CHAPTER I

INTRODUCTION: MANY DEFINITIONS OF CONSCIOUSNESS

Consciousness means different things to different people,[1] and debates around it exist in many disciplines. What in lay terms is conceived as 'the feeling of being inside oneself looking out' or as 'having a soul' bears testimony to a long tradition that is still nowadays discussed among doctors, neuroscientists and philosophers, to name but a few.[2] Indeed, the topic triggers recurrent polemic about perceptual experiences and bodily sensations, as well as questions regarding mental imagery, emotions, thoughts and behaviours. As a result, it is not unusual that according to the context and the field of research, the notion acquires different nuances, where overlapping ideas such as 'awareness', 'wakefulness', 'sentience' are often involved and not seldom confused.[3]

This book aims to explore some ancient medical contributions to this tradition. To do it, it will analyse a few accounts of impaired consciousness that spread out over a substantial geographical and chronological extension, namely, from Greece, Rome and Asia Minor; and between the Greek classical period (around the fifth century BCE) and the heights of the Roman Empire (in the second century CE). Whilst contextualising the different works amid their contemporary debates, the analysis will explore the scientific milieu in which the texts were conceived, as well as the chronologic changes in medical thought from one period to the other.

Sources

Given the breadth of the chosen temporal frame, and in order to narrow down the scope of the project, I will focus on a limited number of sources. The selection was based on their relevance within medical historiography; their varied approaches to the

[1] Rao (1988: 310). [2] Burkeman (2014). [3] Carmel and Spreavak (2015: 103–4).

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subject, which allow different perspectives; our access to their direct tradition; and the completeness of their extant works, that is, whole texts were preferred because they enable a more comprehensive understanding of the writers' stance. (Hellenistic authors are not dealt with in-depth, because their evidence is mainly doxographic and often fragmentary, thereby entailing a serious risk of deformation and misinterpretation.)[4]

In terms of specific texts, I have divided the authors into three groups: a selection of treatises from the Hippocratic corpus,[5] some post-Hellenistic books (particularly, Celsus' *On medicine*, and *On the causes, symptoms and cure of acute and chronic diseases* by Aretaeus of Cappadocia),[6] and a few works by Galen, the great physician of the Roman Empire.[7]

Hippocratic corpus and Hippocratic authors

From the Hippocratic corpus, I am particularly interested in signalling some general views on impaired consciousness shared by different practitioners, which challenge the often-flagged heterogeneity in terms of genres,[8] origins,[9] voices,[10] theories and perspectives.[11] Indeed, modern researchers struggle to find widespread ideas or

[4] The main extant sources for studying this period are some quotations and reports by Rufus and Soranus of Ephesus, the third section of the *Anonymus Londinensis*, Celsus' work and especially, Galen (Longrigg 1993: 182–3).

[5] The particular choice of works – inevitably arbitrary, as any other selection – tries to reflect the wide variety of genres and approaches to impaired consciousness that the collection offers. They are all pre-Aristotelian and I will designate their medical writers collectively as 'Hippocratic authors'.

[6] 'Post-Hellenistic' refers to medical writers from the first and early second century CE (excluding Galen, who will be discussed separately). Their works incorporate and build on crucial scientific developments from the Hellenistic period to which we no longer have direct access. Beyond Aretaeus and Celsus, references will be made to two didactic handbooks wrongly attributed to Galen, the *Introduction* and the *Medical definitions*, as well as the *Anonymus Parisinus*, a catalogue of diseases, where the author summarises the points of view of prestigious doctors.

[7] From Galen's extensive production I have selected nine treatises belonging to different genres, where impaired consciousness is addressed from various perspectives: *On the distinction of diseases* (*Morb. Diff.*), *On the causes of diseases* (*Caus. Morb.*), *On the distinction of symptoms* (*Symp. Diff.*), *On the causes of symptoms* (*Caus. Symp.*), *Coma according to Hippocrates* (*Com. Hipp.*), *The method of medicine* (*MM*), *On the affected parts* (*Loc. Aff.*), *The art of medicine* (*Ars. Med.*) and *The capacities of the soul follow the mixtures of the body* (*QAM*).

