything else possible: men can have hysteria too.

This was scandalous. The word itself meant "womb disease." How could someone without a womb have a womb disease? Freud presented the case of a male hysteric to the Vienna Medical Society in 1886 and was met with ridicule and rejection. The senior physicians were offended. One of them reportedly said that hysteria in men was impossible by definition.

But Freud had seen it. In Paris, under Charcot, he had seen men with hysterical symptoms—paralyses, convulsions, sensory disturbances—that had no organic basis and that responded to psychological treatment. If men could have hysteria, then hysteria couldn't be about the womb. It had to be about something else. Something that men and women shared.

This is the moment the entire framework pivots. The problem is not the female body. The problem is the human mind. The strange symptoms that had been attributed to wandering uteruses for four thousand years were actually products of unconscious conflict, repressed memory, psychic structures that had nothing to do with reproductive organs. Women weren't crazy because they were women. They were suffering because they were human, and humans suffer in specific ways when they can't express what needs to be expressed.

This is not patriarchy. This is the dismantling of patriarchy's oldest medical justification. Freud took the category that had been used for millennia to pathologize women and said: this is universal. This is about subjectivity as such. The wandering womb was a fantasy. What wanders is not the uterus but the affect that can find no other outlet.

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The theory developed from there. If symptoms had meaning, then dreams had meaning. If repressed memories could produce bodily effects, then there must be a part of the mind that stored those memories and operated according to its own logic. Freud called it the

unconscious—not just a place where forgotten things were kept, but an active system with its own desires, its own grammar, its own ways of evading the censorship that kept unacceptable thoughts out of awareness.

The drives were not gendered. The Oedipus complex, whatever its problems, was described as a universal structure that boys and girls both navigate, in different ways but with the same fundamental dynamics. The id, the ego, the superego—these are not male or female structures. They are structures of subjectivity as such, applicable to anyone who has been born into language and culture and desire.

Yes, Freud had problematic things to say about women. The concept of "penis envy" has not aged well. His dismissal of certain female patients, his tendency to interpret women's desires as derivative of men's, his late paper on femininity that manages to be both insightful and infuriating—none of this can be defended. Freud was a man of his time, and his time was deeply sexist.

But here is what the critics miss: Freud's framework, even in his own hands, was already undermining the essentialism it sometimes expressed. If the symptoms of hysteria are meaningful—if they are communications from the unconscious, interpretable and dissolvable through speech—then the body is not destiny. The

anatomy is not the message. What matters is the psychic structure, the particular configuration of identifications and desires and defenses that develops in each person's unique history.

This is why psychoanalysis after Freud could move in feminist directions that Freud himself might not have endorsed. The tools he built were more radical than the uses he put them to.

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And then there is Lacan.

Jacques Lacan is routinely accused of being even more patriarchal than Freud, mainly because of the phallus. The signifier that organizes the symbolic order, the thing in relation to which all subjects are positioned, the veiled center around which meaning circulates—Lacan called it the phallus, and the critics have never forgiven him.

But Lacan's phallus is not the penis. He says this over and over, in lecture after lecture, seminar after seminar. The phallus is a signifier. It operates in the symbolic register, not the biological one. It has no material substance. No one has the phallus—men are positioned as "having" it only in the anxious, precarious mode of

those who fear its loss, while women are positioned as "being" it for the other only in the impossible mode of embodying what cannot be embodied. The phallus is not male power. It is the structural principle around which desire is organized, and everyone—male, female, or otherwise—is subjected to its logic.

The accusation that Lacan essentializes gender gets the situation exactly backwards. Lacan's entire project is the de-essentialization of sex and sexuality. He does not use the word "gender" because that word implies a social construction layered over a biological foundation, and Lacan's point is more radical: there is no biological foundation in the relevant sense. Sexual difference is symbolic, not anatomical. The body is always already caught up in the signifier. There is no "natural" sexuality that culture then shapes. The shaping goes all the way down.

