The Gress Project: a threshold thesis

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The Gress Project: A threshold thesis

by

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This is to certify that the master's thesis of

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Signatures have been redacted for privacy
This thesis is dedicated to M, L, & J
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ABSTRACT

*Threshold* is a fundamental concept in architecture, denoting inside, outside, and the transition between. It therefore implies movement. The concept of threshold is used in this work to develop a mental health recovery center - a place of healing and reactivation. The spectrum of mental health states one experiences throughout the healing process is acknowledged and considered holistically. The movement between states is studied in parallel with spatial issues of threshold: pause, movement, transition, and encounter. The proposed architecture is generated through an understanding of dynamic psychological and emotional conditions. I propose this empathetic approach to architecture and, in particular, to the design of a healing environment in tandem with a reconsideration of contemporary mental health treatment; threshold is central to both.

The document provides background information about mental health, various attempts at innovation, systems of care giving, and the site of the proposed interventions. The architectural design is described in detail based upon the aforementioned concept of threshold.
CHAPTER 1. INTRODUCTION
THRESHOLD

1. A piece of wood or stone placed beneath a door; a doorsill. 2. An entrance or a doorway. 3. The place or point of beginning; the outset. 4. A point separating conditions that will produce a given effect from conditions of a higher or lower degree that will not produce the effect, as the intensity below which a stimulus is of sufficient strength to produce sensation or elicit a response...\(^1\)

The term threshold describes a “point” between two conditions; it is interstitial. Threshold, as used in this thesis, is always more than an autonomous object such as a single piece of wood or stone beneath a door. It involves a profound comprehension of the conditions it lies between. The definition of the “point” and the degree to which it separates these conditions will be explored in the following chapters.

Threshold can refer to both a concrete spatial and material construct and an abstract moment. In this thesis, the architectural aspects of thresholds are explored in parallel with relationships of physical, mental, and emotional thresholds.

Threshold demarcates a change in passage and henceforth involves movement. A consideration of threshold requires consideration of how we move from one state or place to another through both time and space. Threshold is the moment through which we transition; the moment through which we pass “from one form, state, style, or place to another.”\(^2\)

Movement as such is embedded within the etymology of threshold. Scholars hypothesize that the Germanic word threskan, refers to “thresh” and “tread”.\(^3\) “This association with the feet is probably retained in Old English therscold or threscold (Modern English threshold), “sill of a door (over which one treads).”\(^4\)

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\(^4\) Ibid.
MOVEMENT THROUGH THRESHOLDS

Moving through thresholds involves vulnerability, uncertainty, hesitancy, ambiguity, and encounter, all of which are pertinent to how one experiences space. Vulnerability results as one leaves a known comfort and moves toward something new; uncertainty occurs as a result of not knowing what lies on the other side; hesitancy occurs when one is afraid of what is on the other side. Ambiguity occurs from the lack of ability to define one’s position.

The process of moving through thresholds is prone to heightened levels of emotion and therefore the qualities of encounter - what one meets along the way - need to be considered. Like threshold, encounter involves the state of being between. Encounter occurs between two or more things: it is not just between people, but is also between people and objects, places, spaces and buildings. The qualities of encounter - its temporality, intensity, and framing - involve all of the senses, not just vision.

But how many daydreams we should have to analyze under the simple heading of Doors! For the door is an entire cosmos of the Half-open. In fact, it is one of its primal images, the very origin of a daydream that accommodates desires and temptations: the temptation to open up the ultimate depths of being, and the desire to conquer all reticent beings. The door schematizes two strong possibilities, which sharply classify two types of daydream. At times it is closed, bolted, padlocked. At others it is open, that is to say, wide open. But then come the hours of greater imagining sensibility. On May nights, when so many doors are closed, there is one that is just barely ajar. We have only to give it a very slight push! The hinges have been well-oiled, and our fate becomes visible.

And how many doors were doors of hesitation! In La Romance des Retour, by Jean Pellerin, this tender, delicate poet wrote: La porte me flaire, elle hesite. (The door scents me, it hesitates).5

As you move from inside to outside by passing through a door, you become increasingly aware of the conditions outside. As you approach the threshold you might feel the cold winter draft leaking past the weatherstripping, or you might see, through a window in the wall, that it is snowing outside.

Are you ready to expose yourself to these conditions? Do you have the necessary garments to protect your body from the cold? Perhaps you still need time to put your shoes on, or after seeing through the window that the snow has really piled up out there, you might

change your mind and decide to put boots on instead. What if there was no window in which to judge the conditions? You might instead open the door momentarily (let’s hope that there is a storm door to prevent the snow from gusting in- a second door to look through that provides a better view of what lies beyond). Then, after this further understanding, you would be more informed to make decisions about what you need to wear to go through the threshold fully – to completely put yourself on the other side. You open the door momentarily to feel the weather more completely, then shut it and reevaluate the situation before proceeding through fully.

This scenario can be applied to other situations besides weather, but it does demonstrate the uncertainty, ambiguity, hesitancy, and vulnerability that many of us have experienced along with the elements that affect these emotions, namely time, space, and degrees of exposure. Christian Norberg-Schulz recognizes the significance of the door’s ambiguity as “one of the important symbolic elements of architecture”: 6

The door can close off or open up, it can unite and separate. Psychologically it is always open and closed at the same time although one aspect is dominating, as any door may be opened. The opening is the element that makes the place become alive, because the basis of any life is interaction with an environment. 7

Movement through thresholds thus involves:

1. Time: How quickly do we move between ‘x’ and ‘y’—what is the pacing? Are there moments of rest as we move - pauses - commas within the progression? When are we ready to encounter something unfamiliar - now, later or never?

2. Space: How do spaces affect encounter, from the macro to the micro scale? To what extent is encounter modulated by spatial qualities and on what scale? What is chosen to be revealed or hidden and to what degree?

3. Senses: Through which of our senses do we encounter something? For example: We might look through our window to see the weather conditions outside. We might smell the bread baking from a restaurant blocks away before seeing its entryway. We might hear the jingle of an ice cream truck down the street before ever leaving our home. We might

7 Ibid.
touch the pool with our toe before jumping in. We might sip someone else’s’ drink before ordering our own.

Are you ready to encounter something unknown? Thresholds are the moments in time and space where this question of encounter comes up. And then, what degree of unfamiliarity are you ready to face? Perhaps you need more time to understand the situation like the unexpected pile of snow outside of the front door. How can thresholds allow one to “test the water” before “jumping in”? What are the elements that contribute to exposure and protection when moving through thresholds and how do these elements appropriately affect encounter? How does each modulate and alter our degree of protection and exposure?