[8] Lonie (1983: 148). [9] Jouanna (2018: 39). [10] Craik (2018: 29).
[11] Nutton (2013a: 60).

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constructs that remain consistent throughout this first comprehensive textual testimony of Greek learned medicine.[12] Scholars tend to limit such coincidences mostly to the period that these practitioners inhabited – characterised by the 'seismic social, cultural, and intellectual changes' that accompanied the emergence of written prose to communicate ideas – and by their stance as a group: they identified themselves and their *technê* by distinction from other disciplines, and developed a form of literary expression to claim authority.[13]

On the contrary, I aim to show that both from a conceptual and a terminological point of view, these authors shared some rudimentary ideas regarding consciousness. In this sense, I will argue that the Hippocratic collection witnesses a 'theory of mind' and a 'technical vocabulary' in the making. I do not agree with Lloyd's opinion that the situation was 'bordering on terminological anarchy';[14] nor with Holmes' view that 'ideas about the *sôma*, the *psuchê* and human nature were "messily" proliferating in the late fifth and early fourth century BCE' (at least in this respect).[15] I shall claim that there was a consistent – though vague and ill-defined – embryonic notion of consciousness, which underlies several Hippocratic accounts, and that doctors were struggling to delimit the concept.

Post-Hellenistic authors

The massive loss of textual evidence from Hellenistic Alexandria[16] and its prominent figures, Herophilus and Erasistratus,[17] makes it difficult for us to explore elusive notions such as consciousness in this period. We can, at best, catch small glimpses of the main sectarian debates regarding Hellenistic developments through our post-Hellenistic medical writers, who quoted, challenged or

[12] Actually, we can define this material as 'loosely' medical because along with the discussions about the body and its diseases, there is a wealth of ethnographic, historical and philosophical considerations (Cross, 2018: 4).

[13] Dean-Jones (2003: 102–3). [14] Lloyd (1983: 163). [15] Holmes (2010: 32).

[16] Lang (2013: 243–67) offers a good summary of the main features of the medical activity in Alexandria.

[17] Longrigg (1993: 474–5), von Staden (1989) and Garofalo (1988) have published the most complete collection, to date, of the remaining fragments by Herophilus and Erasistratus, respectively.

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supported their forerunners.[18] As a result, when analysing this group of sources, particular attention will be paid to the way in which their authors positioned themselves in the face of alternative or rival discourses, as well as their strategies to acquire and organise knowledge. Naturally, all these issues were strongly dependent on the specific period that each writer lived in, on the kind of project that they were carrying out and on the ongoing debates that surrounded each of them.

As will transpire from the discussion, the Hellenistic discoveries of the nervous system and its functioning – especially, their understanding of the body, its movement and perceptions – are of particular importance for later doctors' conceptions of impaired consciousness.

Aulus Cornelius Celsus

On medicine is a paradigmatic example of Roman encyclopaedism, a phenomenon related to a strong quest for learning among the upper classes, paralleled by a substantial expansion in the book-world.[19] As such, its eight volumes provide us with a systematic digest of practical medical knowledge[20] available to the Roman elites during the early Republic.[21]

As with the Hippocratic authors, we are faced with a plurality of voices claiming authority. However, in Celsus' project the alternative discourses have been filtered by a single writer, whose job involved picking out a few texts, ignoring several others and articulating opposing views. Celsus construes the evolution of medicine as a genealogy of disagreements, and positions himself at all times 'somehow in the middle between opposite opinions'.[22] His legitimacy (thus, his claim to authority) relied on demonstrating

[18] Nutton (2013a: 135–8). See also von Staden (2002: 83–91). [19] Contino (2000: 49).
[20] Although his work is theory laden, Celsus avoids theoretical discussions beyond the *prooemium*. As Mudry (2006a: 12) has remarked, not even his descriptions of diseases are exhaustive; he merely outlines some distinctive traits that enable the reader to recognise them, but his focus is on treatment.
[21] Langslow (1994: 300) has defined the audience as 'amateur Roman *curantes*'. Undoubtedly, medical literacy was useful for the *patresfamiliae*, who needed to make relevant medical decisions when choosing doctors for their household, and interacting with them (Flemming, 2000: 59).
[22] *media quodammodo diversas in sententias* (*Med*. 1. Proem. 45).

