CHAPTER 8

SLEEP IN THE HIPPOCRATIC CORPUS

It seems as though scholars have paid much more attention to dreams than to sleep itself, even though allusions to the latter permeate the whole Hippocratic corpus.[1] Moreover, despite the fact that such allusions often describe patients disconnected from their surroundings, the link between sleep and impaired consciousness has been persistently overlooked.[2] In fact, the way in which this disconnection was interpreted defined how these doctors actually approached this process. Not only did it guide their stance in the debate about limits (that is, where sleep starts and wakefulness ends), but it also determined their view concerning the more theoretical challenges (namely, where each author set the boundaries between health/normality, disease/abnormality). Furthermore, as Thumiger points out, sensory perceptions allow the interaction of the body with the outside world, and the health of the mind is strongly dependent on that interaction.[3] Consequently, the disruption that occurs during sleep can also tell us about these doctors' ideas about the mind.

Disconnection and the fuzzy edges of sleep

The ambiguities in the relationship between sleep and health are ubiquitous.[4] Some authors considered sleep as a natural healthy and physiological process, others as a pathological state where

[1] Recent examples are Harris (2009: 174–84) and Hulskamp (2013: 33–54).

[2] Thumiger (2017: 174–88) does devote a whole chapter to sleep; however, given her broad definition of mental illness, the role of sleep in consciousness is only tangentially touched upon. Marelli's paper (1983: 331, 337), on the other hand, offers some insight into the matter, although he specifically explored how sleep is related across the corpus to the pre-Socratic philosophers, on the one hand, and to Aristotle, on the other.

[3] Thumiger (2017: 334).

[4] Byl (1998: 34) offers several examples that illustrate the ambivalence of sleep in terms of health and disease. I will focus on those where this ambivalence concerns alterations of consciousness.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

consciousness was altered. There is yet a third group that distinguished between a healthy and a pathological kind of sleep. Similarly, the fuzzy edges of the notion of consciousness manifest through the fact that in certain texts there is such an overlap between hallucinations, nightmares and visions that it is difficult to know whether the writer is talking about dreams, wakeful hallucinations or intermediate states.[5]

Sleep as health

This approach is illustrated in the theoretical work *On regimen*. In book 4 sleep is described as the perfect and most active phase of the *psuchê*, where – while disconnected from the environment – κινεομένη καὶ ἐγρηγορέουσα διοικεῖ τὸν ἑωυτῆς οἶκον ('setting itself in motion and being awake, it [the *psuchê*] administers its own household').[6] Namely, by becoming detached from the outside world the *psuchê* is able to concentrate on and organise the body. Moreover, through this inwardly directed focus, it can provide, by means of dreams, valuable information about its current condition and emotional state.[7]

In a like manner, in *Aphorisms* sleep is opposed to sick conditions, which it resolves: παραφροσύνην ὕπνος παύει ('sleep puts an end to delirium').[8] Also in *Prognostic* τὴν μὲν ἡμέρην ἐγρηγορέναι χρή, τὴν δὲ νύκτα καθεύδειν· . . . κάκιστον δὲ μὴ κοιμᾶσθαι, μήτε τῆς νυκτὸς μήτε τῆς ἡμέρης . . . ὑπὸ ὀδύνης τε καὶ πόνου ἀγρυπνοίη ἂν ἢ παραφρονήσει ἀπὸ τουτέου τοῦ σημείου ('it is necessary to be awake during the day and to sleep at night', and 'worst of all is not sleeping whether by night, or by day' because in such a situation 'either are pain and distress causing insomnia, or it is followed with delirium').[9] Through the 'medicalisation' of insomnia and sleep during untimely hours, this excerpt offers a glimpse into Taylor's question 'When do we sleep?' Unlike other societies where sleep can be biphasic or

[5] Unlike Thumiger (2017: 296) I refuse to discuss hallucinations and nightmares as the same phenomenon because, as we shall see, there are explicit attempts in certain texts to separate them, which suggests that authors were interested in distinguishing one from the other.

[6] *Vict. CMG 4.86*: 218, 8.

[7] van der Eijk (2005: 171) has related this tradition to Orphic circles and Democritus.

[8] *Aph. LCL II.2*: 109, 15.

[9] *Prog. CUF 10.1*: 26, 6–7; *X.3*: 27, 2–5.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

polyphasic,[10] this medical writer seems to be privileging a nightly and monophasic pattern of sleep. Beyond the social regulation that could be read into this passage – labelling sleep as unhealthy at any time but at night could be useful in terms of social organisation and economic production – note how the two passages are a mirror image of each other: while sleep cures delirium, insomnia causes it.[11] Namely, the identification between health and sleep here is rather strong.[12]

Sleep as disease

On the other hand, the author of *On breaths* suggests an opposing view, by considering both sleep and drunkenness as states of altered *phronêsis*.

ἡγέομαι οὐδὲν ἔμπροσθεν ὀυδενὶ εἶναι μᾶλλον τῶν ἐν τῷ σώματι συμβαλλόμενον ἐς φρόνησιν ἢ τὸ αἷμα. τοῦτο δ' ὅταν μὲν ἐν τῷ καθεστεῶτι μένῃ, μένει καὶ ἡ φρόνησις· ἑτεροιουμένου δὲ τοῦ αἵματος μεταπίπτει καὶ ἡ φρόνησις . . . πρῶτον μέν . . . ὁ ὕπνος . . . μαρτυρεῖ τοῖς εἰρημένοισιν· ὅταν γὰρ ἐπέλθῃ τῷ σώματι . . . καὶ τὰ ὄμματα συγκλείεται, καὶ ἡ φρόνησις ἀλλοιοῦται, δόξαι τε ἕτεραί τινες ἐνδιατρίβουσιν, ἃ δὴ ἐνύπνια καλέονται. πάλιν ἐν τῇσι μέθῃσι πλέονος ἐξαίφνης γενομένου τοῦ αἵματος μεταπίπτουσιν αἱ ψυχαὶ καὶ τὰ ἐν τῇσι ψυχῇσι φρονήματα. . . *Flat. CHF 14.1–2*: 121, 9–16; 122, 4–6.

I believe that nothing in the body is more favourable for anyone towards *phronêsis* than the blood: whenever it remains in a stable condition, so does the *phronêsis*; as soon as the blood is altered, *phronêsis* also changes . . . First of all . . . sleep . . . is a testimony of what has been said. Indeed, when it falls upon the body . . . the eyes close, the *phronêsis* is altered, and certain other visions linger, which are called dreams. Again, during drunkenness, when the blood suddenly increases in quantity, the *psuchai* (plural) change, and so do the *phronêmata* that are in the *psuchai*. . .

