Between My Body and My “Dead Body”: Narratives of Coma

Limor Meoded Danon

Abstract

This article is based on narrative research that focuses on corporeal experience during coma and during the rehabilitation process. Seventeen participants from different areas of Israel who had been in various kinds of coma states reveal what the corporeal experience of coma is. The participants are divided into three types of narrative protagonists—“dead-alive,” “rational,” and “emissaries.” Each of the participants redefined the boundaries of the body, especially in cases when they spoke of experiences they did not understand as corporeal, for example, out-of-body experiences, near-death experiences, or experiences of being between the earthly and unearthly. Their struggle to find suitable words to tell their coma stories emphasizes these boundaries between experiencing and telling, which crossed the normative discursive border of the medical establishment and illustrates the ambiguous nature of human existence.

Keywords

coma; body; unconscious; near-death experience; narrative research

This study was inspired by Iris Arad’s (2010) autobiography Building Castles With a Spoon [Hebrew1], in which the author describes the physical experiences she underwent during a coma. Arad retells how she heard, saw, and felt the touch of her family members and the treatment team that surrounded her, but at the same time was present in different realities, heaven, hell, dreams, and hallucinations, all of which she remembered in minute detail years after she awoke from the coma. She writes the following:

Imagine that you are fast asleep, dreaming strange dreams, and even feel your soul traveling in other worlds. When you hear a familiar and beloved voice from afar, you try to respond, to answer, and discover that your body will not obey you. It’s as though all the systems of command are mixed up and the machine is out of control. When you try to talk, your leg jumps, your body moves uncontrollably. My soul was not here. (Arad, 2010, p. 58)

In her book, Arad seeks to convey the message that death is not the end, that people in coma are not objects and are indeed aware of their surroundings, and that love is of the utmost importance in the continued existence of human beings. Arad’s story intrigued me because it stretches the boundaries of the human body. Until I began to study this topic, I had assumed that people in coma were in a liminal state, half living, half dead. The body is present and reacts to external stimuli and changes in temperature, responds or does not respond to medications, but consciousness, thinking, and communication are absent, and it seems that the body is completely detached from its surroundings. However, Arad’s story challenged my assumptions regarding the comatose body, so I sought to explore narratives of people who had been in coma and were able to describe their experiences.

This article is based on narrative research that focuses on corporeal experience during coma and during the rehabilitation process. The central questions aim to explore the limits of the body. How do people who have been in a coma experience their bodies? How do they perceive them? How is the tension between the discursive body and the phenomenological body, which experiences things, manifested? The discursive body is the body that is perceived, spoken about rationally, endowed with meanings, and studied through normative assumptions (Foucault, 2006; Turner, 1992). The comatose body is established through therapeutic practices, and depends on technology and medical care for its continued existence. In contrast, the phenomenological body experiences the world through its senses, its unique inner world. This is a pre-discursive body that comes before the rules of language and challenges the boundaries that frame it.

1Ben-Gurion University of the Negev, Beer-Sheva, Israel

Corresponding Author:

Limor Meoded Danon, Ben-Gurion University of the Negev, Moshe Kahiri 6/15, Beer-Sheva 84718, Israel.

Email: limormdanon@gmail.com
Coma and Existential Liminality

Subjects who are in coma states (which include varying states of consciousness) raise many questions about the meaning of human existence. What or who is a person? Is the definition of a human being inevitably dependent upon consciousness in the sense of awareness, or of awareness in the sense of consciousness? Does the way in which a person communicates, expresses his experiences, and is aware of his surroundings define his humanity? Various scholars argue that coma is a clinical condition historically associated with the creation of life-extending medical technologies such as the artificial respirator that simulates the function of the heart and lungs. Life-extending technologies allow patients previously defined as dead due to cardiac arrest or respiratory arrest (apnea) to survive in a coma state. At the same time, life-prolonging technologies forced medical science to redefine the boundary between life and death and to determine a single cause of death (Boaz, 2009; Lizza, 1999; Lock, 2002).

Today, death is defined as brain death. The brain is the sole organ that determines one’s ability to survive and function. The development of medical imaging technologies (e.g., magnetic resonance imaging [MRI] and electroencephalogram [EEG]) has made it possible to penetrate the systems and sub-systems of the body and determine which regions of the brain have ceased to function, but it seems that the more neurologists penetrate the systems of the brain, the farther away they move from the definition of death, as Hagai Boaz (2009) explains. This is due to the addition of an increasing number of elements that must be taken into account to define the sole cause of death (e.g., the destruction of brain stem cells or of the cerebral cortex). Paradoxically, life-prolonging technologies have resulted in the fragmentation of the human body, dividing it into different sections, with some systems perceived as alive, whereas others are perceived as dead. This physical fragmentation is reflected in various coma states in a wide-ranging spectrum of “disorders of consciousness,” with, at one end, the “permanent vegetative state,” which has three main criteria: (a) cycles of eye opening and closing, (b) lack of awareness of self and surroundings, and (c) partial or total dysfunction of the brain stem and hypothalamus (Monti, Laureys, & Owen, 2010, p. 292). At the other end is the “minimally conscious state” (Giacino et al., 2002), in which patients are awake but do not communicate, and show inconsistent signs of responses or voluntary behavior. In recent years, neurological experts have used advanced technology in their attempt to define the boundaries between the various states of consciousness on the coma spectrum. Improved diagnosis can be achieved by examining activity in various brain regions, making it possible to predict the likelihood of recovery (Laureys & Boly, 2007, 2008).

