Liminal Asymmetries

Making Sense of Transition Dynamics in Relations with Dying Persons

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Abstract The article presents one option for an anthropologically informed understanding of onto-hierarchical particularities that can characterize and shape relationships between non-dying persons (e. g. researchers) and dying interlocutors. The article draws on research with responsive and conscious persons who 1) suffer from a terminal illness, 2) have been informed about their terminal prognosis, and 3) regard their diagnosis as reliable information about their own dying. The classic Turnerian ideas of *threshold* and *transition dynamics* are applied to make sense of *liminal asymmetry* as an important factor that permeates research relations with consciously dying persons and can sometimes create challenging situations during fieldwork. Liminal asymmetries are characterized by at least three dimensions. First, as dying persons are in a 'betwixt-and-between' state, they often desire liminal companionship and guidance when dying. (Persons who are not terminally ill are inherently incapable of adequately fulfilling the role of liminal guide or companion because they are not in a state of betwixt-and-between.) Second, the experience of hierarchy is crucial, as the dying have privileged access to a mode of being that the non-dying have not yet entered. Third, as another existential hierarchy, dying persons – having accepted a terminal diagnosis as a reliable statement about their presence and future – usually consider their state of being, agency, and vitality to be less privileged than that of non-dying persons. By acknowledging liminal asymmetries as formative for experiences of dying, we gain an additional tool for understanding research situations in which liminal asymmetries are directly or indirectly thematized. The article describes two exemplary fieldwork scenarios to illustrate the types of situation identified as arenas for negotiating the (im)possibilities of liminal companionship and liminal guidance, as well as capability-related hierarchies.

Keywords dying – participant observation – liminality – liminal asymmetry – terminal illness

Introduction

On entering into a relationship with an aware-of-dying[1] person – that is, a person in a phase of life that they themselves identify as an irreversible process of dying – researchers are meeting someone who is willing to spend part of the last weeks of their life with someone they barely know. This comes with a responsibility; there is a particular requirement for politeness and a heightened necessity not to annoy a person who is terminally ill, often exhausted, and sometimes rather desperate. Despite the researcher's best efforts, there is still a risk of appearing tiresome or even overburdening a dying interlocutor (MENZFELD 2022; 2018a; APPLETON 2004; PALGI & ABRAMOVITCH 1984; see also CHATTERJI 2016, WOODTHORPE 2011, RIESSMAN & MATTINGLY 2005, BEHAR 1996). Through an anthropological lens, this article describes one way of understanding some possible sources of exhaustion and annoyance for the interlocutor that can also cause researchers to feel insecure.

Field research with people who are dying means working with people whose current mode of existence necessarily remains fundamentally incomprehensible – at least unless the researcher is acutely and terminally ill. On the one hand, this does not essentially distinguish end-of-life participant observation from other ethnological work contexts; after all, anthropologists are constantly trying to understand people and circumstances whose being and doing they cannot always comprehend from an emic point of view. On the other hand, when working with the dying, the characteristically anthropological residual omission in the field can appear especially drastic. Interlocutors who have been informed about their terminal prognosis and have internalized this as a statement about their personal future and state of being are especially likely to have a strong sense of their situation as radically different from that of the researcher. Some dying persons experience anger, envy, and deep feelings of injustice when they realize that they probably have only a short time to live; in contrast, the researcher and other non-dying persons may assume that they have far more time (MENZFELD 2021). In addition, long periods of conscious silence, partial inability to communicate, and communication-inhibiting fatigue are to be expected among dying interlocutors, and researchers must also endure and recognize the particular nonverbal expressiveness of these situations. 'Coming in as the nothing' – as BORGSTROM ET AL. (2020) recently characterized the attitude adopted by some palliative carers (not only) in UK contexts as an alternative to overactive or curative action logics – is perhaps neither task-appropriate nor possible for researchers. However, the underlying idea – to avoid giving unsolicited advice, interfering uninvited, or simply causing undue annoyance to the dying person – is worth considering as a useful aspiration for research attitudes, including settings beyond palliative care (see also FITZPATRICK 2022; ANDRADE NEVES 2022, both in this volume).

