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Liminal Competence: An Original Construct for Sustainable Threshold-Dwelling in Ongoing Loss

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Abstract

Healthcare chaplains and clinicians increasingly encounter patients whose losses do not conclude: those in palliative trajectories, persons with progressive neurological disease, dementia caregivers, displaced persons, and incarcerated individuals. This article is a conceptual contribution that derives its construct from interdisciplinary literature rather than from new empirical data. The dominant resolution paradigm in grief theory—which treats mourning as a problem to be resolved through stages, tasks, or reconstructed meaning—is structurally inadequate for these contexts because no terminus is available. The article extends Victor Turner's anthropological theory of permanent liminality into contemporary medical and psychosocial contexts and introduces the construct of liminal competence: the set of cultivable capacities that enable sustainable dwelling at thresholds that do not close. Liminal competence comprises four interrelated dimensions—ambiguity tolerance, oscillation flexibility, communitas access, and liminal meaning-making—each grounded in established interdisciplinary scholarship from anthropology, phenomenology, contemplative studies, and grief science. The construct addresses a gap in liminal theory by distinguishing sustainable from entrapping permanent liminality, and it is differentiated from adjacent constructs such as resilience and psychological flexibility. Applications are developed across palliative trajectories, chronic progressive illness and dementia, and displacement and incarceration. The article concludes with limitations regarding Western-centric framing, the absence of empirical validation, and the boundary between liminal competence and the redress of structural injustice that produces ongoing loss.

Subject Areas

Palliative Care

Keywords

Liminality, Permanent Liminality, Ongoing Loss, Ambiguity Tolerance,

Communitas, Threshold-Dwelling, Grief, Chaplaincy

1. Introduction

Contemporary grief theory and clinical practice are governed by what may be termed the resolution paradigm. By this term the present article means, specifically, a teleological framework organized around three assumptions: that grief is a problem to be resolved rather than a relationship to be lived; that mourning follows, or ought to follow, a trajectory of diminishing intensity toward a recognizable endpoint; and that the persistence of grief past an expected interval is therefore a marker of something gone wrong. These assumptions trace to Freud's account of mourning as the gradual withdrawal of attachment from a lost object [1] and were formalized in stage and task models [2] [3]. It is important to be precise about the target of critique. The argument here is not a rejection of contemporary grief models as such—the Dual Process Model [4] [5], continuing bonds theory [6], and meaning reconstruction [7] have each substantially advanced the field, and each remains appropriate for episodic bereavement. The objection is narrower: that the residual telos of resolution persists even within these later models, and that this residual assumption, not the models in their entirety, is what fails in ongoing loss. The DSM-5-TR's introduction of prolonged grief disorder gives the assumption its most consequential institutional form [8].

That diagnosis is frequently summarized, including in earlier drafts of the present argument, as pathologizing grief that persists beyond twelve months. The summary is imprecise and worth correcting. The DSM-5-TR criteria require not only that intense grief persist for at least twelve months after a death but also that it cause clinically significant distress or impairment in functioning and that it exceed expected social, cultural, or religious norms for the bereaved person's context [8]. Duration is thus a gate, not the whole criterion. The concern this article raises is therefore not that the manual reduces disorder to elapsed time, but that a duration threshold, once salient, tends to organize clinical and cultural expectation around an assumed timeline of recovery—and that the impairment and contextual provisos, while genuine safeguards, are difficult to apply precisely in contexts where distress and functional disruption belong to the loss situation itself rather than to any disorder within the griever.

This framework was developed for and tested against episodic bereavement: a discrete loss followed by a process with a recognizable end. It is structurally inadequate for ongoing loss contexts—palliative trajectories, progressive neurological disease, dementia caregiving, displacement, and incarceration—where loss is not an event followed by recovery but a continuous, unfolding condition. For patients and families in these contexts, every day brings new losses before the previous day's have been integrated; resolution is not deferred but structurally unavailable [9]-[12]. The clinical consequence is iatrogenic: applying resolution-oriented

frameworks where resolution is impossible generates a secondary shame of failing to progress on top of the loss itself [13].

