

THE HEALING NATURE
OF DWELLING

by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

Master of Architecture

MONTANA STATE UNIVERSITY

Bozeman, Montana

April 2008

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Andrea Ardele Newman

April 2008

Dedicated to my mother and father,
who have served their mentally ill patients with care and respect.
Though it may seem be a thankless job, please know it has never gone
unnoticed by those who need you.

ACKNOWLEDGEMENTS:

I would like to acknowledge Joanne Mennell Noel
for all of her encouragement and support in the writing of this book.

TABLE OF CONTENTS

1. INTRODUCTION.....	1
2. CHAPTER ONE The Current State of Treatment for the Chronically Mentally Ill.....	8
3. CHAPTER TWO Historical Background.....	20
4. CHAPTER THREE Communication and Maxwell Jones – Therapeutic Community.....	30
5. CHAPTER FOUR Line of Communication, Spine, Horizon Line.....	42
6. CHAPTER FIVE Site Analysis.....	50
7. CHAPTER SIX Programing.....	64
8. CHAPTER SEVEN Precedent Studies.....	76

TABLE OF CONTENTS - CONTINUED

9. CHAPTER NINE	
Final Presentation	84

BIBLIOGRAPHY

these issues concerning the “ill” and that environmental factors do play a large part in the effective treatment of this population. It is my intention to design a facility where the chronically mentally ill can live and communicate freely without the stigma that has plagued them for so long. I will use the tools that social theory, philosophers such as Heidegger and the concepts of phenomenology have given me to explore the question: how can architecture help heal the chronically mentally ill.

abstract

My thesis will discuss the historical pattern of mistreatment and misunderstanding of the chronically mentally ill and the continued struggle the population faces. I believe that architecture holds some of the answers for

introduction

The mind of a human being is a fragile thing. It gives way to madness when a basic understanding of human

relationships is lost. This understanding of relationship to other individuals, to society and to the universe as a whole can be difficult and elusive; it can sneak in and out of our minds as a complex mathematical formula might. First we understand the equation, then we do not; first we understand our place in the universe, then we do not. It is this experience of loss of place and loss of understanding that brings us all to the edge of sanity. On one side of this edge are the sane and on the other are the insane. The insane have lost their way; they have lost the ability to maintain the understanding of those complex relationships existing in the universe that allow us to function in our world. The sane have been able to maintain that understanding; they are able to keep an open line of coherent communication with the surrounding people and

things in their universe. This is a delicate balance however, one that can be toppled easily. Who has not experienced a moment of erupting rage that gives way to the ability to do unthinkable acts? Who has not experienced fear so intense that she is rendered paralyzed, unable to move in her own defense? Surely these are not sane reactions - one should be able to fully control the emotions of rage and fear, and yet we might all be capable of remembering times when the grip of insane emotion has grabbed too tightly and our perception of reality slipped. Why then do we treat those of us who have crossed to the other side of the sane threshold with such disdain and misunderstanding? Michel Foucault talks about the banishment of the mad to ships where the insane endlessly sailed the sea seeking a revelation which would allow them to

return to dry land and the sane world.¹ This treatment, which was introduced at the end of the fourteenth century, seemed to make rational sense to the people of the time. But from our vantage point in the twenty-first century it seems cruel and unusual, impossible even to fathom the logic that led to that decision.

Surely our treatment of the mentally ill has greatly improved over the last six hundred years; surely society has become enlightened about the treatment of this population of "ill" individuals. Unfortunately the quality of treatment over the centuries still lacks tremendously in its ability to connect the mad to the sane. The connection that would build health and understanding for all who have succumbed to the pressure of the world has yet to be made. This lack of connection has led us all, on both sides of the

sanity coin, down many paths of treatment ranging from the creation of the asylum where the mentally ill are warehoused, kept neatly away from those “well” parts of society who fear and misunderstand them, to today’s method of the prescription of major psychotropic drugs for all mental illnesses. Medical science now agrees that it is the treatment of the symptoms of all types of illnesses that offers us the “cure;” that the “cure” in the case of the chronically mentally ill is a matter of adjusting the brain chemistry of the individual sufferer until the symptom quietly disappears. This current theory, though effective, leaves a laundry list of new questions and problems that have yet to be addressed. As with the “ships of fools”² that Foulcault writes about, there are many holes in the logic of the practitioners of the current form of treatment for the chronically mentally ill. For instance what has become of the question of environmental contribution to the state of mind? Are we, as both well and ill members of our society, going to accept as fact the notion that our perception of reality has nothing to do with our experience in life and all to do with the layout of our brain chemistry? How could this be so, when we have such incredible ability to learn behavior from the people and world around us? If we were to accept the pure brain chemistry argument as fact, wouldn’t it be logical that children could skip their education process all together and take a pill instead? They could learn ancient Roman history by simply releasing its correct chemistry in the brain; the correct line up of pills would elicit the same response and understanding as if the youth took two semesters to truly internalize the

meaning of the information presented there.

Because the issues set before the good people of the medical industry have been questions about relieving symptoms that cause discomfort and turmoil to a given population, the solutions have been far more successful than the previous discussion credits. This is not to say however, that the approach taken by the medical industry is entirely correct either. It is my contention that the treatment of the chronically mentally ill is both a medical question and an environmental one. Environmentally, the mentally ill have been isolated from the "well" population. The isolation that has historically taken place for this population could be addressed by changing the way the "ill" population lives and interacts with the world of the "well." For instance, the current locked institutional settings suggest to

the "well" community that the inhabitants within are dangerous and must be locked away to maintain the safety of the community outside. The "well" community might be shocked to realize that in many cases the units are locked in large part to protect the inhabitants within from the people outside. This type of direct misunderstanding from both populations is a large contributor, both historically and currently, to the conditions of the chronically mentally ill. To dispel such misunderstandings, adjustments to the physical environment of the chronically mentally ill should take place, ones that entwine both populations together, inextricably linking both as one and allowing for dialog between the two. This connection and resulting relationship would, for the first time, create a true sense of belonging for an excluded and marginalized

population. This massive environmental change would be the environmental component missing in the current treatment regime of the chronically mentally ill. explore the question: how can architecture help heal the chronically mentally ill.

My thesis will discuss the historical pattern of mistreatment and misunderstanding of the chronically mentally ill and the continued struggle the population faces. I believe that architecture holds some of the answers for these issues concerning the “ill” and that environmental factors do play a large part in the effective treatment of this population. It is my intention to design a facility where the chronically mentally ill can live and communicate freely without the stigma that has plagued them for so long. I will use the tools that social theory, philosophers such as Heidegger and the concepts of phenomenology have given me to

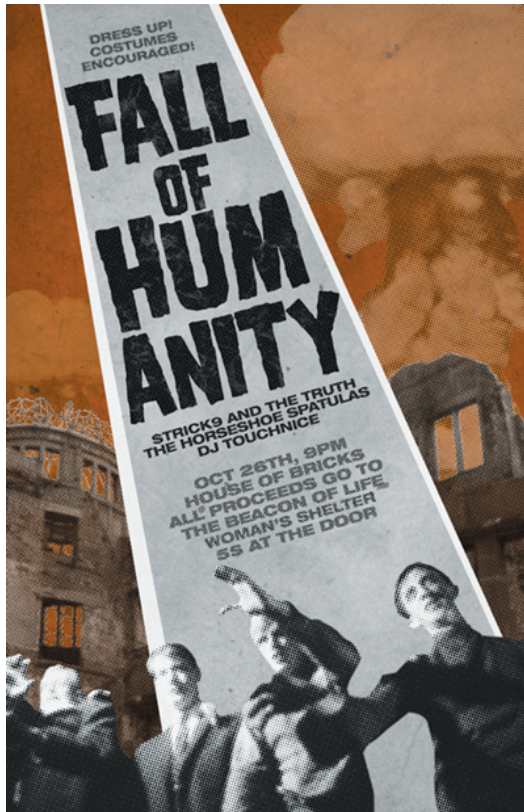
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chapter one:

The current state of treatment for the chronically mentally ill

There are many things to consider when discussing the treatment of the marginalized population of the chronically mentally ill. In the

United States, 4% of the population is affected by serious mental illness. The chronically mentally ill as a population is subject to increased risk of physical health problems, substance abuse, incarceration and homelessness.¹ This population suffers paranoia, obsession, massive and psychotic breaks that may cause them to harm to themselves and others if treatment is not provided. The “well” culture tends to steer clear of people with such disorders because of a general lack of understanding and acceptance of the issue and because of an historical fear of those who seem different. Among the many theories and thinkers addressing the problem of chronic mental illness, Maxwell Jones, a leader in the field and author of *Beyond the Therapeutic Community*, stated “One must add to the familiar psychiatric treatment

methods, both psychological and physical, the relatively neglected *social and environmental dimensions*.”² (Emphasis mine) His ideas, though revolutionary at the time (his book was first published in 1968), have found their way into official government policy. In order to move away from the institutionalization of the chronically mentally ill, the Office of Disability, Aging and Long-term Care policies and the U.S. Dept of Health and Human Services have reported that the goal for long term care for this population should contain, according to C. Kuntz, a rehabilitation model including:

“...assistance with social relationships, recreation, vocational skills, and self-care. Psychosocial rehabilitation’s goal is to enable individuals to compensate for or eliminate functional deficits, interpersonal barriers and environmental barriers, and to restore ability for independent living, socialization, and effective life management. After an as-

essment process, a rehabilitation or treatment plan is developed. Through activities of psychosocial rehabilitation, skills are learned involving daily living, social interactions, and problem solving. The activities of such programs are designed to represent the real activities of every day life, thus much of the rehabilitation must occur within the community.”³

While this goal is well intentioned and optimistic for the future of the mentally ill, the reality of the situation is not improving; with less funding from the government due to policy changes and budget cuts, less is being done for this population.

While the government gives the impression that it is doing what it can for this population of stigmatized individuals, there remains a social question: What is the importance of this population to the rest of “normal society?” Do we find value in these individuals? And are we, as a “well” culture, interested in curing them

or simply hiding them away as we might an embarrassing secret? This treatment of hiding away pieces of our culture has significant meaning that historically can be linked to the manipulation of the masses for the “betterment” of the whole. For instance Michel Foucault discusses in his book *Madness and Civilization* the subject in reference to Western European cultures as they worked to separate themselves from those individuals who had contracted Leprosy. Western cultures devised ritualistic and religious meaning to make the estrangement of the lepers’ seem moral and ethical in the face of the lepers truly painful isolation. Foucault discusses the need in these western societies to link the devastation the lepers were facing with the will of God. The lepers were used quite effectively as an example of what the truly



Figure 1.1 Bosch, “Ship of Fools,” 1490-1500

unholy might expect as wrath from God. The lepers were therefore seen as a gift given to the church to be used as a tool to shepherd its flock willingly into the light. He then goes on to discuss the change that European “well” culture experienced when the leper population finally died out across Western Europe. At the time, political and economic strength rested on the shoulders of the church and it was known that with a pious population came a prosperous nation. Unfortunately though, without this valuable tool of the leper at its disposal, a new marginalized population was needed to elicit a similar response for the wavering flock. So the poor, indigent and insane would take the social place of the lepers and provide the needed affliction to keep the holy in line.⁴

In our Eurocentric American culture we

also work to isolate the population of poor, indigent and insane. The reasons may have changed slightly, but the effect is the same. In our case it is the role of the insane to act as a warning for those who might waver from the accepted road of the American dream. Stay on track and you will be accepted as smart, reliable and “well;” complain too loudly that the world causes more pain than it should or talk too strangely about the nature of reality and you are considered weak, shameful and “ill.” This is not to say that the affliction the mentally ill are experiencing is not real or that the nature of their illness requires no attention. The true nature of the question is about how the “well” parts of society think of and therefore treat the “ill” parts of society. If the “well” need to keep the “ill” marginalized in order to maintain the

status quo in the same way the church needed the lepers to shepherd its flock, then the way we treat the “ill” will never change. The “well” will always see the “ill” as an example of a condition to be avoided and feared. It is a historical model that has been perpetuated and encouraged over time. This stigma is hard to change, but not impossible.

The unfortunate truth is that many of the “ill” individuals do have real physical and emotional needs that they are unable to meet by themselves. I believe it is our job as a civilized nation to care for these people in the most proactive way possible. There is a need to change the community’s perception about this marginalized population and therefore a need to change as well the marginalized population’s perception of themselves. Not only is there

a stigma placed on the mentally ill by the surrounding culture, but there is consequently a stigma that the mentally ill places on themselves. There is a notion that mental illness is a sign of weakness and therefore if one surrenders to it he is intrinsically weak even if he recovers from the illness. An account in the *Medical Anthropology Quarterly* discussed a patient who would not admit to his illness: after being diagnosed with schizophrenia he refused to acknowledge his diagnosis claiming he was “just having fantasies.” His contention was that he was not and never could be one of the “others.”⁵ The thought to him was ridiculous and offensive. The medications that he took, he claimed, were only for stress and to insure his mother would let him stay at home with her. The illness in his mind did not exist. For this

man, who was well educated, wealthy and of upper class, being diagnosed with schizophrenia was socially unacceptable.⁶ This man, who was so deeply connected to his social environment, could not accept the illness based on the stigma he knew came along with it.

In many cases, not seeking treatment is seen as the short term solution to the problem, which leads eventually to a more serious condition, such as a psychotic break. I argue that it is not only the treatment of the illness that is necessary but also the treatment of the cultural attitude toward mental illness as a whole. As suggested by C. Kuntz above, this problem might be combated by including the community of the “well” as part of the potential solution to the problem: “thus much of the rehabilitation must occur within the community.”⁷ By including the

larger “well” community as an integral part of the treatment plan, the “well” will learn to take some responsibility for the issue. Therefore, the “well” will stop seeing the chronically mentally ill as the “Other” and start contributing to the solution.

The term the “Other” was originally coined by Simone de Beauvoir in *The Second Sex* as she discussed the inequality between men and women. Later she and other authors applied the concept to any marginalized population who is forced to be described in reference to someone else. De Beauvoir drives home the idea that man and maleness are the gauge by which woman and femaleness define itself. De Beauvoir writes: “Thus Humanity is male and man defines woman not in herself but as relative to him; she is not regarded as an autonomous

being.”⁸ De Beauvoir then goes on to say that “She is the incidental, *the inessential as opposed to the essential*. He is the subject, he is the absolute – she is the Other.”⁹ (Emphasis mine) In the case of the “well” population as opposed to that of the chronically mentally ill, the relationship is clear. One needs simply to insert the terms “well” and “ill” into the discussion and the relationship becomes apparent. Thus “Humanity is [Well] and [wellness] and defines the [Ill and mental illness] not in itself but as relative to the [Well]; the [Ill] are not regarded as autonomous [beings]. The [Ill] is the incidental, the inessential as opposed to the essential. The [Well] is the subject, The [Well] is the absolute – The [Ill] is the Other.”¹⁰ There is a natural tendency to label and classify people who belong to groups differing from our own. Because this tendency is universal, just as we classify a

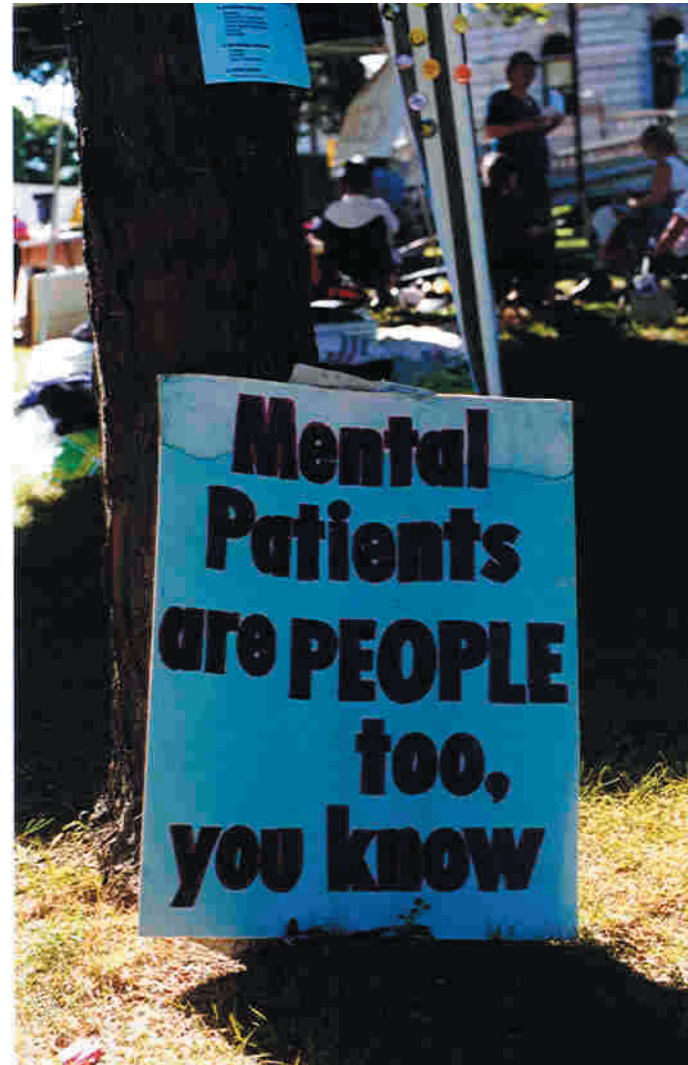


Figure 1.2 www.antipsychiatry.org/peopletoo.jpg

group as the Other, so does that group classify us as Other. The "ill" begin to see the "well" as the Other and the division widens as the "ill" accept their fate. De Beauvoir suggests: "As a matter of fact, wars, festivals, trading, treaties and contests among tribes, nations, and classes tend to deprive the concept of *Other* of its absolute sense and to make manifest its relativity, willy-nilly, individuals and groups are forced to realize the reciprocity of their relations."¹¹ So where then is the moment of reciprocity for the "well" and the "ill?" De Beauvoir goes on to suggest that the feeling of Otherness a woman experiences is never experienced by a man, and is therefore absolute.¹² This commentary suggests a relationship where one (in De Beauvoir's case the male sex, in this case the "Well,") is considered to be the natural condition and that the Other,

the "ill" or female, is considered unnatural, undesirable and "inessential." But in reality man can not exist without woman and therefore her otherness is an irrational stigma. Such is the case with the chronically mentally ill.