A THRESHOLD OF CARE

The idea of threshold is applicable to the issues of mental health and especially to the process of recovery. The process of recovery is in itself a tremendous threshold. Moving between the intensity of an unstable mindset all the way to a stable mindset involves a tremendous transition through time, emotional states, and a spectrum of an individual’s capabilities.

The terrors of suffering, sickness, and death, of losing ourselves and losing the world, are the most elemental and intense we know; and so too are our dreams of recovery and rebirth, of being wonderfully restored to ourselves and the world.

As one passes through these emotional states, the continuum of health care should support the individual by offering corresponding levels of care. This usually doesn’t happen within the current system, which takes a piecemeal approach (as described in Chapter 5).

The continuum of health care is viewed holistically, identifying the current programs that are in the continuum, noticing gaps between them, and honing in on the most pertinent gap that needs to be filled. This filling-in-between is the origination of the Gress Project (and is further explained below). It is a threshold that implements a new program of care in

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the existing system. The Gress Project fills in gaps on multiple levels, but always with a holistic understanding of the people involved.

Man cannot walk by himself, yet he may walk perfectly if there is someone with him...not necessarily touching him, for visual touch is enough.9

A TRIPARTITE OF THRESHOLD ISSUES

Threshold is addressed simultaneously through social, design and programmatic issues, all of which impact one another. Social Threshold concerns emotional issues, degrees of independence, identity, and isolation. Programmatic Threshold concerns the type of program and its position relative to other programs. Design Threshold concerns speed, pacing, temporality, and the articulation of specific moments in space.

A THEORETICAL INVESTIGATION OF THRESHOLD: THE GRESS PROJECT

The aforementioned issues of threshold are explored through the Gress Project, which entails the following: Threshold is studied programmatically at a mental health recovery center, titled the Gress Center, and its associated Community Programs. The thresholds between the two, which constitute the entry and exit areas of the Gress Center, are studied in further design detail. These elongated thresholds occur at the Gress Periphery and are titled Ingress and Egress, respectively. (The choice of the term Gress is explained in Chapter 2).

The Gress Center is the private center point from which layers of threshold stem, each layer progressively increases its degree of intensity of exposure toward the public realm. The secondary layer is the Gress Periphery (which is comprised of Ingress and Egress) and the tertiary layer comprises the Community Programs. When speaking of all of these as a whole, they will hereafter be collectively referred to as the Gress Project.

9 Ibid, 281.
We use the metaphor of a double spiral to describe the character of the Gress Project. Ingress works centripetally, coiling itself into the protective sanctuary of the Gress Center. From the point of Egress, the Gress Center expands centrifugally into the public realm with its Community Programs. These relationships are diagrammed in Figure 2.

Figure 2. Gress Project Relationships within the spiral metaphor: Gress Center, Ingress (I) & Egress (E): (Gress Periphery), and Community Programs (CP) relative to the surrounding public realm.

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10 All figures and images are by the author unless otherwise denoted.
The Gress Center also has thresholds within itself. Its various Levels of Care (LOC) address individuals at different stages in the recovery process and link into the broader thresholds as shown in Figure 3. This is diagrammed relative to an individual’s level of dependence on care, which is high at Ingress (on the left) and low at Egress (on the right).

![Diagram](image)

*Figure 3. Gress Project in the Recovery Process: Various LOCs within Gress Center (GC) - Gress Periphery: Ingress (I) & Egress (E) – Community Programs (CP) amidst public space (P)*

The process of recovery is holistically considered and results in an innovative way of approaching the architecture, which will reveal threshold at multiple scales, from the large scale of the city to the detail of a handrail. Furthermore, social, programmatic, and design issues are addressed simultaneously.

**Socially**

The concept of threshold pertains to encounters between humans. These interactions are addressed in space and time through architectural programming and in more detail through architectural design. The places within the Gress Project where the role types generally encounter one another are shown in Figure 4. These encounters are modulated as appropriate to the various people involved including:

- the individual working through the process of recovery,
- the variety of staff caring for the individual,
- the friends and family supporting the individual and
- the general public.
Socially, thresholds are addressed between:
- Different role types (individual, staff, visitors, and the general public)
- Public and private life
  (those “inside” of the Gress Center and those “outside” of the Gress Center)
- Emotional states
- Protection and exposure, which works both ways
- Individuals in different states of recovery
  (which physically occurs between care levels within the Gress Center)

Programmatically

In this thesis, the current mental health care system is critically studied and a theoretical modification is proposed. A gap between two existing health care types has been recognized and will be discussed in Chapter 5. The Gress Project is a threshold that intends to fill in this gap (as discussed in Chapter 7).
Through Design

In the Gress Project, the significance of thresholds within the recovery process is recognized and these moments as they occur in space are articulated. Mental and emotional transition informs the architectural design, which is one of many significant factors contributing to the quality of health care. The Gress Center’s two most critical thresholds, entry and exit, are studied in the greatest design detail, because these are the places that are the most emotionally charged and thus where the idea of crossing between is the most important.

The theoretical investigation occurs at a site in Minneapolis, Minnesota; the conditions of which are further explained in Chapter 8.

SUMMARY OF THRESHOLDS WITHIN THE GRESS PROJECT

The Gress Project is a series of thresholds that address transition, (moving between places/states) on multiple scales, from the thorough understanding of Minneapolis’ cityscape to the detail of a handrail. Thresholds are examined relative to social, programmatic, and design issues.

These thresholds occur:
- between people
- between built environments
- between care levels.
- between emotional needs and desires
- between needs of seclusion and needs of inclusion.

The Gress Project is a threshold between and overlaps portions of the existing care systems of hospital (H) and Transitional Living Programs (TLPs) extending into Autonomous Living (AL). The Gress Project consists of three spiraling layers: the Gress Center (which comprises thresholds of care in an inner core), the Gress Periphery (which comprises Ingress and Egress, thresholds between private and public space), and Community Programs (an edge where Gress becomes city).
Figure 5. The Gress Project relative to the existing care systems

Ingress (I) and Egress (E) comprise the Gress Periphery. Their architectural program and design modulates between the protected core spaces of the Gress Center (GC) and the public city (P). Ingress carefully extends into the public realm offering a protective entry into the Gress Center. Egress extends into public space (P) and links into Community Programs (CP).