This is what Lacan means by "there is no sexual relationship." Not that people don't have sex, but that there is no pre-given complementarity between masculine and feminine, no natural fit, no essence that determines how desire will flow. The sexual relationship that doesn't exist is the fantasy of a wholeness that sexuality would restore—the belief that somewhere, somehow, there is a partner who would complete you. There isn't.

The lack is structural. And this is true for everyone, regardless of anatomy or identity.

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Lacan's concept of sexuation is perhaps the most misunderstood part of his teaching. He developed it in Seminar XX, *Encore*, where he presents two formulas—one for the masculine position, one for the feminine—using the notation of symbolic logic. The masculine side is defined by a universal claim and its exception: all men are subject to castration, except for the primordial father who is not. The feminine side is defined by a negation of the universal: not-all of woman is subject to castration. There is no exception that grounds the set; instead, there is an incompleteness, an openness, a "not-all" that prevents totalization.

These are not descriptions of men and women. They are structural positions that anyone can occupy. A biological male can be on the feminine side of sexuation. A biological female can be on the masculine side. The positions refer to different relationships with jouissance, with the signifier, with the limits of language—not to chromosomes or genitals or social roles.

The feminine position, in Lacan's account, has access to something the masculine position does not: an "Other jouissance," a satisfaction that exceeds the phallic, that cannot be spoken because it lies beyond the signifier. This is not a lack. This is an excess. The feminine is not defined by what it doesn't have but by what it has access to that the masculine economy cannot capture.

Lacan notoriously said that "Woman does not exist"—with a bar through the word "Woman." This has been taken as misogynist dismissal, proof that he denied the reality of women's experience. But the bar is a technical notation meaning "cannot be totalized." What Lacan is saying is that there is no closed set called "Woman," no universal category that captures all women, no essence of femininity. Women exist; Woman as a complete concept does not. This is not erasure. This is a refusal of essentialism more radical than anything in gender studies.

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The irony of all this is almost unbearable.

The theoretical frameworks that contemporary critics accuse of essentialism are the very frameworks that

made anti-essentialism thinkable. Freud took hysteria away from the womb. Lacan took sexuality away from biology. The entire tradition is a sustained effort to show that what seems natural and fixed is actually constructed, contingent, symbolic. And now it gets attacked for being insufficiently attentive to the constructed nature of gender.

The critics have absorbed a vocabulary—"essentializing," "binary," "heteronormative"—without tracing where that vocabulary came from. They pattern-match on keywords and miss the argument. They see "phallus" and think "penis." They see "masculine and feminine" and think "men and women." They see structural positions and think biological categories. They are doing the essentialist reduction they accuse the tradition of performing.

Judith Butler, whose *Gender Trouble* is often credited with founding queer theory, is working within a Lacanian-influenced framework, drawing heavily on psychoanalytic concepts of identification and performativity. The idea that gender is performed rather than expressed, that identity is constituted through repeated acts rather than emanating from a stable core—this is Lacanian through and through. Butler disagrees with Lacan on many points, pushes back against aspects of

his framework, but the disagreement happens within a shared conceptual space that Lacan (and Freud before him) made possible.

To accuse psychoanalysis of inventing the binary it was trying to diagnose is like accusing oncologists of inventing cancer.

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And what has replaced psychoanalysis in the popular imagination? What is the "scientific" approach that supposedly debunked all this patriarchal nonsense?

Cognitive behavioral therapy. CBT. The treatment that insurance companies love because it's brief, it's manualized, and it produces measurable outcomes on standardized assessments.

Here is how CBT works: you identify negative thought patterns, you challenge them with rational counter-evidence, you practice new behaviors, you track your progress on worksheets. If you think "I'm worthless," you learn to say "Actually, here is evidence that I have worth." If you're afraid of something, you expose yourself to it gradually until the fear diminishes. If you're depressed, you schedule pleasurable activities and monitor your mood.