There is a sense that the marginalization of the chronically mentally ill population is easy and natural because of the differences between the "well" population and the "ill." Additionally, the common belief is the "ill" contribute little to "well" society and so at no point does the relationship become reciprocal in the way suggested above. "They have no past, no history, no religion of their own..."¹³ However the "ill" may provide an essential element that the "well" population has overlooked; they provide a gauge for the "well" to decipher their own "wellness." They also help us gauge the

meaning of reality and therefore allow us to question our perception of our own universe. With the "ill" person's constant challenge of reality and her insistence that the reality and the universe she exists in is different than the one the "well" exists in, it becomes impossible for the "well" to live without trepidation about their perception of reality as a whole. The "ill" person's value then may come from her ability to create a unique perspective and doubt about the true nature of the universe for the "well."

This feeling of doubt or instability in the universe leads us to question; it leads us to search more deeply into the nature of our reality. We do this in an amazing variety of ways: we invent, create and discover our way to new understanding and enlightenment. It is here that the "ill" become essential and offer reciprocity. Grasping this

relationship and incorporating into the culture of the "well" the value of having a changed sense of reality can dispel Otherness. If wars, festivals, trading, treaties and contests force groups to realize the reciprocity of their relations, and this realization helps negate Otherness, then understanding and accepting the significance of the relationship through *communication* between the "well" and the "ill" should be the first step towards eliminating Otherness.

This parallel is essential in understanding the potential for change in the treatment of the chronically mentally ill. There is a long history of subjecting the "ill" to serious acts of segregation and unjust behavior. Society tends to subject any group it deems different to all sorts of horrifying acts of depravity. Because of historical treatment of this population, a

new understanding of the value of the “ill” is required to create an environment where healing can be accomplished. It is always through communication that we gain understanding. If a dwelling is created, where communication is intrinsic then the understanding and acceptance will naturally follow.

endnotes

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images

Figure 1.1, Bosch, “Ship of Fools,” 1490-1500.
<<http://www.wga.hu/art/b/bosch/5panels/11shipfo.jpg>>

Figure 1.2, Poster, www.antipsychiatry.org/peopletoo.jpg



be taken by the field of medicine? I believe it is possible to create a meaningful place for this population to “dwell”¹ while they focus on healing. Historically speaking many institutions have simply warehoused the mentally ill, known collectively as the insane, to keep them safe from themselves and others.

Consider Bedlam, in England, for example. It was first constructed to act as a priory and hospital for the poor in 1247. It was originally called Bethlehem, “house of bread,” and was located on Bishopsgate Street in London. It was partially used as an asylum for the insane at the start of the fourteenth century and was used exclusively for that purpose by the start of the sixteenth century. “The old English word ‘a Bedlam’ signifies one discharged and licensed to beg. Such persons wore a tin plate

chapter two:

historical background

How can architecture help heal the chronically mentally ill? What are the steps that I, as an architect, can take that can not

on their arm as a badge and were known as Bedlamers, Bedlamites, or Bedlam Beggars.”² This stigma toward the insane beggar was so tightly associated with the place where the insane were housed that the name of that place worked its way into the language and still persists today. Bedlam is a powerful image we westerners hold in our minds. It is there for a reason. The images of the place are rampant in popular culture and drive many people to fear and mistrust the mentally ill. It is no wonder. In the mid sixteen hundreds it became the practice of the noble men and women to go to the Bedlam hospital and pay one penny each to watch the antics of the patients there. This was a form of amusement for those fortunate enough to live in the surrounding community.



Figure 2.1 - "The Interior of Bedlam," from A Rake's Progress by William Hogarth, 1763.

"Writing in a personal journal in 1656, a man known as Evelyn noted that "'he saw several poor creatures in Bedlam in chains.' In the next century it became the custom for the idle classes to visit Bedlam and observe the antics of the insane patients as a novel form of amusement. This was done even by the nobility and their friends. One penny was charged for admission into the hospital, and there is a tradition that an

annual income of four hundred pounds was thus realized. This would mean that nearly 100,000 persons visited the hospital in the course of a year.”³

Fortunately under the current administration of the hospital it has become one of the more respected facilities in the world. It now accommodates about three hundred patients, with over sixty attendants. The management is so good that each year more than one-half of the patients are returned as cured. ⁴ But does this statistic change the way we as a “well” culture feel about Bedlam and the insane, or has its horrors and dark images affected the “well” too deeply? Even today the stigma is perpetuated in the popular media, movies and video games where the insane are depicted relentlessly as psychotic killers capable of the most depraved acts known to man. With games like *Manhunt 2*, which depicts an insane asylum escapee

committing acts of violence so depraved it has been banned already in England and Ireland,⁵ it is hard to know whether our culture will ever truly understand this population and its affliction. Will we as a culture ever come to accept this ill population or are they doomed to be banished behind the stone walls with no hope of ever escaping their stigma as the “Other?”

In the 1960’s, when civil rights for all human kind moved to the forefront, we found a leader in John F. Kennedy, a pro-active and influential advocate for a positive change toward the attitudes and treatment of the mentally ill. In a message to congress, Kennedy stated that “public funding must underwrite nearly the entire cost of major mental illness.”⁶ As funding became available for the proper treatment of the chronically mentally ill, more facilities opened

around the country; Colorado Mental Health Institute at Fort Logan (CMHI-FL) was one of them. It took over the grounds of the abandoned Ft. Logan Army base in Denver, Colorado, with preexisting living quarters and houses along with land and recreation facilities.

In the early years of the facility, Maxwell Jones, a prominent psychiatrist and theorist on the subject of therapeutic modeling, provided the basis for the therapeutic model to be used at the facility. He advocated for the use of the therapeutic community theory which took into account the view of all the staff in the facility and catered to voluntarily admitted patients.⁷ This period of time, lasting from 1960 to 1975, was considered the hay day for CMHI-FL; yet after this, things started to slide downhill.

In 1975 the Care and Treatment of the

Mentally Ill Act was passed followed closely by the Mental Health Involuntary Treatment law, which basically allowed for and encouraged the involuntary admission of patients to mental health centers. This caused a large change in the way CMHI-FL had functioned up to that point. Not only were people in the facility not voluntarily seeking treatment for their illness but the units housing involuntary patients were locked. This changed greatly the possibilities set forth by Jones' Therapeutic Community and gave way to a need for a new management style. Later in that decade massive budget cuts started to take hold of the mental health center. By 1981 CMHI-FL was forced to accept 1000 fewer patients and by 1985 CMHI-FL was forced to cut certain community based programs in order to maintain a more hospital like setting.

The funding crisis continued into 1990 as fewer and fewer beds were available in what was becoming a much more institutionalized setting. In the 1990-2000 the power of external influences on the hospital, such as the federal government and managed care, caused more failings at CMHI-FL. The Congress cut proposed budgets and contributed to the further decline in affective care at the CMHI-FL. Unfortunately, the funding cuts by the US government did not eliminate the need for treatment. In fact there was a marked increase in the need for public mental health at this time due in part to the increase in involuntary clients at CMHI-FL.

Today CMHI-FL is a shadow of what it was originally intended to be. The clients who reside there are mostly involuntary, criminal and chronically mentally ill patients. The facility itself

is physically crumbling around the residents' ears and there is no hope for revival. The current theme in the federal government is to cut most if not all funding to such programs. For most, if not all, of the individuals who currently live at CMHI-FL a closure of the facility would mean release in to the community, homelessness and death. The lack of care that this population has received over the last 15 years has been referred to in the field as a "Passive Genocide"⁸ by our government. And I agree.

facility typology

After the very early days of expelling the mentally ill from towns and city walls to wander freely and hopelessly outside the gates, the chronically mentally ill were housed in various ways ranging from being sent out on large

ships to sail the sea, to being locked away in large prison like structures where they could be observed and harassed by visitors to the spectacle. Even the earliest insane asylums in the United States were nothing more than glorified prisons meant for the "maintenance and support of idiots, lunatics, and other persons of unsound minds." ⁹ The Williamsburg Public Hospital in Williamsburg, Virginia was the first asylum built in the United States expressly for the purpose of housing the insane. It was a built in 1773 by builder-architect Robert Smith.¹⁰ The Public Hospital, as it was known commonly, was nothing more than a dormitory of cells with a high walled courtyard to contain the inhabitants. It was only after the deeper exploration of the human mind and the creation of psychiatry as a field of science that the need for a better housing

facility was recognized and the possibility of a *therapeutic* facility was conceived. By the nineteenth century a treatment that included attention to the environment of a patient was employed; it was called "moral treatment."¹¹ Such treatment required the patient to move to an asylum, and change his daily habits. In 1792 William Tuke, a British Quaker founded the York retreat in England, the building resembled that of a modest family farm. This form of structure was utilized in the United States by the Friends Asylum in Frankford outside Philadelphia by 1817.¹¹ The facility included a central building with two hall ways projecting linearly from its center. The single loaded hallways provided access to the rooms. Men were housed on one side of the main structure and women on the other. "The keepers were particularly proud of

the light and airy atmosphere, since proper ventilation was considered absolutely critical for both physiological and bodily care.”¹³ These linear asylums won the popular vote among doctors and officials of the time in the United States. The plan became the norm by the mid nineteenth century because of the effective and humane treatment the facilities allowed for.

In these new buildings hope was found for the sufferers of chronic mental illness. Gone were the days of banishment, torture and humiliation. However it was still the common belief of the time that isolation from the family and from society as a whole was needed to elicit the cure for the insane. In 1968 Maxwell Jones refuted this belief with his publication *Beyond the Therapeutic Community*.

endnotes time as is supports my thesis.

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8 This term was discovered in a philosophical conversation I was having with a former employee of CMHI-FL, Carol Newman. She has worked closely with this population for over twenty years. She stated that the way the current government treat the chronically mentally ill is in her eyes "Passive Genocide."

9 Journal for the Society of Architectural Historians, "The Linear Plan for the Insane Asylums in the United States before 1866." Quote from Peterson, Greiff, and Thompson, Robert Smith. The interest in the language of the

10 Yanni, Carla "The linear plan for the insane asylums in the United States before 1866." *Journal for the Society of Architectural Historians* (2003): 26.

11 Yanni, Carla "The linear plan for the insane asylums in the United States before 1866." *Journal for the Society of Architectural Historians* (2003): 27.

12 Van Arsdale, Amy "The Fort at Forty, a History of the FT. Logan Hospital's First Forty Years of Service," The Center for Cultural Dynamics (2001): 28.

13 Yanni, Carla "The linear plan for the insane asylums in the United States before 1866." *Journal for the Society of Architectural Historians* (2003): 29.

images

Figure 2.1, "The Interior of Bedlam," from A Rake's Progress by William Hogarth, 1763. McCormick Library, Northwestern University <<http://www.sos.mo.gov/archives/exhibits/quest/images/bedlam.jpg>>





chapter three: communication and

maxwell jones – therapeutic community

Maxwell Jones saw communication as the key component to the success of the mental hospital. His work on the subject was

incorporated into the inter-workings of many hospitals such as Fort Logan. His theory was based on the reorganization of the top down model that had historically dominated the field of medical and psychiatric medicine and one which Jones saw as a failure of the medical field. He claimed that by flattening out the power structure in the hospital, i.e. allowing administrators, doctors, nurses, social workers and line staff to take an active role in the planning and treatment of the patients, with no one entity being more dominant than the rest, the treatment plan would be more effective and better applied than in a top down model. He even suggested that the patients themselves become active participants in the model by openly communicating with the staff to come up with their own treatment plans.

The three objectives set forth in his book *Beyond the Therapeutic Community* define and clarify his intention for the mental hospital.

1. An establishment of a two way communication involving personnel, both patients and staff.

2. Discussion Making Machinery at all levels- so everyone has the feeling that she or he is identified with the aims of the hospital, with change, and with success and failure.

3. The development of the therapeutic culture reflecting the attitudes and beliefs of the staff and patients and highlighting the importance of roles and role relationships.¹

One can clearly see the importance of consensus in this system. Jones' theory maintained that if everyone agreed on a given

course of action everyone would work diligently to achieve that goal. If there was one member of the group who did not agree – she would not only disengage from that goal, but would be free of responsibility for the outcome of the treatment and therefore have no commitment to the treatment plan. Jones stated "In the therapeutic community, any unilateral decision, no matter how wise, is seen as contradictory to the basic philosophy."²

Jones believed that change in any system is inevitable and should be allowed for. He claimed that his "therapeutic community" accounted for that change and accommodated it. Here Jones discusses the way his system accounted for change.

"Action invites reaction, and people are traditionally resistant to change, which is usually equated with uncertainty and a threat to their own security. The more the individ-

ual knows about the proposed change – the more he has been consulted and listened to – the greater will be his identification with the new situation and the greater the opportunity for change”³

This is a powerful statement about the reason Jones called for the change of the hospital leadership model. The roles that he defined are clear: the patients or residents should be voluntarily seeking treatment for their illness and therefore interested in their treatment plan and its outcome; the staff who work in a facility like this one should also be committed to the outcome and interested and engaged in the treatment of the patients. Possibly, the most important factor in the triad (the resident, the staff and the community, discussed below) is the surrounding community, who should be concerned and engaged in the creation of a dwelling place for the individuals who occupy

the facility.

the resident

The residents of the Jones facility are considered an integral part of their own treatment plan. If the patients do not participate in the planning and treatment of their own illnesses and if they are not consulted about their own opinions about their treatment, the treatment will be less successful. Jones spoke to this concept and benefits of the expectation as follows:

“The concept of a therapeutic community carries the idea of the patient’s self determination to a new stage and invests the patient body with an increasing responsibility for their own treatment and living conditions, in collaboration with the staff. In this way, some patients become active participants in the planning and carrying out of their own treatment.”⁴

Jones’ discussion suggests that here are healing properties to responsibility. If a patient

takes +responsibility for her treatment then she will heal faster than those who do not. The community and particularly the therapeutic community the patient lives in is still the integral part of the treatment thought. It is not just one person caring for herself, it is a group of individuals all working toward the same end. The architecture surrounding that individual should also work toward that end. It should create a dwelling where healing can take place. Not simply an institution that houses her but a place where she can heal.