Anthropological liminal theory offers a rigorous alternative. Van Gennep identified liminality as the middle phase of ritual transitions—a threshold period suspended between separation from a prior status and incorporation into a new one [14]. Turner extended this concept to recognize that for certain persons and conditions, the threshold itself becomes a permanent site of dwelling [15]. Patients in ongoing loss occupy precisely this position: no longer inside the social categories that assume health, productivity, and future orientation, yet not yet located within any new stable identity. Turner's anthropology, however, was developed to describe structural positioning, not to specify the capacities required to inhabit such a position skillfully. That gap is what the present article addresses.

A note on method and scope is therefore warranted at the outset. This is a conceptual, theory-building paper: the construct it proposes is derived through synthesis of interdisciplinary literature—anthropology, phenomenology, contemplative studies, and grief science—rather than generated or tested through new empirical study, and it is offered as a framework to be evaluated and validated rather than as an empirical finding. The article introduces liminal competence as an original construct: the set of cultivable capacities that enable sustainable dwelling at permanent thresholds. Four interrelated dimensions constitute the construct—ambiguity tolerance, oscillation flexibility, communitas access, and liminal meaning-making. Each is theoretically grounded in established literatures: ambiguity tolerance in psychological research on uncertainty [16] and the liminal hotspot construct [17]; oscillation flexibility in the Dual Process Model [5]; communitas access in Turner's anthropology [15] and peer-support research [18]; and liminal meaning-making in meaning-making scholarship [19] [20] and contemplative traditions [21] [22]. The construct extends Turner without departing from him: it operationalizes for clinical and pastoral application what Turner described structurally.

The article is organized as follows. Section 2 develops the theoretical framework, tracing van Gennep's tripartite structure and Turner's extension to permanent liminality. Section 3 examines why permanent liminality describes ongoing loss contexts more accurately than the resolution paradigm. Section 4 presents the liminal competence construct, distinguishes it from adjacent constructs, and elaborates its four dimensions. Section 5 grounds the construct existentially and contemplatively. Section 6 applies the framework across three classes of ongoing loss. Section 7 acknowledges limitations and identifies directions for empirical investigation.

2. Theoretical Framework: From Transitional to Permanent Liminality

2.1. Van Gennep and the Three-Phase Structure of Passage

Van Gennep's foundational study, originally published in 1909, identified a uni-

versal three-phase structure underlying ritual transitions across diverse cultures: separation, transition (liminality), and incorporation [14]. Separation involves detachment from a previous social status, role, or identity through symbolic and physical removal from the usual social structure. The liminal phase—from the Latin limen, meaning threshold—places the initiate in an ambiguous in-between state. Incorporation marks the completion of the transition: initiates are formally reintegrated into society with a new status, recognized in their transformed state by the community.

Van Gennep named the three phases with characteristic precision: "I propose to call the rites of separation from a previous world, preliminal rites, those executed during the transitional stage liminal (or threshold) rites, and the ceremonies of incorporation into the new world postliminal rites" ([14], p. 21). In the context of serious illness, this preliminal separation mirrors the transition from the social world of health into the clinical space—a transition that initiates a status shift without conferring a new stable identity [23] [24]. What is critical for the present analysis is that van Gennep's framework assumes successful reincorporation as the structural endpoint. Contemporary ritual scholarship has expanded this framework [25]-[27], but the assumption of eventual reincorporation has remained substantively intact within ritual theory itself.

2.2. Turner's Extension: Permanent Liminality

Turner's crucial development was the recognition that for certain persons and conditions, the threshold itself becomes a permanent site of dwelling [15]. The threshold is no longer a passage between states but the state itself. Turner characterized the liminal position with anthropological precision ([15], p. 95):

> Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial.… Liminality may perhaps be regarded as the Nay to all positive structural assertions, but as in some sense the source of them all, and, more than that, as a realm of pure possibility whence novel configurations of ideas and relations may arise.

Turner recognized that the passage quality of liminality could be institutionalized into a permanent condition, exemplified in monastic and contemplative life: "The Christian is a stranger to the world, a pilgrim, a traveler, with no place to rest his head" ([15], p. 107). The most striking formulation appears in his account of shamanic vocation, where the liminal phase is transformed into "a permanent condition of sacred 'outsiderhood,'" in which the shaman or prophet "assumes a statusless status, external to the secular social structure" ([15], pp. 116-117). Permanent liminality identifies positions of indefinite dwelling at thresholds without prospect of reintegration. Contemporary sociologists have expanded the concept to include modern contexts where traditional rites of passage have broken down or been extended indefinitely [28]-[30].