But why is that so? Are there specific features of the relationship between dying and non-dying persons that explain why it seems so easy to overstep the line during contact and why different professionals[2] explicitly or instinctively conceptualize a respectful approach to the terminally ill as 'coming in as the nothing'? In explaining the hidden or open hierarchies between aware-of-dying persons and non-dying persons, are we missing something by focusing on the general vulnerabilities of the terminally ill – on death anxiety, emotional turmoil in the face of dying, or the general tragedy of mortality?

I would like to draw attention to a dimension of dying that, in my opinion, can be a source of misunderstandings and problems if it remains an unconscious co-factor in relationships between non-dying persons and dying people. I explore what I call *liminal asymmetry* by resorting to the classic anthropological concept of liminality, which will be explained in detail below (TURNER 1967, 1974; VAN GENNEP 2006[1909]). In particular, I explicate the frequent absence of eye-level companionship and guidance within the liminal phase of terminal illness. This absence can make dying persons feel abandoned and stressed, and cannot be compensated for by non-dying persons: not by the most dedicated physicians, not by the most skilled therapists, not by the most loving relatives, and certainly not by anthropological researchers. Unless understood and reflected, a lack of liminal guidance and companionship can be frustrating, leaving both sides – dying and non-dying alike – with feelings of helplessness. However, simply being aware that liminal asymmetries are no one's fault but are rooted in fundamentally different modes of liminal or non-liminal states of being can help both sides to understand and accept their individual and mutual limitations. More particularly, the awareness can open up a space for dealing constructively with possible thematizations of liminal asymmetries by accommodating them within the research relationship. In this article, I present and analyse two examples from my long-term fieldwork with dying persons in Germany to illustrate some concrete situations in which the issue of liminal asymmetry may be assumed to occur.

Liminal Guidance and Companionship: A Need That Non-Dying Persons Cannot Meet

Although dying is widely acknowledged as a prime example of a liminal phase (see for example SCHRÖDER 1986; KAUFMAN & MORGAN 2005; THOMPSON 2007), research on dying tends to treat this as a standalone insight – which is a pity, as it has sufficient explanatory potential to be considered much more than a commonplace. I argue that some potentially stressful or even research-inhibiting situations occur not only during research-related contact with dying persons but also during other contact between non-dying and dying people. The reasons for this can be more precisely identified by paying due regard to TURNER's (1964,1967, 1969, 1974) understanding of liminal situations.

As I explain in detail elsewhere (MENZFELD 2018a) and as addressed and conceptualized in a slightly different way by thanatologists rooted in sociology (WALTER 2007; WALTER ET AL. 2012; SEALE 2004),[3] a demand for what TURNER (1974) called *communitas* can be observed from time to time in terminally ill persons. Terminally ill persons may experience moments of deep happiness on finding a support group where they can exchange experiences about their situation. Sometimes, they benefit from knowing that an old friend or relative is suffering from an incurable illness at the same time as they are, affording opportunities for comradeship. In contrast, dying persons who have no contact with others who are terminally ill[4] may feel existentially lonely, different from everyone else, and misunderstood – even those who are constantly surrounded by caring relatives, doctors, nurses, and friends.

Such feelings cannot simply be explained away by characterizing the existential loneliness of dying merely as some kind of cultural fault or as a means of denying death, as some classic tropes of thanatology suggest (most prominently perhaps ARIÈS 1976 and 1981; see also BECKER 1973; GIDDENS 1991).[5] Instead, to understand what dying people may long for but cannot get from non-dying persons, it helps to look at what TURNER (1964, 1967, 1969, 1974) identified as the core characteristics of liminality. Turner contended that people who experience a liminal transformation find themselves in a betwixt-and-between state of ontological indifference; that liminality is characterized by a change of status involving an initiation; and that people in this liminal phase have very different options and restrictions on agency than those in a non-liminal state.