The link between sleep and drunkenness should remind us of the two lads described above, where alcohol abuse was associated with

[10] Brunt and Steger (2003: 16–21).

[11] This idea might have influenced the association between insomnia and *phrenitis* that we have seen in post-Hellenistic texts.

[12] Interestingly, beyond the anthropological dimension, these ideas are also resonating with other extra-medical discourses. Bartos (2015: 176) has related this passage to Democritus, who associated day-sleeping with disturbance of the body, distress of the soul, idleness and lack of education, whereas Thumiger (2017: 183–4) connects it to Attic tragedy, specifically to Sophocles' *Philoctetes* and Euripides' *Heracles*.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

wakeful impaired consciousness. This author seemingly considered that sleep shared important similarities with those conditions.

From a less medical perspective, the passage may be, again, reflecting socially regulated discourses. Just as nowadays inebriation and sleepiness are regarded as at-risk corporeal states,[13] perhaps, the negative connotation of sleep according to this author (he identifies it with alcoholic intoxication) may be related to the disapproval of excessive drinking in classical Greek culture. Along the same lines, the author of *Epidemics V* describes Timocrates' case, in which he fell into a deep sleep or swoon after drinking heavily, and ἐδόκει τοῖσι παρεοῦσιν ... τεθνάναι ('looked like he had died to those surrounding him'),[14] thereby relating drinking with sleeping, fainting and death. Nissin has also found the negative connotation of sleep among the Romans to be related to death and to vices.[15] The usefulness of establishing socio-medical relations in this case is that they point to specific circumstances or moments during the day, in which sleep was associated with pathology. This illuminates a boundary that otherwise seems rather confusing in the purely medical discourse, and allows us to establish a provisional sociologically informed line between healthy and abnormal sleep.

Be that as it may, it is worth highlighting that regardless of their side in the debate, the authors seem to stress disconnection from the environment as a key feature of sleep. In *On regimen 4*, this disconnection is considered as a positive condition, because it allows the *psuchê* to offer valuable information – in the form of dreams – for us to interpret (*Vict. CMG 4.86*: 2, 12–13).[16] In *On breaths*, conversely, the author suggests that any *enupnion* (that is, any conscious disconnection) is pathological, causing a detachment from reality that makes sufferers 'forget about the present evils and become hopeful about a pleasant future'.[17]

[13] Williams (2008: 649). [14] *Epid. V. CUF V. 2.2*: 3, 2–3. [15] Nissin (2016: 53).

[16] Debru (1982: 31) points out that 'la maladie se prépare et s'annonce dans le sommeil'. Diseases are independent from sleep, but if we have the ability to discern (*krinein*) the dreams correctly (*orthôs*), we are in a better position to understand their nature.

[17] γίνονται τῶν μὲν παρεόντων κακῶν ἐπιλήσμονες, τῶν δὲ μελλόντων ἀγαθῶν εὐέλπιδες (*Flat. CHF 14.2*: 122, 6–7).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

Third position: healthy and ill kinds of sleep

The author of *On the sacred disease* adopts the third way, namely, only certain dreams and nightmares are associated with pathological states:

ἔν τε τῷ ὕπνῳ οἶδα πολλοὺς οἰμώζοντας καὶ βοῶντας, τοὺς δὲ πνιγομένους, τοὺς δὲ καὶ ἀναΐσσοντας τε καὶ φεύγοντας ἔξω καὶ παραφρονέοντας μέχρι ἐπέγρωνται, ἔπειτα δὲ ὑγιέας ἐόντας καὶ φρονέοντας ὥσπερ καὶ πρότερον. *Morb. Sacr. CUF 1.3*: 3, 10–15.

I know that during sleep many groan and scream, others choke, and yet others stand up, rush outdoors and remain delirious until they wake up. They then become healthy and rational as before.

There is a clear connection in this passage between what we would nowadays designate as 'parasomnia' and delirium. Certain abnormal kinds of sleep are equated with a condition of illness – delirium (*paraphroneontas*) – from which health and reason only return with arousal. Although the author does not explicitly mention a normal kind of sleep, we can assume that those who do not belong to the many (*pollous*) who suffer this condition are unaffected by it, hence, healthy. A comparable dichotomous attitude towards sleep can be found in *Epidemics VI*. On the one hand, there is a list of τὰ ἐν τοῖσιν ὕπνοισι παροξυνόμενα ('conditions that exacerbate with sleep');[18] on the other, sleep belongs to the catalogue of ἔθος δέ, ἐξ ὧν ὑγιαίνομεν … ὕπνοισιν ('habits from which we become healthy')[19] – in Williams' terms, the '*healthicisation*' of sleep.

Peripheries of sleep and the boundaries of consciousness

The elusive distinction between normality and abnormality, health and disease is reinforced by the blurred boundaries between wakefulness and sleep. There are ambivalent descriptions with intermediate phenomena, where it is not clear if delirium happens with the patient awake or asleep.

… παραφρονέει· καὶ προφαίνεσθαί οἱ δοκέει πρὸ τῶν ὀφθαλμῶν ἑρπετὰ καὶ ἄλλα πανατοδαπὰ θηρία καὶ ὁπλῖται μαχόμενοι, καὶ αὐτὸς ἐν αὐτοῖσι δοκέει μάχεσθαι·

[18] *Epid. VI. LCL 8, 5*: 262. [19] *Epid. VI. LCL 8, 23*: 270.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

τοιαῦτα λέγει ὡς ὁρῶν καὶ ἐπέρχεται, καὶ ἀπειλεῖ, ἢν μή τις αὐτὸν ἐᾷ ἐξιέναι . . . τῷδε δὲ γινώσκομεν, ὅτι ἀπὸ ἐνυπνίων ἀΐσσει καὶ φοβεῖται· ὅταν ἔννοος γένηται ἀφηγεῖται τὰ ἐνύπνια τοιαῦτα ὁρᾶν ὁποῖα καὶ τῷ σώματι ἐποίει καὶ τῇ γλώσσῃ ἔλεγε . . . ἔστι δ' ὅτε καὶ κεῖται ἄφωνος ὅλην τὴν ἡμέρην καὶ τὴν νύκτα ἀναπνέων ἀθρόον πολὺ τὸ πνεῦμα. ὅταν δὲ παύσηται παραφρονέων, εὐθὺς ἔννοος γίνεται, καὶ ἢν ἐρωτᾷ τις αὐτόν, ὀρθῶς ἀποκρίνεται, καὶ γινώσκει πάντα τὰ λεγόμενα. *Int. LCL 48. LCL*: 202, 7–11; 14–22.