Greco and Stenner developed a critical refinement of Turner's framework that bears directly on the present argument [17]. They observed that permanent liminality is not univocally generative; under conditions of insufficient resources, it can become entrapping rather than productive. They describe the entrapping form thus: "Instead of ever widening they can be ever tightening. Instead of reaching out, our world can collapse into smaller and more constricted space-times, entrapping us into our individuality and cutting us off from our powers of action and understanding" ([17], p. 149). One enters "the vicious circle of a liminal hotspot when one becomes stuck in the transition from one circle to the next, unable to integrate them into a wider unity" ([17], p. 149). This distinction is foundational for what follows: liminal competence names the set of capacities that distinguish sustainable from entrapping permanent liminality. Recent work has begun to consolidate the use of liminality in health contexts, calling for a more systematic and theoretically disciplined application of the concept than the scattered, opportunistic borrowings that have characterized much of the clinical literature [31].

3. Ongoing Loss: The Contexts of Permanent Liminality

The clinical contexts in which permanent liminality describes lived reality more accurately than resolution-oriented frameworks share specific structural features: loss is continuous rather than episodic; no socially recognized endpoint is available; identity must be reconstructed repeatedly in relation to an ongoing and often progressive condition; and the trajectory afforded by recovery narratives is structurally unavailable. The following populations are illustrative rather than exhaustive.

Patients with progressive terminal illness or conditions such as amyotrophic lateral sclerosis (ALS), Parkinson's disease, and dementia face cascading losses of physical autonomy, cognitive function, and social identity [32]. Charmaz's concept of loss of self describes fundamental identity erosion in which illness strips away not merely what one does but who one is [11]. One patient's account of dialysis dependency renders this concretely: "This [the dialysis machine] is an ego destroyer. You come, and you're depending on a machine to keep you going, and if you don't, then you don't go.... I know that sometimes I feel less than human, having to go through the process... it is just a constant struggle" ([11], p. 173). The language captures precisely what the resolution paradigm cannot register: not a wound that heals but an ongoing assault on the self that does not conclude because the condition does not conclude. A recent metasynthesis of qualitative studies confirms the breadth of this experience, identifying grief in people living with dementia for the person they used to be, for how others now see them, and for the person they will become—losses that are simultaneously past, present, and anticipated [33].

Mishel's reconceptualized uncertainty theory provides a complementary account [12]. Mishel observes that "abiding uncertainty can dismantle the existing cognitive structures that give meaning to everyday events" and that "when the

stimuli associated with illness, treatment and recovery are vague, ill-defined, probabilistic, ambiguous and unpredictable, the sense of coherence is lost" ([12], p. 259). The stabilization that resolution-oriented models require becomes structurally impossible when each day brings new uncertainty before the previous day's has been integrated. Frank's account of narrative breakdown maps the same terrain: the restitution narrative—in which illness leads back to health—collapses entirely in ongoing loss, replaced by what Frank calls the chaos narrative [34].

Ambiguous loss provides perhaps the structurally purest form of permanent liminality [9] [10]. Dementia caregivers and the families of missing persons live with a loved one who is simultaneously present and absent, demanding simultaneous mourning and caregiving without the permission that clear loss would confer. Boss states the foundational premise directly: "Ambiguous loss is the most stressful type of loss because it defies resolution. Unlike with death, there is no official verification of loss and thus no finality with rituals of support" ([10], p. 270). Recent ethnographic work deepens this picture, showing that anticipatory grief in dementia is at once temporal and relational—a continuous negotiation between the loss that is underway and the relationship that nonetheless continues—so that loss and connection are entangled rather than sequential [35]. Demanding resolution where none is available causes secondary harm: when patients in ambiguous loss cannot resolve their grief, they may conclude that the inability is a personal failure rather than a structural reality ([36], p. 141).

Displacement and incarceration generate further classes of ongoing loss. Bhugra identifies cultural bereavement as the grief correlate of forced displacement: living in the past while being excluded from the present, carrying guilt about what was left behind alongside fading memories of what was lost [37]. Incarcerated individuals occupy thresholds of indefinite deprivation, separated from previous social positioning without integration into any recognized new status—a position Turner's shamanic statusless status describes with structural precision, though shorn of the religious recognition that made the shamanic position bearable [15]. In each of these contexts, the resolution paradigm not only fails clinically but generates iatrogenic harm by adding the shame of non-progression to the loss itself.