All of these aspects of liminality inform contemporary aware dying in European biomedical contexts (see also REHSMANN & SIEGL 2022) in the following way. Dying people live with the ontological particularity of being aware that their future is very limited; they receive this message through a unique initiation that usually involves a diagnosis statement from a biomedical specialist (who is assumed to be capable of making reliable prognoses in this regard). Moreover, dying people receive specialized medical care (e.g. palliative rather than curative), are excluded from certain financial transactions (e.g. bank loans), and are no longer expected to work the same hours as before. They are also encouraged to think about their last will and to engage in final conversations with those close to them, et cetera (see MENZFELD 2018a for a contextualized account of shifts in agency options and activity limits for dying persons).

However, Turner also identified elements that are *not* entirely met when the dying process is initiated by a biomedical expert as crucial in liminal situations; these include:

- initiation by an already initiated person;
- guidance throughout the liminal phase from an already initiated guide;
- conventionalized communitas among liminal companions;
- a conventionalized procedure of personal reintegration that the liminal person herself experiences although transformed through liminality.

(TURNER 1964, 1969, 1974; see also VAN GENNEP 2006 [1909])

In exchanges with persons who are consciously dying and who are initiated through the normalized procedure (i.e. diagnosis by a biomedical expert whose judgement is considered reliable), we meet people who have had no opportunity to talk to someone who has already experienced dying. As those who have already experienced the liminal phase of dying are already dead, they are not available to give advice to the newly initiated.[6] The dying person is not initiated by someone who has successfully completed the initiation process but by a specialist who assesses their physical condition and, based on this assessment, draws conclusions about their current and future ontological and action-related status in terms of capacity (i.e. whether the person is living or acutely dying, needs rest, or is able to perform daily routines as usual). While every biomedical prognosis refers only to probabilities and likelihoods – that is, assumptions about how a disease might manifest in a particular individual and how quickly it might kill them – the constitutive speech act of communicating a terminal diagnosis and the associated proceedings and requirements provoke a massive shift in how they see themselves and are seen by others, in the possibilities and limits of action, and in the emergence of new uncertainties and limitations.

It also becomes clear that *communitas* is uncommon; when dying persons are deliberately brought together, it is often for reasons of care management (e. g. in a palliative care unit or a hospice) rather than to encourage engagement with others in the liminal phase of dying. Non-dying people may even view spontaneous alliances between dying persons with suspicion or worry that contact between terminally ill people might increase the likelihood of sadness and despair (MENZFELD 2018a). It is not entirely normal for dying people to seek advice or contact with other dying persons; no cultural script suggests that dying people should seek the company of other dying people or envisages bringing dying persons into contact with each other. This clearly sets dying apart from other liminal phases, such as becoming a mother, which affords myriad opportunities for advice and contact (e. g. pregnancy yoga, birth preparatory courses). Although some prognoses indicate that seeking connections with fellow sufferers may be a trend among dying persons (WALTER 2017, 2003), we have not (yet) found evidence of any commonly shared assumption that it is good and normal for dying persons to socialize with others in a similar situation.

Among other concerns, the reintegration phase is confusing for many dying persons in terms of belief. Even among those who cultivate a strong belief in a personal life after death, the nature of personal reintegration cannot necessarily be regarded as reliable knowledge. Plainly speaking, dying persons cannot be sure they will experience some form of reintegration after passing away, and while some hold firm beliefs in this regard, many assume there will be no reintegration after the body dies.

The absence of liminal guidance and companionship and the uncertain prospects for reintegration can cause extreme discomfort. One can imagine similar levels of discomfort in other liminal situations. For example, some women would prefer to give birth for the first time under the guidance of someone who is not only a specialist but has also experienced childbirth herself. Similarly, young persons may experience initiation to adult life as adverse without liminal companions, and so on. In the liminal phase of dying, these missing features may cause stress. Keeping that in mind, encounters in the field, such as the two described below, can be seen in a new light.