. . . he becomes delirious (*paraphroneei*): in front of his eyes there seem to appear animals, all other sorts of beasts and fighting soldiers. He even thinks he is fighting amongst them, speaks as though he could see such things and attacks and threatens if somebody does not let him out . . . In this way we can know that he is afraid and startled by a nightmare: when he regains consciousness (*ennoos genêtai*), he recounts what he saw in his dreams, which corresponds with what he did with his body and said with his tongue . . . There are also times when he lies speechless for the whole day and night taking sudden deep breaths. When delirium stops (*pausêtai paraphroneôn*), he immediately regains consciousness (*ennoos ginetai*) and if somebody asks him a question he answers accurately and is able to understand all that is said.

This passage offers a good compendium of different kinds of alterations of consciousness: the author first talks about delirium (*paraphroneei*), and then he seamlessly moves to sleep and nightmares (*enupnion*), without mentioning a transition, as though both were one and the same kind of phenomenon. It should be emphasised, nevertheless, that the author is grappling to separate dreams from wakeful hallucinations. As a result, although the findings in both are so similar that it is difficult to tell one from the other,[20] this doctor's attempts at distinguishing them suggest that he conceived them as two different entities.

In other words, this passage is highlighting the fuzzy edges between two ideal prototypes of impaired consciousness (sleep and delirium), which become even more blurred when analysing the vocabulary of recovery or 'lucidity' (to use Pigeaud's terms).[21] The terminology used to refer to the interruption of the nightmare (in other words, to waking up) is exactly the same as the author later uses to mention the end of the delirium, namely, *ennoos ginomai*.

[20] Our model of alertness, connectedness and responsiveness explains this difficulty more clearly, for in both states – that is, wakeful hallucinations and vivid nightmares – alertness is present, but connectedness disturbed.

[21] Pigeaud (1987: 15).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

Ultimately, both processes – nightmares and hallucinations – and their recovery seem to be framed as similar and related phenomena, because waking up and becoming *compos mentis* were expressed with the same terms.

This and the other above-mentioned cases, where sleep is associated with a terminology akin to wakeful impaired consciousness (*phronêsis alloioutai*, *Flat. CHF 14.2*: 122, 4–6; *paraphroneontas*, *Morb. Sacr. CUF 1.3*: 3, 12) point towards wakeful impaired consciousness as a peripheral phenomenon of sleep, hinting that delirium should be understood as being beyond the outer edge of sleep.

There are other examples that illustrate a similar ambiguity between sleep and total loss of consciousness. In *Epidemics V*, thirty-year-old Appellaeus from Larissa had a disease that affected him at night after dinner:[22]

τῇ δὲ ἐπιούσῃ νυκτὶ ἡ νοῦσος ἐπέλαβε δεδειπνηκότα ἀπὸ πρώτου ὕπνου, καὶ εἶχε τὴν νύκτα καὶ τὴν ἡμέρην μέχρι δορπηστοῦ ἔθανε πρὶν ἐμφρονῆσαι. *Epid. V. CUF 22.4*: 14, 12–15.

The following night the disease seized him, after having dined, as soon as he went to sleep. It persisted during the night and following day until the evening. He died before coming round (*emphronêsai*).

In this passage, sleep seems to be in the peripheries of (or poorly distinguished from) total loss of consciousness. Again, the vocabulary of recovery gives testimony to that: instead of *egeirô* or *epegeirô* (the most common Hippocratic terms to convey the idea of waking up) the use of the verb *emphronêsai* suggests that the writer conceived this *hupnos* as a loss of consciousness rather than normal sleep, and therefore waking up can be equated with coming round.

So far, the examples suggest that these medical writers conceived disturbed sleep and delirium, on the one hand, and deep sleep and fainting, on the other, as related clinical signs (or as phases of similar processes) beyond the normal and physiological type of sleep. A comparable phenomenon can be found between delirium

[22] Many scholars have assumed that the author is describing a case of epilepsy (Lo Presti, 2013: 207, n. 43; Jouanna, 2000: 135, n. 9).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

and fainting. Thynus' son in *Epidemics VII* regained consciousness (*ephronei*) after his swoon (*apsuchiê*).[23] Therefore, while sudden loss of consciousness (*apsuchiê*) was conceived as a temporary disconnection from the environment, coming round is referred to as the recovery of cognitive capacities (*phroneô*). In other words, the recuperation from fainting is expressed with the same terminology as the recovery from wakeful impaired consciousness, which again suggests that in the Hippocratic texts, delirium and swoons were different forms of 'not *phronein*' or 'not being in their (right) minds',[24] or conversely, that becoming *compos mentis* and coming round were identical processes.

To sum up, the type of disconnection that characterised agitated sleep was perceived by these Hippocratic doctors as a disorder, which they tried to distinguish from wakeful impaired consciousness and from normal healthy sleep. On the other end of the spectrum, the disconnection that occurred during deep dreamless sleep could be easily confused with fainting. Bearing in mind that delirium and fainting were also perceived as related phenomena, it is safe to argue that the three exemplars of impaired consciousness were perceived by these Hippocratic doctors – just as we do nowadays – as a group of medical conditions that shared some common clinical features (hence our methodological choice is not an artificial anachronic modern imposition on the ancient material).[25]

Levels of consciousness

In line with the idea of a link between the three exemplars, it could be argued that the deepest and the most superficial depths of sleep – that is, the extremes of this spectrum – are, precisely, at the blurry borders where this prototype starts to blend with the

[23] *Epid. VII. CUF 108, 2*: 111, 14–15.

[24] ἐντὸς ἑωυτοῦ ἐγένετο ('being in his mind') is also used to talk about recovery from both a delirious sleep (*Epid. VII. CUF 2, 4*: 49, 21) and fainting (*Epid. VII. CUF 1, 7*: 48, 20).

[25] The idea of the disruption of senses as the common ground for all three prototypes of impaired consciousness – although intuited by the Hippocratic authors, as shown in previous passages – is explicitly proposed by Aristotle. As Thumiger (2017: 299) rightly argues, he related sleep, delirium and fainting as conditions caused by the interruption of perception (*Somn. et Vig*. 455b4–6).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

others (fainting and delirium, respectively). As we shall see, Hippocratic medical writers resorted to two main linguistic devices when attempting to describe these changing levels of consciousness (and they found a correspondence between them and the seriousness of the diseases).