Figure 6. Ingress and Egress thresholds between private sanctuary and public activity

The Gress Project’s Community Programs (CP) are thresholds of encounter between the recovering individual and the public citizenry. These programs comprise a series of social thresholds that have various degrees and means of encounter between the public and private.
Contextually, the Gress Project site is a threshold between the central city and a river-park edge and the differing activities they offer. To this extent, the Gress Project site is also a threshold between varying speeds of life. The Gress Center slows things down (as care and recovery need to be considered slowly). But Egress and the Community Programs are thresholds that gradually adjust to the speed of the surrounding context, which include various horizontal movement: the pacing of car, bus and light rail versus the pacing of walking or riding a bike. Pacing between types of vertical movement is also acknowledge: skyscraper elevators versus the slow raising and lowering of the lock and dam.
CHAPTER 2. GRESS CENTER IDEOLOGY
THE STEP

My aim is not to make a system, or to see patients as systems, but to picture a world, a variety of worlds – the landscapes of being in which these patients reside. And the picturing of worlds requires not as static and systematic formulation, but an active exploration of images and views, a continual jumping-about and imaginative movement.\(^{11}\)

The process of recovery is taken one day at a time; this requires that each day is taken one step at a time. The delicacy of the situation (one’s mental state/perception) requires this, as each and every step is about relative emotions, encounters, perceptions - all of which correlate to issues of threshold.

The Gress Project’s name stems from the root word of -gress to which we may add many prefixes. Etymologically, -gress and the past participle gressus relate to walking and the Latin gradi: “to step, walk, go”.\(^{12}\) Therefore, it illustrates the stepping process of convalescence - implying action and movement.

For those in a state of mental illness, and for all of us on the “path of life,” stepping is not simply going forward. We might sidestep, step away, step backwards, step in, step out, step with, etcetera (transgress, digress, regress, ingress, egress, congress, etcetera).

In Gress ideology we thus acknowledge this movement is not straightforward. It is not always logical or most efficient, but it is stepping nonetheless; it concerns stepping between or through different states of being. The -gress words describe movement through thresholds relative to space and time.

Through its different types of stepping, the Gress Project proclaims itself as a process, something that is not product driven. While the stepping process seeks satisfying results, it realizes that there is not a final outcome. There is no finished product in mental health, but an ongoing and active process.

The ideology of the step also suggests human scale and attention to detail as well as speed. We are always in motion, but sometimes ever so slightly. Change may occur dramatically, as in a psychotic break, where a “snap” almost instantaneously removes an


individual from a collective sense of reality. Change may also occur slowly, as in the process of convalescence, where the smallest steps may in fact produce the most critical results. This is where the Gress Project “begins”.

Gress is a verb, an act. The Finnish architect Juhani Pallasmaa writes:

Architecture is usually understood as a visual syntax, but it can also be conceived through a sequence of human situations and encounters. Authentic architectural experiences derive from real or ideated bodily confrontations rather than visually observed entities. Authentic architectural experiences have more the essence of a verb than a noun. The visual image of a door is not an architectural image, for instance, whereas entering and exiting through a door are architectural experiences. Similarly, the window frame is not an architectural unit, whereas looking out through the window or daylight coming through it, are authentic architectural encounters.13

**GRESS LANGUAGE**

The Gress Project spans the present and future health care systems. The vocabulary used within this document to invent and describe also spans existing and new terminology. All of the -gress words address mental health processes – moving forward, backward, sideways, but always moving – and carry with them the suggestion that these movements are not strictly linear. The titling of places and programs within the Gress Project – “Employment Cafe Prelusion” rather than simply “door,” for instance – seeks to make evident and highlight the hesitation and intensity of the experience.

Language and identity are irrefutably intertwined. There is a long history of labeling the mentally ill and their environments; today, too, diagnosis labels tend to “stick,” pursuing one through health insurance and employment possibilities as well as in more subtle ways.

To suffer a psychological disturbance is to be stigmatized and stigma is like tar, very sticky and hard to wash off. Not only does it affect an individual, but also his neighbors and his family. It influences expectations on three levels: public, professional and patient.14

The -gress words (verbs) intend to convey the fluid and changing nature of mental health states. Gress language challenges stasis.

CHOICES

Health, after all, is simply an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions. In *Homo sapiens*, “healthy” is an adjective that qualifies ethical and political actions. In part at least, the health of a population depends on the way in which political actions condition the milieu and create those circumstances that favor self-reliance, autonomy, and dignity for all, particularly the weaker. In consequence, health levels will be at their optimum when the environment brings out autonomous personal, responsible coping ability.

The words “environment” and “milieu” as used by Illich can be extended to include the literal context in which care occurs. In the Gress Project, the design of the zone called Egress in particular seeks to empower the individual. Egress affords the individual with opportunities to step (both literally and psychologically) into places and situations that involve contact with the public. Recovery involves reactivation – social involvement, a sense of participation in society – and Egress is designed to promote this by offering choices. Not everyone wants to read a book, but one might want to step out onto a balcony, look out a window, or paint.

Egress offers these and other possibilities through its various programs, which can be engaged according to one’s mood and level of agency. Bookshelves throughout Egress invite one to read, while their arrangement defines niches within the larger space for this or other individual activities such as writing. The Reference Point is a staffed information checkpoint that addresses residents’ needs as they progress through Egress. The Versatile Studios provide ample open space for a variety of group arts and exercise such as dance and yoga. It can also be subdivided with folding screens for more privacy if desired. Activities such as painting, drawing, and sculpture are accommodated here. The Visitor Access provides space for people to meet in a semi-private environment. The Turning Point includes places for refreshment and reflection. The Park Balcony overlooks the park, engaging outdoor activity without directly coming into contact with it. The Employment Cafe provides a sociable reference point for people to seek out work and volunteer opportunities. The Park Terrace mediates between the park and the Cafe, extending the café atmosphere outdoors.

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Within each of the Egress programs (Visitor Access, Niches, Versatile Studios, Turning Point, Employment Café, and Park Terraces, and others explained in Chapter 11) there is a varying degree of exposure or contact with others and with the public. For example, the Versatile Studios have an upper level that provides the possibility of direct visual connection between public and private space. Both the resident and the public can alter the transparency of the wall between these two spaces.

... Then, on the surface of being, in that region where being wants to be both visible and hidden, the movements of opening and closing are so numerous, so frequently inverted, and so charged with hesitation, that we could conclude on the following formula: man is half-open being.  