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his qualities as a 'virtuoso reader and critic', and on showing off his 'wide erudition and cunning arrangements'.[23] Despite the long list of doctors referred to in the *prooemium*, the canon of writers that he repeatedly quotes are mainly limited to Asclepiades, Erasistratus and Hippocrates.[24] The analysis of his work will argue that his ideas on impaired consciousness are significantly influenced by corpuscular theories such as Ascelpiades' and the Epicureans'.

Aretaeus of Cappadocia

I will consider Aretaeus as a learned physician from the second half of the first century CE and the first half of the second[25] with an evident commitment to reason, who looked for physical causes as a means to explain health and disease. In other words, he will be regarded as a 'non-sectarian author', or a 'physician without further affiliation', who laid claim to Hippocratic authority.[26] The analysis of his ideas on consciousness will show that, whilst his explanations did not strictly fit in any single philosophical system or sect, they laxly referred to several of them.[27]

Although he likely shared with Celsus a profound awareness of the Hellenistic tradition, and both their projects presuppose several voices underpinning an allegedly single discourse, Aretaeus did not feel the need to make alternative opinions compatible. He simply generated knowledge by choosing whichever theory better explained a specific point that he wanted to make, regardless of whether they contradicted (syncretism) or were compatible with (synthesis) other later assertions.[28] Consequently, I will argue that,

[23] König and Woolf (2013: 36). [24] von Staden (1994a: 83).

[25] Oberhelman (1993: 958–9) offers an overview of the centuries-lasting debate regarding Aretaeus' chronology and sectarian belonging. He limits his *floruit* to the latter part of the first century CE, whereas Perez Molina (1998: 14) is less categorical and widens the bracket. I agree with the latter, for Oberhelman's argument is based on ascribing Aretaeus to a certain sect, which I will challenge.

[26] Flemming (2012: 70, 79).

[27] Whereas Wellmann considered him as an Eclectic, Oberhelman (1993: 958) and Stannard (1964: 30) highlight the Stoic basis of his Pneumatic approach. Other authors nuance these views: McDonald (2009b: 118) sees in his work the Hippocratic influence on Pneumatic medicine, and Pigeaud (1987: 85) acknowledges the role of *pneuma* in Aretaeus' theory, but questions whether he can be exclusively ascribed to the Pneumatic school.

[28] Syncretism supposes an uncritical juxtaposition of ideas that fails to reconcile heterodox views (Albrecht, 1994: 104); synthesis is the opposite phenomenon, that is, when

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based on his understanding of impaired consciousness, it makes sense to characterise his approach as eclectic,[29] even while avoiding any implication in terms of his belonging to the Eclectic sect (if such a group ever existed).

In other words, my reading of his work will suggest that he embraced eclecticism as an 'intellectual attitude',[30] and I shall describe it as 'lax' eclecticism to distinguish it from the Eclectic sect. In his use of the terminology and his appropriation of others' ideas we can, at best, find a certain 'family resemblance' with different well-known theoretical frameworks available during his lifetime, but he does not fully commit to any of them.[31]

Galen of Pergamum

As opposed to the abundant philosophical scholarly research on Galen's psychology, this analysis will look at his understanding of impaired consciousness from the more medical side of the debate. My argument aims to show how Galen's take on impaired consciousness is based on the intersection of two theoretical traditions: the anatomical and the humoural, both of which were part of the intellectual zeitgeist.[32]

diverse ideas are successfully combined, without evident contradiction amongst them (Donini, 1988: 21). *Sumphorêsis* – from '*sumpephorêmenos*' (mixed, jumbled) – is a coinage inspired by Epicurus' criticism of philosophers who disregard the semantic distinctions for the same term across different philosophical systems (Hatzimichali, 2011: 19). All three concepts have been associated with eclecticism.