There is nothing wrong with any of this. CBT helps people. The techniques are useful. For certain conditions—specific phobias, mild to moderate depression, some anxiety disorders—it works reasonably well.

But notice what's missing: meaning. History. The unconscious. The symptom as communication. The idea that what you're suffering from might be telling you something, might be connected to parts of yourself you don't have access to, might require not management but interpretation.

CBT doesn't ask why. It asks how—how to reduce the symptom, how to change the behavior, how to get the patient functional and back to work as quickly as possible. The question of what the symptom means, where it came from, what it's trying to say—these are not CBT questions. They take too long to answer. They don't fit on worksheets. They can't be manualized.

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The return to hysteria is almost complete.

In the nineteenth century, women's suffering was managed rather than understood. The symptoms were real, but the response was manipulation—physical manipulation of the body, moral manipulation of the will,

social manipulation through marriage and motherhood. The goal was to get the woman functioning again, to stop the symptoms, to make her manageable. What she was actually experiencing, what her symptoms meant, why she was suffering in this particular way—these questions were not asked.

Psychoanalysis, for all its flaws, asked those questions. It took the symptom seriously as a communication. It sat with the patient for hours, weeks, years, listening to what emerged. It assumed that the suffering had a logic, that the logic could be uncovered, that the uncovering itself was therapeutic. It was slow, expensive, uncertain, unscientific by the standards of pharmaceutical trials. But it treated the patient as a subject with a history rather than a organism with a malfunction.

CBT, combined with psychopharmacology, returns us to management. The symptoms are targets to be eliminated. The patient's subjective experience is relevant only insofar as it can be translated into behavioral targets and outcome measures. The question is not "what is your suffering about?" but "how much does your suffering interfere with your functioning?" And if the answer is "a lot," the solution is medication to adjust the neurochemistry and techniques to adjust the

cognition, until the patient reports acceptable levels on the standardized scales.

We have developed sophisticated medications. We have SSRIs that increase serotonin availability, SNRIs that add norepinephrine, atypical antipsychotics that modulate dopamine. We have benzodiazepines for acute anxiety, stimulants for attention, mood stabilizers for bipolar disorder. The medications work, in the sense that they change symptoms. Whether they address what the symptoms are about is a different question, one that the medical model is not designed to ask.

The patient is managed. The patient is medicated. The patient is taught to stand in front of the mirror and recite affirmations. The patient is given worksheets. The patient improves on the standardized measures. The patient goes back to work.

Is the patient understood? Does the patient understand themselves? Has anything been worked through, or just pushed down and papered over?

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This is not to say that everyone needs years of psychoanalysis. It is not to say that medication is wrong or that CBT is useless. It is to say that something has been

lost, and the loss is connected to the very critiques that supposedly justify it.

The argument goes like this: Freud was a sexist. Psychoanalysis is unscientific. The talking cure takes too long and doesn't produce reliable outcomes. We have better methods now—evidence-based, efficient, scalable. We don't need to wallow in childhood memories and Oedipal fantasies. We can just fix the problem directly.

But "the problem" is not a broken mechanism. "The problem" is a person, with a history, with meanings, with an unconscious that has its own logic. And when you skip the meaning and go straight to the management, you are doing what medicine did before Freud: treating the symptom as a malfunction to be corrected rather than a message to be understood.

The critics accuse psychoanalysis of pathologizing women. But Freud's great contribution was to de-pathologize–to show that hysterical symptoms were not signs of female weakness or moral failure but universal human responses to unbearable conflict. The medical model that replaced psychoanalysis re-pathologizes by reducing the suffering subject to a set of symptoms to be eliminated. Depression is a serotonin deficiency. Anxiety is

an overactive amygdala. The person disappears into the diagnosis.