Within the thresholds that constitute the Gress Project there are sub-thresholds that allow one to test the waters of reactivation through different programs and through different spatial relationships and adjacencies. This occurs in both plan and section and empathetically relates to the range of emotions (hesitation, uncertainty, ambiguity, etc.) associated with crossing thresholds.

**WHOLE INDIVIDUAL/WHOLE CARE**

There is nothing alive which is not individual: our health is ours. Our diseases are ours; our reactions are ours — no less than our minds or our faces. Our health, diseases, and reactions cannot be understood _invitro_, in themselves; they can only be understood with reference to _us_. As expressions of our nature, our living, our being (da-sein) in the world.  

_Awakenings_, by Oliver Sacks, is a series of clinical narratives about individuals suffering from Parkinsonian symptoms under his care in the 1960s. Sacks’ approach to the medical case study — the writing of the individual’s story — is a wonderful methodological parallel to the architectural design process of the thesis. Throughout this process, I sought to move with the individual, envisioning their capabilities, needs and desires one step at a time. The Gress Project empathetically pays attention to the story of the individual, understanding

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that the process of recovery is but one part of the whole person, who has had and will have a life beyond this process, beyond the walls of the Gress Center. These walls do not separate but connect to and from where they have been and where they are going.

Considering the person's story as a means of understanding their condition is not a new technique, however it all but vanished as medical care became increasingly technological and professionalized in the 20th century. As Oliver Sacks describes:

The elaborate case-history, the 'romantic' style, with its endeavor to present a whole life, the repercussions of a disease, in all of its richness, had fallen very much out of favour by the middle of the century... But as the seventies progressed, this antipathy to case history diminished- it even became possible (though difficult) to publish case-histories in the medical literature. With this thawing of atmosphere, there was a renewed sense that complex neural and psychic functions (and their disorders) required detailed and non-reductive narratives for their explication and understanding. 18

Sacks' narrative approach is analogous to the architecture of the Gress Project. They are both person-centered approaches to care that acknowledge the importance of understanding the individual's perspective. Viewing through this lens (that of the person going through the process of recovery) may permit us to see problems and possibilities not otherwise visible when looking at the current situation in mental health care from an administrative viewpoint.

Hospitals organized like factories turn the patient into the object of impersonal mechanical treatment devoid of any individuality. This happens inevitably if the starting point in planning is to rationalize treatment. It is typical of our culture with its adulation of strength and performance that more attention is paid to the characteristics of the work environment than to the characteristics of the curing environment from the point of view of the patient and his cure. 19

Understanding and applying -gress ideas to the health system results in an innovation in care. It results in care-full architecture. Architecture does not replace care but supports care along w/ many other factors such as the quality of staff, social attitudes, insurance,

18 Ibid, xxxviii.
health care funding, etcetera. Therefore, architecture is not an end all solution to the problems of mental illness, but it is one of many significant contributors to the quality of care.

Alvar Aalto’s Paimio Sanatorium is a magnificent example of empathetic design and is elaborated upon in Chapter 5. Juhani Pallasmaa explains that Aalto’s approach is partially due to his hospitalization while designing the Sanatorium.

On the basis of his hospital experience, Aalto concluded that the subject of the design should always be “man at his weakest”. In thinking of man at his weakest the designer should consider even the most insignificant details of the building in order to help in orientation, movement and the use of spaces, as well as in creating a feeling of security, comfort, meaning and familiarity. 20

**EMPATHETIC APPROACH**

The design of the Gress Project offers contact between the recovering inhabitant and the public passerby, to the mutual benefit of both, while acknowledging the fragility of both. Through such encounter, it attempts to promote empathy rather than alienation between these parties.

The relation of the person to the architecture is also a relationship of empathy and adjusts to the needs and desires of the parties involved. Oliver Sacks speaks of the profound psychic interaction between institution and person, in this case, patients who suffer a host of disabling symptoms, here referred to as Parkinsonism and neurosis: 21

We have seen that Parkinsonism and neurosis are innately coercive, and share a similar coercive structure. Rigorous institutions are also coercive, being, in effect, external neuroses. The coercions of institutions call forth and aggravate the coercions of their inmates: thus one may observe, with exemplary clarity, how the coerciveness of Mount Carmel aggravated neurotic and Parkinsonian tendencies in post-encephalitic patients; one may also observe, with equal clarity, how the "good" aspects of Mount Carmel — its sympathy and humanity — reduced neurotic and Parkinsonian symptoms. 22

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20 Ibid.
21 I was introduced to this concept in the following article, to which I am greatly indebted: Karen Bermann, “Love and Space in the Nursing Home,” *Theoretical Medicine* 24(2003):511-523.
“Sympathy and humanity” in the Gress Center are exemplified in the programs, building systems and the design details at Ingress and Egress. For example, the wooden handrail, a sign of support, greets the individual from the very first moment of arrival. It progresses from the exterior parking area, inviting one to proceed into Ingress. At Egress, the outer wall gradually opens itself to public space, first through a window, then a balcony, and finally a terrace. Egress’ Turning Point addresses the subtle shift toward the outside and back again, providing points of reflection and refreshment for this bi-directional change.

Ingress’ staircase (the point of Ascension) provides a more detailed example. It begins as elongated landings that incrementally step up to a mezzanine. The spindles of the stair propel themselves forward with each step, encouraging the handrail upward. The staircase’s granite base adjusts its proportions according to the gradual action of stepping up.

The empathetic design approach to the Gress Project values hapticity, which, by its very nature, pays close attention to how the user intimately experiences space. It is careful and slow rather than unobservant and fast. Juhani Pallasmaa recognizes haptic architecture as an ideology in opposition to the norm – the “architecture of instantaneous imagery”.23

Our culture of control and speed has favored the architecture of the eye, with its instantaneous imagery and distant impact whereas haptic architecture promotes slowness and intimacy, appreciated and comprehended gradually as images of the body and the skin. The architecture of the eye detaches and controls, whereas haptic architecture engages and unites. Tactile sensibility replaces distancing visual imagery by enhanced materiality, nearness and intimacy.24

Tactility plays an important role in the empathetic approach to design. Materials in the Gress Project have been chosen with a consciousness of their language – they may not say the same thing to everyone, but there are relative differences that we can sense. For example, we can feel the roughness of unpolished granite along a wall, or the smoothness of a wooden handrail. We can hear the difference between a stream of water trickling in a stone basin and that of a waterfall cascading down concrete steps. We can smell the difference

24 Ibid.
between vines growing up a trellis at Ingress and plastic flowers stuck into a planter at a conventional waiting room.