[29] Eclecticism has been defined as 'an intellectual stance that involves approving of and adopting views that are not part of a uniform tradition, but might stem from different, even incompatible, ideologies' (Hatzimichali, 2011: 9).

[30] In his analysis of eclecticism in modern philosophy, Schneider (1998: 177) draws a useful distinction between doctrinal eclecticism as opposed to an eclectic 'intellectual attitude'.

[31] Wittgenstein's account of family resemblance is useful for characterising Aretaeus' approach. The idea that a general concept (in this case a general theory) applies to all the particular instances (in the explanations) by virtue of some specific feature or principle that is shared by all such explanations does not apply in Aretaeus' examples. On the contrary, we find that theories apply by virtue of multiple features or principles only shared by certain subsets of such explanations in a criss-crossing and overlapping manner (Forster 2010: 67). Consequently, instead of a single theory (or sect, or school of thought) that captures and underpins all Aretaeus' work, we are faced with a network of concepts that belong to different theories, which are constantly crossing and intersecting.

[32] I disagree with Pigeaud's idea that there is a breach between 'fine anatomy' and 'humouralism, which guides therapeutics' (2008: 582). On the contrary, I will claim

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On the one hand, the anatomical expertise, which Galen had gained through dissection with the most prestigious teachers,[33] provided him with the *locus affectus*, namely, the bodily location where the compromise occurred, hence, where treatments needed to be aimed at.[34] On the other, Galen drew his pathophysiological explanations from the theory of the four humours (*chumoi*). His merit was to articulate these allegedly Hippocratic ideas with the theory of the four elements (*stoicheia*) – which after Empedocles had exerted a powerful influence on philosophical thought.[35] The nexus that enabled him to bridge elements with humours was the notion of qualities (*poiotêtes*), which had been independently related to both systems for centuries.[36] As Schöner pointed out, although only one step was missing to join both theories, 500 years went by before Galen established such a relationship.[37]

The hot, the cold, the dry and the wet underpinned the theory of mixtures (*kraseis*), whereby diseases were caused by an imbalance of qualities (*duskrasia*).[38] Through this move, Galen was able to claim the prestige of both the philosophical elemental tradition and the Hippocratic humoural one, while he actually moved away from both towards a system based mainly on qualities. Furthermore, this approach offered Galen a qualitative and quantitative framework to guide the choice of allopathic therapies. In his system the kind of

that both are constantly in play, and that it is their precise combination which determines the type and site of the therapy required.

[33] Gourevitch and Grmek (1994: 1493–525) offer a thorough account of Galen's educational journeys.

[34] According to McDonald (2011: 63, 76), this concept had emerged in the post-classical period and achieved its fullest expression with Galen. Although Archigenes had shown a keen interest in the topic, he based his treatments on an authoritative therapeutic tradition, but not on the physiological theories that he supported (Lewis, 2018: 172). It was Galen who took the crucial step of integrating anatomy and humoural pathophysiology into diagnosis and treatment.

[35] Very schematically, Galen considered that the primary elements (water, fire, air, and earth) were formed out of matter and qualities (*hulês* and *poiotêtôn*). The former, in turn, constituted the whole cosmos, and entered the body through food and drink, in order to compose the humours (blood, phlegm, yellow and black bile). The latter, finally, constituted the homogeneous parts that were components of the organs (*Hip. Elem. CMG VIII*: 126, 5–9 –*K. I.* 479, 480).

[36] Already in *On the nature of man* (fourth century BCE) each humour was related to a couple of qualities and a time of the year (*De Nat. Hom. CMG VII*: 182–6). Similarly, Plato (*Tim*. 82A–B) related the imbalance of elements and qualities to diseases, and Aristotle (*P.A. II.1*: 646a 13–24) attributed certain qualities to each element.

[37] Schöner (1964: 65). [38] Jouanna (2012: 339).

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duskrasia was crucial not only to determine the type of qualities imbalanced – which needed to be opposed – but also the degree of their disturbance. Thus, the skilled doctor was able to choose the drug that would have the exact potency to counterbalance the level of disturbance of each altered quality within the mixture.