This discussion brings into light for the first time the notion of dwelling. Few if any facilities have explored the notion of creating a dwelling for healing, rather than a mere shelter. Conceptually, the difference between dwelling and shelter has much to do with belonging to

something bigger than ones self; by giving responsibility to the patients over their own treatment and surroundings, Jones may be truly working to instill a sense of “dwelling.”

Heidegger’s “dwelling” is an elusive and powerful concept that introduces the spirit of being to the built environment. We should not simply occupy a shelter, treating our housing as though it was nothing more than one of our life’s necessities. We as humans, derive meaning in our lives and identities from our dwelling. We know the things we build should be more than simply structures that house us; an apartment is not truly a dwelling in its nature, we as dwellers make it so. We look to dwellings for more than shelter and warmth. These things we build can bind us to them and them to us until finally the division between dweller and dwelling becomes

blurred and the meaning of each is dependent on the other. Heidegger examined the concept of dwelling by looking in to the words "I Dwell, You Dwell."

"What does ich bin mean? The word Bauen, to which bin belongs, answers: ich bin, du bist mean: I dwell, you dwell. The way in which you are and I am, the manner in which humans are on earth, is Bauen, dwelling. To be a human being means to be on earth as a mortal. It means to dwell. The old word Bauen, which says that man is insofar as he dwells, this word Bauen however also means at the same time to cherish and protect, to preserve and care for, specifically to till the soil, to cultivate the vine. Such building only takes care – it tends the growing that ripens into fruit of its own accord"⁵

The first part of this definition states that a human is human by definition because he dwells. In the second part of his discussion, Heidegger brings to light the importance of maintaining a human's relationship to the earth or environment

which is done through cultivation or building. This second section implies that human beings are able to dwell without necessarily building a structure of any kind.

The act of cultivation can provide the sense of dwelling as clearly and effectively as a structure. This act of creating any type of dwelling (construction or cultivation) is to be human.

Yet building alone does not equate directly to dwelling, it only contributes to the concept. To dwell has less to do with the physical reality of the built environment and more to do with the sense that is created because of the act of building or cultivating. When we create an environment where what we cultivate is safe from harm we also construct a sense of peace. It is this sense of peace that underpins the true nature of dwelling.

"The Old Saxon wunon, the Gothic wunian, like the old word bauen, mean to remain, to stay in a place. But the Gothic wunian says more distinctly how this remaining is experienced. Wunian means: to be at peace, to be brought to peace, to remain in peace. The word peace, Friede, means the free, das frye, and fry mean: preserve from harm and danger, preserve from something, safeguard. To free really means to spare. The sparing itself consists not only in the fact that we do not harm the ones whom we spare. *Real sparing is something positive and takes place when we leave something beforehand in its own nature, when we return it specifically to its being, when we "free" it in the real sense of the word to preserve of peace. To dwell, to be set at peace, means to remain at peace within the free, the preserve, the free sphere that safeguards each thing in its nature. The fundamental character of dwelling is sparing and preserving. It pervades dwelling in its whole range.*" ⁶ (Emphasis mine)

It is this sphere that we strive for as humans and is what makes dwelling. It is in this way that the architecture of a place can start to create dwelling. If architecture works toward

the construction of such a place where mortals come "to be at peace, to be brought to peace, to remain in peace"⁷ then that architecture is working toward the creation of dwelling. All humans by the very nature of their humanity are entitled to this sense of dwelling. The creation of such a dwelling is dependant on humans and conversely the creating of humanity is dependant on the existence of dwelling. Heidegger put it simply in this sentence: "We do not dwell because we have built, but we build and have built because we dwell, that is, because we are dwellers."⁸ The denial of dwelling for our marginalized populations such as the chronically mentally ill, is a denial of our own humanity. If we as humans do not provide dwelling for a portion of our human population we, in effect, are denying our own humanity and become

inhuman.

"If all of us now think, from where we are right here, of the old bridge in Heidelberg, this thinking toward that location is not a mere experience inside the persons present here; rather, it belongs to the nature of thinking of that bridge that in itself thinking gets through, persists through, the distance to that location. From this spot right here, we are there at the bridge – we are by no means at some representational content in our consciousness. From right here we may be much nearer to that bridge and to what it makes room for than someone who used it daily as an indifferent river crossing" ⁹

Heidegger suggests here that just knowing that a place exists can connect a person to it; she does not actually have to dwell there to know it as a place where for dwelling. This power of thought therefore gives an individual who has experienced the place first hand the ability to dwell anywhere in the world. She must only think about the place she longs to dwell and she will experience it again as if she were there.

This shows us that it is not, in fact, the building that creates the dwelling, but the concept of the place and the sense it gives that creates dwelling. Creating a place where the chronically mentally ill can truly dwell will give them the power to dwell anywhere in the world. Even when they have left the facility, knowing it exists will elicit the feeling of belonging to the world. It will exist as a kind of datum or horizon line in the mind; all one needs to regain balance is to look for it in the mind's eye and balance is restored.

the staff

"The social structure of the psychiatric hospital seems to be the most neglected field in the practice of present day psychiatry" ¹⁰ (emphasis mine) Essential to the argument is the idea that if the staff is not fully included on all levels, the Jones theory will fail. Therefore,

Jones has set out a regimented set of meeting procedures that play a vital role in the communication of the different types of staff in the hospital. These are categorized as types of formal communication and are as follows:

Administrative groups, treatment groups, training groups and work groups. In Figure 3.1 I have included a diagram with the breakdown of the groups to meet on a scheduled basis and what types of subjects they cover. Because of the focus on communication in this model, it becomes clear that building an environment where this type of communication can be assisted by the built environment, rather than impeded by it, is essential. For example Jones discusses a social worker whose office was so distant physically from the patients and other staff members that few came to see her for help.¹¹ The loca-

tion of her office was obviously not conducive to communication. I believe the architecture that is created for this therapeutic model must go far beyond the clinical disposition of institutional facilities; the architecture must create a dwelling where communication takes place. Communication should be intrinsic in the design; it can create the essence of place. Communication should act as line, so to speak, that holds the project together as a whole.

surrounding community: **moab population**

The community in which this facility sits is extremely important to its eventual success or failure. Jones's contention that the hospital is "the microcosm of the community on the outside,"¹² suggests that if one can effectively change the way the hospital treats its patients,

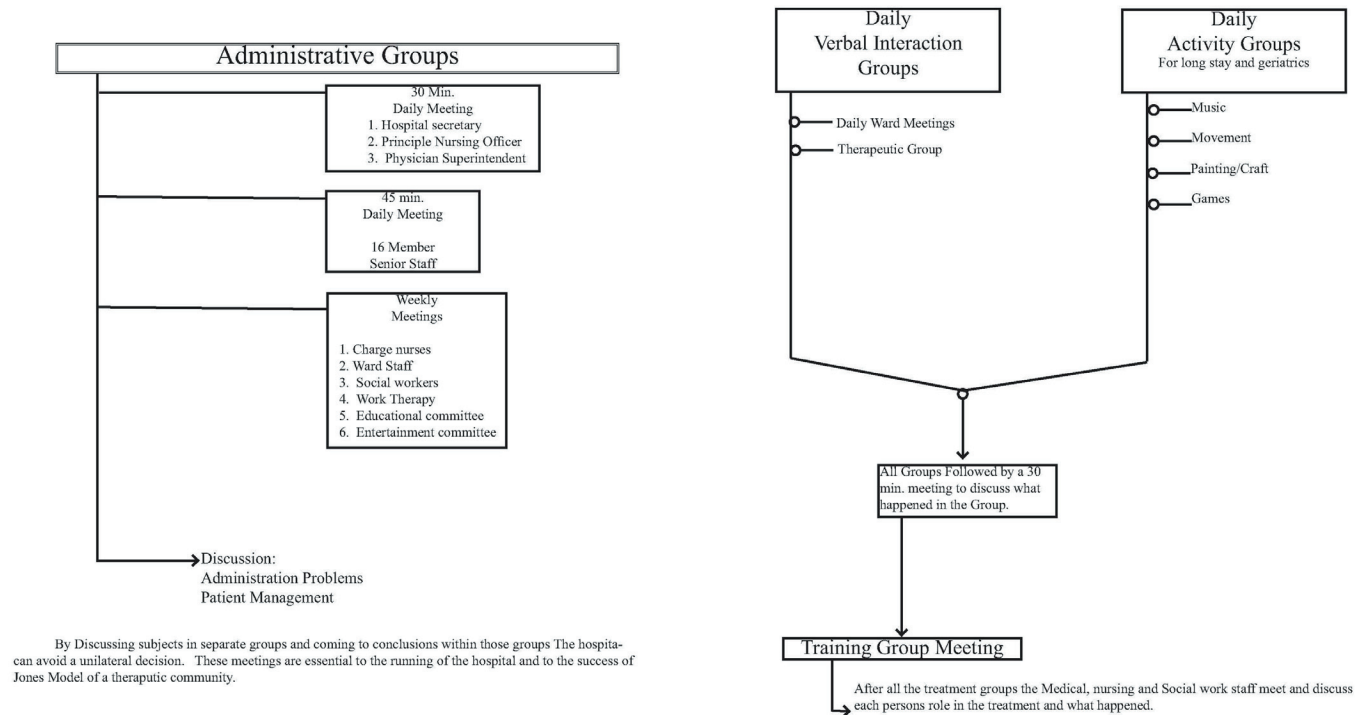


Figure 3.1

then the community might change its attitude toward this population on the outside as well.

Communities of the well are those on the outside of the "walls," the ones who are not part of the "other" population. This community acts

and reacts to the "others" based on historical bias, social norms and communication about the mentally ill, coming from what they see as knowledgeable positions. If a stigma towards a facility exists, it comes directly from the

community that surrounds it and that community's belief about the goings on in that facility. The goal of this facility should be to communicate openly and actively with the community it exists within to insure the health and understanding of the "well" in that community. Again the facility should radiate communication figuratively and literally from its very core and should provide for two way communication and understanding. The facility should not isolate itself and its occupants from the "well" community, but should invite the "well" community in and dwell with it in open communication.

endnotes

1 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), Introduction, xiii.

2 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), 48.

3 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), 20.

4 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), 43.

5 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 147.

6 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 149.

7 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 148.

8 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 148.

9 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 156.

10 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), 1.

11 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), 3

12 Jones, Maxwell. *Beyond the Therapeutic Community: Social Learning and Social Psychiatry* (New Haven and London: Yale UP, 1969), introduction xii.

13 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 154.



chapter four:

line of communication, spine, horizon line

If there is imbalance in a mind, or an inability to make sense of a situation there needs to be something that brings the balance back.

There should be a point to find one's bearings in an otherwise unnavigable sea of disorder and nonsense. By establishing a phenomenological datum, specifically a kind of horizon line, this balance can be accomplished. This concept comes from the feeling of seasickness many experience while sailing on the open sea. If the sea sickness overcomes your body, your eyes can seek out the horizon line and balance your mind; your body then will follow willingly to comfort. This phenomenon is also extremely important to the aerobatic pilot, who must always maintain a visual link with the horizon line to maintain orientation and balance. Without this link the pilot will most definitely crash. In the case of the chronically mentally ill this horizon line should exist more metaphorically than literally. I am not necessarily proposing a structure that

involves a line of any kind. My theory is about the individual's knowledge that a grounding point exists. A dwelling in the Heideggerian sense, that allows the individual to belong to a place and the place to the individual would create a feeling of belonging that has never before been experienced. I believe that by knowing there is such a datum, where imbalance becomes balance, the "ill" are provided with a powerful sense of security that is healing just by the nature of its existence. Those who find themselves struggling to stay in the balanced community can look to this place to find the balance they have lost.

By starting with dwelling as the proverbial site line, the patient knows there is a place of belonging, a place where his otherness is dispelled; a place to go to regain balance.

Heidegger discusses the concept of dwelling in relationship to horizon line and boundary in the quotation below. I think it is this idea that links the concept of dwelling to horizon; here we can also connect balance to communication.

"A boundary is not that at which something stops but, as the Greeks recognized, the boundary is that from which something begins its presencing. That is why the concept is that of *horismos*, that is, the horizon, the boundary. Space is in essence that for which room has been made, that which is let into the bounds. That for which room is made is always granted and hence joined, that is, gathered, by virtue of location, that is, by such a thing as a bridge."¹

If we assume that a true dwelling can be created for the population of the chronically mentally ill and that there is "space" or "room" for such a place in our culture, then the next part of the discussion leads us toward the concept of the threshold and bridging the distance between the two spaces. How is the gap between the

"well" and "ill" bridged? I believe it is through communication.

It is only through communication that room is made for the mad in the minds of the "well." Balance, horizon, bridge, space, place and dwelling all revolve around the ability of the "well" to communicate with the "ill." Communication must become the essence of the facility created; its essence must radiate into the community of the "well" and call out its intention to those looking frantically for its phenomenological horizon line. In those moments of weakness that we all experience the facility and communication should act as the horizon line that holds us all together; to each other and to ourselves.

the project

I will create a multi-unit facility where

dwelling for the chronically mentally ill can take place. Voluntary patients will come to regain their sense of balance and use the facility as a horizon line as they recover from their initial tumble. Families will also use this facility to engage in family therapy. Because the family is the nucleus of the larger community, it is my contention that by providing dwelling for family mental health, the family will incorporate the community as a whole. The facility will also provide a place for individuals from the "well" community to come and seek day treatment for personal mental health. By providing service to both the chronically mentally ill and those who are simply seeking mental health

professionals I believe a deeper connection will be made between the "well" and "ill." This connection will lead inevitably to communication

and open dialog between the larger community of Moab and the residence and users of the facility. A place where this type of dialog is encouraged and dispel the myths and fear about the chronically mentally ill.

This facility logically seeks an edge condition, a place between two distinct worlds. Few landscapes encapsulate this condition better than the desert environment. On one side are the definite rhythms of the universe, constant and timeless, akin to a heart beat in regularity. On the other side is the fast paced, calculated world of human creation, a place where “doing” is paramount, a place that defies natural rhythms for the love of its own. On one side the vast expanse of eternal nature and on the other the cities of human creation. It is on this threshold, between two worlds, that the

facility sits. The facility will sit nestled into the comforting hillside at the edge of Moab, Utah. It backs up to the sheltering cliffs that lead eventually to the wide expanse of the desert beyond. The building will act as a threshold between the existing bustle of town life with its fast paced daily ritual imposed by social norms and human will, and the quiet, eternal rhythm of the desert sand whose only indication of the passage of time is written on the rock.

Figure 4.1 shows the general relationship each unit has to the others. This diagram indicates the way the facility will reach out into the community drawing near those who seek it. It allows for layers of understanding that ripple out from its core. For some who dwell here the comfort of solid ground is required,

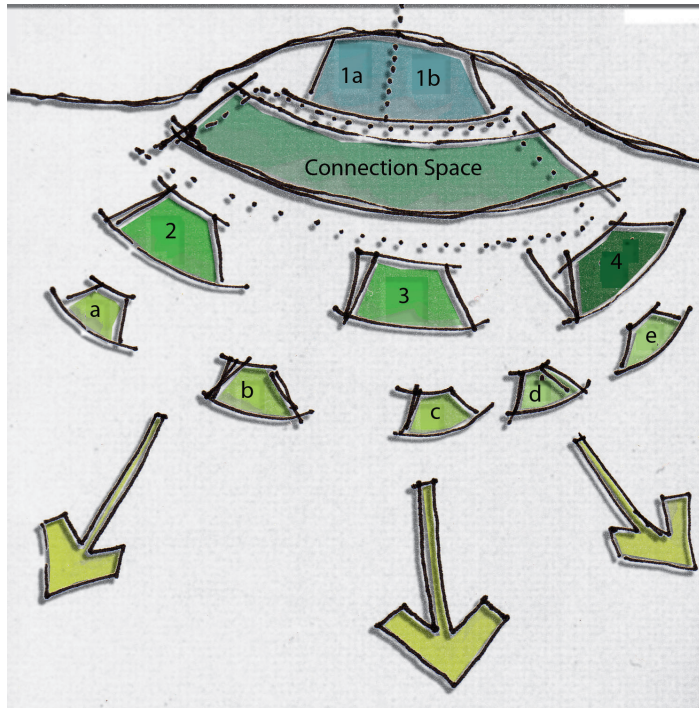


Figure 4.1

and nature can provide the sense of eternal steadfastness that is so needed. For others the more complicated inter-workings of a town and community are necessary for treatment and from this vantage point the city comes alive with

pulse and action. It is on this edge we find both. The facility reaches out to the community and brings the "well" to it; it opens its hands and gently nudges the "ill" into the world. It shelters those who need it and shows and teaches to those who are ready, order and rhythm. It will create the potential for communication between two worlds, between the "ill"

Figure 4.1 and the "well" and between humanity and nature. The program reveals itself as a microcosm of the relationships of the universe; each unit a smaller version of the whole, fractal in nature, as the facility expands outward in response to its environment and spirals ever inward reflecting its own essence.