Unlike the biomedical discourse, which aims to locate the consciousness of subjects in coma, the anthropological-interpretive discourse relates to the liminal human state of subjects in coma as undermining social categories and definitions of personhood. For example, anthropologist Sharon Kaufman defines subjects in coma as “liminal beings.” They are in an amorphous “chronic liminal” state, between life and death, challenging the boundaries of the artificial/natural and the organic/technological (Kaufman, 2000, p. 76). The corporeality of people in such states forms the basis for social relationships and interactions with them, a situation that causes confusion in the social environment and undermines the existing social order. Like Donna Haraway’s (1991) cyborg body, which subverts the distinction between nature/culture and organism/technology, subjects in a vegetative state empty of meaning basic premises regarding human existence and reconstruct them through the treatment team and family who surround the patients, Kaufman (2000) claims. Like Kaufman, other researchers relate to the undermining of traditional categories of subjects in vegetative states, and seek to redefine who a person is. John Lizza (1999), in an attempt to offer alternative definitions of death that subvert the neurological definition of “brain death,” suggests taking into account approaches to personality and the unique characterization of the human being beyond biological and physical functions. Death should include not only the quality of physical and biological functions but also the individual’s psychological abilities, functions, performance, desires, abilities, thoughts, expressions, and ability to perceive reality. Lizza does not favor a particular approach that determines or defines the qualitative nature of man, but suggests that the death of a human being is an irreversible loss of human psychological character, the nature of which must be defined by philosophers to define death. The discourse on the ambiguous situation of people in vegetative states is also reflected in Tal Israeli’s (2005) doctoral dissertation, in which he explains that the ontological vegetative state evokes social embarrassment, embarrassment that he claims increases at the micro-social level in concrete relationships in which people are forced to live with family members who are in vegetative
states or treat patients in vegetative states as part of their work. In such states, the subject is constructed by others, his environment, his therapists, and has no existence apart from his dependence on technology, medical knowledge, and the people around him who feed, wash, and maintain him. Israeli asserts that it is incorrect to claim that vegetative states are a liminal phenomenon, because these states are not located at the point of transition between categories, between life and death, and between object and subject, but rather incorporate features from all these categories simultaneously and consistently. This is a phenomenon that creates a hybrid of existing (biological and cultural) categories (Latour, 1993). The hybrid status of people in vegetative states, explains Israeli, in contradiction to Kaufman’s claim, does not rest on given universal, unequivocal categories, but is, rather, constructed through “relationships.” That is, the ontology of a person in a vegetative state is the product of his relationships between people and the output of those relationships (Israeli, 2005). Thus, in the biomedical discourse, the human body is reduced by fragmentation, which divides it according to its various functions and seeks the consciousness of the comatose person through technology that images various brain waves, whereas the anthropological discourse attributes to the body symbolic meanings and interpretations through cultural values.

Unlike these approaches, the phenomenological approach perceives the body as subverting the boundaries of language and scientific framing. French philosopher Maurice Merleau-Ponty describes how the human body includes, in a single unit, material properties and perceptual, cognitive, and linguistic abilities. That is, he does not distinguish between body and consciousness. Merleau-Ponty’s philosophy is one of ambiguity. Human beings are ambiguous because of the duality that exists between them and their bodies, which are intimately connected to the world, experiencing it through its special senses and through movement in space while the body reflects, thinks, and perceives its experiences (Merleau-Ponty, 1962, 1968). The body is our being-in-the-world. The body in the world is like the heart of an organism, that is, the body and the world are equivalent ontological entities (Merleau-Ponty, 1962, 1968). Merleau-Ponty seeks to return us to the feelings, the physical senses through which we experience things. The body cannot be defined or disciplined by rational biological reduction that seeks to formulate its components through scientific ideas. Instead, it evades definitions and social discourse because it is fluid, transformative, simultaneously feeling and tangible, absorbing and absorbed, touching and touchable, seeing and seen, hearing and heard, and experiencing and experienced. Merleau-Ponty’s metaphysical approach to the body subverts the scientific attempt to make the body a coherent object, because for him, the body exists between the material and the spiritual, between the concrete and the abstract, and therefore, produces dialectics that reveal many complex layers of our corporeal being-in-the-world (Cohen Shabot, 2008; Marshall, 2008).

With the framework of Merleau-Ponty’s phenomenological-corpporeal approach, this study focuses on the embodiment of feelings of subjects who have been in coma states and who have undergone long processes of rehabilitation, to understand how they experienced their bodies in these circumstances and, thus, to shed light on the difference between the “discursive body,” the body perceived by and discussed through medical and social perceptions, and the “subjective body,” which is the phenomenological, material, dynamic, and changeable body.

**Method**

This qualitative research is based on narrative methodology, whose purpose is to understand various social phenomena through life stories and cases related to participating subjects. Narrative research examines the life stories of human beings through various methodological lenses. This methodology aims, among other things, to give voice to subjects who are usually silenced in public discourse, to search for the meaning of life, and to demonstrate how participants shape the reality of their lives and give them meaning (Chase, 2005, Lieblith, Tuval-Mashiach, & Zilber, 1998). Subjects who have been in coma states and are able to tell their stories are not common in the public sphere, and are indeed perceived as “rare” or as “medical miracles,” especially if they remember the experience of the coma and are able to talk about and describe it. Therefore, I was surprised to be able to recruit 17 participants from different areas of Israel who had been in various kinds of coma states. Casual conversations with relatives, friends, and students, whom I will call “mediators,” led me to the participants. Most came to the study coincidentally, with the exception of 2 who reached me through the help of the staff of a soldier’s rehabilitation facility, who contacted them and requested their help.

To maintain a high standard of research ethics, I was required to obtain the consent of potential study participants before I approached them directly. For this purpose, I asked the “mediators” who knew the potential subjects to contact them and request their consent to participate in the study. Once they confirmed their agreement, I made initial contact in a telephone conversation in which I introduced the study and its goals, and then we agreed on an interview time and place, taking into account their convenience. As it was important for me to find a quiet place that allowed us to have an intimate conversation, some interviews were held in the homes of participants,
some in other locations, such as cafes, which the participants chose themselves. All participants signed an informed consent form at the beginning of the interview. I read the form word for word to participants who had difficulty reading it due to visual problems, I explained that they could stop the interview and leave the study at any time, and that I was obligated to maintain their anonymity and privacy, and I would be the only one to listen to their interviews, to create trust between us and to maintain a high level of research ethics. The interviews ranged from 2 to 4 hours in length. I conducted more than one interview with two participants to clarify points that were not covered in the first interview. I contacted three participants by phone to ask additional questions. The participants range in age from 22 to 70. The reasons for their coma were car accidents, stroke, bacterial infection, shooting at close range, combat injuries, complications of surgery, and mixing medications. The length of the coma ranged from 24 hours to 3 months.

Narrative research is concerned with the multiplicity of contexts through which participants construct their stories. Tamar Zilber, Amia Lieblich, and Rivka Tuval-Mashiach, for example, focus on following three key contexts through which narratives are constructed: the inter-subjective context, or the way in which the interaction between the narrator and the listener structures the narrative; the social-collective context in which the narrator lives (the influence of institutions, shared events, and social frameworks on the narrative); and the ethical context that lends significance and cultural meaning to the narrative (Zilber, Tuval-Mashiach, & Lieblich, 2008; Lieblich, Tuval-Mashiach, & Zilber, 2010). The study participants came from worlds that are different in terms of knowledge and content and had a variety of experiences, histories, and life circumstances. Without a doubt, their “store of knowledge” of each subject, along with the interaction between us during the interviews, played a role in the construction of each of their narratives. The analysis process of the interviews, which was based on the concepts of Zilber, Lieblich, and Tuval-Mashiach regarding narrative analysis, took into account both a holistic treatment of the narrative and a systematic organization of the narratives into sections (including: a. chronological events. How are the narratives organized by the tellers? b. linguistic descriptions. Which metaphors, comparisons, and what kinds of reasoning are included?; and c. thematic analysis. Which themes are dominantly manifested the narratives? I paid particular attention to the content of each narrative, the description of the events that led to the coma, corporeal experiences during the rehabilitation process, the current daily functioning of the subject, and the dominant themes related to physical experience or “nobody” experiences, near-death experiences, and physical alienation during rehabilitation.