In summary, with these three components – bodily location, quality disturbed and degree of disturbance – Galen developed a coherent, cohesive and efficient system to address possible disturbances of consciousness. We shall see that whenever such conditions were under discussion Galen funnelled the arguments into this tripartite scheme, which could be effectively managed by his medicine, thereby providing him with authority.[39]

Definitions of consciousness: perspectives, specificity and pitfalls

An initial hurdle for the present undertaking – exploring impaired consciousness in these authors – is the vagueness of its key concept. Scholars grapple with definitions of consciousness because they vary substantially across different theoretical frameworks. This possibly enriches the debate by illuminating alternative perspectives, but also leaves it rather unresolved. Below are a few examples of attempts at systematising this elusive notion.

Broadly speaking, philosophers of mind have distinguished between two types of constructs: an easily accessible one, which according to Block involves the rational control of thought and action, and therefore is designated as 'access consciousness', and the more elusive 'phenomenal consciousness'.[40] While the former is objective, representational and comprised of verbally transmittable contents, such as thoughts, desires and beliefs,[41] the latter refers to the subjective feelings that accompany mental processes. Phenomenal consciousness comprises the 'qualia' or subjective

[39] As von Staden has remarked (1997: 36), Galen's claim to authority was influenced by the values of the Second Sophistic. Within his self-construed image as a *pepaideumenos* physician, his system – legitimised by the alleged endorsement of the ancients, his outspoken studies in philosophy and logic, and his own experience – is used as a powerful argument to discredit rivals and promote himself.

[40] Block (2002: 207). [41] Carmel and Spreavak (2015: 104).

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experiences that respond to the question 'what is it like?' In this sense, 'an organism is conscious if there is something it is like to be that organism'.[42] Why and how that 'inner life' – that is, phenomenal consciousness – arises is, according to Chalmers, the hard problem.[43]

On the other hand, neuroscientists have mainly attempted to tackle the allegedly 'easy' problems, namely, the neural correlates of consciousness. In general terms, they have focused on understanding the patterns of brain activity that determine different levels of consciousness, and the processes that shape our perceptual awareness.[44] In this manner, they have isolated different components such as 'wakefulness' or level of consciousness, and 'awareness', which refers to the content thereof. This concept can be further subdivided into external (awareness of our surrounding environment) and internal (our inner world). Thus, by combination of these independent components neuroscientists classify various possible states of consciousness.[45]

Because doctors are forced to work at the practical interface between the mental (including the phenomenal) and the bodily (including the neurophysiological) aspects of consciousness,[46] they have been more successful in describing and assessing its impairment, rather than actually defining it in itself. Even if the concept as such is not unequivocally delimited, conditions with altered levels of consciousness are quite common, well-characterised and quantifiable clinical findings. Indeed, they are ubiquitous and easily recognisable in current medical practice: not only in physiological processes, such as spontaneous sleep, but also induced by certain substances such as anaesthetics or recreational drugs. Furthermore, they are common during various types of disease, both mental and physical.

In everyday practice, changes in consciousness are considered to belong in a continuous spectrum that ranges from patients who are 'awake, alert and appropriate' (that is, normally functioning individuals) to deep coma and vegetative states. Between these extremes, several levels of drowsiness, agitation, delirium and

[42] Nagel (1974: 435–50). [43] Chalmers (2010: 5).
[44] Carmel and Spreavak (2015: 109). [45] Laureys (2007: 32–7).
[46] Fulford (2006: 24–5).

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confusion have been singled out. As will be shown below, ever since antiquity, physicians have strived to measure, grade and label these various states of consciousness and have devised tools to achieve this goal. The famous Glasgow Coma Scale (GCS) – created around the mid-1970s[47] – is a relatively recent example to numerically quantify the level of consciousness. As will be discussed, other arguably similar attempts (which even utilise surprisingly similar parameters) date back to as early as the Hippocratic corpus.

In other words, this book aims to identify in ancient texts an extremely common medical finding that stands at the interface between physiological and pathological phenomena, and between what we consider as 'mental' and 'somatic' conditions. Inevitably, the way in which ancient doctors framed such situations was influenced by other deeper understandings about the workings of the soul, the mind and the body, which the analysis will try to expose.