It will create dwelling for those who seek treatment willingly. The "ill" and "well" alike will be welcome here. Intrinsic in this dwelling will

be the knowledge that we are not so different from those we call the "other." The nature of the facility will beckon one closer, to explore and understand, to speak and listen, to communicate. Here we shall all find the acceptance and understanding we need.

Endnotes

- 1 Heidegger, Martin. *Poetry, Language, Thought* (New York: Harper and Row, 1971), 154.



chapter five:

site analysis

The desert with its red sand, its blue sky and its sense of endlessness will provide a deep connection to the rhythms of the universe. It is

important to regain an understanding of both the regular rhythms of life that are so easily forgotten during a deep mental illness and the larger rhythms of the universe that help us all gain perspective and enlightenment in our day to day lives. The Moab desert landscape provides both a small town to recognize human pace and a wide expansive horizon to call those back who are struggling with perspective and reality. The sense of time and timelessness is written here in the stone. The wind has torn apart its outer layers reminding us all of the constant juxtaposition of permanence and impermanence. The fine sand that results from the destruction of the stone is as soft as the stone is hard, again pointing to the constant duality of natural things. The sky with its clear black depths and quilt of meandering stars never lets us forget our place

in the larger universe, but does not neglect to warm us in the day with its blazing hot sun. This place is the epitome of spiritual healing. There is no other location as natural a selection for the proposed structure. Dwelling is intrinsic in the caves and temperature, horizon sings out from the stone and sky, threshold is reborn at every corner and the twisting Colorado River brings a splash of green life to the heart of the mix. It is already the place for healing as it sits, already where one travels to find peace. One need only celebrate its attributes, one need only a frame to capture its spirit.

site location

The Site is located in Moab, Utah, near the intersection of 500 West and Kane Creek Road. The exact location is 38° 34' 12.61" N, 109° 33' 11.02" W. The elevation is 4023 ft. The site I have chosen starts as a flat open plot of land and rises to rolling hills in approximately 500 yards. Beyond the hills a steep and massive cliff shoots upward creating a protective wall to the south west. This map represents the site's general location in relationship to Moab in the east and the desert to the south west. It is truly an edge condition as it sits on the open land between the two conditions. One of the biggest advantages to this site is its relationship to the Mill Creek Park and trail system. This park is lush and green in comparison to the desert surroundings and offers an immediate connection to nature and

its rhythms. The Mill Creek Park eventually leads seeking.
to the Colorado river to the west and connects
to Moab to the east. This site is ideal in terms of
its edge condition and offers the context I was

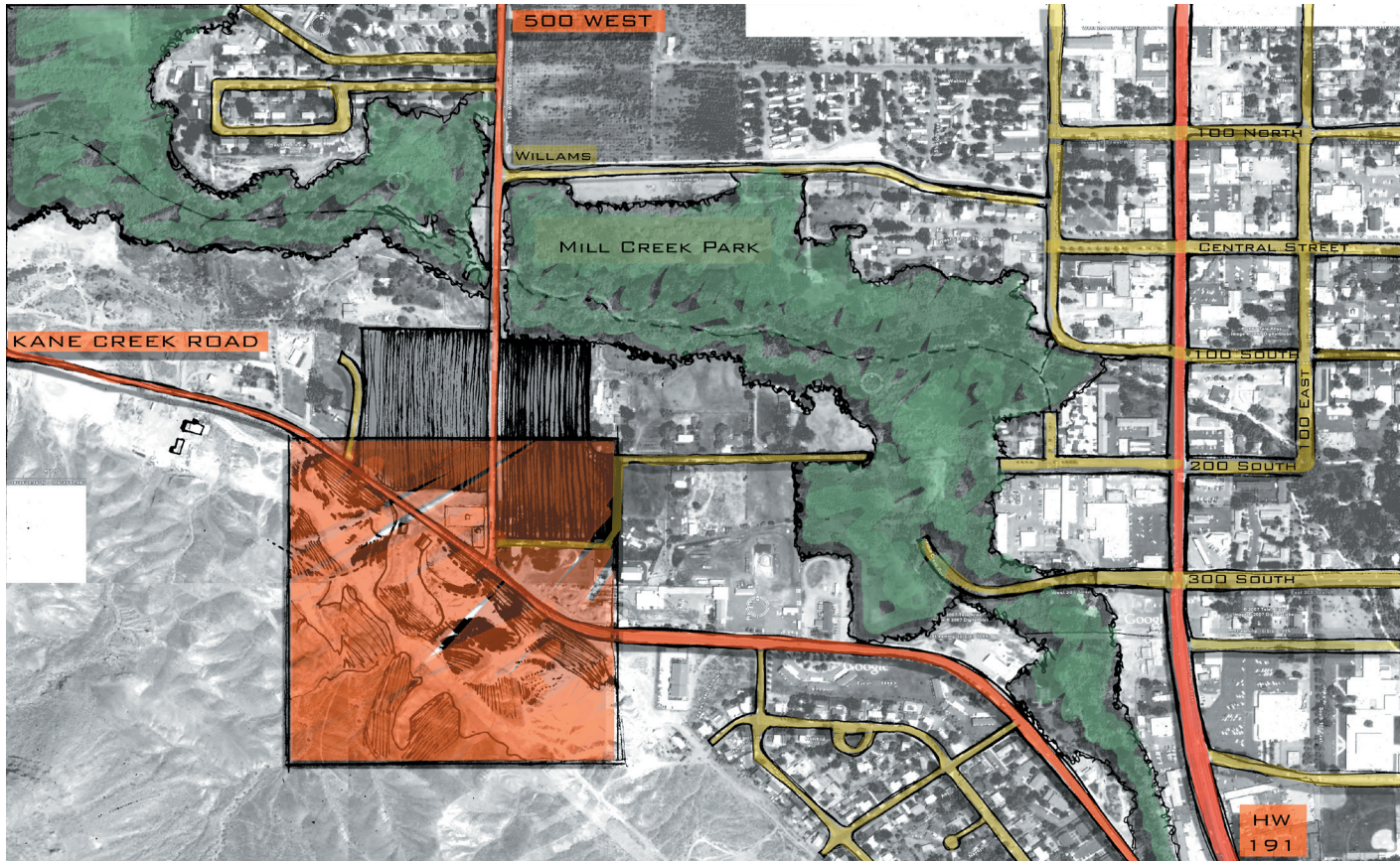


Figure 5.1

views of site is so essential for the facility to work. The

Figure 5.2 shows the main views from the site. The orange arrow points toward the Colorado River and canyon that surrounds it, this represents the connection to nature that the rhythms of the town. As the lights turn on in

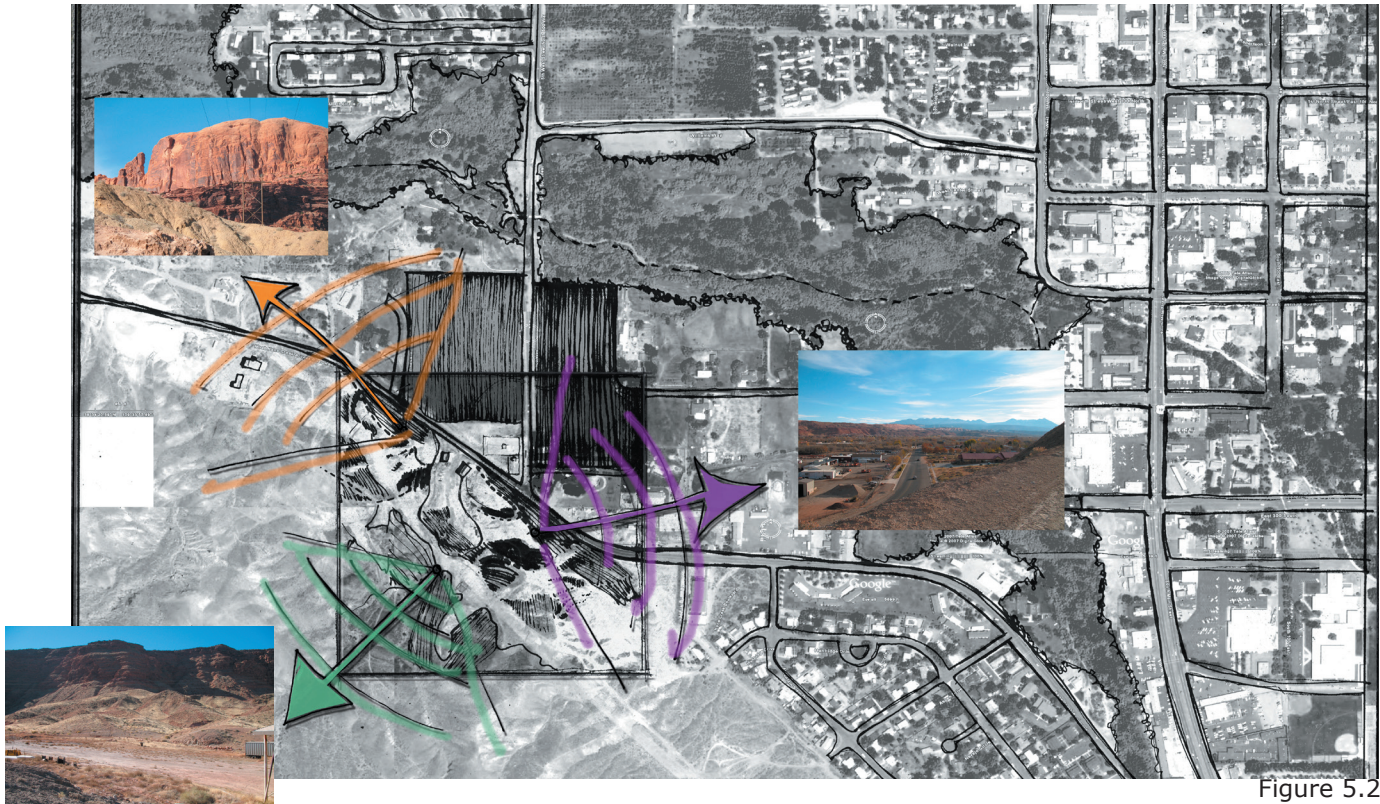


Figure 5.2

the evening and off late at night the clients will start to associate their personal lives with that of the town. The green arrow points to a view of the cliff discussed previously.

Figure 5.3 and Figure 5.4 indicate the overwhelming dry nature of the site with its sandy soil and rolling hills it is the quintessential picture of a desert landscape.



Figure 5.3



Figure 5.4

surrounding area

Figure 5.5 represents the site's relationship to the surrounding environment. The commercial section to the east, indicated in green is the main street district where most of the tourist industry is located. Moab is driven mainly by the tourist industry and grows and shrinks with the seasonal schedule of Arches and Canyon Lands National Parks. Its population is 5200 people on average. The sections indicated in yellow make

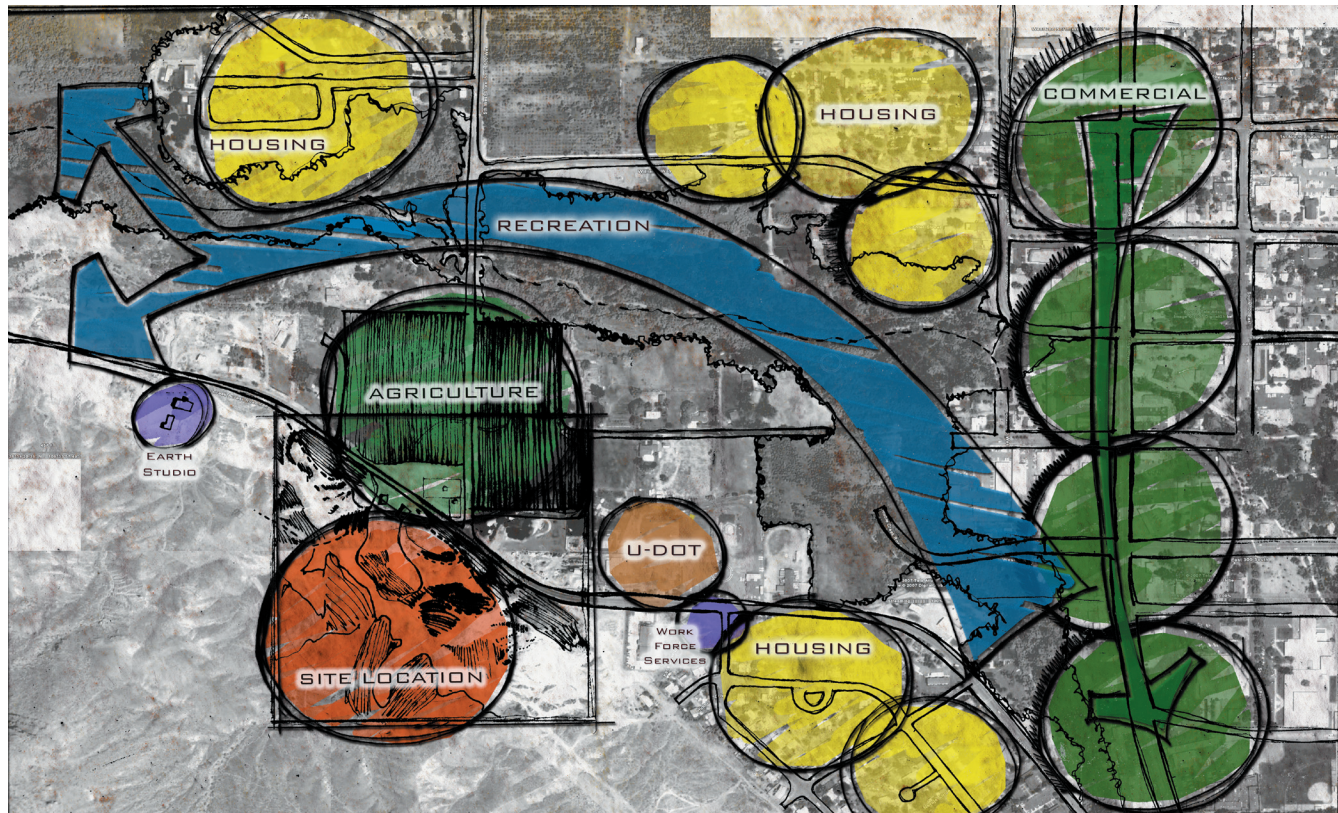


Figure 5.5

up the areas where housing is located. The homes here are mainly single family residence of low to middle level income. The blue section indicates the park systems and its connection to Moab and the Colorado River. The images below show in detail this park and its connection with the environment.