**STRONG AND WEAK FORM**

The Gress Project is process driven, not product driven. The goal of both the recovery process and its corresponding architecture is not to get “released” from the Gress Center per se, but to appreciate the complex and ongoing process of mental illness, acknowledging the fact that there may be additional periods of care required after having left the Gress Center.

The Gress Project is attentive to detail, not only at programmatic places of “a” and “b” where we usually define “architecture,” but, more importantly, it concerns how we move through thresholds, between places. The architecture is developed from an appreciation of movement and the state of being between; it is a composition of interrelated events.

Alvar Aalto’s Villa Mairea (Figure 8) serves as a precedent for such episodic architecture, which gains profound meaning when experienced over time. My visit to this 20th century home revealed a unity with variety achieved through architectural systems and materials that altered according to setting and mood. For example, the surrounding Finnish woods extended into the home through moments of entry, sauna link and sun porch. The Finnish architect, Juhani Pallasmaa eloquently elaborates upon the “sequence of architectural parts” that maintain a “fragile formal structure”.

The composition aims at a specific ambience, a receptive emotional state, rather than the authority of form. This architecture obscures the categories of foreground and background, objects and context, and evokes a liberated sense of natural duration. An architecture of courtesy and attention, it invites us to be humble, receptive and patient observers. This philosophy of compliance aspires to fulfill the humane reconciliatory task of the art of architecture.

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25 Ibid, 82.
26 Ibid.
Figure 8. Villa Mairea

Similarly, the architecture of the Gress Project, is not about a strong image or an architecture with a strong form. It seeks to diffuse and express care through a number of empathetic, architectural gestures, breaking them down into a series of integral moments. Juhani Pallasmaa elaborates upon such concepts of architecture through "weak ontology" and "fragile thought" which he notes was first introduced by the Italian philosopher Gianni Vattimo as *Il pensiero debole*: 27

Vattimo’s idea...seems to be interestingly parallel to Goethe’s method of ‘Delicate Empiricism’ (*Zarte Empirie*), an effort ‘to understand a thing’s meaning through prolonged empathetic looking and understanding it grounded in direct experience’. We can speak of a ‘weak’ or ‘fragile’ architecture, or perhaps, more precisely, of an ‘architecture of weak structure and image’, as opposed to an ‘architecture of strong structure and image’. Whereas the latter desires to impress through an outstanding singular image and consistent articulation of form, the architecture of weak image is contextual and responsive. It is concerned with real sensory interaction instead of idealized and conceptual manifestations. This architecture grows and opens up, instead of the reverse process of closing down from the concept to the detail. Because of the negative connotations of the word ‘weak’, we should, perhaps use the noting ‘fragile architecture’ 28


Other examples of “fragile” architecture have influenced the Gress Project including Carlos Scarpa’s Castelvecchio and Dimitris Pikionis’ footpath to the Acropolis in Athens. These are noteworthy examples, because of their process-orientated approach and attention to detail.

Figure 9. Detail of Castelvecchio (photo by Velimir Manjulov)

Figure 10. Footpath to the Acropolis (Photo from the following website: Santiago Varela Botella, “Paseos, recorridos. Movimiento: Walks, Routes, Movement” Via Arquitectura. 2005. http://www.via-arquitectura.net/12/12-138.htm April 11, 2005)

TECHNIQUE OF REPRESENTATION

A series of perspective drawings reveals a sequential progression through Ingress and Egress. The decision to use a perspectival representation technique parallels the Gress ideology of the importance of narrative – the user’s perspective is valued. The perspective drawing favors the individual’s viewpoint to that of the typical architectural representation techniques of plan and section (which are used as supporting information to the perspective).

The privileged status of communication that medical professionals adhere to also appears in the realm of architectural practice. Plan and section are the medical jargon of architecture, used to communicate amongst those who understand the language. This separation through language, in this case visual language, occurs in architecture as the client oftentimes does not understand plan and section. Such use of language, as beneficial as it may be amongst those who know it, creates a barrier between user and designer. It negates the experience of space for the technicalities. What is comprehended are “real” images, or perspectives, which show three-dimensional spatial relationships.

Before sickness came to be perceived primarily as an organic or behavioral abnormality, he who got sick could still find in the eyes of the doctor a reflection of his own anguish and some recognition of the uniqueness of his suffering. Now, what he meets is the gaze of a biological accountant engaged in input/output calculations. His sickness is taken from him and turned into the raw material for an institutional enterprise. His condition is interpreted according to a set of abstract rules in a language he cannot understand. He is taught about alien entities that the doctor combats, but only just as much as the doctor considers necessary to gain the patient’s cooperation.29

The perspective is thus an empathetic representation technique, putting the viewer into the shoes of the individual. Juhani Pallasmaa is critical of the perspective drawing as one off single visual image; it evokes what Pallasmaa, echoing Vattimo, calls “strong architecture”.30 The perspectives used in this document, however do not “exist” autonomously. They are only completely understood when experienced as an interlinked series of relationships. Such experiential relationships parallel my design process for the Gress Project, a process which Pallasmaa eloquently compares to the norm:

Whereas the usual design process proceeds from a guiding conceptual image down to the
detail, this architecture develops from real experiential situations towards an architectural
form. As drawings, in fact, these buildings might sometime appear vague, fragmentary
or incomplete, as the design aims solely at qualities arising in the lived experiential
situation.  

I am proposing a "fragile" way of using the perspective via a perspective series,
which puts the image in relation to other images. The viewer is not a disembodied eye, but a
person moving through space. The perspective "chain" as it might be thought of, reveals
parts of a whole spatial experience. It further consists of multiple secondary links of both 3d
and 2d drawings. These augment the perspective by revealing design details and the location
in which the drawing is taken.

31 Ibid, 80-81.
CHAPTER 3. GENERAL BACKGROUND TO THE RECOVERY PROCESS IN MENTAL ILLNESS
Mental illness is difficult to define because our understanding of its complexity is always changing. The Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR is the fourth and most recent edition) is the “bible” of the mental health care profession; published by the American Psychiatric Association, it provides criteria with which to issue diagnoses. The continuously expanding list of behavioral disorders and how they are defined and/or subcategorized begins to reveal the complexity associated with understanding mental illnesses. Schizophrenia, for example has been increasingly subcategorized; its most current subtypes “are defined by the predominant symptomatology at the time of evaluation.” Additionally, “the diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time.”