Narrative research does not seek “truth” of any kind or attempt to distinguish between factual truth and lies, but rather examines the ways in which people construct their internal and external truths, perceive the world, talk about the reality of their lives, and use rhetorical devices to persuade others to see things from their perspective. When we refer to the experience of coma, of course, it is impossible to enter into the experience that these subjects have experienced. I was not present during the coma of each of the participants and even if had been, I could not have entered their experiences, just as no researcher or practitioner can enter any other person’s experience. Instead, the narrative researcher asks subjects about their experiences of coma as they are engraved on his or her body. Indeed, memories are constructed and undergo various kinds of processing, but even taking into account the construction of memory, narrative research seeks to examine the nature of memory as it is processed through subjects and determine how it is significant to them. What do they want to tell? What do they ignore? Years after the coma, the participants sought to understand and process what had happened to them, and attempted to verify their experiences through others, whether family members or physicians. They attempted to gather information with which to create a meaningful life story for themselves. Most participants in the study represent success stories of survival against all odds (the odds of surviving as given by medical experts). They are considered “medical miracles” because the medical system underestimated their chances of surviving, being rehabilitated, and functioning. The participants are divided into three holistic types of narrative protagonists—“dead-alive,” “rational,” and “emissaries.” “Dead-alive” subjects perceive life and death as a part of a continuous sequence rather than as dichotomous categories. Both the content of the narrative and its form reflect the fluidity of life and death. The narrators “relive” moments of the disaster that brought them close to death, experiencing it anew when they tell their stories during the interview, closing their eyes, getting goose bumps, crying, laughing, and becoming emotional. The narrative of the “dead-alive” subject includes (a) the intertwining of a chain of events that nearly led to their death, in detail, especially the physical feelings and various signs they received from the world that heralded the impending tragedy; (b) near-death experiences, a-spatial experiences, a-temporal experiences of the coma; and (c) giving new meaning to life in light of the experiences of the coma. “Rational” narrators are those for whom the coma event is but another hurdle to be dealt with in the journey of life. There is no ambiguity, no liminality in their experience; they either live or die, even when they have a near-death experience. They do not seek to explain the irrational experiences they have during their coma, to give their experiences a significant role in the way they
understand their lives or, to make a connection between life and death as the “dead-alive” narrators do. For them, the coma was one of life’s struggles to overcome, and they overcame it as they did other hardships in their lives. The “emissaries” are those narrators whose coma experience caused them to realize that they had a purpose in life and that the fact that they are still alive means that they have not yet completed their mission. Their purpose is usually to help others and to change people’s perceptions and prejudices. They volunteer, write books, present lectures, work in therapeutic fields, and seek to create a better world.

By defining these different types of narrators, my intention is not to construct a definitive categorical identity of the participants, but rather to reflect the representation of the narrative protagonists as it is presented in their stories, as they themselves constructed them during the interaction between us. There is no doubt that their experiences subvert any narrative representation they themselves wish to construct, because the actual experience is hard to describe through linguistic means. Now I will describe the coma experience according to the narrative types mentioned here. Next, I will describe the experience of rehabilitation, focusing on the tension between corporeal experience and the discursive body.

**Between Being-in-Coma and Unconsciousness Body**

Critical rationalism has apparently eliminated, along with so many other mythic conceptions, the idea of life after death. This could only have happened because nowadays most people identify themselves exclusively with their consciousness, and imagine that they are only what they know about themselves . . . Rationalism and doctrinairism are the disease of our time; they pretend to have all the answers . . . Our concepts of space and time have only approximate validity, and there is therefore a wide field for minor and major deviations. (Jung, 1963, p. 300)

Jung’s (1963) criticism of rationality relates to his own experience and perception of life after death, among other things, and hints at the tension between rationality and our participants’ experience of coma. I have placed Amit, aged 50, in the “dead-alive” category, because she sees life and death as parts of a fluid continuum rather than as dichotomous categories, and because her story challenges the boundaries of the discursive body, that is, the assumptions about her physical condition as expressed by physicians. Amit describes how 2 weeks after the birth of her son (in 2003), she experienced a severe asthma attack that almost resulted in her death. She explains that her heart stopped beating and she was placed in a cold suit to preserve the functions of her body. Several hours after they removed the cold suit, she says that she was present, that

. . . I saw I was nauseous, and the most stupid nurse in the world came and gave me something for nausea that is not good for the nervous system, and of course I immediately began to twitch and scream (becomes excited and raises her voice), but the great “sages” said, “She is twitching and screaming. We should give her something to tranquilize her.” . . . and they finished me . . . why give so many things [medications] to a person who just almost died? Leave him alone. Why tranquilize him? . . . Gradually, it was as if I was descending into something black, eternal night, but a night fraught with dreams and hallucinations. . . . I arrived at a place where I saw things and those things actually happened [in the future].

Amit was in a coma for 2 months, in a state defined by neurologists as a minimally vegetative state, on a respirator, fed through nasogastric tubes, not reacting to or interacting with her surroundings. Amit’s brain stem was damaged, according to brain imaging physicians, who explained that the chances of her regaining consciousness were very slim and that if she did regain consciousness, she would never be able to speak or walk. Although in coma, Amit moved between two realities, the earthly reality of the hospital and an a-spatial, a-temporal reality. She relates that in the earthly reality, she often heard things that her family and acquaintances said to her, listened to music that they played for her, and that sometimes there was music that she disliked and it bothered her. “I also felt the hands that touched me. There were hands that I liked and others that I didn’t like as much.” At the same time, she “saw” and experienced other realities, which often predicted future events, sometimes reached back to the past, realities that were beyond space and time:

. . . I saw warfare with large, long-range missiles, missiles coming at Israel from every direction . . . it happened just a few years ago [a few years later]. I saw a huge tsunami. When I saw it on television several years later, I recognized it and said, “It’s that thing, the thing that eliminates so many people.” I saw things that happened. I came out of there completely “green”; the key messages were about preserving our planet . . . I loved spending time on Uranus, because it was a good place where people really exchanged thoughts with each other and where you could meet higher spiritual figures and learn from them and that was always nice.