Two areas of interest for the facility are indicated in purple. The Earth Studio is an art studio that is located near the boundary of the site. There is real potential for a programmatic relationship between my facility and the Earth

Studio. The other purple bubble indicates the Work Force Services building, where clients of the facility might find work as they reenter the “well” culture. Another interesting aspect of this site is its adjacency to the agricultural land across the road. The order and rhythm of farm life is a valuable addition to the site because by watching and understanding the working of the land over the seasons a deeper connection may be made to the rhythms of the humanity and nature.



sun and light

Here diagram 5.6 indicates the magnitude of the sun during different parts of the day based on the way the site is situated. Moving from east to west the magnitude and intensity of the sun

decreases. This is because of the slope of the site and the location of the cliff. This is a great advantage in Moab where the maximum temperature can reach 109 degrees in July.¹ The importance of being protected from the summer

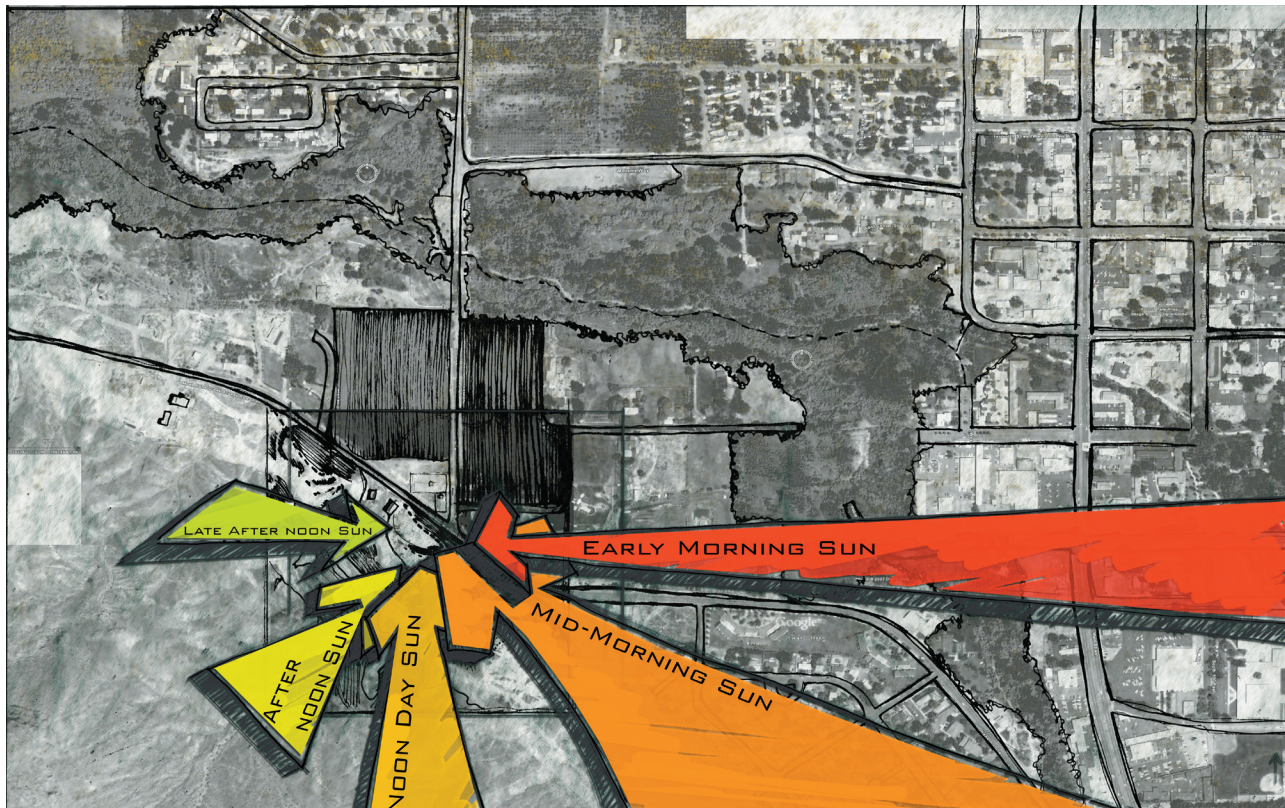


Figure 5.6

sun in this area is paramount. Figure 5.7 and Figure 5.8 give exact information about the temperature and precipitation over the year. The sun and light in this environment are extremely important to control. I have experiences cool winter nights in Moab, but nothing in comparison to the heat at the height of summer. Here, the blinding afternoon sun will dip behind the cliff and its glaring rays will never reach the facility. This cool shade will be a blessing for the clients who will respond happily to the cool shadow as it pushes over the site. However the cliffs to the

south west will indicate the setting sun as the light causes a red glow, without over heating the facility. The real attribute of this site is its relationship to the rising sun. The early morning sun, from sun rise to 10 am will shine on the facility. But after a cool evening it will be a warm welcome. The mid-morning, from about 10 am to noon, provides an opportunity for heat collecting mass. As the sun gets hot and high in the sky, the cliff will start to do its work and help shade the facility.

	Avg. High Temp.	Avg. Low Temp.	Max High Temp	Max Low Temp	# Days Over 90 F	# Days Under 32 F	Avg. Precip (inches)	% of Annual Precip.
Jan.	43.9	18.8	67	1	0	30	0.5	5%
Feb.	52.7	25.1	75	1	0	23	0.5	5%
March	63.9	33.3	86	19	0	15	0.9	9%
April	76	38.9	92	26	2	3	1.2	12%
May	84.3	49.4	97	34	10	0	1.1	11%
June	97.6	57.9	108	38	28	0	0.1	1%
July	99.5	61.9	109	50	29	0	1.2	12%
Aug.	98.6	61.5	107	49	30	0	0.8	7%
Sept.	86.1	50.4	102	30	12	1	0.8	7%
Oct.	77.1	40.3	92	26	4	2	1.6	15%
Nov.	58.4	31.7	78	16	0	17	1.2	12%
Dec.	47.9	21.4	60	10	0	29	0.5	4%

Figure 5.7

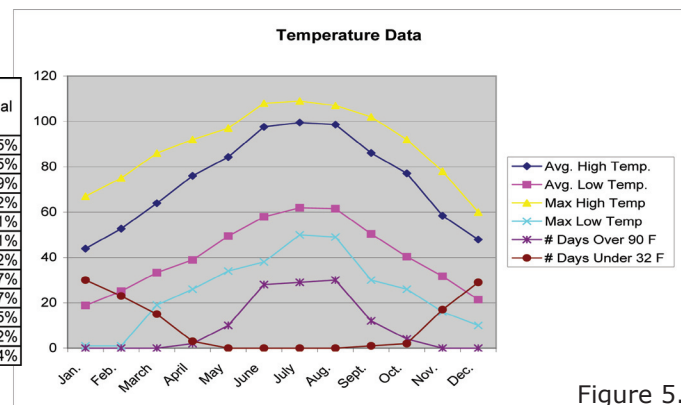


Figure 5.8

wind from to the wind and protects the site from the

Prevailing wind is also a powerful force in this environment. The wind moves from the south and south west in its strongest gusts. Fortunately again, the cliff acts as a shelter

wind's potential damage and irritation. Figure 5.9 indicates, in the purple arrow, the intensity and direction of the wind; it is highest out of the south west. The wind from the south east is also

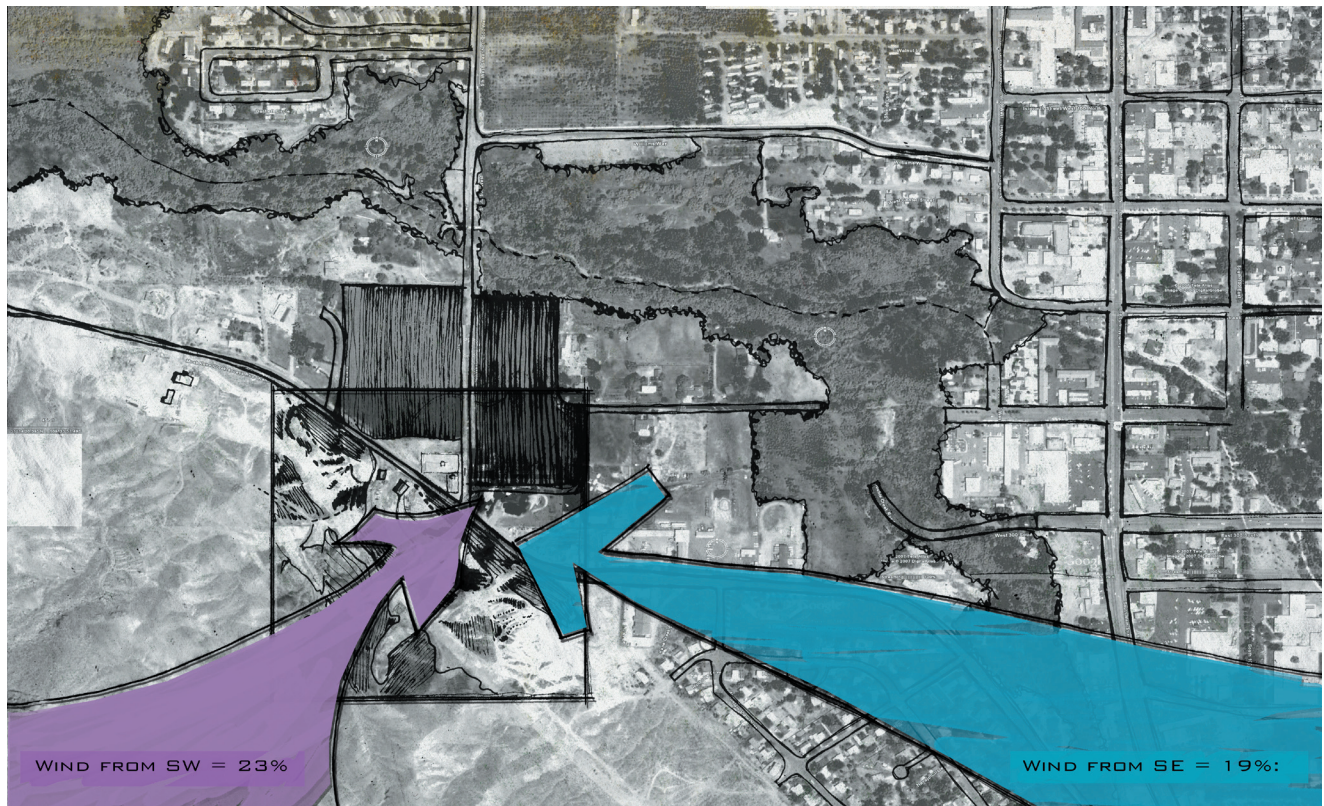


Figure 5.9

strong, as indicated in the diagram. There would not be as much protection naturally on the site from wind coming from this direction. The bowl shape of the site might offer some protection but the answer may come from an architectural

response rather than relying entirely on the layout of the site. It is an important consideration because many chronically mentally ill people respond negatively to wind.

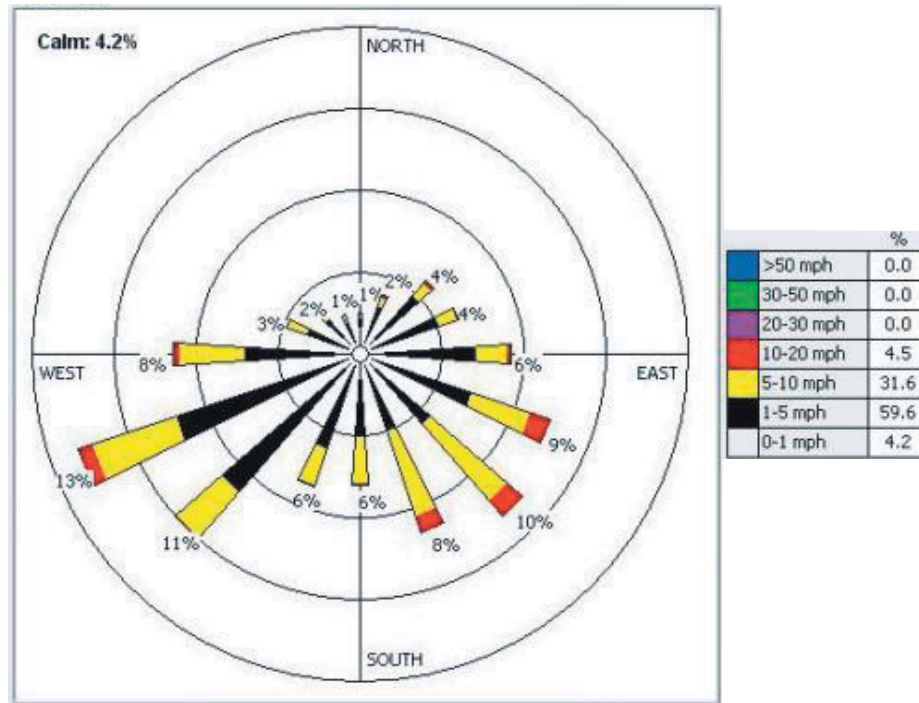


Figure 5.10

endnotes

1 Historical Climate Records Office, Northern Arizona University, Flagstaff Arizona, 1991.





the issues at hand. My project will also work in this way, providing space where all levels of communication, from understanding the larger community to understanding the self, can take place. Ideally one would be able to gain an understanding of the larger community by observing and participating in its rhythms and also gain an understanding of the natural rhythms of life and every scale in between.

chapter 6: programing

Maxwell Jones' therapeutic community works by moving from large group dynamics to small ones, discussing and re-discussing

Those who choose to seek the shelter of the place will be arranged by need. Those who need the deep comfort found in security will be accommodated closest to the heart of the facility (see figure 4.1). This area will shelter one from the over stimulation of the outer world. Controlled and simple, very little outer stimulation will reach the patients here while they recover from their initial break. If you think about the

facility as ripples in a pond, the next level out from the center is where the staff of the hospital is located. They are positioned where they can have the greatest contact with the patients and the patients with them. The staff also acts as a form of shelter for the inner most patients, creating the literal and metaphoric threshold between complex rhythms of the outer grounds on the outer layers and the newly admitted patients towards the center. Beyond that level exist units and grounds for those for whom the connection between the town and deserts is clearer. There is personal meditation space, walking paths and gardens and views of the surrounding environment. The clients here dwell in a liminal world, not fully integrated, but not fully removed. They seek understanding and rhythm and find it here. They are able to "do" as they reestablish their

connection and work to understand its meaning. Beyond those units are the family therapy huts and day and group use facilities. They are the outstretched fingers from the facility to the community, the place where the line blurs between "well" and "ill."

The facility will accommodate 80-100 beds consisting of 4 resident units numbered 1-4. Unit 1 will be the intake unit and will be divided in two sections 1a and 1b so patients can be separated if need be. Units 2 and 3 will be unlocked, and will accommodate voluntary treatment programs with higher levels of freedom on the grounds of the hospital. Unit 4 will be a locked, voluntary unit designed to allow more supervised movement onto the grounds. There will be 3 family therapy huts called a, b and c. (refer to Figure 4.1). The purpose of

these structures is to provide in depth family treatment. They are voluntary and should accommodate families of 6-8 people. Two more structures named d and e accommodate group and community day treatment, such as Alcohol/ Narcotic Anonymous and personal day therapy. The facility also includes offices for staff, staff lounge, medical clinic, cafeteria food services, occupational therapy and physical therapy, meditation spaces and /or non-denominational chapel, security and maintenance. You will find the breakdown of sizes below in list format. These are to be used as guidelines and are not set in stone.

unit 1a and 1b: **20 beds total**

Quantitative Description:

Qualitative Description:

The space will be the least complicated of all the units. It should offer a clear and concise layout that does not confuse the inhabitants. The bedrooms will be free of complicated decoration and over stimulation. Line of sight and safety consideration is critical for this unit. The key to this entire unit is its simplicity. The patients who utilize this space will be the least stable of all the clients in the facility and therefore need and environment to initially regain balance. This will be accomplished by sheltering them from the complexity of the over stimulation of the city life and focusing mainly on the steady rhythms of nature. Here they will find peace and enjoy true dwelling.

- 10 bedrooms 200sqft each, 2 beds each split between 1a and 1b
- 1 ADA Bathroom in each room w/ shower, 10 total for patient use (safety)
- 1 ADA Staff Restroom Toilet and sink only. Locked and separate from patients
- Unit ADA Restroom 1 Men, 1 Women.
- Nurses station – connected to Med room 500sqft total service 1a and 1b
- Main Milieu - 1000 sqft one in each section.
- Unit Kitchen 300 sqft service 1a and 1b
- 4 offices 100-150sqft each 1 clinic room with bed, sink and counter
- Staff Lounge – 400sqft (one on each unit if the units are separate or one main lounge if that makes more sense)

unit 2 and 3: **40 beds total**

Qualitative Description:

These units are to be celebratory of their surroundings. The next step in complexity will be attainable here. The patients should have access to the grounds of the facility yet still have an unexposed feeling. Glimpses and views of the town from within these units are important for the patients to understand their own habit in relationship to those in the town. The lights of the town come on as they turn on their own lights. As they sit down to eat so do the people of Moab. The feeling inside the units should be one of home. It should feel personal and warm, not institutional and cold. The bedrooms should allow the individuals who occupy them to change them in small ways: the color of the walls, the

drapes and the location of the furniture can all be modified. These small changes create a sense of identity, ownership and permanence that is needed to create a sense of dwelling.