4. The Liminal Competence Construct

If patients in ongoing loss inhabit permanent thresholds rather than transit through temporary ones, the relevant clinical question shifts. It is no longer how can the threshold be closed but what capacities enable sustainable dwelling within a threshold that does not close. Liminal competence names this set of capacities. The construct extends Turner's structural account of permanent liminality toward a practical framework, and it operationalizes the distinction Greco and Stenner draw between generative and entrapping permanent liminality [17]. Four interrelated dimensions constitute liminal competence: ambiguity tolerance, oscillation flexibility, communitas access, and liminal meaning-making.

Before elaborating these dimensions, the central theoretical move requires justification: how can a structural anthropological category—Turner's description of a social position—be translated into cultivable clinical capacities residing in persons? The move is warranted on three grounds. First, Turner's own account is not purely structural; he repeatedly describes liminality as a condition that generates dispositions, sensibilities, and "novel configurations of ideas and relations" in those who occupy it, treating the position and the capacities it calls forth as inseparable [15]. The structural position and the human response to it are, in his anthropology, two aspects of one phenomenon. Second, the refinement Greco and Stenner introduce is precisely about capacity: their distinction between generative and entrapping permanent liminality turns on whether the person and their surrounding resources can effect a "pattern shift," which is a description not of social structure but of a cultivable competence for resignifying paradox [17]. The structural concept, in other words, already contains within it the variable of skill. Third, the translation follows a well-established pattern in the health sciences, in which structural or descriptive constructs—uncertainty [12], biographical disruption [38]—are routinely operationalized into capacities that clinical accompaniment can support. Liminal competence is the name proposed here for the capacities implicit in Turner's structural account once that account is brought into the clinic.

Because the four dimensions overlap at points with familiar psychological constructs, the boundaries of liminal competence should be stated explicitly. It is not resilience: resilience typically denotes the capacity to recover or "bounce back" to a prior baseline of functioning after adversity, whereas liminal competence concerns sustainable dwelling where no return to a prior baseline is available and recovery is not the relevant outcome. It is not acceptance: acceptance generally implies an eventual settling, peace, or resignation in relation to a loss, whereas liminal competence involves actively inhabiting an unresolved and continuing tension that is not expected to settle. It is related to, but broader than, coping flexibility and psychological flexibility: the oscillation-flexibility dimension is continuous with the Dual Process Model's account of flexible movement between coping orientations [5], and with the broader literature on psychological flexibility, but where those constructs orient flexibility toward eventual adaptation or valued action within a recoverable life, liminal competence orients it toward indefinite habitation of a threshold that will not close. What distinguishes the construct, in short, is its telos: not restoration, adaptation, or closure, but the skilled and sustainable occupation of permanent liminality itself. The dimensions are not stages and do not occur in fixed sequence. They are simultaneously operative capacities, each addressing a distinct pressure of permanent threshold-dwelling. Their conceptual independence is necessary for clinical assessment—a patient may demonstrate high ambiguity tolerance but limited communitas access, or fluent liminal meaning-making coupled with rigid loss-oriented fixation—but their functional interaction is what produces sustainable dwelling. Each capacity is cultivable rather than dispositional: while individual differences in baseline capacity exist, all

four can be developed through practice, accompaniment, and the relational holding that pastoral and clinical care provide.

4.1. Ambiguity Tolerance

Ambiguity tolerance is the capacity to live with paradox, uncertainty, and unresolvable tensions without forcing premature resolution or collapsing into despair. Liminal positions inherently involve contradictions—being living yet dying, present yet absent, connected yet separated. While resolution-oriented approaches attempt to eliminate these contradictions through acceptance, integration, or narrative closure, the recognition framework acknowledges that some contradictions cannot and should not be resolved but must instead be inhabited.

Clinical observation supports the simultaneity that ambiguity tolerance requires. Byock documents from his hospice work: "Even as they are dying, most people can accomplish meaningful tasks and grow in ways that are important to them and to their families" ([39], p. 32). The conjunction even as names growth and dying not as successive stages but as simultaneous realities within a single experience. Chochinov ([40], p. 2256) corroborates this structurally: acceptance and fighting spirit appear as simultaneously operative repertoire items within a single patient's experience, not as successive stages.