The widest used mechanism was nuancing and qualifying the specific terms through adjectives, adverbs or descriptive periphrasis: the writer of the first catastasis of *Epidemics II* describes – while talking about skin rashes in summer – a parallel progression between disturbed sleep (that is, a change in the level of consciousness) and the peak of the disease. He starts by explaining how women were not stuporous before the onset of the condition, and once it had started, πρόσθεν δὲ οὐ κάρτα ἦσαν κωματώδεις . . . κωματώδεις δὲ καὶ ὑπνώδεις τὸ θέρος καὶ μέχρι Πληϊάδων δύσιος, ἔπειτα μὴν ἀγρυπνίαι μᾶλλον ('though stuporous and somnolent (*kômatôdeis*,[26] *hupnôdeis*) during the summer until the setting of the Pleiades, afterwards there were instead periods of sleeplessness (*agrupniai*)').[27] The clarification that *kôma* was *hupnôdes* during that summer is not irrelevant, because in other cases it can be slightly different. In fact, in the third catastasis of *Epidemics III*, patients affected with ardent fever and *phrenitis* suffered ἢ τὸ κῶμα συνεχές οὐχ ὑπνῶδες, ἢ μετὰ πόνων ἄγρυπνοι ('either continuous non-somnolent stupor (*kôma suneches ouch hupnôdes*), or sleeplessness with distress (*meta ponôn agrupnoi*)').[28] Note the writer's exquisite precision when separating the non-somnolent continuous stupor from sleepless restlessness with discomfort.

On other occasions doctors are less sophisticated and make do with simple adjectives. Certain severely ill patients who were stuporous (*kômatôdees*), ἢ βαρὺ κῶμα παρείπετο ἢ μικροὺς καὶ λεπτοὺς ὕπνους κομᾶσθαι ('either suffered a deep stupor (*baru kôma*), or had light and short snatches of sleep (*leptous hupnous*)').[29] Similarly, the

[26] The notion of *kôma* refers to some kind of sleep disturbance with impaired consciousness, as McDonald (2009a: 42) suggests.

[27] *Epid. II. LCL 3, 1*: 44, 26; 45, 1–4. As McDonald (2009a: 41) has accurately pointed out, *agrupnia* designates a state of disturbed sleep and restlessness, probably accompanied by mental or physical discomfort.

[28] *Epid. III. CUF* catastasis *VI.2*: 84, 6–7.

[29] *Epid. III. CUF* catastasis *XI.2*: 88, 4–5.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

author of *Prorrhetic I* states that κωματώδεες νωθροὶ οὐ πάνυ παρὰ αὑτοῖσιν ('patients affected with heavy stupor (*kômatôdees nôthroi*) are not well in their senses').[30]

In all these cases, changes in the level of consciousness seem to be correlated with clinical worsening of the patient. Particularly explicit of this parallel progression between severity of disease and depth of sleep is the case of Python's child: ὁ πυρετὸς παρωξύνετο, καὶ ἡ καταφορὴ διὰ τῶν αὐτῶν . . . αὐτίκα τὸ κῶμα ἐπέπαυτο, καὶ ὁ πυρετὸς ἐπεπρήϋντο ('the fever peaked and so did drowsiness (*kataphorê*) to the same extent (*dia tôn autôn*)'). This doctor does not seem to distinguish between *kataphorê* and *kôma*, because after the treatment he states that 'immediately drowsiness (*kôma*) stopped, and the fever became mild'.[31] Possibly this is a case of partial synonymy, which will be discussed later.

The other linguistic device to grade the depths of sleep, which was also common in modern times before the emergence of the GCS, is the use of diminishing suffixes.[32] Probably, the alteration of consciousness that the wife of Dromeades suffered on the fourth day after the onset of symptoms, *hupekarôthê*,[33] was slightly less than she would have had, had she been hit in the temples: πληγαὶ καίριοι καὶ καροῦσαι αἱ κροταφίτιδες γίνονται ('blows to the temples are mortal and cause stupor (*karousai*)').[34] Similarly, in *Prorrhetic I* (*LCL 38*) the writer claims that *hupagrupniê* is associated with diarrhoea. This prefixed derivation to grade levels of consciousness extends also to the syndromes related to hyperactive impaired consciousness (Theodorous' wife *elêrei* and *hupelêrei* alternately, *Epid. VII. CUF 25.2*: 13; 3, 19).

It appears that these linguistic devices evidence an explicit effort among these doctors to study various and changeable degrees of disconnection from the environment, which paralleled the degree of compromise of their patients. Within the spectrum of consciousness, drowsiness, agitated sleep and wakeful hypoactive delirium, on the one hand, and deep unreactive states of disconnection and fainting,

[30] *Prorrh. I. LCL 37*: 176, 23–4.
[31] *Epid. VII. CUF 118.2*: 114, 19–20; *118.3*: 115, 3–4.
[32] Comatous and hypocomatous were common terms to describe the level of consciousness before they could be quantitatively defined by the GCS.
[33] *Epid. I. CUF A11, XXVII.11*: 56, 10. [34] *Artic. LCL 30*: 252, 21–2.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

on the other, seem to both be in the peripheries of normal dormancy, just outside the limits of healthy sleep. Moreover, the more the clinical presentations differ from the ideal prototype of dreamless quiet sleep, the sicker the patient.

Terminology, mental capacities or HOFs, and the idea of mind

Terminology to describe the peripheries of sleep

Ever since Galen, scholars have tried to understand the exact meaning of the Hippocratic 'vocabulary of insanity'.[35] A usual strategy in recent studies has been to link the specific terms to the verbs and abstract nouns from which they derive. Thus, diseases like *phrenitis* or symptoms like *paraphronêsis* and *ekphrones* were related to the verb *phroneô* ('to think' or 'to be sound') and its more abstract derived noun *phronêsis*.[36] Similarly, *paranoia*, *paranoeô*, *paranoos*, to an abnormal way of performing the verb *noeô* ('to reason') and its abstract construct *nous*, contrary to their sound and healthy opposite, *katanoeô*. The same could be claimed about *suniêmi* ('to understand', 'to comprehend'), *sunesis* and their disturbed derivatives *parasunesis*, *asunetos*.[37] I consider this quest for a strict definition and delimitation of each term to be futile.