Many of the dying interlocutors I grew close to described particular ways of responding to liminal differences (see also MENZFELD 2018a), leading me to a re-reading of Turner. Both of the situations described below occurred during fieldwork I undertook with dying persons in Germany between 2013 and 2016. I have chosen not to characterize either of my dying interlocutors in terms of their diagnosis, as this is unnecessary for understanding their situation. In addition, they were reluctant to be defined by their disease, and I regard it as a gesture of respect not to reduce them posthumously to a predominantly biomedical framing.

Konstantin

It was a rainy autumn evening in 2014. My interlocutor Konstantin, a married engineer aged 56 years, had agreed to see me despite feeling a little short of breath and tired that day. I went to his house without a second thought because I knew that he favoured conversation – despite the potential for exhaustion – rather than boredom and overthinking. More than once, he had told me that ‘being part of all your lives means I’m still part of everything’. As he said this, he pointed at me and at his children, who were present at the time, but also at the blabbering TV. Konstantin often joked about his diagnosis; he allowed himself to cry, when he felt so inclined, in the company of his relatives. He was very busy preparing his last Christmas celebration and never ceased to be interested in his neighbours’ smallest everyday problems or the latest political news. In short, Konstantin was the ideal image of someone who remains happy, joyful, and self-controlled to the very end.

Yet, like many aware-of-dying persons, he had his moments of deep anger and loneliness. When I entered his room on that rainy autumn evening, I instantly sensed that his glance seemed different from what I recalled of my previous visits. He sat partly upright in his bed; his face was still, his jaw slightly clenched, and he barely greeted me. I grabbed a chair and sat down by his bed. I said ‘Hello’ and asked how he felt. Konstantin did not indulge in flattering words or superficial politeness but simply answered ‘Not well’. I nodded and sat silently beside him. Usually, our meetings would start with lighter conversation, but he apparently had no need for light conversation that day.

After a little while, Konstantin said, slowly, ‘You know what’s going on? Everything falls apart. I fall apart here. I watch myself falling apart. You do not know what this means’. During that last sentence, his eyes met mine. He did not seem angry or sad – just very, very serious. I looked back at him, touched by the seriousness and openness and nodded slowly. He said ‘The problem is – you all think you understand. I also thought that once. But you do not [understand]’. I took some time to respond, because I felt a little shy; then I said ‘Would you want us to understand you better? Maybe you can explain what we do not *get*?’ Konstantin smiled kindly and answered ‘I do not think this is possible. But that is just how it is’. He closed his eyes, and we were just present next to each other – him following his private thoughts or getting some rest, and me thinking about what he had said.

When Konstantin opened his eyes again, he asked me to get some juice and wanted to chat a little about what he called ‘the tradition of groundless incompetence’ of the local municipality in failing to build houses and community areas that do not look like they hate their own town ‘because why else would they drown each little corner in concrete and ugly architecture?’ His wife joined us a little later, and we chatted for about two hours in what seemed an easy-going atmosphere. When it was time for dinner, and I offered to leave this part of the day to him and his wife, Konstantin agreed. While his wife went to prepare an evening snack for him, Konstantin said a special goodbye to me: ‘About our conversation when you came; you’re not the problem [if you don’t get everything that I experience]. Actually, I like it better this way, because if you were to get it [my experience] from the inside, you would all soon be lying here next to me’.

What first appears to be a contradictory tension – the initial wish to be understood and the awareness that this wish is not realizable in relations with non-dying persons – becomes more understandable if interpreted as an expression of Konstantin’s longing to be understood by other dying persons rather than as a statement of non-dying persons’ inability. In fact, he is not simply mourning the fact that nobody could ever understand what he is going through but recontextualizes his feelings by adding that anybody who *could* understand him would necessarily be dying too. In his last sentence, Konstantin echoes a statement that I heard increasingly when I began to develop research relationships with dying persons over a period of weeks or months. This leads me to assume that at least some aware-of-dying persons possess a strong sense of the limits of non-dying persons’ comprehension of what life is like during the process of dying. Other interlocutors made similar comments when disappointed that no doctor could tell them how they would feel the next day, or when they struggled to find out whether it was normal to often feel sad in their situation or whether this form of depression required treatment, or when they received well-meant advice from their children to meet up one last time with old friends with whom they no longer had any contact, or even when they had just had a nice, easy-going chat with their partners. In short, demarcation statements of this kind highlight the difference between the dying and the non-dying and arise in a wide range of situations.