Quantitative Description:

- 20 bedrooms 200sqft each, 2 beds each
- 1 ADA Bathroom in each room w/ shower, 10 total for patient use (safety)
- 1 ADA Staff Restroom, Toilet and sink only. Locked and separate from patients
- Unit ADA Restroom 1 Men, 1 Women each
- Nurses station – connected to Med room 500sqft total each
- Main Milieu - 2000 sqft each.
- Unit Kitchen 300 sqft each
- 2 offices 100-150sqft each
- 1 clinic room with bed, sink and counter

unit 4: **20 beds total**

Qualitative Description:

This unit should act similar to units 2 and 3, with one exception, the unit is locked. The patients within are still voluntary but they simply require more security than the other patients. In some cases and particularly in the case of paranoid schizophrenia the patient is fearful of his own safety and would prefer to be in a locked unit. He would still have access to the outside and to the grounds but supervision would be required.

- 10 bedrooms 200sqft each, 2 beds each
- 1 ADA Bathroom in each room w/ shower, 10 total for patient use (safety)
- 1 ADA Staff Restroom, Toilet and sink only. Locked and separate from patients
- Unit ADA Restroom 1 Men, 1 Women each
- Nurses station – connected to Med room 500sqft total each
- Main Milieu - 2000 sqft each.
- Unit Kitchen 300 sqft each
- 4 offices -100-150sqft each
- 1 clinic room with bed, sink and counter

Quantitative Description:

family therapy huts: a, b, and c

Qualitative Description:

These home-like structures will provide dwelling to families seeking an intensive therapy program offered by this facility. The structures will act like a regular house, yet feel quite different from the architecture associated with a 21st century home. They should connect in every way to the landscape and natural elements allowing for plenty of outdoor living space. These units start to truly reach out and engage the surrounding community, bringing both the community here to be treated and allowing those who are being treated at this facility to go to the community of Moab. In this way a dialog will be started between those seeking treatment and the "well."

Quantitative Description:

- 3 to 4 bed rooms - 200-300 sqft each
- 2 bathrooms ADA
- Kitchen - 200 sqft
- Living space - 300 sqft
- Closets and Storage – 100 sqft

group and day therapy: d and e

Qualitative Description

These nondescript structures offer a place for those members of the community such as alcohol anonymous to come and use the facility for their meetings. It also provides a gathering place for those inside the facility. Group therapy, classes and meetings can be held in these structures. They should be able to open to the outside, but also be capable of closing up for the cooler season. The quality of space should be as healing and inspiring as any other part of the facility.

Quantitative Description:

- “Open specific” structure should accommodate groups of 20 comfortably
- Should have access to potable water
- Should be close to or have a ADA accessible Restroom

other facilities: for communal use

- 4 clinic rooms with beds and sink and counter - 150 sqft each
- Small waiting room – 300 sqft
- Check in desk – 100 sqft
- Storage, 200 sqft for files and medical equipment
- 2 Offices – 100 sqft each
- Physical Therapy Area, 500 sqft
- Occupational Therapy Area, 500 sqft
- 1 men, 1 women Restrooms (ADA)
- Cafeteria/Food service
- Large Industrial Kitchen 1000sqft
- Dining hall able to seat 50 people at a time
- Men and Women public Restrooms (ADA)

nondenominational chapel meditation space

1000-2000 sqft

Qualitative Description:

This space should elicit a moment of calming connection to the greater universe. It should not favor one religion more than another but should simply allow the inhabitant to meditate freely as they see fit. Gatherings of all religious types can take place here. This is always open to the facility residents and community. It should connect to the outdoors in some way, by framing views, or literally opening up to the outside. It should also connect to the town of Moab visually so the connection to both conditions is never forgotten.

Quantitative Description:

- Seating for 25-30
- Area/stage for speaker at the front of the Chapel
- Storage for equipment 100 sqft
- 2-3 coves for individual meditation 100 sqft each
- 1 men ,1women Restrooms (ADA)

**several small meditation
structures
200-300 sqft each**

Qualitative Description:

Each structure is site specific. Each should engage the site in different ways. One may allow the user to feel the wind blow on her face while another may be used to listen to the sound of birds and the wind in the trees. Each will be designed to elicit a contemplative frame of mind, and would be a perfect place for one on one therapeutic moments.

Quantitative Description:

- Adequate for one or two people located throughout the site.





Figure 7.1



chapter seven: precedent studies

gins and arakawa reversible destiny lofts

Gins and Arakawa completed the Reversible Destiny Lofts in October, 2005.¹ These loft where designed to work as “procedural

architecture” or as architecture which helps the mind reorganize thoughts and ideas. Though Gins and Arakawa have a slightly different agenda than mine, namely to stop death, their ideas about the type of architecture that can affect behavior is similar. On their web site, in discussion of the Reversible Destiny Lofts, they state:

“What could be more optimistic and constructive than a living space that in every way both prods and coaxes its residents to continue living for an indefinitely long period of time?! That is what the term reversible destiny signals loudly and clearly. Each reversible destiny loft has structured into it the capacity to help residents live long and ample lives.”²

This same notion could easily be applied to the concepts I have set forth in my thesis. My facility also “prods and coaxes” its inhabitants to a healthier life style. If Gins and Arkawa’s building is a machine for immortality, mine is a machine for wellness.

Figure 7.2



bi young cho
village of the dancing fish
(special needs housing)
paju, south korea

The way in which this project uses the site and the concept of its overall plan is useful when trying to understand my concept for my site. In the case of the *Village for the Dancing Fish*, trees in the back ground surround one side of the project protecting and sheltering the inhabitants. In my facility it is the cliffs that

provide the shelter. Below there is a connection to the fields where the inhabitants work; in my case it is the view of the community the patients are trying to relate to. Here Cho discusses his intention for the site:

“The site was located on a peaceful hill called “Hill with Fish Playing.” Woods gently embrace the site and open into rural fields. The farmable field to the south of the complex is their workplace. The dormitory building was designed to retain the gentle sense of the hill and woods surrounding it but still provide a village-like atmosphere for the inhabitants.”³

Also, its over all master plan attracted me to the *Village of the Dancing Fish*. I like the individuality of each section of buildings, leaving plenty of interstitial space for the development of outside space. It is these relationships to its surroundings that make this project such a powerful precedent.

Figure 7.3



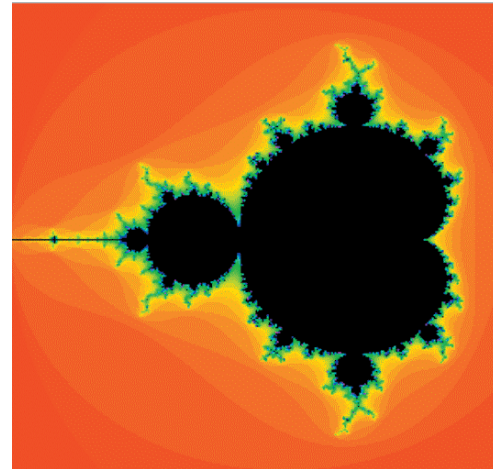
**colorado mental health institute
at fort logan
denver, colorado**

Though we have previously discussed CMHI-FL as a historical model in terms of its relation to Maxwell Jones' theories, I would like to turn now to its general lay out. There are mutable buildings which sit in the center of the existing housing units of the old army base. The buildings that were built for the purposes of housing the hospital and its various functions

radiate from a central admission unit. This building is a multi-story building accommodating the admissions unit, offices, gym, and snack shop. There are a series of disconnected units that accommodate different groups based on their needs. Similar to the "Village of the Dancing Fish" this is a conglomerate of buildings surrounded by grounds which connect the structures and make one large hospital structure. Though the architecture of the facility is out dated and unsuccessful in terms of creating dwelling for the chronically mentally ill, it does make sense in terms of its layout. If there was enough funding for up keep on the grounds and buildings, and enough dedicated staff to maintain Jones' ideal, I believe the concept would have worked well to increase the health of the patients who live there. It is a great example of the need to keep

all the people involved with the administration of my facility on the same page pragmatically and philosophically.

Figure 7.4



fractals

and the mandelbrot set

The mathematical equation $Z = Z^2 + C$ is an equation that is used to discuss chaos theory and infinity.⁴ By using this equation and the calculating and graphic power of a computer one can actually see infinity taking place for the first time in human history. The images that are produced by this equation are a window into what I believe is the explanation of the universe.

These Mandelbrot sets are able to expand and contract infinitely at the same time and by doing so, describe the nature of all things. This perpetual movement towards decay and rebirth is graphically apparent in Fractal geometry and it is this concept that helps inform my architectural design. Each unit is simply a smaller version of the whole design; the whole facility should reflect our culture, just as our culture mimics the inter-dependent workings of universal relationships. This fractal like relationship to all of the cultural and physical surroundings makes the design of this place universal, not in the sense that it can be anywhere, but in the sense that it can respond without judgment to those who seek it because it is a version of them, of all of us and of everything.

endnotes

1 Gins and Arakawa, *Reversible Destiny Lofts*: <http://www.reversibledestiny.org/texts/lofts.html>

2 Gins and Arakawa, *Reversible Destiny Lofts*: <http://www.reversibledestiny.org/texts/lofts.html>

3 Cho, Bi Young, *Village of the Dancing Fish*, Paju, South Korea. <http://www.bchoarchitects.com>.

4 For more mathematical information on this subject please see the movie "Colors of Infinity." Also for a clear and concise explanation of the equation from a mathematician visit <http://www.ddewey.net/mandelbrot/>.

images

Figure 7.1 - Room in Reversible Destiny Lofts
<<http://www.reversibledestiny.org/mitaka.php>>

Figure 7.2 - Building in Village of the Dancing Fish
<<http://www.bchoarchitects.com/>>

Figure 7.3 - Fort Logan Figure

Figure 7.4 - Computer Generated Fractal Image
<http://courses.nus.edu.sg/course/elljwp/fractals_files/image004.gif>



chapter eight

final presentation

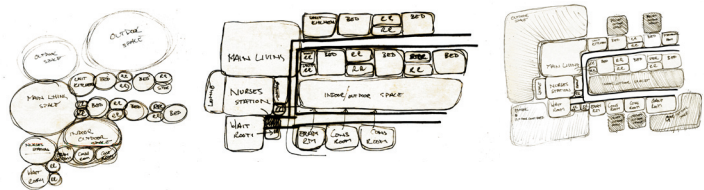
Due to the massive program set forth in the thesis it was important to strategically narrow down the scope of the project to a manageable size for design. The decision was

made to create a master plan for the entire facility and then select one unit for more intricate design. By using master planning techniques the overall layout of the buildings on the site was completed rather quickly. The master plan strategy included letting the buildings string out over one topographic level, letting the road and walking paths follow the same contours as the buildings and by doing this allowing the units to encircle the central pieces of the facility such as the cafeteria and parking.

The advantage of this design technique was the ability to quickly move from a larger design layout to a much more focused design strategy while still incorporating the design theories found in both phases. One of the disadvantages of using this technique is the loss of a truly in depth understanding of the facility

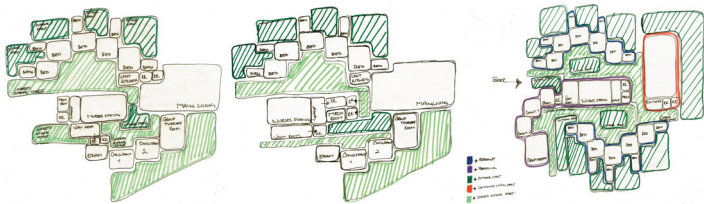
as a whole.

Below is a series of images that show the technique used to start the layout of spaces for each unit type. Though the shape of each unit as a whole is not comparable to the end design decision the spaces within each schematic layout led eventually to the desired type of final space.



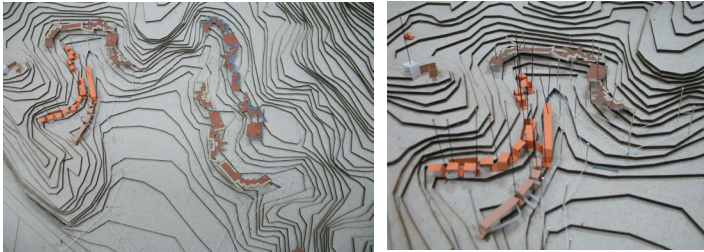
schematic search

Searching for relationships that include efficiency and appropriate adjacency. Bubble diagrams are fast and simple ways to search for such formation.



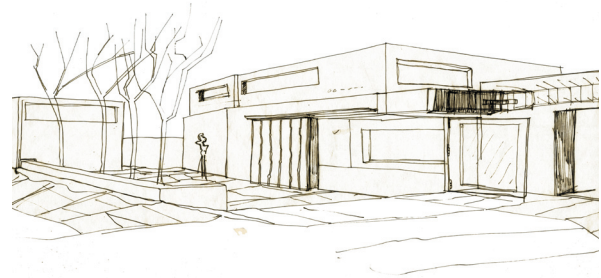
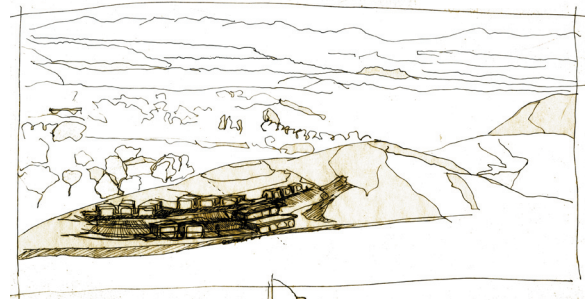
schematic search

Searching for relationships that include efficiency and appropriate adjacency. Bubble diagrams are fast and simple ways to search for such formation.



further explorations with pin models

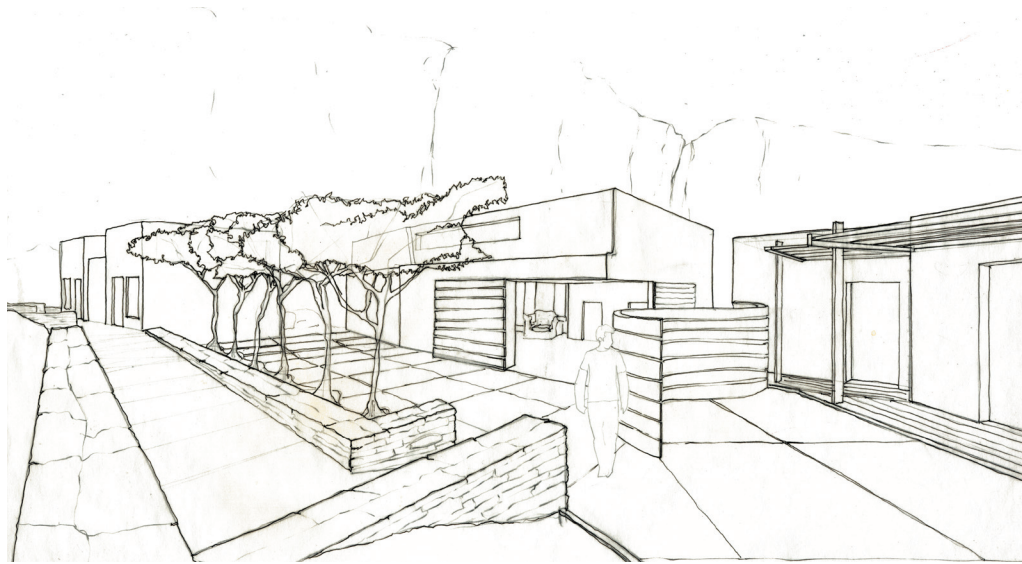
With the addition of the site to the earlier discoveries of the bubble diagrams it became apparent using a study pin model that the unstringing of the larger form was desired. This allowed for further opportunities for the exploration of enclosing outdoor space by using the steep hillside as an integral part of the enclosure design. The site starts to directly inform the shaping of space with the movement of the contours and the steepness of the hill side.



further development of place

Creating plan diagrams made it possible to understand how people would move through and within the space, where and what type of interactions would happen, and how the landscape would work to enclose the unit. Sketches and perspectives worked to get inside the spaces and begin to understand the quality of space that was being captured.