Working definition of consciousness

It is evident from the above – even after this short glimpse at only three disciplines – that each specialist (whether philosopher, doctor or neurobiologist) approaches the matter in a particular way, asks specific questions and fragments consciousness into distinct components according to those questions. The picture would become even more intricate if we dug deeper into any of these fields of study, let alone if we added other areas of knowledge where consciousness was also addressed. As a result, it looks as though this concept precluded any attempt at a universal, comprehensive, clear-cut definition. Such Aristotle-inspired lists of essential criteria and attributes seem inadequate for these kinds of complex notions, which acquire different nuances depending on the aspect being addressed, and whose boundaries are often 'fuzzy'.[48]

Alternatively, in order to establish what I will regard as belonging within the sphere of consciousness and its impairment, I have used a cognitive model inspired by Rosch.[49] Beyond the evident

[47] Teasdale and Jennet (1974: 81–4). [48] Aitchinson (1994). [49] Rosch (1975).

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advantage of bypassing the impossibility of establishing strict boundaries to such an elusive construct, this approach has the added benefit of allowing an analysis of compatible ideas on consciousness – in antiquity and nowadays – without anachronistic assumptions.

According to this model, classifying objects into a category requires establishing relationships between those objects and an ideal exemplar that represents the most typical case within that category, or its 'prototype'. In this way, each member within a group shares only certain characteristics with the prototype (not all of them, and different members share different characteristics with it).[50] Additionally, by matching the features of a certain object to an ideal exemplar, one can determine the extent to which that object identifies with the prototype, and hence, how much it belongs to the category. This introduces another advantage to this model, which is the membership gradience, namely, the idea that different members have different degrees of affiliation to a category.[51] As a result, this model is also capable of reflecting the above-mentioned tendency among doctors of all eras to distinguish different levels of consciousness: ultimately, the closer a condition resembles a prototype that defines impaired consciousness, the lower the level of consciousness of that condition.

In our current medical understanding there are three easily recognisable clinical presentations that we nowadays unequivocally consider within the compromised end of the spectrum of consciousness. They are delirium (or wakeful impaired consciousness), sleep (or drowsy impaired consciousness) and fainting (or total loss of consciousness). I shall use them as prototypes to identify the phenomenon in antiquity. They will function in the discussion as ideal exemplars; namely, I will assume that the medical writers were talking about impaired consciousness whenever their accounts resembled one of these three presentations. To avoid the trap of importing anachronistic concepts into the texts,[52]

[50] Aitchinson (1994) explains the usefulness of this model to categorise what he defines as words with 'fuzzy edges', that is, words whose limits are uncertain. Given that consciousness has very 'fuzzy edges', the prototype model seems like a valid method to approach the definition challenges.

[51] Lackoff (1987: 13). [52] Singer (1992: 132).

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I will not presuppose that ancient doctors actually had an idea of consciousness. On the contrary, I shall simply explore how they framed – and how (if at all) they linked in their discourse – certain conditions, in which their patients suffered swoons, slept too much or too little, talked nonsense or were simply not their usual selves. Ultimately, my aim is to understand what they made of these findings (which they often described and acknowledged within their sphere of expertise, and which we nowadays regard as paradigmatic examples of impaired consciousness); how they related them to other ideas and beliefs; and to assess the extent to which they perceived them as connected conditions. By doing so I aim to single out this concept, generally overlooked by scholars, which reflects a distinct reality and permeates different aspects of these doctors' more general beliefs, including ideas about the soul, the body, illness and even death. . .

Similarities and contrasts between the three prototypes of impaired consciousness

There is a further set of subcategories (in a lower hierarchical level) that will be useful in thinking about the relationships among these three prototypical presentations. As a matter of fact, much like the idea of consciousness itself, delirium, sleep and fainting also present fuzzy edges between them, and there are certain situations where it is difficult to separate one from another (this is why we nowadays consider impaired consciousness as a continuous spectrum and not as a collection of discrete independent states). For instance, vivid nightmares with sleepwalking can be hard to distinguish from wakeful delirious states with hallucinations. Similarly, it is not always straightforward to differentiate cases of fainting from episodes of deep dreamless sleep. To overcome this hurdle and articulate such ambiguous interphases between prototypical presentations, there is a network of concepts that provides a simple theoretical framework. It is comprised of three notions: 'alertness', 'connectedness' and 'responsiveness'.