If we turn to our current technical language for such issues, there is no clear distinction between 'delirium', 'derangement', 'confusion' and 'disorientation'. In fact, two doctors presented with the same case would not necessarily choose exactly the same term to describe it, because these words have fuzzy edges. The very nature of the phenomenon is characterised by constant fluctuations, which make it difficult to choose only one of these categories.[38] Even if the terms do have subtle semantic differences, in actual clinical practice, they tend to be used

[35] The most important analyses on this topic are di Benedetto's (1986: 43–7), Pigeaud's (1987: 15–19) and Thumiger's (2013: 63–81). All three scholars focus on the composition of terms, the exact meaning of suffixes and lexemes, or they compare the collocations with older or contemporary extant sources. Other scholars have strived to seek equivalent modern translations (Matentzoglu, 2011: 7).

[36] Thumiger (2013: 69). [37] Thumiger (2013: 75–6).

[38] Josephson and Miller (2018: 24).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

interchangeably.[39] In other words, our clinical vocabulary disproves Langslow's postulate that unlike everyday language, where synonymy is mostly partial, in technical language synonyms are always absolute.[40] On the contrary, our medical vocabulary for impaired consciousness is mainly comprised of partial synonyms.

I have already highlighted this phenomenon when analysing the case studies in Part I (where different delirium terms such as *parakruô*, *parakoptô*, *paraphroneô*, etc. – some hyperactive and some hypoactive – were used interchangeably). I therefore do not agree with Thumiger's claim that ancient terms are interchangeable in modern translations because the subtleties are inaccessible for modern readers.[41] I propose, instead, that they were also interchangeable among ancient doctors, and it could even be argued that the phenomenon is not limited to the vocabulary of wakeful impaired consciousness. We have just seen how it is also extensive in sleeping terminology, where *kataphorê* and *kôma* are both associated with drowsy impaired consciousness and used as partial synonyms (in Python's child's account),[42] whereas *agrupniê* tends to suggest a more agitated sleep.

In terms of the historical debate about the intellectual context, this vocabulary bears testimony to a certain regularity or a certain community of ideas within the diversity of the HC. This specialised terminology seems to share several common features and to be in a developed stage of evolution: the abundance of verbs,[43] the extensive coinage of terms by derivation[44] and the repeated use of certain prefixes show both that doctors felt familiar with these terms and that they had similar ways of thinking and making sense of the world through language. In other words, the symmetries in the way that terms are coined and used may be reflecting a converging relationship between thought and expression of new ideas among these medical writers.[45] Therefore, the development of this jargon,

[39] The closest modern doctors can get to a distinction between these terms is whether they point towards hypoactive disturbance, such as 'stupor', or conversely, towards impaired consciousness with hyperactive responsiveness, such as 'agitation' (Josephson and Miller, 2018: 24).
[40] Langslow (2000: 21). [41] Thumiger (2013: 82).
[42] *Epid. VII. CUF 118.2*: 114, 19–20; *118.3*: 115, 3–4. [43] Langslow (2000: 23–4).
[44] Lloyd (1983: 158). [45] Cross (2018: 12).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

which enabled them to articulate relevant nuances for their novel theories, can be thought of as another sign of these physicians' distinction as a group and their claim to authority ahead of competing opponents.

In a nutshell, the terminology to describe delirium, sleep and its peripheries seems to refer to changeable conditions that can acquire opposing types of symptoms. A group of similar terms is used to describe states of utter bewilderment and passivity in the peripheries of sleep, on the one hand, and hyperactive impaired consciousness and hallucinations, on the other. The fact that, despite such contrasting presentations, the authors used equivalent terms constitutes a strong hint that they regarded them as essentially similar illnesses or as different manifestations of the same condition. When collating the collocations and the descriptions of these terms throughout the different authors, treatises and conditions, there seems to be a certain interchangeability and affinity in the meaning, which reminds us of the partial synonymy in our own vocabulary for impaired consciousness.[46] Undoubtedly, in a delirious person signs and symptoms are in constant change and fluctuation: within one single episode, one can be sleeping, agitated, drowsy, talking nonsense or silently staring into the void. It is understandable, therefore, that the different terms accounted for all those findings in some texts, but for only some of them in others.

HOFs in the Hippocratic texts

Closely related to the above-commented terminology, there is a number of vague or ill-defined concepts that these authors considered to be relevant in discussions about impaired consciousness (the derivatives of which were used to describe delirious symptoms). Such concepts – *phronêsis*, *sunesis*, *nous* (among others) – seem to subsume various combinations of capacities that are nowadays included in our idea of consciousness, for example, perception, movement, speech and reasoning. In other

[46] There are also examples of partial synonymy in non-technical texts. In Aristophanes' *Clouds* (*Nu*. 844–6) *paraphronountos* is used interchangeably with *paranoias* and *manian*.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

words, they loosely group together constructs that correspond to what we nowadays regard as HOFs.[47]

If we go back once again to the study cases discussed in Part I, for the author of *Diseases I* the hallucinatory and delirious component of *phrenitis* was caused by bile affecting the *sunesis*.[48] The same problem, according to another nosological treatise, *On affections* (*Aff. LCL*: 10), originated in a stricken *nous* (*tou nou parakoptei*), and yet another medical writer related hallucinations to the *gnômê* (an abstract derivative of the verb *gignôskô*, 'to know, to perceive'). The latter discussed this idea in a short work that explores the different physiological and pathological aspects of glands:

ἡ γνώμη ταράσσεται, καὶ περίεισιν ἀλλοῖα φρονέων, καὶ ἀλλοῖα ὁρέων· φέρων τὸ ἦθος τῆς νούσου σεσηρόσι μειδιήμασι καὶ ἀλλοκότοισι φαντάσμασιν. *Glan. 12.2. Brill(C.)*: 76, 18–18.

The *gnômê* is disturbed, and [the sufferers] end up both thinking and seeing aberrations – things that are different [from reality] – as they bear this disease with a grinning laughter and strange visions.

It is interesting to point out that the author perceives this phenomenon as being different from spasms (that is, movement disturbances), speechlessness and breathing difficulties, which he associates with a bewildered (*aphronei*) *nous* (*Glan. 12.2. Brill (C.)*: 76, 13–15) in cases of *apoplexy.*

It seems that *gnômê*, *sunesis*, *nous* (and also *phronêsis* and *dianoia*) were associated according to these doctors with different combinations of HOFs, which played an important role in the workings of the mind, and therefore were involved in the development of impaired consciousness when affected.

[47] Alongside these terms, there are other constructs, mainly *thumos* and *psuchê* (that we often equate with philosophical representations of the soul and the spirit), which in certain passages are also related to these concepts: the author of *On diseases of girls* associated the *thumos* with hallucinations (*Virg. CUF II.3*: 190, 4–8), and the author of *On breaths* linked the alterations of consciousness during drunkenness with changes in the *psuchai* and the *phronemata* located in it (*Flat. CUF 14.3*: 122, 6–10).