I assume that in statements such as Konstantin’s last words to me at that meeting, there is a hint of an emic awareness of the liminal asymmetry between dying and non-dying persons. This awareness can be reflected practically in (among other things) the urgent feeling of being misunderstood by non-dying people, pointing indirectly (and sometimes directly) to the fact that non-dying people cannot actually guide or help the dying through the dying process. A mode of being that includes knowing that one has no more than a few months (at most) of a future or a life differs radically from anything that a non-dying person faces.[7] Even we establish a connection, dying persons themselves sometimes point out that radical difference between the dying and the non-dying.

Judith

The second situation I would like to introduce arose during a visit to a care institution. Judith, a divorced 66-year-old former taxi driver, had decided to move to an institution after she realized that living alone at home was becoming increasingly difficult for her. Her story, like Konstantin’s, illustrates the experience of liminal asymmetries between oneself (as a dying person) and others who are not yet dying. Judith's story also shows how things can change when the people around you actually 'get' what dying means.

I had not visited Judith during the Christmas holidays, but I came to her room in January to see how she was and whether she was doing well in the small hospice. I was a bit worried that she might not like it there because, when she was test-living there to see whether she would find it comfortable to spend her last weeks in such an institution, there were conflicts with two of the nurses. In particular, Rudi – a carer she did not like and considered impolite – seemed to have become something of an in-house enemy, not least because she responded to his assumed rudeness with snappy comments of her own.

Judith also had reservations about talking to psychological counsellors and even to the younger doctors who were responsible for her medication and well-being. She was very compliant in respect of the doctors' recommendations, but she suffered from what she referred to as a dependence on 'little children right from university who mean the best but know nothing', which on some days included myself as a then-young researcher.[8] In expressing these views, she offended more than one of the professionals who were caring for her, and surely at least some of her friends, whom she clearly regarded as unable to understand her situation (although not as childlike, given their age or life experience). According to Judith, 'It is not enough for them that they are healthy and I am not; they also want me to tell them that they understand everything so they do not feel shut out or something [...] But that would only make *them* feel good; it would not be honest'.

Judith often felt lonely and once even complained, half-jokingly, that 'there is no Brockhaus [a lexicon on all matters of general knowledge] to look up what all this [dying] will be like'. At the same time, she strongly rejected advice and expressions of empathy from those who did not share her mode of living as a terminally ill person. To cope with this specific aspect of loneliness, she tended to read everything about dying (written by other dying persons) that she could get her hands on. For instance, she was a huge fan of Wolfgang HERRNDORF's (2013) book and his blog about his experience of dying from a glioblastoma. She also reported feeling very inspired and 'seen' when she read Christoph SCHLINGENSIEF's (2009) diary about his own process of dying of lung cancer.

When I entered her room on that January day, Judith appeared to be flourishing despite an obvious and apparently dangerously rapid loss of weight over the holidays, indicating that her physical condition may have worsened. As soon as I closed the door, Judith informed me excitedly that she had made contact with another resident at the facility who lived just down the hall. She had met him two days before Christmas Eve in the small park visible from the window of her room. She made a point of telling me that while he might not be the most handsome man, he was a person she could 'really talk to'. Although her new friend was much younger than her, he seemed to be one of the very few people that Judith could explicitly accept as an equal partner in conversation. Spontaneously, she characterized her relationship with her new friend as follows: 'If there's someone who knows what it feels like ... That's better'. After meeting her new friend, being misunderstood all but vanished from the list of topics that she regularly addressed. Although they rarely seemed to talk explicitly about the actual situation of dying, the mere fact that they were both going through a similar experience seemed comforting. This brought them closer together, and they accepted each other's company and advice despite rarely allowing anyone into their lives or permitting physical proximity.[9] One of the last things that Judith said about being annoyed by carers was the following: 'Since I found him [her new friend], I am not alone anymore, and honestly, I am less annoyed [by people who annoyed me before]'.