Anaesthetists, whose job is to manage and regulate different levels of consciousness, explain physiological and pathological states through these notions, as well as the above-mentioned shifts

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and the grey areas between them. Alertness is the ability to experience and perform intellectual tasks, to reason, to plan, to acknowledge perceptions, and the awareness of these functions as belonging to the self. Connectedness alludes to our link with the inner and outer world, that is, internal and environmental connections which enable us to experience stimuli. Finally, responsiveness refers to our complex behavioural interactions with our surroundings. It can be spontaneous or goal-directed (when obeying an order).[53]

Different combinations of these concepts can explain both undisturbed and altered levels of consciousness. In the normal wakeful state, individuals are typically alert, connected and responsive. Similarly, in dreams – which are normal physiological states – alertness is intact (we can perceive and perform intellectual operations during oneiric experiences), but there is a lack of connectedness to the environment and no responsiveness. Conversely, in dreamless sleep all three are absent. On the other hand, abnormal states – such as delirium – can be characterised by various combinations of malfunctioning. In some cases connection to the environment is intact (perception is preserved) but alertness fails. Such patients can normally receive environmental stimuli but are incapable of complex processing; in other words, their cognition is impaired. The degree of responsiveness in these cases will determine whether we talk of hyperactive impaired consciousness, where the patient moves, resists, acts aggressively or speaks incomprehensibly, or hypoactive impaired consciousness such as drowsy states or 'coma vigil' (in which the affected individual can open their eyes, but is otherwise completely unconscious with no response whatsoever).

These concepts are particularly useful in understanding the fuzzy edges, namely, the links and interfaces where the boundaries between these prototypes become blurred. In this sense, the similarities between vivid dreams and delirium can be framed as conditions with preserved alertness and impaired connectedness to the environment, for both are present in nightmares and wakeful hallucinations. Similarly, the difficulty of distinguishing between swoons and deep dreamless sleep can be explained by

[53] Sanders el al. (2012: 947).

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the coincidence in the complete abolition of alertness, connectedness and responsiveness that occurs in both. In other words, the advantage of dividing the prototypical presentations into these subcategories is that they highlight the grey areas where they touch each other and help us understand the points where syndromes can be easily confused. This model will be particularly useful in grasping the reality underlying some ancient medical sources.

A brief glance at recent scholarship

There has been growing interest in mental disorders in antiquity during the last few decades, as evidenced by the interdisciplinary approaches from which they have been tackled. However, scholars have persistently avoided discussing consciousness.[54] Due to the nature of the ancient descriptions, they have, instead, funnelled these accounts into two main thematic discussions. They have either framed them as cases of madness (failing to distinguish between delirium and mental illness) or as evidence of ancient philosophical debates on psychology.[55] Regardless of whether the focus of discussion is limited to a particular author, a specific aspect or a more general analysis of the topic across different ancient sources, the approaches tend to lean towards one of these two groups.

The model that addresses madness – perhaps influenced by current controversies in the domain of mental health – usually yields psychiatrically informed analyses that attempt to fit descriptions found in ancient texts into contemporary classifications of mental illness.[56] However, such an exercise demonstrates our own

[54] Harris' book (2013) on mental disorders offers a good example, for he presents a collection of studies from rich and diverse perspectives, but there is no allusion whatsoever to impaired consciousness.

[55] From the first group the main representative bibliography is: Pigeaud (1987), Pigeaud (1994), Stok (1996), Murphy (2013), Nutton (2013b), McDonald (2014). From the second: van der Eijk (2005), Tieleman (2003). Naturally, there are several other analyses (which will be discussed in the different chapters), where scholars lean towards one of these approaches. The above-mentioned ones are just a sample of the most relevant.