Furnham and Ribchester provide the foundational psychological account: "the person with low tolerance of ambiguity experiences stress, reacts prematurely, and avoids ambiguous stimuli. At the other extreme of the scale... a person with high tolerance for ambiguity perceives ambiguous situations/stimuli as desirable, challenging, and interesting and neither denies nor distorts their complexity of incongruity" ([16], p. 179). While often conceived as a personality trait, ambiguity tolerance can be cultivated through practice and appears particularly essential in healthcare contexts where diagnostic, prognostic, and therapeutic uncertainty abound [12] [41]. It differs fundamentally from acceptance: while acceptance often implies eventual peace or resignation, ambiguity tolerance involves actively dwelling with ongoing tensions that contain irreducible contradictions [9].

Greco and Stenner sharpen the clinical relevance of this capacity through their analysis of the liminal hotspot—"an occasion during which people feel they are caught suspended in the circumstances of a transition that has become permanent" ([17], p. 153). They identify four features: paradox, paralysis, polarization, and, crucially, pattern shift—the potential for new forms-of-process capable of embracing a greater degree of complexity than the original gestalt allowed ([17], p. 154). Because hotspots do not cool into settled narratives but remain charged with existential pressure, ambiguity tolerance is revealed as an active capacity requiring ongoing cultivation, not a passive state eventually achieved.

4.2. Oscillation Flexibility

Oscillation flexibility is the capacity to move intentionally between loss-oriented coping—confronting grief, processing pain, and engaging with the reality of

loss—and restoration-oriented coping—attending to life changes, engaging in distractions, and taking respite from grief. The capacity is empirically grounded in the Dual Process Model [4] [5], which challenged linear stage models by demonstrating that healthy grief involves flexible oscillation between orientations rather than unidirectional progression toward resolution.

In ongoing loss contexts, oscillation flexibility carries a distinctive structural quality. The movement is not toward equilibrium but toward an increasingly refined capacity to remain present within a threshold that will not close. Turner names the dialectical necessity of such oscillation: "There is a dialectic here, for the immediacy of communitas gives way to the mediacy of structure, while, in rites de passage, men are released from structure into communitas only to return to structure revitalized by their experience of communitas" ([15], p. 129). The dialectic Turner identifies maps onto the Dual Process Model's oscillation between loss-oriented and restoration-oriented coping: each pole revitalizes rather than negates the other, and neither represents a destination.

Loss-oriented fixation manifests as inability to attend to anything other than the loss, continuous grief without respite, and collapse of all restoration-oriented coping. Restoration-oriented fixation manifests as compulsive busyness, avoidance of grief engagement, and brittle positivity that collapses under clinical pressure. Healthy oscillation involves both poles being accessible and neither requiring the permanent suppression of the other. The clinician's role is to recognize and support this oscillation explicitly—validating the restoration dimension as sophisticated coping rather than denial, and affirming the patient's capacity to remain active within a narrowing world.

4.3. Communitas Access

Communitas access is the capacity to connect with fellow threshold-dwellers who share a similar liminal positioning. Turner coined the specific term to distinguish this modality of connection from an "area of common living" ([15], p. 96). Communitas represents a form of anti-structure: an unmediated human connection that stands in sharp contrast to hierarchical social systems. Turner characterizes its emergence ([15], p. 128):

> Communitas breaks in through the interstices of structure, in liminality; at the edges of structure, in marginality; and from beneath structure, in inferiority. It is almost everywhere held to be sacred or "holy," possibly because it transgresses or dissolves the norms that govern structured and institutionalized relationships.

What makes communitas clinically distinctive is that the recognition it offers cannot be supplied by ordinary social support, however well-intentioned. Little *et al.* capture the structural reality in patients' own words: "I do know what it's about. I have experienced some things that people, some people, will never have.... I feel, sometimes I just wished he would understand" ([23], p. 1488). Most patients, they

note, "could only relate directly and with belief to those who had undergone similar experiences" ([23], p. 1489). This is not a gap between articulate and inarticulate people; it is a gap between those who have crossed the threshold and those who have not.