Furthermore, though it is one the most important parts of our body, there is relatively little known of how the brain actually works. Chemical imbalances (especially those involving serotonin and dopamine) were recently thought to have been primarily responsible for brain disorders. However, more current studies suggest more complicated nerve transmission problems involving further chemical changes at the molecular level.

As the nature of mental illness is convoluted so too are the ways of dealing with it. “Medical and social services are complex and frightening to approach, difficult to comprehend, and hard to access. Adjusting to living with the illness requires effort on the part of the consumer and of family and friends.”

There are many groups who are seeking to help those facing such complexities. The National Alliance for the Mentally Ill (NAMI) was begun in 1978 as one such group. Today it is one of the leading organizations offering support, self-help, and advocacy for those with

33 Ibid.
36 Ibid.
37 Ibid, 1.17.
mental illness and their family and friends. NAMI’s Family-to-Family Program acquaints those who are unfamiliar with mental illness to its many tribulations, while offering educational and emotional support to confront its challenges.

**Generalizations**

For the purpose of this thesis, some generalizations need to be made:

Throughout time and culture psychiatric symptoms have been redefined and reinterpreted differently by society, professionals, and individuals. Illness, as such, has even been excluded in some interpretations. Psychiatrist Thomas Szasz, for example, views mental illness as a myth.

R.D. Laing and his like-minded colleagues also challenged the meaning of mental illness during their time. Laing and the so-called Brotherhood (which included David Cooper, Aaron Esterson, Sidney Briskin, Clancy Sigal, Joan Cunnold, and Raymond Blake) founded the Philadelphia Association in 1965 with the following ideology:

Its founders were all firmly committed to the idea that a psychotic breakdown is not a symptom of genetic abnormality or a neurological disorder, but an existential crisis; that it is potentially a break-through to a more authentic and integrated way of being; and that professional and patient roles, as understood in mainstream psychiatry, are not conducive to the process of cure.

In this thesis I do not take a position on such issues; I simply acknowledge the complexity of interpretation. My intent is not to proclaim or disclaim definitions of mental health or whether or not mental illness exists. However, contemporary scientific knowledge and the existing systems of mental health care do provide a starting point. I move forward

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39 I am indebted to the Ames, Iowa Family to Family Education Program of Fall 2001, its leaders (Fran Berger and Deb Niehoff), and fellow learners, in addition to the Joyce Burland publication (cited above and throughout this document) for providing continued support.


42 Ibid.
with the fact that there are people who need help stabilizing their lives after having experienced symptoms associated with a break from reality.

Throughout the text some terms that are in use within the existing health care system appear; they are not necessarily endorsed. These are marked with an asterisk.

One's mental state involves degrees of being ill or healthy, yet how these two states are defined depends upon a health professional's perception; two such opinions may not coincide. Methods of defining sane and insane have drastically changed throughout history and continue to evolve as more is discovered about the workings of the human brain. Furthermore, the role of social factors in matters of health, illness and how they are perceived must be acknowledged.

There are symptomatic similarities amongst individuals which have resulted in the classification and terminology that modern medicine uses, but even these are continually being redefined or added to. In addition, it is widely acknowledged that people with the same diagnosis can have different subjective experiences. Diagnosis is an inexact and continuously changing science. For example, the noted psychologist Fred Frese, who himself has been diagnosed with schizophrenia, points out that there are now numerous subcategories for schizophrenia, and as more is learned, more will likely be added.43

SIMPLIFIED CONTINUUM OF MENTAL HEALTH

One can speak in relative terms of mental health states along a continuum. This is, of course, an oversimplification; movement along this continuum is not linear but dialectic, and stability is not "reached" as a permanent state.

...in its own way, the journey to recovery is just as dramatic and hectic as the descent into madness itself. Just as madness forces a confrontation with oneself, so does recovery. Moreover, recovery is not a temporary process, a fire through which to be burned and then forever healed; it is an ongoing achievement in which one may have to face essential realities about oneself over and over again.44

The notion of threshold addresses the process of movement between the two extremes of stability and instability known in the mental health care profession as recovery. The process of recovery is also uncertain and involves all forms of -gress, as discussed in Chapter 2. Progress does occur, but usually it is not straightforward; moments of transgression, digression, and regression cycle within this in-between state.

![Simplified Continuum of Mental Health](image)

**Figure 11. Simplified Continuum of Mental Health**

**INSTABILITY: PSYCHOTIC BREAK**

This striking moment is perceived by those in contact with the person as a break from reality, hence its name. It dramatically affects both the person in question and those close to her or him. The process is often scary and sometimes dangerous as an excerpt from the NAMI Family-to-Family Program explains from a family member’s perspective:

> In this process, their personality alters in ways you could never have imagined. They will no longer be inhabiting a world that is remotely familiar to you. When psychosis strikes, you will find that you can no longer reason with your relative or persuade your relative on the basis of shared understanding. This will frustrate many of your efforts to aid and assist the one you love.\

> However, the experience of a parallel reality has also been described as intensely compelling or as a passage into another, often mystical realm. This passage frequently bears religious connotations and the person “entering” feels “Messianic”. It has been described as a

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creative “breakthrough” rather than a “breakdown”. Such transformations are “treasured possessions of the psychotic experience, jewels within the psychotic debris.”

But whether or not the psychosis is a positive or a negative experience, the fact remains that it reaches a point which is emotionally, physically, and mentally draining. During this period “one’s world seems incredibly fragile; one may feel broken, ragged, or simply worn out.” And it is from this moment forward that the recovery period slowly begins.

Furthermore, once a person has experienced a psychotic break, the difficulties of understanding what that means are just beginning. Such persons are often diagnosed with schizophrenia or bipolar disorder, but as these diagnoses are dependent upon time, usually an accurate diagnosis cannot be made during the first consultation. Many mental illnesses are defined by how long the symptoms have been present; the required duration for textbook diagnoses can be up to 6 months or longer. One of the diagnostic criteria of Schizophrenia, for example, is “continuous signs of the disturbance persist for at least 6 months.” Therefore the initial realization that something has changed in the person’s behavior usually doesn’t even begin to be resolved until over a half year later. This intermediate period is wearing on both the person suffering from a mental illness and their friends and family.