[56] Benett (2013: 27–40), and Hugues (2013: 41–58) both draw parallels between the *Diagnostic and Statistic Manual* (DSM) of the American Psychiatric Association and some ancient classification endeavours. Possibly the most radical example within this

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difficulty in categorising mental disease, rather than exploring the ancients' view on these matters. Moreover, in most of these studies there is a caveat with the construct 'mental illness'. It is either conceived differently by each scholar, depending on the aspect that they are trying to highlight, or the concept is so broadly and vaguely defined that it ends up being inadequate to distinguish specific conditions, such as impaired consciousness.[57]

Regarding the approach that looks at the philosophical reading of these passages, modern scholarship tends to explore notions such as mind, soul and their anatomical location.[58] Under the overarching construct of the mind, authors have made inquiries into the functioning and interaction of body, thought, spirit and intelligence,[59] as well as into theories about the substances involved.[60] Even if scattered allusions to consciousness might arise in such discussions,[61] authors seldom remark on some links that the ancients intuited between unusual perceptions, sleep disturbances and behaviours perceived as abnormal. In general, most approaches to these texts have discussed the peripheries – or the fuzzy edges – of impaired consciousness, but they have not been able to reach to its core.

Grmek is one of the few exceptions, for he posited that most Hippocratic descriptions were not referring to psychotic disorders,

group is Matentzoglu's thesis (Matentzoglu 2011: 16–18), where she looks for 'psychopathological symptoms' in the Hippocratic descriptions, and utilises the *International Classification of Diseases* (ICD-10) to provide a systematic phenomenological classification of them. Also within this group, Devinant (2020) grapples with delimiting the 'psychic troubles' in the Galenic corpus.

57 A good example of the latter problem is the recent book by C. Thumiger (2017), which offers a very interesting analysis of these issues. However, by defining her object of study as a 'continuum between pathology and sanity' (46), and considering 'every mental sign as a manifestation of madness' (44), she eliminates any possibility of more specific or nuanced characterisations.

58 Hankinson (1991: 194–217).

59 Gundert (2000: 13–35). Bartos (2015: 185–222) and Devinant (2020) have touched upon the relationship between body and soul in the Hippocratic *On regimen* and in the Galenic corpus, respectively.

60 van der Eijk (2005: 119–35).

61 Gundert (2000: 18) mentions the temporary loss of consciousness in the Hippocratic corpus and van der Eijk (2005: 127) translates *phronêsis* as consciousness (as opposed to *sunesis*). Pigeaud (1987: 14–21) even acknowledges that the ancient texts are not discussing psychopathological conditions, but the loss and recovery of lucidity, which he relates to the field of consciousness. Nevertheless, he explicitly disregards this aspect and focuses on '*la folie*' (1987: 15).

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but to '*obnubilations de la conscience*'. Unfortunately, he did not pursue this hypothesis further.[62] In a similar manner, Boehm's analysis of 'unconsciousness and insensitivity in the Hippocratic collection' suggests an association between sensory perceptions and the spirit (*l'esprit*), thereby identifying their impairment with a state of unconsciousness.[63] Nevertheless, despite the title, her study is more focused on insensitivity than on unconsciousness, which, again, is barely tackled. Padel, on the other hand, does embark upon an original scrutiny of the manifestations and representations of consciousness in Athenian tragedy. Although not specifically medical, her thorough study draws some interesting conclusions about the Hippocratic corpus, which will be useful to contrast with the rest of our sources.[64]

Because the idea of impaired consciousness challenges most of the recent scholarly theorisations, the present analysis will primarily attempt to revisit – with this novel framework – the usual set of questions concerning the mind, the soul, the body and their workings. In this way I aim to provide fresh perspectives on these older debates. At all times, my goal will be to ascertain if and how different authors – belonging to diverse traditions and historical periods – perceived the notion of consciousness. These understandings will shed light on their authors' ideas about human functioning more generally, as well as how they conceived the relationship between mind–body–soul, health–disease and life–death.

[62] Grmek (1983: 412). [63] Boehm (2002: 257–70). [64] Padel (1994).

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