Peer support research confirms the clinical significance of this distinction. Embuldeniya *et al.* demonstrate that "meeting and sharing experiences with similar others in a safe and non-threatening peer support context reduced feelings of being alone, normalizing the disease experience and promoting acceptance" ([18], p. 8)—a finding that grounds the communitas construct empirically beyond its anthropological origins. Liminal peer groups offer a vital continuity of self in the face of biographically disrupting conditions, providing a social space where a person's identity is not reduced solely to their diagnosis [24]. Communitas access also redefines the clinician's relational position: it names what happens when two persons meet at the threshold without the hierarchy of expert and recipient, simply recognizing each other as human beings facing the same existential exposure.

4.4. Liminal Meaning-Making

Liminal meaning-making creates significance in the act of dwelling itself rather than seeking redemptive narratives that attempt to make suffering comprehensible or worthwhile. Turner identifies liminality itself as a generative condition for meaning: "Liminality, marginality, and structural inferiority are conditions in which are frequently generated myths, symbols, rituals, philosophical systems, and works of art" ([15], p. 128). The threshold is not a void in which meaning is absent but a site where new forms of meaning are capable of emerging.

Liminal meaning-making differs from the meaning reconstruction described by Neimeyer in a critical respect [7]. Where meaning reconstruction often tethers grief work to the reconstruction of a coherent life narrative, liminal meaning-making finds significance in the practice of habitation itself. Learning to live at the threshold becomes meaningful regardless of why the threshold exists. Greco and Stenner's construct of pattern shift provides the mechanism: "if paradox cannot easily be escaped using existing resources it can push those involved towards the invention of new forms-of-process based on new gestalts and hence new normativities, capable of embracing a greater degree of complexity, within which the paradox can be resignified" ([17], p. 154). Pattern shift is not resolution: the loss does not become acceptable. What changes is the capacity to hold the paradox from within a wider frame rather than being paralyzed by it.

The empirical literature on meaning-making supports this expansion. Davis *et al.* report that "none of the particular meanings that respondents reported related more strongly to adjustment than the others. Instead, it appeared to be the case that what mattered was whether or not one had made sense of or found something positive from the experience" ([19], p. 569). Park's review extends the point: "a substantial minority of people do not report meaning making following a range of potentially stressful situations," which she notes "could suggest that the model

does not universally apply" ([20], p. 288). If meaning reconstruction is neither universal nor uniformly necessary for adaptive adjustment, then frameworks that treat its achievement as the sole telos of grief work are theoretically inadequate and empirically unsupported. Liminal meaning-making does not require a redemptive narrative; any form of meaning that enables sustainable dwelling at the threshold is clinically sufficient.

5. Existential and Contemplative Grounding

Liminal competence is not a freestanding clinical construct. It is philosophically grounded in de Beauvoir's account of authentic existence within ambiguity [42], and it finds confirmation in contemplative traditions—particularly Christian apophatic theology and Buddhist teachings on impermanence—that have addressed sustained encounter with the unresolvable for centuries. These traditions are not introduced as confessional impositions on patients but as evidence that the capacities liminal competence names have been recognized, across cultures, as marks of maturity rather than as failures of progress.

De Beauvoir distinguishes bad faith—attempts to escape ambiguity through rigid certainties or premature closure—from authentic existence, which embraces ambiguity as the condition within which meaning must be continually created: "To declare that existence is absurd is to deny that it can ever be given a meaning; to say that it is ambiguous is to assert that its meaning is never fixed, that it must be constantly won" ([42], p. 129). Liminal competence embodies this stance, treating ambiguity not as a problem requiring resolution but as the structural condition within which meaningful dwelling becomes possible.

Christian apophatic tradition—the via negativa—approaches the divine through negation, recognizing that ultimate reality exceeds all positive description. Pseudo-Dionysius describes the epistemological consequence: "As we plunge into that darkness which is beyond intellect, we shall find ourselves not simply running short of words but actually speechless and unknowing" ([22], p. 136). Louth reads this as a way that "involves the abandonment of all affirmations and negations about God... the movement itself of abandonment" ([43], p. 171). May's interpretation of John of the Cross renders the tradition clinically operational through the distinction between two Spanish words for darkness: "In oscuras things are hidden; in tinieblas one is blind" ([44], p. 68). The distinction provides a precise clinical vocabulary: the grief of ongoing loss is oscuras, not tinieblas—not the blindness of pathology but the hiddenness of a process that exceeds what resolution-oriented frameworks can register.