During her coma, angels she met in an alternative reality gave Amit the mission of saving the children of the world. Although those around her, in her earthly reality, thought she was sleeping an extended sleep, she was “breaking her head” to find ways to save the children of
the world from the dangerous planet earth. The spiritual figures that Amit met (in the alternative reality) transmitted to her messages about the world and the importance of love, whether love of self, love of others, or love of nature. Love is a common theme among people who have had near-death experiences, or who were close to death, including neurologists such as Eben Alexander (2013) and Jill Bolte Taylor (2006).

What kind of vision is this? How do the body’s senses work while the body seems to be in a long sleep? It is impossible to empirically, scientifically prove the existence of the vision of coma, but Amit attempts to interpret it as follows:

The truth is that I had dealt with this since childhood. If you pay attention, you’ll notice that you see as if through glasses. You cannot see everything in all directions. I would ask myself, “Okay, so beyond these angles, what do I see? Can I only see what is in front of my eyes?” No, because I know I see more. So, since childhood I have been aware of the fact that I see more.

The medical staff related to Amit’s experiences as hallucinations that resulted from the various drugs, no different from the experience of schizophrenics who experience an alternative reality. Amit describes the attitude of the medical staff when she told them that she saw angels and experienced alternative realities:

At some point, they gave me pills for hallucinations because, from their point of view, I was talking nonsense. When the psychiatrist came to me, my mother suggested she take me off the pills, so the psychiatrist asked me if I still saw all kinds of strange things. So I asked her “like what?” So she said, “like someone who comes to steal from you.” That seemed really low to me. I was experiencing alternative worlds and she was asking me about someone who came to steal from me [laughs].

In contrast to the psychiatrist in Amit’s story and other rational–professional perspectives on hallucinations and dreams, Merleau-Ponty (1962), in his *Phenomenology of Perception*, discusses the example of hallucinations of schizophrenics who experience different stimuli in the world that are not perceived by other people, hear voices, feel that people are following them, and see in all directions simultaneously, beyond the capabilities of vision. He explains,

There are hallucinations because through the phenomenal body we are in constant relationship with an environment into which that body is projected and because, when divorced from its actual environment, the body remains able to summon up, by means of its own settings, the pseudo-presence of that environment . . . hallucination does not present me with protuberances, or scales, or words like ponderous realities gradually revealing that meaning. It does no more than reproduce for me the way in which these realities strike me in my being of feeling and of language . . . but this fiction can have the value of reality only because in the normal subject reality itself suffers through an analogous process. (pp. 340–342)

Hallucinations, explains Merleau-Ponty, unlike reality as we perceive and experience it through external stimuli experienced by our bodies, are experienced through the sensory means of the body, but they are not given to the subject in a structured way and do not take place in the “geographical” ontological world that we know and judge according to facts and rules, but rather within the individual landscape through which the world enters us and by means of which we interact with it. Sarah Cohen Shabot describes how, for Merleau-Ponty, the body penetrates the world and the world penetrates the body in a kind of invagination. The world and body comprise one entity (Cohen Shabot, 2008). People who experience hallucinations simultaneously experience the world (or other worlds) through the specific material means of their bodies, but simultaneously collide with the understood rules, facts, ideas, and linguistic concepts of the “geographical world” in which we live.

Amit interprets her experience of seeing other realities, different worlds during her coma as “the vision of the soul.” The soul is connected to the world, while the body is ephemeral, sick, disabled, limited, but for Amit the soul is immortal, and sees and knows things. Although Amit distinguishes between the soul and the body, her attempt during the interview to explain what a soul has experienced is, paradoxically, translated into language that expresses physical characteristics:

Amit: Your soul, the soul you can connect with through meditation, can you feel your soul? Your big soul? Not the little one.
L: I don’t know. I’ve never done it.
Amit: I think it’s happening now during our meeting, because you are kind of groping in the dark. You don’t know me, you’re kind of creating something new, so as you grope a little in the dark, you are pretty dependent on your soul. It could be your soul is beginning to whisper to you. You just have to listen.
L: How should I listen?
Amit: Listen with your heart. You know what it is to listen with the heart? To listen with your feelings? You know?

“Listening to the soul with the heart, with feelings” actually happens through the body and reflects, as Merleau-Ponty suggested, the corporeal duality that exists in us. We are simultaneously body and no-body, experiencing the world through the body and attributing to it interpretations that are allegedly not physical, such
as “mind” and “soul.” For Merleau-Ponty, the distinction between body and soul, mind, or consciousness reflects the duality and ambiguity of the physical reality. In other words, what is perceived as consciousness during coma actually reflects one single unit that Merleau-Ponty calls “the flesh.” The flesh has the ability to be inside and outside simultaneously, subverting boundaries. This is not a trick or a coincidence, but rather the norm of the flesh. The flesh sees itself, is revealed to itself, is analogous to itself, embraces itself, and is contradictory (Cohen, 2000).

So-called out-of-body experiences, or dissociation, are experiences attributed by the scientific discourse to altered states of consciousness (ASC), in which the consciousness undergoes changes in accordance with the material and social situation (and the connection between them) of the subject. Yochai Ataria and Yuval Neria (2013) describe the way in which prisoners of war survive by “exiting their bodies,” (out-of-body experience) and see this phenomenon as the management of two phenomenological bodies—one is the captive body, feeling pain, hunger, isolation, whereas the other is a conscious body, a body with “no body,” experiencing dreams and hallucinations to survive. This separation from the body, which is experienced by people in coma as well, is another expression of the flesh (see Merleau-Ponty), which is simultaneously subject and object for us. The brain is an integral part of the body, of course, and is at once material and a subject that creates perceptual and cognitive abstraction. Thoughts, dreams, and hallucinations are constituted by corporeal materiality. Out-of-body experience is also part of Ami’s story.

Ami refers to himself as “dead-alive” because in his story, he was twice defined as dead by the physicians who were treating him (he has the death certificates to prove it) and, despite their assumptions, he is still alive. His story also subverts the boundaries of the body as determined by medical doctors. Ami was injured in a terrorist shooting in 2002. He was hit by 18 bullets, including one that pierced his skull. After being shot, he “saw” from a bird’s-eye view what happened in the attack, while he was in a closed body bag. (He showed me the pictures of his “corpse” at my request.) Ami underwent near-death experiences, which he describes as follows:

I began to ascend with a huge light . . . like a pipe, a huge tube illuminated with a huge light . . . it’s a light that doesn’t exist here . . . it’s impossible to understand this, it’s a light we don’t have here . . . it’s not like a light you turn on, not hot, not cold . . . light is usually warm when you touch it, but here there is no heat. How can I explain? Babies singing . . . I cannot explain it. Tremendous . . . babies singing. Once in a while it appears and I have this picture . . . and my wife is horrified. I’m stuck like that sometimes, she needs to shake me, she cries and I cannot hear, she can scream until tomorrow [laughs].