A psychotic break usually requires hospitalization where the highest amount of care can be administered on an “around the clock” basis and a diagnosis can begin to be made. Generally, the criterion for admittance into a hospital is that one has to be “a threat to themselves or others”. Within the health system the hospital fills the role of ensuring that the most severe danger has been alleviated.

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47 Ibid, 211.
49 See the article at the end of Chapter 5: “Editorial: Psych Beds: They Needn’t all be in hospitals,” which explains that many can’t get help unless “they prove that they are suicidal.”
STABILITY: REACTIVATION

At the other end of the spectrum lies stability. In a consistently stable state, one is able to live independently and interact with other members of society while receiving less intense forms of care. Perhaps most importantly, the individual is managing their symptoms.

RECOVERY

Successful recovery involves learning about the illness and available treatments, empowering oneself through the support of peers and family members, and moving to a point where one takes action to manage their own illness.\textsuperscript{50}

The process of recovery is an \textit{elongated threshold}, mediating between the moment in which an individual has become stable enough to leave the hospital (where they receive the highest intensity of care) and the moment in which they are ready to live independently. These delicate transitions are modulated throughout the cyclical process of convalescence, which may last upwards of two years.\textsuperscript{51}

It can be a long and tedious process.

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...from the view of an observer, the experience of recovery is not unlike a coming out, a tentative process in which the patient begins to peek out from his enclosed world....Moments of recovery...may be tentative, quickly withdrawn, hesitant, practicing motions, as though by trial and error.\textsuperscript{52}

Although recovery is not a simple linear process, moments throughout it can be loosely defined in a variety of relative terms. The "Emerging Best Practices in Mental Health Recovery" defines "Four Stages of Recovery" according to the degree of dependence on care from others and the degree of awareness that the "consumer" of mental health care has toward their illness.\textsuperscript{53}

Dependent/Unaware:
Consumer relies on others and is not aware of his/her own status and needs.

Dependent/Aware:
Consumer relies on others but is aware of his/her own status and needs.

Independent/Aware:
Consumer relies on self and is aware of his/her own status and needs.

Interdependent/Aware:
Consumer relies on self and others in a mutual exchange of beneficial support, services and resources.\(^{54}\)

The NAMI Family-to-Family Education Program describes the period immediately following a break as the "post-psychotic phase," which also begins a period of recuperation that has identifiable characteristics.\(^ {55}\) These predictable features are described below:

1) Exhaustion: People in post-psychotic phases of mental illness simply want to sleep and be left alone. Some of this is a reaction to medication, but the greater part is due to the terrible "wear and tear" of psychosis and breakdown. Their physical depletion is overwhelming.

2) Depression: The phenomenon of "post-psychotic depression" occurs frequently in schizophrenia. There is tremendous inertia and passivity, with feelings of hopelessness and isolation. It is very difficult for our family members to "join in," or function, under these circumstances.

3) Delayed Stabilization: Experts are only now acknowledging that the process of regaining equilibrium after a psychotic breakdown takes far longer to achieve than they had first anticipated. It is now estimated that as much as 2 years are sometimes necessary following hospitalization for an individual to become stabilized. During this time people with serious brain disorders are extremely susceptible to stress, to change, or to too many demands being made up on them.

This extended period of vulnerability routinely goes unrecognized by professionals as well as families. Although many professionals may now agree that biology causes the illness, they often assume that recovery is a matter of "psychological will." Consequently, many programs involve ambitious psychosocial treatments and full-day scheduled activities during the early recovery period when the individual is least able to participate.

In the Bridges Consumer Peer Education Course, developed by consumers in Tennessee, this early period is termed "Recuperation," which is defined as a normative stage of dependence after the trauma of mental breakdown. In their view, this period of physical, emotional and spiritual "mending" is critically important to the recovery process; anything that puts consumers under pressure to "pull yourself up by your bootstraps" is painfully defeating.\(^ {56}\)

\(^{54}\) Ibid.


\(^{56}\) Ibid.
Dr. Fred Frese remarks that care and cope are possible, but not cure. A psychotic break usually indicates that the individual will endure a lifetime of sliding along the continuum of mental health states. It is crucial to pay close attention during the recovery phase of each individual; to learn what enables and disables their recovery. In this thesis recovery is addressed by considering rest, care, and reactivation in terms of social, programmatic, and design issues. Rest needs to occur after experiencing the intensity of a psychotic break. Care is needed to support the individual moving forward toward the challenge of reactivation. Reactivation involves self-initiative and meaningful contact with others.

A CONTEMPORARY DEFINITION OF TWO COMMONLY DIAGNOSED MENTAL ILLNESSES

As the nature of mental illness is not fully known, our understanding and definition of what constitutes a particular mental illness is continually being modified. The information presented here is done so with the understanding that it will certainly change as time passes.

Schizophrenia and bipolar disorder are discussed because they are two of the most common types of mental illness, and the two most common diagnoses that emerge after a psychotic break. In no way is this to disregard other illnesses; it is to briefly exemplify the context in which the thesis exists. It is theorized that approximately 3% of the world's population has schizophrenia or bipolar disorder and about 90% of the cases appear between the ages of 15 and 25.  

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58 Ibid.
Bipolar Disorder (Manic-Depression)

It is theorized that approximately 1.5%, of the world’s population has been diagnosed with manic depression. The fourth edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR) outlines the following examples of symptoms for “296.80 Bipolar Disorder Not Otherwise Specified,” the category of Bipolar Disorder that doesn’t meet other, more specific requirements:

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that meet symptom threshold criteria but not minimal duration criteria for Manic Hypomanic, or Major Depressive Episodes
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms
3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder Not Otherwise Specified
4. Hypomanic Episodes, along with chronic depressive symptoms, that are too infrequent to qualify for a diagnosis of Cyclothymic Disorder
5. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition or substance induced

Schizophrenia

It is theorized that approximately 2%, of the world’s population has been diagnosed with one of the many forms of schizophrenia. The DSM-IV-TR outlines the following diagnostic criteria for schizophrenia:

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59 Ibid.
61 Ibid, 400-401.
A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other. 63

The criterion goes on to describe: “B. Social/occupational dysfunction” and “C. Duration” whereby “signs of the disturbance persist for at least 6 months.” 64 Other stipulations are titled: “D. Schizoaffective and Mood Disorder exclusion, E. Substance/general medical condition exclusion, and F. Relationship to a Pervasive Developmental Disorder.” 65

People may have characteristics of more than one subtype of Schizophrenia; these include: Catatonic Type, Disorganized Type, Paranoid Type, and Residual Type. 66

“Although the prognostic and treatment implications of the subtypes are variable, the Paranoid and Disorganized Types tend to be the least and most severe respectively.” 67

Concerning subtypes, the DSM-IV-TR also notes:

Because of the limited value of the schizophrenia subtypes in clinical and research settings... alternative subtyping schemes are being actively investigated. The alternative with the most empirical support to date proposes that three dimensions of psychopathology... may come together in different ways among individuals with Schizophrenia. 68

64 Ibid.
65 Ibid.
66 Ibid, 313.
67 Ibid.
68 Ibid.
CHAPTER 4. THE EXISTING MENTAL HEALTH CARE SYSTEM
The following looks at general types of care within the existing mental health system as it is intended to function. The level of care is high for those in an unstable emotional or mental state, lower for those in a more stable state. In between, the degree of care adjusts accordingly.