Buddhist teachings on impermanence (anicca) provide a complementary framework. The Satipaṭṭhāna Sutta directs sustained awareness toward the arising and passing away of phenomena—not as intellectual assent to change but as direct attention to impermanence as it shows itself concretely [21]. Halifax develops this orientation for the bedside, arguing that the capacity to remain present with dying depends on a formation in which impermanence has become a structural feature

of perception [45]. Kumar names the category error the resolution paradigm makes: "If we view grief as a problem, we will think of one of the most natural parts of life, and love, as a pathology or 'disorder.' But grief has always been part of the order of things, and it always will be" ([46], p. 11). These traditions converge on a single claim: the capacity to dwell with what cannot be resolved is a mark of maturity, not its failure.

6. Application across Ongoing Loss Contexts

The liminal competence framework applies differentially across ongoing loss contexts. Each population shares the structural feature of permanent threshold-dwelling, but the temporal and spatial dynamics of each threshold differ in ways that shape which capacities carry the greatest clinical priority. Three application contexts are developed here as illustrations, not as an exhaustive typology. Across all three, the framework is intended to complement rather than replace the established provision of spiritual care, whose value in serious illness is now supported by high-quality evidence [47].

6.1. Palliative Trajectories

Palliative patients occupy thresholds between living and dying—no longer healthy, not yet dead, and often suspended in this liminal space for months or years. Little *et al.* establish that "the liminality of cancer is not a phase in a rite of passage; it is an enduring state of being" ([23], p. 1492). What is structurally distinctive about palliative liminality is the convergence of biological, social, and identity loss within a single compressing timeline. Chochinov articulates the clinical stance this requires: "dignity-conserving strategies should attempt to reinforce the patient's sense of self-worth by adopting a therapeutic stance that conveys steadfast respect for the patient as a whole person" ([40], p. 2257). In palliative contexts, the most distinctive clinical demand is ambiguity tolerance: witnessing the living-yet-dying paradox without demanding resolution. Liminal meaning-making—finding significance in how one dies rather than in an explanation of why—completes the framework for accompaniment.

6.2. Chronic Progressive Illness and Dementia

Individuals living with chronic progressive conditions—multiple sclerosis, Parkinson's disease, dementia—occupy a threshold between health and illness indefinitely. This experience of biographical disruption [38] and sustained illness uncertainty [12] [41] shares surface features with palliative liminality but is structurally distinct: where palliative patients face a trajectory ending in identifiable death, those with chronic progressive disease face a trajectory without clear terminus. A specialist working with patients with non-malignant progressive disease confirms this distinction from within clinical practice:

> I don't think it does [end] because the prognosis is so bad and so fixed isn't it. You just can't change it and I think it is worse, much worse than cancer in

> a way because with cancer usually within a year or two, you have either recovered reasonably well or you have died and there is some closure one way or the other but this [muscular dystrophy] goes on ([24], p. 24).

Lindgren *et al.* identify chronic sorrow as the grief correlate of this indefinitely deferred condition, defining it as "cyclic sadness over time in a situation that has no predictable end" ([48], p. 31). Chronic sorrow does not resolve because the condition generating it does not resolve. The distinctive clinical demand is oscillation flexibility above all: the capacity to move between processing ongoing functional losses and actively engaging with the life that remains, without the false promise that the oscillation will eventually stabilize into resolution. Mishel's observation that "the longer chronically ill subjects lived with continual uncertainty, the more positively they evaluated the uncertainty" ([12], p. 257) provides preliminary support for the claim that chronic threshold-dwelling, when accompanied skillfully, can develop into liminal competence rather than cumulative collapse. Dementia caregiving represents the ambiguous-loss extreme of this category, in which all four dimensions of liminal competence are simultaneously in demand, and in which the caregiver's grief is itself temporal and relational rather than a delayed reaction awaiting the death [9] [10] [35].

6.3. Displacement and Incarceration

Forced displacement and incarceration produce ongoing loss contexts of a different structural kind. The losses are not biological but social, relational, and positional—and they are often produced by structural injustice rather than by biological inevitability. Bhugra identifies cultural bereavement as the grief correlate of forced displacement: living in the past while being excluded from the present [37]. Turner's account of those who occupy a statusless status external to the normal social structure is directly applicable: the displaced person inhabits a position that is not a failure of social belonging but a different, harder form of it [15]. For these populations, the most urgent task is liminal meaning-making—the capacity to make a home in the threshold itself [28]—paired with communitas access where conditions permit it. The framework here must be supplemented by a clear acknowledgment that the suffering is produced by structural conditions that demand political response, not only by individual capacities that admit cultivation.