In his story, Ami repeats the experience of hearing babies singing several times. He has difficulty expressing it, but tries to explain it by comparing it with hearing a singer with an amazing voice, being drawn to the singing and dancing with it, as if in a trance. Even years after the events, Ami often re-experiences the singing of the babies, and it causes a physical dissociation, a detachment from his external environment. Several months ago, he asked to go to a specialist and tried to explain to him what he was experiencing, the singing inside him, which is wonderful, but which also disturbs him and cuts him off from his surroundings. The expert attached electrodes to Ami, and they showed sound waves on computerized scales. He was very surprised and said that in all the 25 years of his work, he had never seen such a thing, and even told him that if he managed to translate this song he would become very wealthy. Thus, Ami sought material confirmation of his physical material experience, to connect his subjective, corporeal world and the earthly, mundane scientific world that believes in experiences only when they are measurable.

While Ami saw the light and was drawn into the giant pipe by the singing of the babies, he also experienced earthly realities:

I took the bullet in the head, and then there was a detachment, a strong shaking of the body . . . I don’t wish such a thing on anyone . . . there was a cutting off, but of a completely different type . . . you see the body like a complete rag . . . at this point I was floating over the car . . . I saw my friend lying dead, I saw bullets, shooting like rain, a completely spiritual vision, a different vision . . . I saw the whole area, the dead, I saw someone who had been killed, a catastrophe. And you see a “film” of your life, what you did during your life and once again, it’s over in seconds, and again, and again and again . . . all the transgressions, all the joys, and all the good deeds, all the help you gave people . . . The Border Guard doctor got there first. He came up to me immediately, that’s what I remember when I was looking down from above. I saw him, he came up, he looked here, looked there, and made an X, because I was shot in the head . . . teeth that came apart from the pressure, an arm destroyed, an arm with a hole in it—they could put their hands through here [holding the area on his arm that has since recovered], and went on to save others. And I looked, I said to myself up there, “Doctor, what’s the rush? Where are you going? Why have you left me?” . . . For an hour and a half I was in that closed black bag. That was it, I was dead.

While floating above his body, his “corpse,” Ami observed how the paramedic looked at the body bag and saw it moving up and down. Ami stresses in his story the coincidence that is not really coincidental, the exact
moment when the paramedic saw his last breath and called the doctor and the policemen to get him out of the bag, the resuscitation that was carried out against all odds, and the exact sequence of events, which he saw from a bird’s-eye view until he reached the hospital. There he was in a coma for a week. He describes it as something not absolute, between life and death, during which he was tried for all the actions of his life. His life appeared like a movie before him. In it he saw things he had forgotten he had done, like helping someone in a wheelchair across a flooded road. He was also shown his moments of decision making at his “trial.” According to Ami, the “film” was shown in the court continuously, with each topic in it discussed and debated separately.

L: Who are the religious judges?
Ami: Of course the Lubavitcher Rebbe himself and other judges I didn’t know. There was a real fire burning in them, like fire and a baby’s face, a beautiful face . . . Master of the Universe, you say that such beauty can be made, to give flesh and make such beauty? Like a tremendously beautiful woman, you say that God could have created it? When a person is beautiful, he is looked at differently from the outside. If it is a man, especially a man who is strikingly beautiful, people shy away from him . . . This is a real introspection on whether what I did was right or not, and the person judges himself because he is melting . . . like ice, they get him back on his feet . . . physically melts, you see the body melting, becoming water. Offenses, nonsensical things that he did, and they get him back on his feet, but when he does good things they give him tremendous strength, as strong as strong steel that cannot be bent.

The body that Ami describes to me is simultaneously meaningless—a “rag,” “melting” but it also has strength—“cannot be bent.” This dialectic is woven throughout Ami’s story. For years, Ami lifted weights, developed his muscles. He was a sniper in a combat unit and was considered one of the best. He believed in the ability of the body to respond at the moment of truth, but was proven wrong when his body did not function in the way he thought it should when attacked, did not function and was paralyzed, and for him it was a “rag.” His survival reflects the enormous power of survival of his body, without which we could not have had an interview or a story. Because Ami is an ultra-Orthodox Jew, he interprets his survival as stemming from his faith in God and his fulfillment of commandments, which enabled him to win the trial for his life that he experienced during the coma.

Amit, Ami, and other participants described how they saw a strong, marvelous light that gave them a feeling of well-being, how they met their relatives who were no longer alive, how time lost its meaning and seemed like an eternity, how they could see things that were happening elsewhere, exit their bodies, and even predict the future—all experiences known as “near-death experiences” (Bailey & Yates, 1996; Greyson, 1983; Kübler-Ross, 2008; Moody, 1976). Near-death experiences cross the boundaries of physicality, of corporeality, because the people who describe them have been defined as dead for some time and were not meant to experience anything, according to the scientific assumptions that determine the moment of death, mainly through brain activity. But according to the narratives, it seems that there is brain activity that produces sensory and perceptual experiences that apparently cannot be explained by bio-technological means.

The narrative of Mazal, aged 43, also belongs to the “dead-alive” category, which blurs the dichotomy between life and death. One of the most powerful statements she made during our interview was, “You have to die to know how to live.” She explains that she had a serious car accident at age 20. The accident occurred when her partner was driving and stopped to drop her off. As soon as she put her right leg outside the car, a speeding car crashed into their vehicle. Mazal was dragged with the car for several meters and thrown into a field across the road. Her partner lost consciousness for a short time. When the ambulance arrived, the paramedics took the driver who had hit them (a nurse who had fallen asleep at the wheel) and Mazal’s partner to the hospital, unaware of the fact that Mazal lay injured in a field near the road. Several hours later, an employee of a nearby gas station saw the cars and went to the field, where he saw Mazal lying injured and took her to the hospital. When she arrived, she was unconscious, and was connected to a respirator. She remained in a coma for 2 weeks. At this particular hospital, comatose people were placed in a kind of sealed, windowless room. Mazal was aware that the room was sealed. “It’s just a cold room,” she explains, “like a morgue [laughs].” During the 2 weeks of her coma, Mazal was connected to a heart–lung machine. Her pelvis was crushed, her face swollen and broken. This is how she describes it:

I remember very well that I simply did not exist here, but I existed elsewhere . . . I’m not sure if it’s another world. It might be a transition from this world and back again in another form, I don’t know. I just know it’s not the end . . . It’s very hard to explain in words something that is very much not of this world. My father said he would bring the music of my favorite dance . . . he brought me the music and I felt as if I squeezed his hand . . . and then the doctor said “She’s with us,” and then I slowly began to respond. I couldn’t speak because my teeth were wired shut. I couldn’t speak, but I could write. I wrote a lot about light. I was in pain, but when they unwired my teeth, I also began to speak . . . a friend come to me and I said “Wow, you’ve done something amazing.” [She had appeared in a film.] and I knew about everyone, what they had done, where they had gone. A good friend comes in and I said, “Wow, I met your father, sat on a bench and talked with him, and everything is
all right, don’t worry. And he looked at me and everyone made gestures to indicate I was insane. But I met his father! [His father died when he was 6.]