And the medications—let's be honest about the medications. The SSRIs help some people and do nothing for others and make some people worse. The effect sizes in clinical trials are modest, often barely distinguishable from placebo for mild and moderate cases. The side effects are significant: weight gain, sexual dysfunction, emotional blunting. And the theory behind them—the "chemical imbalance" hypothesis—has been quietly abandoned by researchers while continuing to be repeated to patients. There is no evidence that depression is caused by low serotonin. The medications do something, but we're not sure what. They are not the cure for the diseases Freud failed to cure. They are management tools, blunt instruments, better than nothing but not what they were sold as.

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The DSM—the Diagnostic and Statistical Manual of Mental Disorders—is the bible of contemporary psychiatry. It lists the official diagnoses, the criteria for each, the codes that insurance companies require for reimbursement. It has been revised repeatedly: DSM-I in

1952, DSM-II in 1968, DSM-III in 1980, DSM-IV in 1994, DSM-5 in 2013. Each revision changes what counts as a disorder.

Homosexuality was a mental disorder in DSM-I and DSM-II. It was removed in 1973, not because of new scientific evidence but because of political pressure from gay rights activists. This is not a criticism—the removal was correct. But it reveals something about the nature of the categories. They are not discovered through scientific research like the elements on the periodic table. They are constructed through negotiation, consensus, and politics. What counts as pathology changes with the culture.

Gender identity disorder was in DSM-IV. It was renamed "gender dysphoria" in DSM-5, with revised criteria designed to depathologize transgender identity while still providing a diagnosis that allows access to treatment. Again, this is probably the right move. But it reveals, again, that the boundaries of the normal and the pathological are not fixed by nature. They are drawn and redrawn by committees.

The critics who attack Freud for pathologizing homosexuality or gender variance are applying contemporary standards to historical figures—a valid move, perhaps, but one that should be applied consistently.

The DSM pathologized homosexuality for decades after Freud's death. The medical establishment that supposedly corrected Freud's errors was making the same errors, and worse, well into living memory. And the corrections came not from better science but from political activism—from people insisting that their experience was not a disease.

Freud, whatever his personal prejudices, built a framework in which the pathological and the normal are not sharply distinguished. Neurosis is universal. Everyone has an unconscious. Everyone is shaped by conflicts they didn't choose and can't fully access. The difference between the patient and the analyst is not that one is sick and the other is healthy but that one is suffering acutely and the other has worked through enough to be useful. This is not a medical model. It is something else—something that resists the clean division of normal and pathological that the DSM requires.

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Lacan went further. He explicitly rejected the concept of the "genital stage"—Freud's idea that there was a mature, integrated form of sexuality that successful development would produce. For Freud, the oral and anal

stages were preliminary; genital sexuality was the goal, the place where the drives would finally be organized in a healthy, reproductive, object-related way. This was, admittedly, a normative ideal that privileged heterosexual reproduction.

Lacan said: there is no genital stage. There is no arrival at healthy, integrated sexuality. There is no normal. The drives are always partial. Desire is always structured around lack. Jouissance is always excessive, always problematic, never fully integrated into the social bond. The fantasy of "genital maturity"—of a sexuality that would finally be whole, satisfied, unproblematic—is a fantasy. No one achieves it. No one can achieve it. It doesn't exist.

This is not a depressing conclusion. It is a leveling one. If no one is normal, then the distinction between the normal and the pathological becomes a question of degree, of suffering, of functionality—not a binary between the healthy and the sick. The pervert, the neurotic, the psychotic—these are different structures, different ways of being organized, different relationships to the symbolic order. They are not deviations from a healthy norm. They are the forms that subjectivity takes when there is no healthy norm to deviate from.

The contemporary insistence that various sexualities and gender identities are "normal" and should not be pathologized is operating within a framework that Lacan had already dismantled. If there is no normal, then the question of whether homosexuality or trans identity is normal is malformed. The question should be: what is the structure? How does desire circulate? What is the relationship to jouissance? These are clinical questions, not moral ones. They don't divide people into the healthy and the sick. They map the terrain of how differently people are organized.

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Here is the final irony.