In the next part I will discuss the idea of the soul that emerges from the analysis of impaired consciousness, and suggest that *psuchê* (and *thumos* to a lesser degree) is more usually conceived as a broader concept that often operates above the level of mental capacities, and can be determinant of the boundary between life and death.

[48] φρενῖτις δ᾽ οὕτως ἔχει· τὸ αἷμα ἐν τῷ ἀνθρώπῳ πλεῖστον συμβάλλεται μέρος συνέσιος·. . . (*Morb. I.30. LCL*: 158, 1–2).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

In order to elucidate the way in which Hippocratic authors conceived, organised and subsumed the cognitive capacities, it is worth highlighting three outstanding features of these constructs: the divorce between the etymological stems of these terms and the vocabulary used in the clinical descriptions; their blurred boundaries, in other words, the vagueness and the overlapping of notions within each concept; and finally, the linguistic (non-etymological) connection between these theoretical ideas and the actual clinical manifestations.

Lack of etymological link between symptoms and these HOFs-constructs[49]

The futility of an etymological analysis becomes evident in any description where some of the above-mentioned concepts appear associated with symptoms.[50] To name but a few, the young virgins suffer *paranoia*, *paraphrosunê* and they *paraphroneoun*, yet the problem does not seem to be in their *nous* (etymologically related to *paranoia*) nor in their *phronêsis* (etymologically related to *paraphroneein*). On the contrary, the *thumos* is affected. Similarly, the author of *Diseases I* talks about *paranoeô-paranoia-paranooi ginontai*, and *paraphroneô*, but he associates these abnormalities with a disturbed *sunesis* (again, neither *nous* nor *phronêsis*). In this sense, one could even wonder whether *tou nou parakoptontos*, characteristic of *phrenitis* in *On affections* (10), can be equated with the above-mentioned *paranoia* of the *sunesis*, given that both writers are describing the same condition. It appears that the derived compounds utilised to talk about clinical manifestations have become estranged from their etymological roots.[51]

[49] I am not suggesting that one should expect etymology to explain the meaning or uses of the words. My approach presents an alternative solution to the one offered by the existing scholarship, which has mainly focused on the meaning of the composing elements of these terms (especially di Benedetto, 1986: 43–7; Pigeaud, 1987: 15–19; and Thumiger, 2013: 63–81).

[50] Craik (2015: 278–9).

[51] There is also an example of this etymological divorce in an extra-medical source. In a Euripidean fragment '[we, old men] have no nous, yet we believe we think correctly' (νοῦς δ' οὐκ ἔνεστιν, οἰόμεσθα δ' εὖ φρονεῖν (*Eur. fr. LCL*: 26, 4)), thereby suggesting a correlation between having a *nous* and being sane, or being able to think (*euphronein*).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

Various combinations of mental capacities within the constructs

Another salient feature of these concepts is their lack of standardisation, which causes contradictions, overlapping and vagueness concerning which mental capacities are included within them. None of these concepts is clearly or consistently defined. Actually, their scope can vary even within a single treatise.[52]

Despite explicit attempts by the author of *On the sacred disease* to define *phronêsis*, some contradictions arise when analysing the treatise. Chapter 7[53] explains how the airflow that enters the brain enables *phronêsis* and 'the movement of the limbs' (*CUF 7. 4*: 15, 19–20), thereby distinguishing them as two separate capacities. Naturally, when the phlegm blocks the air, two consequences occur: on the one hand, due to the compromised *phronêsis* ἄφωνον καθιστᾶσι καὶ ἄφρονα τὸν ἄνθρωπον ('the person becomes dumb and senseless', which suggests that *phronêsis* subsumes intelligence or reasoning and perceptions;[54] on the other, the limbs suffer spasms and involuntary movements. Later on, chapter 16 reiterates the importance of air as the provider of *phronêsis* to the brain, but immediately afterwards it is stated:

οἱ δὲ ὀφθαλμοὶ καὶ τὰ ὦτα καὶ ἡ γλῶσσα καὶ αἱ χεῖρες καὶ οἱ πόδες οἷα ἂν ὁ ἐγκέφαλος γινώσκῃ, τοιαῦτα πρήσσουσι. γίνεται γὰρ ἐν ἅπαντι τῷ σώματι τῆς φρονήσιος, ὡς ἂν μετέχῃ τοῦ ἠέρος. *Morb. Sacr. CUF 16.2*: 29, 8–11.

Eyes, ears, tongue, hands and feet can accomplish however much the brain can discern. The body has its share of *phronêsis* in the same proportion as it has its share of air.

Unlike the previous definition, in this passage all the functions that are impaired during a seizure are considered as part of *phronêsis*, including perceptions, speech and the movement of the limbs. Yet again, in chapter 17 the author establishes a clear contrast between diaphragm (*phrenes*), heart and brain: whereas

[52] Thumiger (2017: 394) also observes the lack of stable semantic differentiation among these concepts.

[53] I follow the chapter division of the Budé edition (which in turn follows Littré's), as opposed to the Jones edition.

[54] *Morb. Sacr. CUF 7.5*: 15, 22.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

the former two are able to perceive – ἡ καρδίη αἰσθάνεταί τε μάλιστα καὶ αἱ φρένες ('the heart and the diaphragm do indeed perceive')[55] – it is only the brain that partakes in *phronêsis* (*CUF 17.3*: 31, 7–8),[56] which suggests that perceptions are not part of what he includes within the notion. This example – even accepting the theory of different writers[57] – reveals the embryonic state of this terminology, insofar as words are clearly used with a technical intention but their usage is not standardised yet.[58] In this sense, I disagree with van der Eijk's translations of *phronêsis* as 'consciousness' and *sunesis* as 'understanding'.[59] We should regard these notions as rudimentary attempts to fragment what we nowadays include within the sphere of consciousness, but not as clearly defined and consistent concepts. As a matter of fact, things get even more complicated if we contrast these passages with the above-commented excerpt of *On glands*, in which the author fragments most of the same HOFs in a different manner and defines them as *gnômê* and *nous*.