More than once, I noted in Judith's expressions and actions a very palpable enactment of missing liminal opportunities. She wanted to be guided by someone who had been through all the things she was currently dealing with, and if the only available guidance was to be found in books, she would at least read those books. She wanted to be in the company of people who shared her situation, who could really understand her, who would offer her a form of communal experience. Interestingly, the person Judith finally viewed as an equal was not of the same age, educational background, or socioeconomic status.

He was younger, more educated, and better off in economic terms, but she still saw him as an equal because he was also dying. Judith admitted that, since meeting him, she had what she longed for: a friend who understood the situation in which she found herself. Viewed through the Turnerian lens of transition(al) dynamics, Judith clearly had a history of bringing up and suffering from liminal asymmetries but found relief once she had a liminal companion.

Judith and Konstantin: Experiencing Liminal Asymmetries

In narrating these particular encounters with Judith and Konstantin, I want to stress two things. First, it is not easy to be in a liminal state when there is no liminal guide to turn to. Initiation into the dying process is usually performed by an uninitiated expert without any deeper insight into how it feels to be aware of one's own dying. Starting there, the trend continues, as most of the people around a dying person are not yet dying themselves. This can cause feelings of unease, of being misunderstood and clueless, and even of loneliness, sometimes resulting in a sense of existential abandonment during a transformative situation that cannot always be adequately alleviated by encounters with well-meaning, caring, or specialized persons, even those with psychological training. No one is to blame for this situation; the dilemma is typical of other experiences of chronic illness but is especially palpable in the case of dying. No matter how hard they try, non-dying persons cannot comprehend the full meaning and experience of liminality in dying. Even dying persons who say they have been cared for in the best possible way cannot deny that, at least sometimes, the company and guidance of a person who understands what they are feeling would be ideal or perhaps even necessary.

Second, I want to stress that some dying persons *do* actively look for ways of dealing with possible feelings of liminal abandonment and the crucial differences between themselves and the non-dying. Although rarely encouraged to do so (and perhaps even discouraged from doing so by non-dying persons), some dying persons actively pursue opportunities for exchange across the entire spectrum of liminal communitas or look for liminal guidance in the writings of those who have been where they are now. Judith's story is an example of a dying person whose transition from being lonely to being accompanied by a new friend crucially influenced her view of her own dying process and her feelings about her life's ending. It is important to emphasize that these individual orientations towards liminal communitas and companionship are not what SEALE (2004) called *confessional deaths* (i. e. self-revelations in front of an audience that includes non-dying persons) and cannot be framed as a desire to share one's own dying experiences openly – for example, in social networks (WALTER ET AL. 2012). Interlocutors like Judith and Konstantin do not want to display their embeddedness in the social networks of the living; in fact, they do not want to make their dying public at all. While they yearn for guidance and/or companionship, they do not long to share their experiences with a larger non-liminal audience; they want contact with others whose onto-hierarchical specificities align with their own. To put it another way, they find their own ways of dealing with liminal asymmetries. The concept of *liminal asymmetries* helps to explain why Judith feels so much more comfortable as soon as she makes a friend of a very specific kind – another dying person – and why Konstantin declares so strongly that nobody around him could really understand his specific situation unless they were themselves dying. To characterize Konstantin's experience only as everyday feelings of loneliness and being misunderstood would miss an important point. He makes it quite clear that the problem is precisely the gap between himself (as a dying person) and the non-dying. Similarly, failing to acknowledge that the only person Judith really wants to be close to is, of all people, another dying person would neglect a crucial characteristic of her new friendship. Nor is her search for some kind of guidance while dying adequately explained as an ordinary need for security and orientation. However, by viewing Judith's and Konstantin's stories through the lens of liminal asymmetries, I can describe and analyse many of their statements and feelings without either devaluing them as mere individual moods that any non-dying person might also experience or overstating their significance as an assumed repression of the dying from the realm of the non-dying (which is not true in either case).