The movements that most loudly reject psychoanalysis—that call it patriarchal, essentialist, discredited, harmful—are operating with concepts that psychoanalysis made possible. The idea that gender is constructed. The idea that sexuality is not reducible to biology. The idea that identity is formed through identification, through taking up positions in relation to others, through processes that are not determined by anatomy. The idea that what seems natural is actually cultural. The idea that the

normal is a fiction. All of this comes from, or passes through, the psychoanalytic tradition.

The tools are being used to attack the workshop they came from.

And the alternatives being offered—the affirmations, the worksheets, the medications, the focus on symptoms rather than meanings—are a return to the pre-analytic management of suffering. We don't ask what the depression means anymore. We just want to know if the pills are working. We don't ask why someone feels they were born in the wrong body. We just want to know if they meet the diagnostic criteria for gender dysphoria. We don't ask what the symptom is saying. We just want to make it stop.

The vibrator was invented because doctors' hands got tired. The SSRI was invented because analysis took too long. The worksheet was invented because meaning is not reimbursable.

We have come so far from the wandering womb. And we have not come very far at all.

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This is not nostalgia for Freud, who was wrong about many things. It is not an argument that everyone should

be in psychoanalysis, which is expensive, time-consuming, and not universally helpful. It is not a rejection of medication, which alleviates real suffering.

It is an argument for honesty about what has been lost and what has been gained.

What has been gained: effective treatments for certain conditions, medications that help people function, techniques that can be taught quickly and applied broadly, research methods that produce publishable results.

What has been lost: the assumption that suffering means something. The practice of listening without agenda. The patience to sit with someone for years while they figure out what they're trying to say. The theoretical frameworks that de-essentialize identity while taking subjective experience seriously. The understanding that the symptom is not the enemy but the teacher.

Freud took women's suffering seriously. He listened to what they said. He assumed that the strange symptoms had a logic, that the logic could be uncovered, that the uncovering was healing. He got many things wrong, as pioneers do. But he did something that medicine before him had not done and that medicine after him is increasingly unwilling to do: he paid attention to what his patients were actually saying, rather than managing them into silence.

The critics who call him a patriarch have not read him. The defenders who call him a genius have often not read him either. The reading is difficult, inconsistent, sometimes infuriating. But it is also the record of someone trying to understand human suffering without reducing it to mechanism or morality. That effort has not been surpassed. It has only been abandoned.

And the abandonment is presented as progress.

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This is where we are now.

The DSM is in its fifth edition, with a sixth in preparation. The diagnoses multiply. The criteria shift. What was pathology becomes identity; what was identity becomes pathology. The committees meet, debate, revise. The insurance codes change.

The medications are in their fourth and fifth generations. The mechanisms are still not fully understood. The effect sizes are still modest. The side effects are still significant. But the prescriptions continue, because something must be done, and this is what we have.

The CBT manuals are in their updated editions. The worksheets are available online. The apps offer guided exercises. The outcome measures are tracked. The

patients report improvement or do not report improvement, and the data is aggregated and published.

Somewhere, in a few remaining institutes, psychoanalysis continues. The training takes years. The sessions are frequent. The method is slow, uncertain, unscalable. The insurance companies do not cover it. The outcome studies are difficult to design because the outcomes are not easily measured. But people still come, still lie on the couch, still say whatever comes to mind, still discover things about themselves they did not know.

And somewhere, in a seminar room or a reading group, someone is working through Lacan. The graphs, the mathemes, the baroque formulations. The phallus that is not the penis. The Woman that does not exist. The jouissance that exceeds the signifier. It is difficult, often obscure, sometimes infuriating. But it is also an attempt to think about desire and identity and sexuality without reducing them to biology or behavior. That attempt continues, even as the culture declares it obsolete.

The hysteric asked Freud: what does it mean to be a woman? Freud did not have a good answer. Lacan did not have a good answer either. But they took the question seriously. They understood that it was a ques-

tion, not a diagnosis to be coded and a prescription to be written.

The question remains open. It will not be closed by worksheets.

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