A pallet was also discovered during this process informing the end representation of the final building. Hand renderings, neutral colors and sketch diagrams became the language of the project.



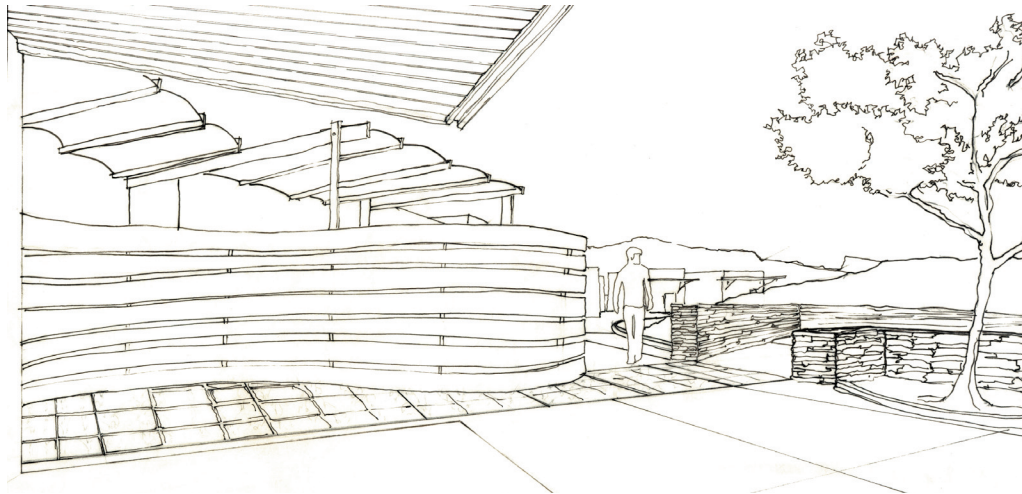
preliminary courtyard design

This early perspective shows the development of space and the possible treatment to things such as roof planes, wall details, and window openings. Here, a curved cedar slat wall is used to divide the counselors offices from the main living space. The design intent with the use of a curved element in a area dominated with rectilinear forms was intended to give importance to the space and pull it out as "special" from the rest of the courtyard spaces. In the end it was eliminated from the design and replaced with an extension of the rammed earth wall.

This illustration also shows the addition of overhead planes. However, that addition was eventually eliminated due to the orientation of the building.

Some elements in the schematic design were successful. As a result, the stacked rock walls, the trees, and the large opening into the main living space remained in the final design.

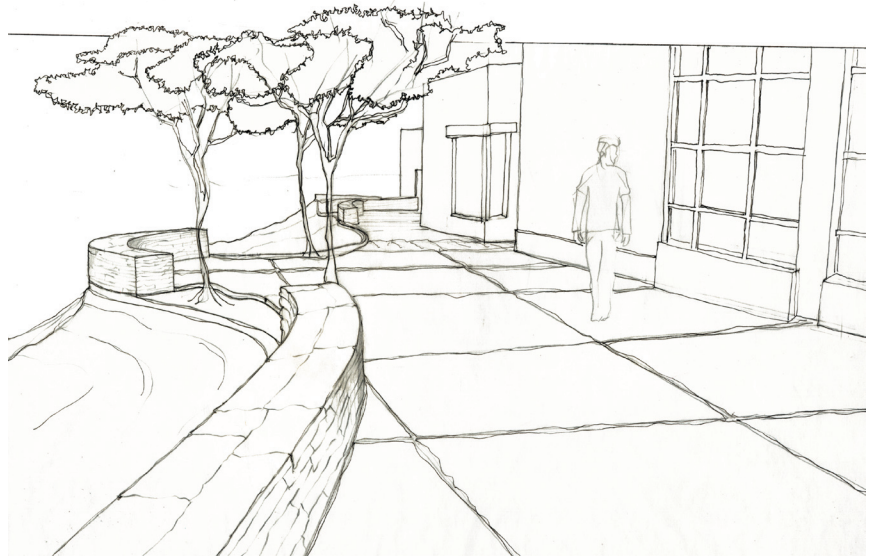
preliminary courtyard design



The interest here is the point of view the perspective is drawn from. The viewer is standing just inside the main living space and has the opportunity to survey the outside from the safety of within. It shows the importance of a screening wall of some kind to maintain the privacy of the patients going into the counselors offices and demonstrates the overall openness of the place as a whole. As with the first drawing, roof planes were incorporated experimentally, but eventually discarded. Here you can also see the change in paving from one element to the next and the important role it plays in defining space.

preliminary pathway design

In this drawing the curve of the pathway, the treatment of the paving, and the mullion and fenestration design was explored. The curve in the pathway was designed to allow for a meandering, contemplative experience rich with the opportunity to pause and chat with passers by or to sit in the shade of the trees. This perspective provided a look at the success or failure of the path as a space that could accomplish more than just movement from one place to another. It was a test to see if the space truly provided a place to sit and meet with the care givers of the hospital, other patients or simply to sit and meditate. With a few adjustments to the width of the path and the treatment of the ground plane and the space turned into a successful space which became a attribute to the facility.

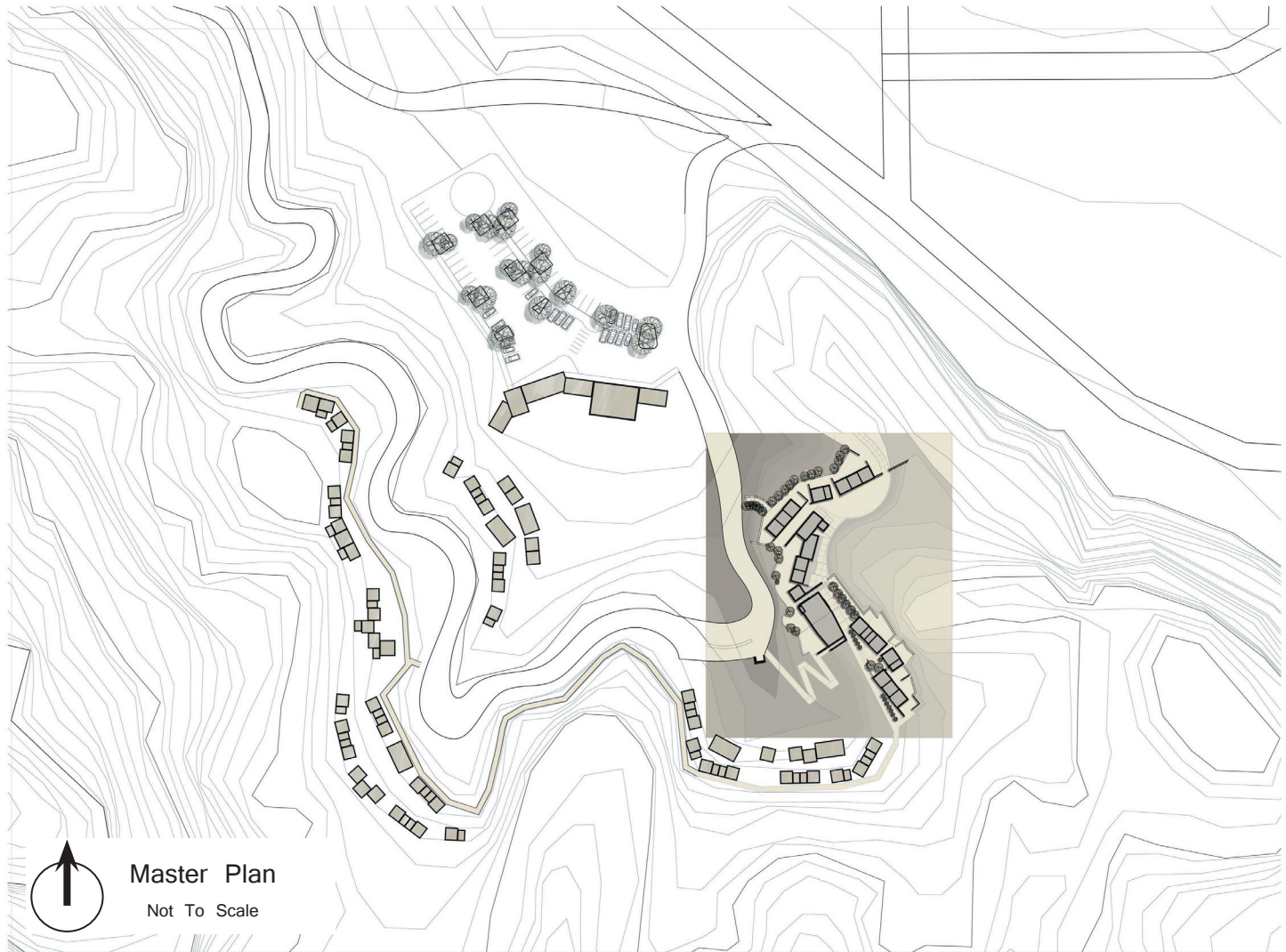


preliminary stair design

Though this stair did not change a great deal from this rendition to the final rendition, it explored a new element that had not been fully shown yet in the other preliminary drawings, the relationship the buildings have to the landscape and particularly the cliffs that stand over the site. This drawing gave context to the buildings for the first time and showed how the buildings were directly influenced by the cliffs.

This drawing also informed the design by showing that there was not yet the desired level of complexity for the clients that are housed in these units. These patients are the most advanced in terms of their development toward interaction with the outside world but it was clear that it was not yet clear in the architecture of the buildings.







plan: unit 4

Unit 4 was selected as the unit to further develop because of the population of clients who will live here. The clients living in units 3 and 4 are the least restricted individuals in terms of their treatment and have progressed the farthest toward their treatment goals. Though the security in this unit is light, other units would have a higher level of security while the materials and design techniques would remain the same. This unit becomes the model for the rest with modification to the other units where security and site dictate.

First and foremost the facility is designed to enhance the use of outdoor space by connecting the people who live here with the natural environment physically and mentally. The balance and order of the natural cycle of life will

return to their conscious understanding through this technique. Here boundaries are defined by the steep hillside, trees and low stone walls, not fences and high walls. In this way the individuals know the limits of their world naturally rather than having them imposed artificially.

The unit is designed with one foot thick rammed earth walls, contrasted by cedar slatted glass walls in the individual living area. This contrast between heavy and light elements is designed to foster an understanding of the elemental differences in structure and work to enlighten the clients ability to reason. The design speaks about simplicity and complexity simultaneously in the same way that nature does. As these associations become apparent to the clients their ability to reason will also become enhanced. This very subliminal shift in their surroundings would work effectively to quietly change the way the client perceives the world. Rhythm, order and reason become the dominate elements surrounding the client, penetrating their being and becoming a part of

them helping to guide them to the next step in their life.

The building is divided into three distinct sections, the "Public Area" consisting of waiting area, nurses station, clinic, and counselors offices, the "Main Living Area" including unit kitchen, bathroom and exterior court yards, and the "Personal Living Areas", including bedroom, bath room and exterior courtyard.

Public Area: Guests, clients, and staff enter the unit through the waiting area to check in and register at the nurses station, guests waiting to see clients, or doctors will wait here for assistance. The nurses station contains a locked medication room and file storage for the clients in the unit. There is also have a kitchenette for breaks and private time during staff shifts. People waiting to see doctors or clients then exit the waiting room to the east moving south west down the board walk to the offices beyond. The extruded wall coming off the last counselors office is designed to provide

separation and privacy for those accessing the offices, without fully dividing the access to both spaces.

Main Living Area: For those who live in the facility this will be the area where they spend most of their time, mental health clinicians will be on staff here to secure the clients and provide access to the unit kitchen and other activities. This area will be staffed 24 hours a day, and the clients will come here first for any assistance. The outdoor court yard should be considered as important of a space as the indoor portion and will also be staffed. The unit kitchen is there to provide storage for clients cigarettes, snack items and any food items served to those who can not or should not use the cafeteria in the lower facility. It is also the secure area for mechanical storage and utility area for trash and laundry to leave the unit.

Personal Living Area: These bedroom units are designed to house two individuals in each room. Though most of the clients time will

be spent in the main living area it is important to provide personalized living space to encourage the feeling of “dwelling” in an individual. Clients are encouraged to bring personal effects into their bedrooms and are allowed to hang art, and paint the closet wall the color of their choice. These seemingly small design features work well to individualize space and give a feeling of home. In this unit there are two distinct types of personal living space. The first type is on the south end of the facility and the other on the north end. Those who live on the south end are tucked into the hillside providing natural protection from the elements. This was designed was to provide a natural sense of security in much the same way that a camper might choose to tuck her tent into an protected area of trees or rocks. In many cases, even with the most developed clients, the sense of paranoia can be overpowering, in this way the architecture works to dispel that paranoia and protect the client in a natural way. On the north side of the facility there are vast expansive views that give a feeling of openness and freedom. This difference is for

those clients who are able to incorporate another level for complexity into their treatment plan. Here they will gain connection to the town of Moab, they will see the lights come on at night and will see the cars drive on the street below. This increased complexity provides the next step toward understanding the intricacies of the “well” world.