Mazal’s experience is very tangible, sensory, and physical, and simultaneously transcends the boundaries of the body. It is physical, because Mazal describes the sensation of pain, its constant presence. Even when she was not connected to the earthly reality, she was always present from her perspective, but in another place.

Mazal’s explanation is that the senses and memories of the body are preserved beyond familiar earthly limits. Some relate to the soul as a sort of physical dimension that remembers and disappears. From Mazal’s and other participants’ descriptions of their bodies, it seems that the comatose body is simultaneously in another dimension, not only fluid, transformative, and conscious but also material because it still feels when touched, and hears speech and music. This in-between-ness—between physical experience and having or not having a body—reflects the existential ambiguity described by Merleau-Ponty, in which the body is simultaneously subject and object. The attempt to describe the experience of coma takes place through a common language, in this case Hebrew, with rules that frame the physical experience with earthly words that depict familiar colors and feelings to illustrate the experience. But in many cases there are no words to describe the light experienced and the feeling of well-being that surrounded them around the light, or the music they heard, or the colors, smells, and shapes seen when walking in heaven, as Malka describes it:

Heaven is very, very beautiful. It’s a green place, a beautiful green place . . . Wow, really no, it’s impossible to describe the special flowers that don’t exist in this world, with special shapes and smells that we don’t have in this world . . . it’s something unique (smiles). Just talking about it makes me feel it. This is a place that you cannot explain or define. Wow . . . it is something . . . I walked and the smell . . . I’m walking and it’s fun, everything is OK with me.

The places in the narratives where participants use phrases like “no words,” “not of this world,” “hard to explain,” and similar expressions are the places where there is a significant gap between the physical experience and the linguistic description of that experience. Many participants, immediately upon awakening from their coma and interacting with their surroundings, wanted to know how long they had been in coma. The lost time was significant for them, and they wanted to gather information about the various events that took place and confirm what they had experienced, seen, and heard through their friends and caregivers. Ami asked to see the doctors who had treated him and to tell them exactly what he had seen as he hovered over his body. Mazal and other participants wanted to write about what they had been through to pass on their unique experiences and make them meaningful for others too.

Aside from the pleasant experiences, known as near-death experiences, there are experiences of pain and continuous nightmares, as we can in the case of Roni, aged 22. I classified her narrative as belonging to the “emissary” category because, in light of her experience, she plans to help and care for children with disabilities. When she was a teenager, a routine eye examination revealed that Roni had a buildup of blood vessels in her right eye. After various tests revealed nothing unusual, she was sent for an MRI, which revealed a large tumor (5/6 cm) in her head. At age 15, her life changed completely. Then non-cancerous growth in Roni’s head is known as an arteriovenous malformation (AVM). AVMs are abnormal connections between veins and arteries. Before the tumor was discovered, the body signaled its existence mainly with headaches and double vision, which Roni had attributed to fatigue and a certain pre-existing visual impairment. Roni was scheduled to undergo a number of catheterizations, every 3 months, during which a catheter would be inserted through the main artery in her groin into the brain to detect the region with problematic connections and to inject biological glue (Onyx®) to close them off. Catheterizations are carried out under general anesthesia while the patient is connected to a respirator. After the third catheterization, Roni became agitated and “insane,” had no idea where she was, and tried to tear out the tubes attached to her body. She recalls,

Once they took me off the anesthetic, half a second passed and I woke up and had no idea where I was. I knew where I was, but it didn’t matter because at that moment I didn’t understand what was happening to me. And then I didn’t wake up . . . 16 hours later, they took me for a CAT scan and saw the massive bleeding on almost the whole right side, which nearly spread to the left side. Suddenly I woke up a month later at another hospital . . . I was in between, as if there was a stage when they tried to remove the breathing tube and then I collapsed . . . like in the movies you see the white light, the light of a better place . . . it’s hard to explain but it’s really this light and there is a white halo around you, and on the other hand you really hear the shouts around you, your mom and dad and your siblings, and the family that came every day.

When Roni uses the term “half a second,” she is not referring to cosmological time, but rather to duration (durée), as described by Henri Bergson. Duration is different from earthly time. It is experiential, subjective, independent of any particular space, and cannot be measured or quantified (Bergson, 2008). For Roni and all the participants in the study, time lost its cosmological significance during the coma experience. Roni
experienced great uncertainty regarding her surroundings. As in all the other stories, family and doctors did not know if or when the subject will awaken after the coma, or whether she will function after awakening. When she was in coma, Roni was not aware of the passage of time. From her perspective, she was in another space, surrounded by light, but at the same time she felt her family around her, encouraging her to “choose,” as she puts it, to live here:

I heard voices . . . you want to wake up but you really can’t and you know that you should, you must wake up . . . I was not supposed to feel it and when I told my mom later that it was like a memory that will never be erased, she says, “What? But you were not there, you were not awake, you couldn’t have known, felt.” But I will never forget it, the smell of the alcohol they rub on your head, the cold sensation of this part of the scar, as if I was a piece of paper that they had stapled and now just decided it was not in place and removed the staples in order to . . . just like that . . . suddenly you feel that you’re being bathed and you’re lying down . . . the water is cold, and suddenly they are touching you, and one side you feel, and the other you don’t . . . kind of like the bad dream where you go into surgery and you are actually awake, but you should be asleep.

Roni experienced pain and helplessness in a state where she was not supposed to be able to feel pain or be aware of what was happening around her. At least this is what her caregivers and others who were with her assumed. This experience is etched on her body, and it was very difficult for Roni to describe it during our interview. She asked for a cigarette break because she is still trying to deal with the experience and would rather not talk about it.

People in coma are extremely dependent on those around them, particularly on the medical system that feeds them and prevents infections and bed sores caused by lying down for long periods of time. They are helpless and very vulnerable, and in extreme cases they may be victims of violence on the part of their caretakers. Malka was 18 when she had a serious car accident on the way to Elisha Hospital in Haifa. I couldn’t stop crying. It made me feel very bad. I could not sleep at night, it took me over again . . . everything I went through and I didn’t even talk about it . . . They slapped me, poured shampoo on my face . . . my leg and pelvis were broken and they would pull me out of bed to the shower bed with such force . . . I thought I was imagining it, you know, but I wasn’t. I remember that they beat me.