What I refer to here as liminal asymmetry extends beyond the fact that liminality in dying may be unaccompanied and unguided, leading to confusion, stress, and challenging situations in relations between the dying and the non-dying. That asymmetry refers ultimately to the liminal imbalances and difficulties of dying as opposed to other liminal phases marked by guidance and companionship. Other closely related facets of liminal asymmetry include the experience of hierarchy. First, simply by going through a liminal phase, dying persons gain privileged access to a mode of being that the non-dying have not yet entered. This affords the dying a certain hierarchical superiority in terms of the modes of experience they can understand from an emic point of view. Second, and at the same time, having accepted a terminal diagnosis as a reliable statement about their present and future, the dying may find themselves in a less privileged state of being than the non-dying, as they lack the full agency or status of a living person and must assume they will soon be dead and can do nothing about it. The term *liminal asymmetry* encompasses all of the ontological and capability-related hierarchies at play when the dying and the non-dying meet (including interlocutor and researcher), all of which are connected to and initiated by the opposing conditions of being or not being in a particular liminal phase.

Concluding Remarks

As I have observed in Germany and other European contexts (such as Finland), the possibility of being aware of one's state as a dying person depends on the idea that biomedical diagnoses are now relatively exact and reliable. This idea is historically and culturally quite new and became widespread only when biomedical diagnoses acquired their current meaning. It is unsurprising, then, that the liminal phase has not yet been fully unfolded to offer comprehensive guidance, initiation by the already initiated, appropriate companionship, and a concrete prospect of personal reintegration; in short, key liminal characteristics (TURNER 1967, 1974) are still missing. While institutionalized and culturally conceptualized options for liminal guidance and communitas in dying are not (yet?) the norm, some dying persons seem to long for these features, seeking insights into the dying processes of others because the advice and companionship of the non-dying is inadequate and/or insufficient.

I have argued here that it is useful for non-dying researchers to keep these deficits of liminal guidance and communitas in mind when engaging with dying interlocutors. In so doing, we can develop a better anthropological understanding of situations that might otherwise evoke feelings of helplessness or inadequacy and fears of irritation or intrusion Acknowledging this liminal asymmetry also respects the fact that, as researchers, we can never fully provide satisfactory liminal companionship, let alone guidance, for the dying person. We can, however, show our understanding of this fact whenever we enter into close and long-term contact with someone who is terminally ill.

I have proposed to conceptualize the onto-hierarchical differences and imbalances that may arise in contacts between dying and non-dying persons as *liminal asymmetries.* In using this term, I am addressing three often interrelated dimensions that can shape and influence relationships between the dying and the non-dying. 1) The non-dying cannot access certain states of being experienced by the dying, who are not themselves prepared for the liminality of dying. 2) For some people, the desire to balance the uncertainties of liminality with companionship and guidance remains unfulfilled, rendering the liminal experience asymmetrical. This contrasts with classical Turnerian liminality, where those uncertainties and challenges are complemented by offers of guidance and companionship from people who are familiar with the particular liminal phase in question. 3) There is a crucial difference between non-dying and dying as modes of being; in the latter case, the ontological state changes as soon as the dying person acknowledges the terminal diagnosis as a reliable statement about the nature of their existence and future.

What I describe as liminal asymmetry can be observed in quite different contexts, marked by particular characteristics in each case. Researchers have described and analysed these concrete instances of onto-hierarchical asymmetries in the relationships between dying persons and professional caregivers, between the dying person and their (sometimes distant) family, and between the dying person and the ethnographer (see for example CHATTERJI 2016; ESCHENBRUCH 2007; LAWTON 2000; BECKER 2002; KRAWCZYK & RICHARDS 2021; BARRETT 2011), paying detailed attention to the specific dynamics of these contexts. Nevertheless, I contend that the more general view of these dynamics proposed here adds further value. In particular, such attempts to conceptualize the general existential differences between aware-of-dying and non-dying persons enrich theoretical efforts to understand the social meanings and dynamics of dying and death[10] by offering a decisively *anthropological* perspective on the onto-hierarchical specificities that shape relations between the terminally ill and the non-dying. This position echoes recent claims that anthropology adds nuanced complexity (SILVERMAN ET AL. 2021) to conventional readings of death-related dynamics such as grieving processes (see CORR & DOKA 2001). These conventional readings are typically rooted in particular psychological concepts that may not be designed for cross-cultural application and are unable to fully capture all that dying entails (IBID.). In contrast, my analyses of the stories of Konstantin and Judith show how a re-reading of Turner can capture certain aspects of dying that non-anthropological concepts, to my knowledge, fail to explain with similar precision.