Another ambiguous approach, where lack of standardisation manifests as overlapping of concepts, is offered in the highly philosophical treatise *On regimen*. This long and elaborate work addresses several topics under the general overarching premise that the human regimen has some influence over health.[60] As far as consciousness is concerned, its medical writer theorised about *gnômê*, *dianoia* (a compound of *nous*) and *phronêsis*. Although a priori they look like different concepts, their differences become sometimes blurred. Chapter 1, for example, opens by stating:

εἰ μέν μοί τις ἐδόκει τῶν πρότερον συγγραψάντων περὶ διαίτης ἀνθρωπίνης . . . ὀρθῶς ἐγνωκὼς συγγεγραφέναι πάντα διὰ παντὸς ὅσα δυνατὸν ἀνθρωπίνῃ γνώμῃ περιληφθῆναι. . . *Vict. CMG 1.1*: 122, 1–3.

[55] *Morb. Sacr. CUF 17.3*: 31, 6–7.
[56] Jones (1923: 181, n. 2) has also pointed out the distinction between *aisthêsis* and *phronêsis*.
[57] A debate about chapters 14–17 being later additions to the book is reported by Hüffmeier (1961: 51–2).
[58] Langslow (2000: 13).
[59] van der Eijk (2005: 127). For a larger discussion about the difficulty in translating the term *phronêsis*, see Thumiger (2017: 389–90).
[60] Craik (2015: 270–1).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

If it seemed to me that any of those who composed treatises about the human regimen … had throughout composed them with correct knowledge (*orthôs egnôkôs*) about everything that the human *gnômê* can comprehend…[61]

By the end of this same chapter, however, the author claims that 'it is part of the same *dianoia* to know what was correctly said (*gnônai ta orthôs*) as well as to discover what was not [yet] said'.[62] The similar vocabulary connected to each term (*orthôs egnôkôs* and *gnônai ta orthôs*), along with the general sense of both statements, points towards notions that are similar. Further into the discussion, *dianoia* virtually disappears, *nous* is mentioned twice,[63] and the author claims that 'the invisible human *gnômê* enables one to cognise visible things',[64] as though this concept was an HOF related to perception. Nevertheless, by the end of the first book, in chapter 35, perception seems to depend on *phronêsis*, thereby producing, again, overlapping of the notions.[65]

It is worthwhile taking a closer look at this long and complex passage, which many scholars have tried to make sense of.[66] Unlike other occurrences, in this excerpt *phronêsis* is regarded as a condition or a state of the *psuchê*,[67] with a variable aspect (discussed in chapter 35) that has control over movements, perceptions, cognitive functioning (including our idea of intelligence) and emotions.[68]

[61] Of note in this passage is the rhetorical 'othering' of the previous writers (*tôn proteron sungrapsantôn*), which is an example of the intellectual debate that was taking place among these authors, in which they distanced themselves from other groups.

[62] τῆς αὐτῆς ἐστὶ διανοίης γνῶναι τὰ ὀρθῶς εἰρημένα, ἐξευρεῖν τε τὰ μήπω εἰρημένα (*Vict. CUF I.1*: 122, 18).

[63] Bartos (2015: 187).

[64] γνώμη ἀνθρώπου ἀφανὴς γινώσκουσα τὰ φανερὰ (*Vict. CMG I.12*: 136, 10–11).

[65] In *On the art*, *gnômê* enables mental acquaintance with imperceptible things. Just as the eyes facilitate sight, *gnômê* facilitates knowing (*Art. 2.1 Brill(M)*: 51, 19–20). As Mann (2012, 89–90) has accurately pointed out, *gnômê* is here independent of perception.

[66] Hüffmeier (1961: 68–82) analyses the value of *phronêsis* in *On regimen*, *On breaths* and *On the sacred disease*. Pigeaud (1987: 41–7) sees in this passage 'une théorie de la connaisance'. Hankinson (1991: 202–6) explores the relation psychology–physiology and reflects on the ways of thinking and theorising amongst the Hippocratic doctors. Lopez Morales (1999: 514–19) and Jouanna (2013: 100–3) have explored the connection between fire and water in this passage with bile and phlegm in *On the sacred disease*. The latter develops his hypothesis about two typologies of madness based on these texts. Lastly, Matentzoglu (2011: 72–9) and Byl (2002: 217–24) offer a systematic description of the classification.

[67] Hüffmeier (1961: 64–5) has made a distinction between *Zustand* (condition) and *Vermögen* (function, capacity), when discussing *On breaths*. I find this particularly useful in understanding this passage.

[68] Matentzoglu (2011: 72–9).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

According to the account, the nature of the *phronêsis* depends on the proportion of moistness or dryness within the fire and water in the *psuchê*. It is conceived as a spectrum that ranges between *phronimôtaton* (*Vict. CMG 1.35*: 150, 30) and *aphronestaton* (*Vict. CMG 1.35*: 152, 7).[69] Indeed, the whole passage is meant to show how different mixtures of the two elements yield different levels of *phronêsis*, which manifest as various degrees of delirium, affective vulnerability, intelligence, perception and motility.[70] It is in this sense that I consider that the concept can be likened to consciousness and disagree with Bartos, who equates it only with intelligence.[71] Undoubtedly, when consciousness is impaired some or many of these capacities can be compromised, and the seven possible mixtures described in the passage refer to various combinations of deficiencies at each level of *phronêsis*. Therefore, it is arguably not only 'the physiology of thinking'[72] that this author is describing, but the physiology of consciousness more generally.

Inevitably, this reminds us of our current gradual understanding of consciousness through the GCS.[73] The reasoning underlying both systems is that a certain level of *phronêsis* or consciousness, respectively, corresponds to observable cognitive responses. Furthermore, the ancient doctor resorted to linguistic devices similar to the ones utilised by modern doctors when trying to describe progressive levels of impairment. The Hippocratic writer contrasts *maniê*, the most altered state of *phronêsis*, with a condition that can easily become *maniê* but has not reached it yet, defining it as *hupomainesthai* (*Vict. CMG 1.35*: 156, 4). In a similar manner, before the emergence of the numeric GCS, doctors used to talk about 'comatose' and 'sub-comatose' patients. The analogy not only highlights the gradual nature of the

[69] *Phronimotaton* is associated with the wettest fire and the driest water. Perhaps this idea is part of the above-mentioned tradition present in Aretaeus' link between dryness and clairvoyance during *kausôn*, and in Galen's discussion in *QAM* (*Teubner 4*: 42–3).

[70] Matentzoglu (2011: 72–9). [71] Bartos (2015: 191–5). [72] Bartos (2015: 199).