Malka’s shocking experience is outrageous and demonstrates the vulnerability of people in coma. It was a humiliating and painful experience that Malka relived after seeing a news report on people in coma who were abused by their caretakers. Although she seemed to be unaware of her surroundings, her body experienced the pain of her broken limbs being pulled and her face being slapped, and preserved them in its memory. Malka explains that she thought she had imagined the torture, but years later, after she told her brother what had happened he told her that she had already told him while she was hospitalized, that he knew about it and tried to catch one of the male nurses, but he had escaped.

The rehabilitation process is an integral aspect of the construction of the narratives in this study. After all, without the rehabilitation process, the narratives and, indeed, the lives of these people would be considerably different. All the participants underwent a long rehabilitation process, but their rehabilitation is considered a success story for their physicians. Their bodies underwent radical transformations and can never return to their previous state. The duration and practice of rehabilitation depend, of course, on the nature of the injuries and the physical condition of any specific person. How do participants experience their bodies after a coma? How does the body, whose activities and movements were taken for granted before the coma, become something else, alien, something whose movements have to be managed and that patients have to relearn how to operate?

**Between Embodied and Dis-Embodied Experience**

Roy, aged 61, was hit in the head by a shell during the Yom Kippur War. His skull was split open (“like an eggshell,” as he describes it) and parts of his brain were scattered on the ground. For 5 or 6 days, Roy was in a state of “very foggy consciousness” and “psychomotor agitation” as defined by his neurologist. I categorized Roy as an “emissary,” one of those subjects who seeks to change attitudes and perceptions about the world. He published a book describing his experiences, but in order not to reveal his identity and maintain a high level of ethics I shall not discuss the book, but refer only to statements made during the interview. Roy describes the experience of being in coma thus:

You’re in a kind of complete darkness, between hallucination and consciousness. There is something of a memory that a moment ago you were in a war, you remember something like that. On the other hand, there is a logical sequence that you create. Wait. Am I a prisoner now? . . . You actually create the only logical conclusion you can from this situation, a man who was just in a war and is now tied to the bed,
thirsty, and no one talks to you, no one responds, no one answers. This is a sign that you are a prisoner, which means that there is a certain consciousness, it exists.

The moment of awakening from a coma is different for each patient. There are those who do not know where they are and become anxious. Responses depend on brain function and the ability in those moments of awakening to remember and connect the various events that took place before and during the coma. And then there are those who know where they are and were aware of what was happening around them throughout the coma. Roy was hospitalized for 6 months. The injury on the right side of his brain caused paralysis of the left side of the body and his vision was damaged. For Roy and other participants whose brains were damaged, the difficulty in the rehabilitation process is in restoring the body’s mobility and cognitive abilities, which in the past had been automatic and an integral part of them. But during the rehabilitation process, patients after coma are more aware of their bodies and their movement in space, and they attempt to push its boundaries. Roy explains,

In cases of brain damage, the organ that helps you to cope with the injury is the brain, the mind. But the mind is damaged, and the paradox of brain injury is that you have no tools to work with, no tools, that you wake up in a hospital and don’t know how you got there. I remember once I could write, today I cannot. I remember I had a good sense of direction and today I get lost everywhere . . . I see, but I see the world as flat . . . There is no depth. I see you as a two-dimensional, I have no depth perception . . . Riding a bicycle, you need to constantly manage your awareness. Where is the path? Where is the left side? Where is the right side? My perception of the center path is incorrect, so if I don’t calculate constantly, I go off the path. I need to see where my foot is on the pedal so it won’t fall, and whether my hand is on the brake, because I can’t feel what it does, and if it did, then I would fly off the bike. You constantly have to manage yourself. You live in the world of control . . . a mechanistic world.

Roy attributes the notion of a physical mechanistic world to Sara Ahmed, who relates to the orientation of the body in space as an intimate connection that allows us to feel, for instance, the emotions of home, to find our way in space. When we are oriented in space, the body and space physically connect like two points in one line. That is, we are in line with the space. Ahmed explains the lack of orientation with space, disorientation, being out of line among queer people. She uses Alfred Schuetz’s term “stranger” to express the experience of queer space and describe the lack of feeling of intimate connection with space, with home, and physical disorientation, feeling outside of the social order, out of place (Ahmed, 2006). Roy and other participants experienced this sense of being out of line, being disoriented during the rehabilitation process, when physical activities and spatial orientation that had been carried out by the brain “automatically,” out of habit, had to be practiced, managed, and controlled, until the movements became habitual. Roy describes how he learned to divide every movement of his body into small components and put them together again, each movement reconstructed by him in accordance with his material terms. Roy recalls,

Not long ago at the soldiers’ rehabilitation center someone said to me “Look, you’re swimming the crawl, but your left leg isn’t moving.” I said, “That’s not true. It is moving.” So he filmed me and I looked and saw that he was right, I was dragging my left leg and doing everything with my right. I have no idea what my left leg does while I’m swimming. I started talking to my leg and telling it to do this movement, and the process is very tiring because you constantly have to discover something and manage your body in a kind of bionic way, as though from above, but with a brain that is damaged.

Roy’s embodied experience might cause us to wonder how the brain actually works after severe damage. Who generates the action when the brain cells have been damaged? What does it mean to talk to your leg? From the stories of other participants affected by brain injury, it appears that it is possible to bypass the damage of certain cells in the brain through practice, training, and movement of the body. The brain is the organ that not only gives commands but also makes it possible to execute them. It can also take orders through the movement of other body parts and adapt to its new situation. That is, the brain is dynamic and influenced by material, motor conditions of the body, and finds ways to bypass its damaged, destroyed cells using other cells for physical activities.

Leahey, aged 39, represents the “rational” group in her narrative. Rational subjects describe the experience of coma as a given fact or a given physical condition that taught them to cope with and adapt to a new physical reality. Leahy experienced a stroke at age 26 as the result of an aneurysm and was in a coma for 5 days. She describes how the head of the department where she was hospitalized told her she would never be able to return to the way she had been, that is, to the physical abilities she had had in the past. Perhaps this statement acted as a trigger for her, because she claims that she is 99% rehabilitated. When she met him years later, he apologized, but Leahy has not accepted his apology. She explains,

Half of my body, the right half, was paralyzed. I couldn’t speak, either, which means that the damage was on the left side of the brain—the linguistic part — and the right side of
the body was not functioning. I mean, hell there’s a hand, but . . . it does not function . . . The body is very dynamic. I saw how then my hand was just lying by my side and now I can do everything. This is something crazy, in my opinion. It’s not something I take for granted. But I think that if we train the body, basically we do see results . . . what has been destroyed [in the brain] is not repaired. This is what is medically known, they say, but other cells can make up for the damage and new cells are built to replace damaged ones. We are dynamic, we work hard to build new cells. The body is not black or white. If I sit and do nothing, then nothing will happen . . . slowly, slowly I began to walk, but speaking took me more time. Walking very slowly is less disturbing than not being able to get a word, a sentence out of your mouth.