Viewing the dynamics of dying in terms of liminal asymmetries between the dying and the non-dying also extends and revives the potential of the concept of liminality in this context as something more than a commonplace. For me at least, this also illuminates how, as researchers, we can find ourselves in situations that seem to entail two modes of participant observation at the same time: an inevitable involvement in the interlocutor's experiences and an essential inability to truly share their views and feelings.

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Notes

1 In this text, I address as '(aware-of) dying' those persons who consciously experience the prospect of fading away soon – that is, those who have been informed of a terminal illness that will lead to physical exitus in the near future and regard this information as a valid statement about their reality and future. There are fundamentally different ideas about how long dying lasts, when it begins, or how it is shaped by dying and non-dying persons (see for example STONINGTON 2020; AULINO 2019; for an overview, see MENZFELD 2018b). However, in the specific context referred to here, I define the dying phase as the period from receiving a terminal diagnosis to physical exitus.

2 Besides the UK palliative carers mentioned by BORGSTROM ET AL. (2020), this attitude is found among palliative and terminal carers in different regions of Europe (see for example BAUSEWEIN ET AL. 2015; KRÄNZLE ET AL. 2007). I have witnessed it many times since commencing my training in my early twenties as a volunteer in terminal/end-of-life care in Cologne and subsequently as a terminal carer. My experiences in this regard mirror those of other terminal carers I have met over the years who were trained in different European countries.

3 They do not refer to Turner or to his predecessor-in-thought VAN GENNEP (2006[1909]) but argue that modern fellowships in dying (end-of-life-care/companionship) is more likely to take the form of public self-revelation, sometimes through social networks.

4 This is the case even in institutional settings that bring dying persons together spatially; there is no conventionalized procedure to promote or enable exchange between dying persons in either hospice or palliative care units.

5 This topos has been acted upon by different groups and movements attempting to counteract the perceived repression of death and dying. For an example of counter-activism, see LOFLAND (1978); for an academic account of recent group and company attempts to re-naturalize and socially re-embed supposed repression of death and dying, see WESTENDORP & GOULD (2021).

6 As we will see, however, some dying persons seek companionship in literature and weblogs written by other dying persons.

7 This may also differ from the situation of those directly confronted with death and dying in different contexts – for example, because they live in regions where war dictates the rhythm of life, because they intend to become a suicide bomber, or because they are awaiting a death sentence. In these latter cases, factors such as the (non)existence of a subjective death wish, risk tolerance, ideas of improvement (e. g. of one's own soul or family nutritional situation) are formative. In all such cases, one's fundamental bodily capacity to continue living is threatened but is not imagined as unalterably or irrevocably absent. It is different when a person assumes that their own body itself limits their life or when an external factor or a decision of some kind is involved in limiting their life.

8 Judith's reservations certainly stemmed in part from having to take advice from people who were more educated and better-off than herself. However, as she referred explicitly to age differences and life experience, I also stress these dimensions here.

9 I would have liked to say more about her friend here. However, for their own reasons, his family did not feel comfortable with my use of most of the notes and quotes that refer to him.

10 See for example influential psychiatric-psychoanalytical and sociological classics as Kübler-Ross (1973) or Glaser & Strauss (1965) and well-known historians like Ariès (1976) or recent biomedical contributions (Albrecht 2015; Hutter et al. 2015).

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