[73] The Glasgow Coma Scale comprises three components that are assessed separately: eye opening (E), verbal response (V) and best motor response (M). Each of these aspects is given a score that increases as the individual becomes more conscious. I have elsewhere discussed other medical scales in current use to assess delirium and cognition that also correlate certain clinical findings with a degree of compromise (Pelavski, 2020: 11–12). Therefore, all these contemporary tools use a similar principle as the one that this author is suggesting to measure the soundness of related capacities.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

impairment in mental capacities (similar to the linguistic devices used to describe the different depths of sleep), but it also shows the need to quantify it, which doctors from such different worlds both felt in their actual practice. Additionally, it illustrates what Langslow has called 'the preference of technical languages for certain forms of derivation'.[74]

To be sure, the collocations and scope of all these terms reveal that they were in the process of becoming specialised vocabulary.[75] As Cross explains, 'written prose most closely reflects the everyday conversational exchanges'.[76] Hence, sometimes they were used as technical terms, whereas on other occasions they appear to be non-specialised words. Like the above-discussed terminology to describe symptoms, this is another example of the emergence of prose as a means for Hippocratic authors to express new shared ideas (although, as the variation in meaning seems to suggest, in a lower stage of development).

Finally, there are other examples that not only illustrate the faint boundaries between these constructs, but also further reinforce the hypothesis about fuzzy edges between sleep and wakeful impaired consciousness. While in *On breaths* (*CUF 14*), sleep affected *phronêsis*, in *Epidemics VI* (*LCL 8.5*: 262), it disturbs (*tarassetai*) the *gnômê*, and in *On regimen* (*Vict. CMG 4.86*) it is a state of the *psuchê*. This could explain why delirium and sleep were sometimes clinically difficult to distinguish for these doctors: because they were explained through the alteration of related theoretical constructs. Or put in another way, these constructs that became altered during delirium and sleep can be framed as embryonic ideas of consciousness. As Thumiger has remarked, we can currently divide this tangle of ideas, concepts and capacities into more specific intellective functions (she distinguishes seven).[77] Even if some of them would not be nowadays considered to strictly belong within our definition of consciousness, they all become impaired in conditions that affect it.

[74] Langslow (2000: 24). In this case moderns and ancients have chosen equivalent prefixes.

[75] Their lack of standardisation is evidenced by the fact that they either used the same name to designate two or more concepts, or conversely, alternative names to designate the same or very similar notions (Lloyd, 1983: 160).

[76] Cross (2018: 12). [77] Thumiger (2017: 394–5).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

Therefore, it is useful to roughly frame these ancient concepts as rudimentary constructs of consciousness.

Phrasal terms: the linguistic link between clinical findings and theoretical constructs

Given the lack of an etymological correspondence between these sets of HOFs and the partial synonyms used to describe the symptoms of delirium, the last point that I aim to address is a plausible hypothesis about their correlation: despite this divorce, there is a clinical link between them. In order to understand this connection, it is useful to look at what Langslow has called 'phrasal terms'.[78] These are lexicalised phrases that have the status of a technical term. The corpus abounds in such constructions that are comprised of a noun head, which – in our case – is abstract and can be assimilated to one of these constructs subsuming HOFs, and different kinds of determiners. A few examples are *gnômês paraphoroi* – 'delirious *gnômê*' (*Coac. LCL 31*: 12, 22), *gnômê kataplêx* – 'stricken *gnômê*' (*Mul. II. LCL 92*: 424, 15), *tên gnômên blabentes* – 'confused, distracted *gnômê*' (*Acut. CUF 17.1*: 2–3) and *ekplêxies tês gnômês* – 'disturbances of the *gnômê*' (*Aer. CUF 23.3*: 243, 5). Or even with other heads: *dianoia thrasuterê* – 'a more insolent *dianoia*' (*Epid. VII. CUF 1.6*: 48, 12), *tou nou parakoptei* – 'the *nous* is deranged' (*Aff. LCL 10*: 18, 9), *parallaxies phrenôn* – 'aberration of the *phrênes*' (*Acut. Sp. LCL 1*: 262, 12).[79] Common to all these instances is the metaphorical dimension of the determiner:[80] the nouns are abstract theoretical constructions, which the authors metaphorically linked to determiners that convey the idea of compromise, deviation or blow. Considering that these phrases are lexicalisations and bearing in mind the 'shorthand nature' of many compositions,[81] we can hypothesise that the verbs used in isolation (such as *parapherô*,

[78] Langslow (2000: 206–68) claims that phrasal terms can be considered as a specific subcategory within the 'stehende Redewendungen' or stock phrases described by Hellweg (1985: 29–52).

[79] Euripides introduces another of them in his *Hippolytus*: *parakoptei phrenas* (*Hipp.* 238).

[80] Langslow (2000: 178).

[81] According to van der Eijk (1997: 104–6) many syntactic peculiarities in the HC can be explained by assuming that the compositions were 'a kind of shorthand for private use or circulation among specialists' intelligible only to the writer or his colleagues.

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009

parakrouô) evolved from previously lexicalised phrasal terms that lost their head through metonymy or brachylogy. In most cases, we cannot be sure whether the author was thinking of the *gnômê*, *phronêsis*, *nous* or any other of the abstract theoretical concepts into which the ancient authors subsumed the HOFs, but at least we can posit that an embryonic idea of consciousness was perceived as being compromised. In this respect, I disagree with Thumiger; I think that these abstract constructs (presupposed in the noun head, even when it was omitted) were often treated like concrete body parts, in the sense that they could suffer and be affected by disease.[82]

In summary, the analysis suggests that the Hippocratic doctors did attempt to break down the abstract notion of consciousness into smaller HOFs, which they variously grouped into discrete concepts. These passages demonstrate that terminology to discuss HOFs was not fully developed, nor was the theoretical framework by which doctors understood these medical conditions. In this respect, Lloyd has accurately pointed out – while discussing Greek anatomical vocabulary – that the oscillation in the meaning of technical terms often indicates the backward state of theoretical speculation.[83] As a matter of fact, even now, scientific journals acknowledge the confusion and overlapping of concepts in the semantic field of consciousness ('awareness', 'wakefulness', 'perception', 'vigilance').[84]

On a more theoretical level, the analysis supports the idea that delirium and sleep were often linked – in these doctors' conception – to the impairment of what we could designate as an embryonic notion of consciousness. It is also in this regard that we can find a sense of consistency and unity across different authors and treatises within the HC.

[82] Thumiger (2017: 398). [83] Lloyd (1983: 153). [84] Sanders et al. (2012: 946).

Downloaded from https://www.cambridge.org/core. UNIVERSIDAD AUTONOMA METROPOLITANA, on 15 Nov 2026 at 14:01:51, subject to the Cambridge Core terms of use, available at https://www.cambridge.org/core/terms. https://doi.org/10.1017/9781009616577.009