7. Limitations and Future Research

The liminal competence construct is offered as a theoretical contribution requiring empirical validation. Several limitations warrant explicit acknowledgment.

First, the framework is theoretically constructed rather than empirically tested. Phenomenological studies with patients in palliative care, persons with progressive neurodegeneration, dementia caregivers, displaced persons, and incarcerated individuals are needed to determine whether the construct genuinely aligns with lived experience and whether the four dimensions adequately capture what threshold-dwellers identify as clinically relevant. Quantitative instrument devel-

opment would subsequently be required to operationalize the construct for outcome research.

Second, the theoretical sources are Western-centric. Turner's anthropology, de Beauvoir's existentialism, the apophatic Christian tradition, and the Buddhist material drawn through English-language scholarship all emerge from specific intellectual traditions. Cross-cultural grief research documents substantial variation in mourning expression, temporal expectations, and meaning-making processes [49]. The construct requires careful translation across cultural contexts rather than universal application.

Third, the construct must not privatize suffering. Liminal competence is a framework for cultivating capacities that enable sustainable dwelling at thresholds; it is not a framework for accepting structural injustice. Suffering produced by systemic racism, healthcare inequity, mass incarceration, or forced displacement requires political response alongside accompaniment. Telling marginalized communities to dwell sustainably with loss caused by systemic injustice could constitute harmful counsel that reinforces oppression [50]. The framework requires a clear boundary distinguishing suffering that requires accompaniment from injustice that demands resistance.

Fourth, the construct does not displace psychiatric assessment. Major depressive disorder, post-traumatic stress disorder, and severe functional impairment remain distinct clinical entities requiring structured intervention [8]. Prolonged grief disorder, properly applied, is itself defined not by elapsed time alone but by clinically significant distress and functional impairment that exceed the bereaved person's cultural and religious norms [8]; the concern is with the misapplication of a duration heuristic, not with the existence of the category. Liminal competence describes the wide range of proportionate sustained responses to ongoing loss; it is not calibrated for presentations that have crossed into territory requiring psychiatric treatment. Future research must develop differential criteria that distinguish adaptive threshold-dwelling from pathological conditions while avoiding the iatrogenic pathologization that an unqualified resolution expectation produces [51] [52].

Fifth, outcome research is required. The construct identifies oscillation flexibility, sustainable dwelling capacity, communitas access, and pattern-shift events as candidate indicators of adaptive threshold-dwelling. Existing patient-reported outcome measures such as the Scottish PROM capture related outcomes but not yet the dimensions this construct identifies [53]. Comparative outcome studies between recognition-oriented and resolution-oriented accompaniment in matched ongoing-loss populations are required to establish the construct's clinical utility.

8. Conclusions

Permanent liminality describes the structural position of patients and families whose losses do not conclude. Turner's anthropological account of the permanently liminal was developed to characterize religious and marginalized figures

who occupied threshold positions as a form of vocation. The present article has argued that the structural account applies with equal precision to contemporary medical and psychosocial contexts in which loss is continuous: palliative trajectories, progressive neurological disease, dementia caregiving, displacement, and incarceration. What Turner's anthropology did not provide, and what the resolution paradigm cannot supply, is a clinical framework for the capacities that enable sustainable dwelling at such thresholds.

Liminal competence is offered as that framework. Comprising ambiguity tolerance, oscillation flexibility, communitas access, and liminal meaning-making, it operationalizes for clinical and pastoral application what Turner described structurally. Each dimension is grounded in established interdisciplinary scholarship; together, they distinguish sustainable from entrapping permanent liminality [17] and provide a vocabulary for what skilled threshold-dwelling looks like in practice. The construct does not replace resolution-oriented frameworks for episodic loss, where they remain appropriate. It provides what episodic frameworks cannot: a way of describing the work being done by patients, families, and the practitioners who accompany them when no resolution is available and the threshold does not close.

Empirical validation is the necessary next step. Until then, liminal competence remains a theoretically rigorous proposal—one that takes seriously what threshold-dwellers have long known: that the inability to resolve a loss is not always a failure to be corrected. Sometimes it is the form that ongoing love takes when love has nowhere else to go.

Conflicts of Interest

The author declares no conflicts of interest.

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