Physical-motor rehabilitation is described here as seemingly easier than linguistic, cognitive rehabilitation. Participants liken the process of rehabilitation to the developmental process of babies, who first learn to stand, walk, and eat alone and only later develop linguistic and cognitive abilities. But the post coma patients are not babies, and these abilities are already etched on their bodies. Now, in the long rehabilitation process, though, they have to learn it all again with an awareness of every action, while they experience their bodies as disabled, alien, other. During the rehabilitation process, some participants experience a physical dialectic between knowledge of the body and the body’s abilities, between the knowledge that their bodies were once able to perform routine actions, and the disabled, paralyzed body that needs to be strengthened, trained, and repaired. This dialectic may cause a lack of desire to cooperate with the treatment process that may, in some situations, cause depression and even suicide attempts. But there are also times of connection and positive perception of the body, even when it is disabled or has undergone a significant transformation, especially when the face is not the same as it was before, as Mazal describes:

I was standing in front of the mirror, and they attached an eyelid, so everything was stitches and metal rods, they opened me up and performed many surgeries. And I would go to the mirror and it was clear to me that I could not see anything . . . I am aware of my body, my face. I don’t feel less pretty [than before the accident] . . . I’m so aware of my body. I know now how I look, I know how I’m sitting. I’m aware of my stomach inside and out, I know how to lighten my smallest muscles, how to move my ears, I have grown with it . . . all at once. First of all my face, you’re not you, you have no nose, I had a hole here . . . this bone—for years it wasn’t here. There was a bandage, and the nose was raised. They removed it during the last surgeries . . . During one surgery my body went crazy, it lost control, all the scars opened: an abdominal scar, a scar on the forehead. Don’t ask. A very large scar remained on my stomach . . . I am a person who is so aware of my body, and my body is constantly changing. From age 20 my body has constantly been changing. Every few months I have surgery, and at some point after a year of this I became aware of the changes I was going through . . . you have to learn to live.

Before the car accident, Mazal had been a dancer. Her physical awareness, she says, was reflected in her capacity to move, to manage her body, but even when her body is not under her control, she does not experience physical alienation, but is, rather, impressed with its abilities. The force that motivated her to cope with life was the coma experience, through which she claims she gained physical insights and learned to heal herself. For example, she claims that several years ago she had a urinary tract infection that she was able to cure herself without medical treatment. Mazal also gained insights into the meaning of life. With the phrase “you have to almost die to know how to live,” she explains that people do not know what real happiness is, instead of forcing themselves to be happy through various kinds of spiritual workshops, they should experience inner peace, live without fear, and know what they want to do in life.

Between Experiencing and Narrating the Body

In his book Proof of Heaven, Eben Alexander (2013), a well-known neurologist who was in a coma for a week, describes the very physical, sensory experience of consciousness without a body in another dimension, a “claustrophobic” place, a kind of dirty, muddy jelly, and a “heaven” surrounded by light and love. Alexander explains how difficult it is to articulate his experience, and at various points throughout the book turns to his readers to try to explain the truths and reality of what he went through. He says that they should not forget who is telling this story, that he is not a sentimental simpleton, that he knows what death looks like. He knows biology, and despite not being a physicist, he can tell the difference between fantasy and reality. The experience he struggles to tell us about, with what are for him vague and insufficient descriptions, is the most significant experience of his life.

Like Alexander, all the study participants sought to share their experience of coma in different ways, whether with relatives, their physicians, or the general public, through books. They also shared their experience with me, a stranger. It seems that telling the story of the coma is an integral part of the rehabilitation process, because paradoxically, to make sense of this very private, subjective inner experience of coma, they had to release it, get it out from under their skin and their minded bodies, and into the open. That is, the practice of talking about the
physical experience simultaneously disciplines the body according to the rules of language and discourse, and makes possible its existence and the subversion of those rules. Although the phenomenological body is pre-linguistic, experiences the world, and is connected to it through its senses, its inner world cannot be measured, reduced, or framed. Paradoxically, it must be a discursive body, a body about which a story is told, which is talked about, perceived, and interpreted, to understand it and express its experiences. In this process, the phenomenological body challenges the boundaries of discourse, broadens our knowledge, and forces us to think about the assumptions that established the discursive body.

Each of the participants redefined the boundaries of the body, especially in cases when they spoke of experiences they did not understand as corporeal, for example, out-of-body experiences, near-death experiences, or experiences of being between the earthly and unearthly. The various interpretations of the experiences, whether religious, rational (hallucinations from medications), or spiritual (the existence of the immortal soul), each in accordance with the individual’s social world and “store of knowledge,” expand the discursive boundaries of the body. Their struggle to find suitable words to tell their coma stories emphasizes these boundaries between experiencing and telling, but at the same time subverts them. In addition, the stories of the participants subvert the biomedical assumptions regarding the chances of survival and the abilities of rehabilitated patients. Most of the participants described how they survived and were rehabilitated, in contradistinction to the expectations of their physicians. Four of the participants were declared dead, and two even received death certificates, a socially approved confirmation of death, but they were revivified, challenging the definition of death as perceived by their doctors. Moreover, many of the participants described the process of their rehabilitation, which was deemed impossible by their doctors, and challenged medical assumptions. There is no doubt that the stories become more dramatic the lower the chances given to them, so that the narrators become more heroic. In any case, their narratives bring us the stories of bodies that have crossed the normative discursive border of the medical establishment and illustrate the ambiguous nature of human existence.

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Notes
1. All Hebrew texts and interviews were translated by Hannah Adelman Komy Ofir, PhD.
2. There are other approaches connected to judicial and religious discourses, but I will not develop them here.
3. This study was approved by the Ethics Committee of the Department of Sociology and Anthropology of Ben-Gurion University of the Negev.
4. See http://www.ynet.co.il/articles/0,7340,L-4440880,00. html
5. Schuetz relates to the phenomenology of the stranger (immigrants and anyone who feels discomfort in his social environment), to disorientation in a new environment, whereas the store of knowledge, the social-cultural menu, and “thinking as usual” are tested, challenged, and not immediately clear (Schuetz, 1944).

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**Author Biography**

Limor Meoded Danon, PhD, is a lecturer at the Department of Sociology and Anthropology at Ben-Gurion University of the Negev, Beer-Sheva, Israel.