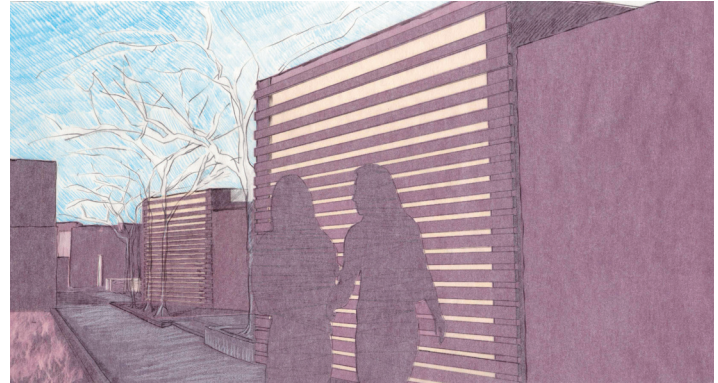


Fig 8.4 Court Yard Perspective

final renderings

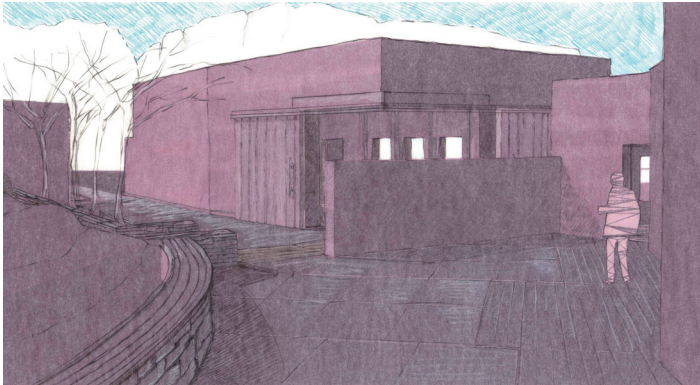


Fig 8.3 Court Yard Perspective

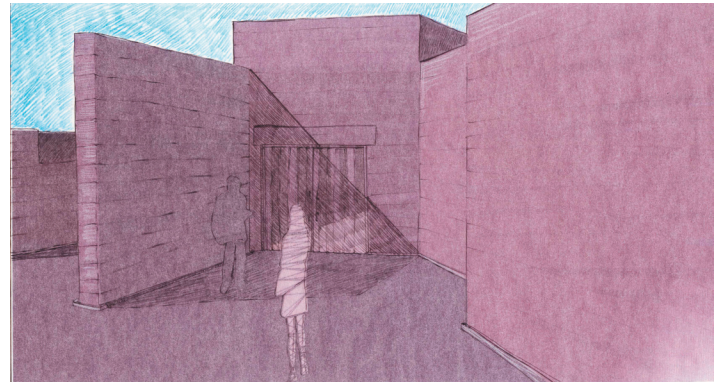


Fig 8.5 Entry Perspective



Fig 8.6 Waiting Area Perspective

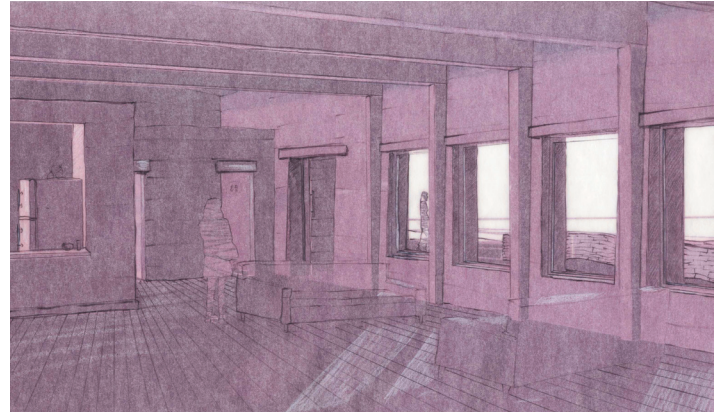


Fig 8.8 Main Living Area Interior Perspective

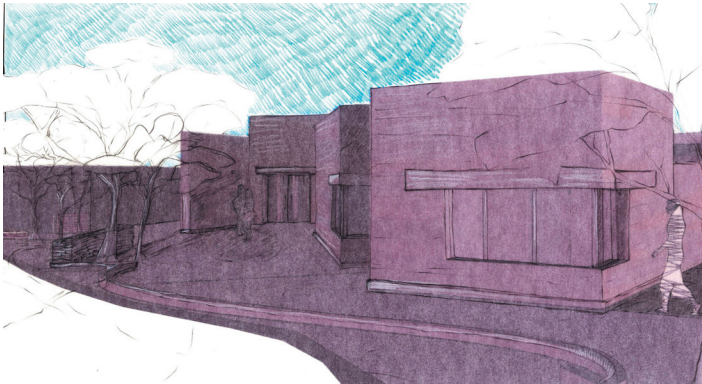


Fig 8.7 Pathway Perspective

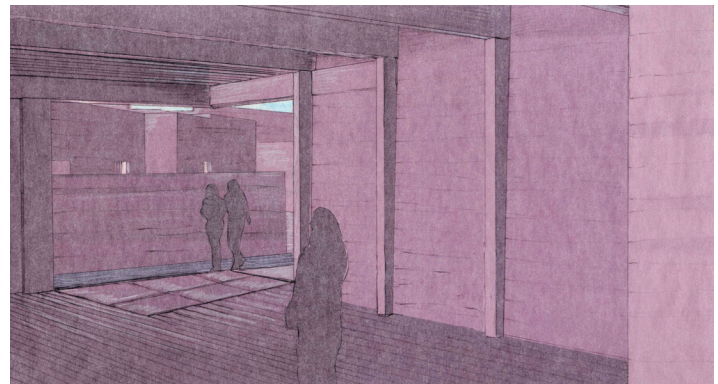


Fig 8.9 Main Living Area Interior Perspective

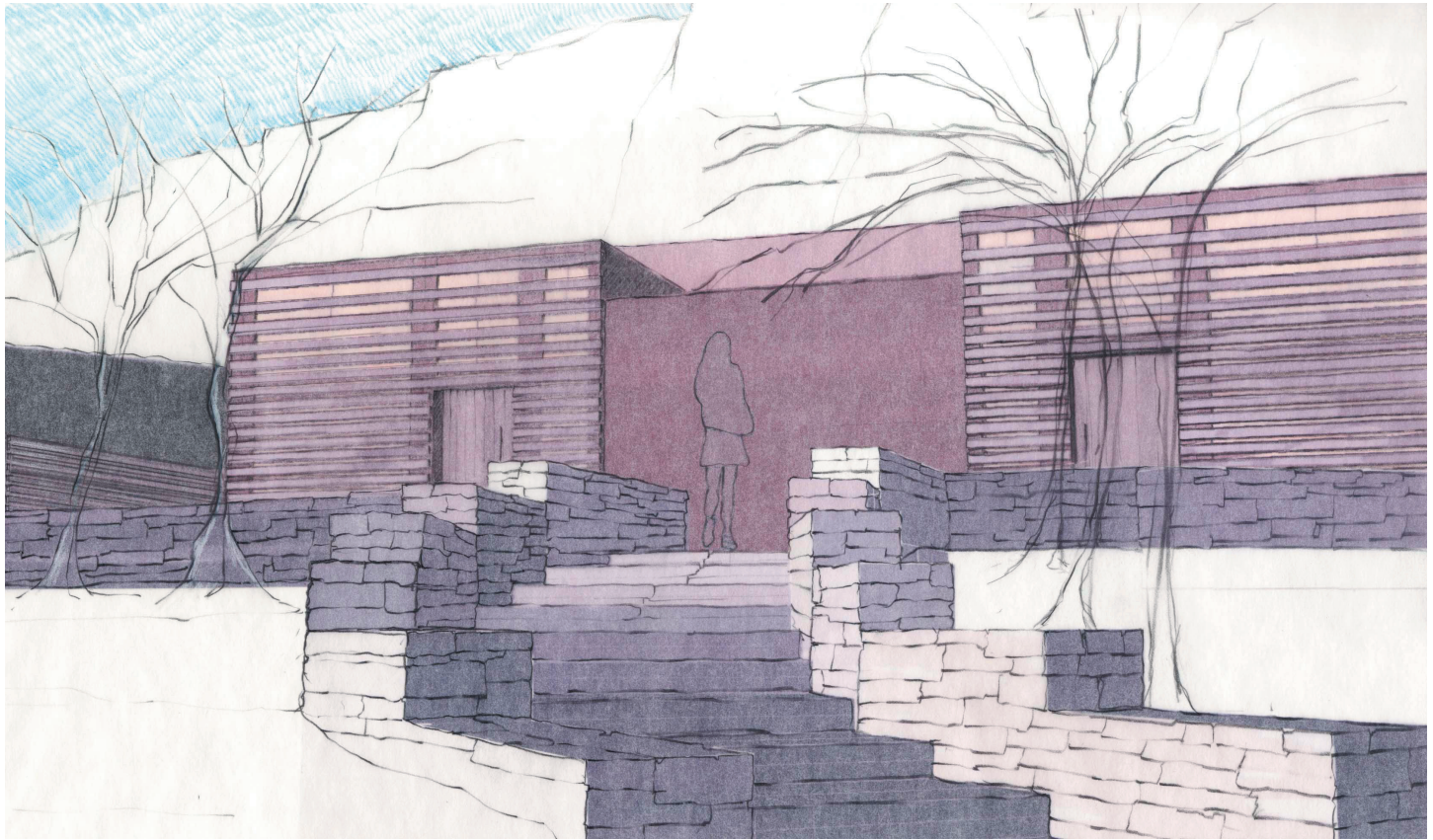
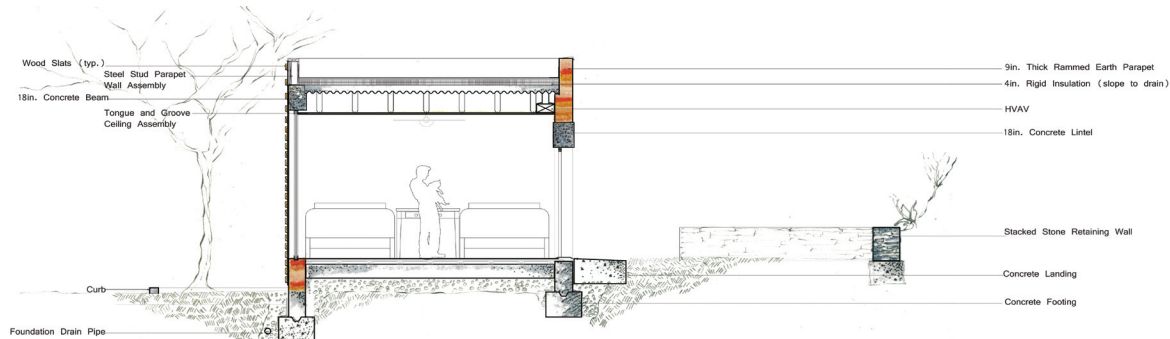
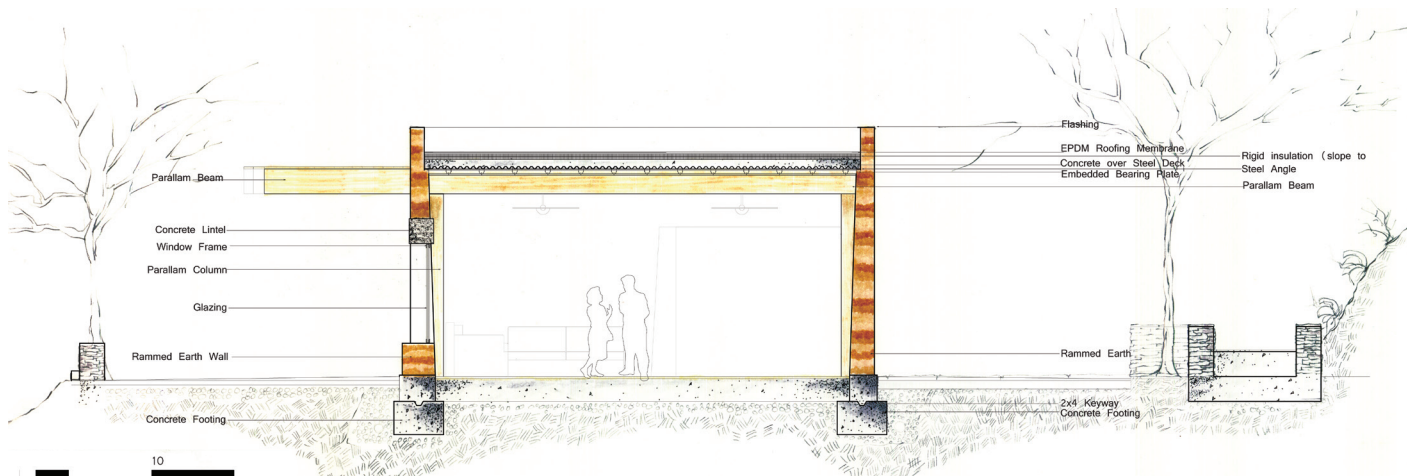


Fig 8.10 Residents Perspective



10
1 2 5
Wall Section 2



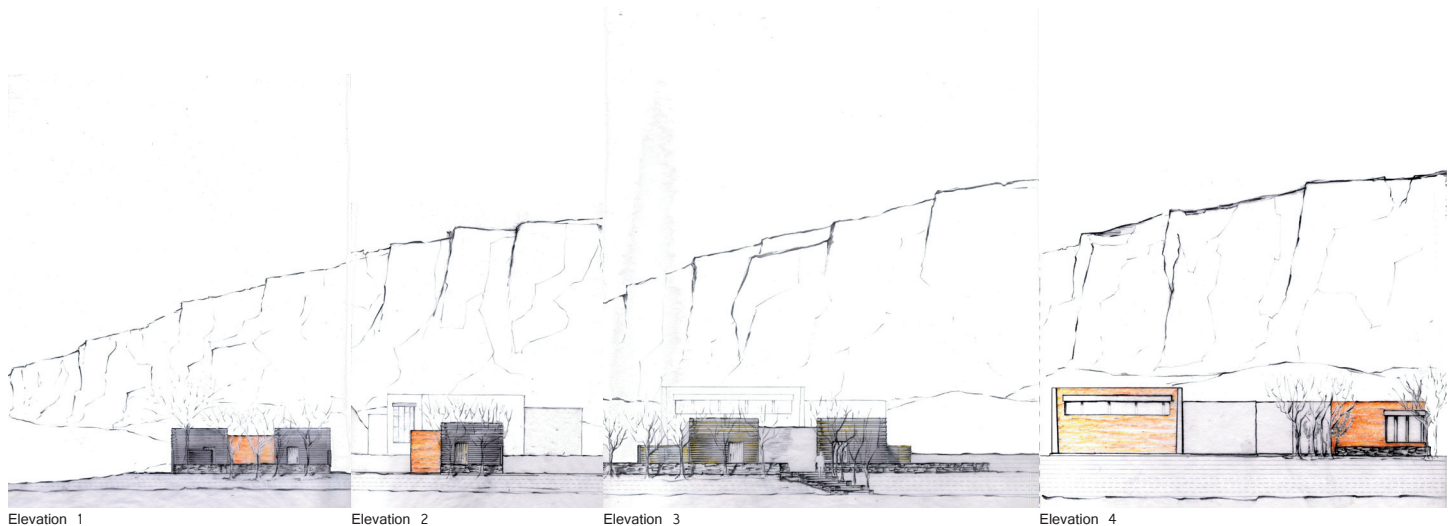
10
1 2 5
Wall Section 1

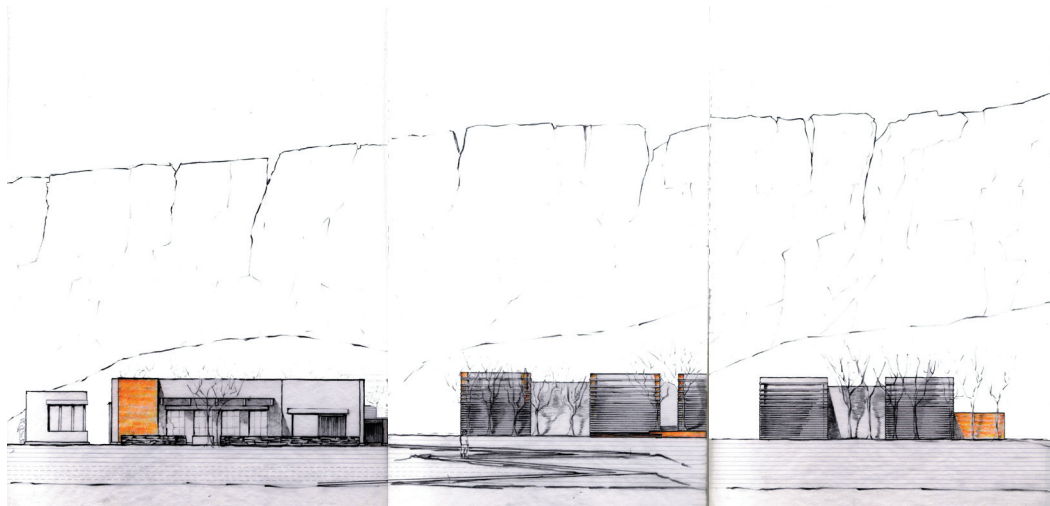
types and treatments.

unwrapped elevation

The elevations in the next sections show the use of different types of materials in different sections of the building. These next images are front elevations of each of the buildings as they turn along the site. See the plan to find the location of each elevation. Finally there are two wall sections, indicating typical construction

The presentation of these images are meant to be schematic and to give only a suggestion of the way the place would appear. It is my hope that by presenting this information the overall feeling of the place is understood not the ridged and exact prescription of the facility.





Elevation 5

Elevation 6

Elevation 7

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Figure 1.1, Bosch, "Ship of Fools," 1490-1500. <<http://www.wga.hu/art/b/bosch/5panels/11shipfo.jpg>>

Figure 1.2, Poster, www.antipsychiatry.org/peopletoo.jpg

Figure 2.1, "The Interior of Bedlam," from A Rake's Progress by William Hogarth, 1763. McCormick Library, Northwestern University <<http://www.sos.mo.gov/archives/exhibits/quest/images/bedlam.jpg>>

Figure 7.1 - Room in Reversible Destiny Lofts
<<http://www.reversibledestiny.org/mitaka.php>>

Figure 7.2 - Building in Village of the Dancing Fish <<http://www.bchoarchitects.com/>>

Figure 7.3 - Fort Logan Figure

Figure 7.4 - Computer Generated Fractal Image
<http://courses.nus.edu.sg/course/elljwp/fractals_files/image004.gif>