<table>
<thead>
<tr>
<th>Place</th>
<th>Hospital</th>
<th>TLPs (24 hour)</th>
<th>TLPs (8 hour)</th>
<th>TLPs (unstaffed)</th>
<th>Autonomously Living with Various Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual’s Dependence on care</td>
<td>Highest</td>
<td>High to Medium</td>
<td>Medium to low</td>
<td>Low</td>
<td>Low to none</td>
</tr>
<tr>
<td>Level of Mental/Emotional state on the Continuum of mental health</td>
<td>Unstable “Breaking Point”</td>
<td>Fragile</td>
<td>Recovering</td>
<td>Reactivating</td>
<td>Stable High-Functioning</td>
</tr>
</tbody>
</table>

Figure 12. A Simplified Spectrum of the Existing Mental Health Care System

**HOSPITAL**

Those who are a “threat to themselves or others” can be admitted into the hospital for psychiatric care; persons having a psychotic break usually enter through the emergency room. The hospital constitutes the highest level of care, involving 24-hour staff and usually a locked ward that controls access.

After the “threat” is deemed to have passed, usually as a result of medication, the individual is either released or kept in the hospital’s psychiatric ward for further treatment. The latter is rarely the case. The average stay at the hospital psych ward varies from place to place, but it is usually no longer than 8 or 9 days. The individual is still desperately in need of care at this time, but the hospital rarely addresses this issue; the hospital is generally not prepared to provide other levels of care, link to other care resources, or assist in an assessment of the person’s individual care needs.

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69 I am paraphrasing from the following interview: Department of Psychiatry Administrator, Stephen C. Blanchard, MSHA, Interview by author, 10 September 2004, Iowa City, Iowa, Hand-written, University of Iowa Hospitals and Clinics, Iowa City, Iowa.
However, some hospitals, such as the University of Iowa Clinics, offer outpatient care, with the intent to gradually lessen the intensity of care. A “partial program” allows one to live elsewhere, while going in the hospital for 6 hours a day. Other outpatient services offer hospital visits whose frequency ranges from daily to monthly. There are a few problems with this approach. One is that daily or very frequent travel can be tiring for a recently-discharged, already-tired recovering individual who would do better in an “inpatient” care environment; another is the return to a site of trauma (the psychotic break); another is that the hospital as care environment is usually severely lacking in caring, as discussed in chapter 5.

TRANSITIONAL LIVING PROGRAMS (TLPS)

The mandate of TLPs is to provide varying levels of care according to the individual’s mental state. Throughout this period the individual is in the coping phase of mental illness, which is to say that they do not require hospitalization and are adjusting to their symptoms (usually via medication and therapy).

TLPs offer care in a residential environment rather than a hospital setting in an attempt to transition the individual from a state of high dependence on care to a state of low dependence on care. They include a range of degrees and types of care offered, but there are also variations in the structure and philosophy offered. Gould Farm, for example, is a TLP that does have staff, but requires its “guests” to actively participate. (This innovative TLP will further be discussed in Chapter 6)

There are a variety of TLP options based upon the level of care offered. Levels of care in TLPs are most simply defined in terms of the duration of time in which they are staffed. Therefore, the TLP that is staffed 24 hours a day offers the highest level of care and one that is staffed for 8 hours offers a lower level of care. A TLP might also include an un-staffed situation in which individuals in a more stable state live together and offer support to one another. There are TLPs that help locate an individual in a “normal” housing situation

70 Ibid.
71 Ibid.
and then proceed to have social workers and other professionals “check-up” on the individual. Such an outreach program exists in Iowa City, Iowa, but focuses specifically on those unable or unwilling to come into the hospital. Finally, it should be noted that other programs similar to TLPs exist, such as Residential Treatment Facilities and Group Homes. For purposes of simplicity they will be considered within the realm of TLPs.

Though TLPs attempt to accommodate the full range of states between stability and instability, the extreme unpredictability, fluctuation, and cycling between these conditions as well as the variations which belong to each individual means that, functionally, they are unable to always do so. Inevitably there are states of being and care needs that fall outside the range of any TLP. This is most problematic at the point of release from hospital, at the time of greatest fragility, when the individual requires care but is not ready for a TLP.

**INDEPENDENT LIVING**

This stage in the continuum of mental health is identified by the ability to take care of oneself and live independently from care facilities. At this stage, the individual is said to be high-functioning* and therefore is able to carry out the necessary tasks of daily living. Usually the person will need, on a permanent basis, various types of care: therapy, medication, financial counseling, vocational training, job placement, etcetera.

**OTHERS**

There are other types of care in the existing mental health care system, which are not elaborated upon as they don’t directly involve the focus of the thesis. For example, the mental institution is currently a place of last resort for those who are deemed to be too deep into persistent mental illness to ever be able to function well in society; it also holds others who for a range of reasons (often economic) cannot receive “care” or housing elsewhere on a long-term basis.

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72 Ibid.
CHAPTER 5. PROBLEMS IN THE EXISTING SYSTEM
DESIGN PROBLEMS

The hospital functions as a place for healing, but it is usually not a healing environment. The individual must begin the recovery process in a setting that can feel as isolative and as harsh as a prison, as the following quote explains.\textsuperscript{73}

Fear, isolation, and a sense of numbing helplessness characterize hospital experiences for the majority of patients. To enter a hospital, especially a mental hospital, either as a visitor or a patient is to encounter an environment which has no equal in barrenness anywhere in our culture save for the prisoner's cell.

These environments may be described as disintegrated or degraded because they lack wholeness. Settings are missing, they cannot adequately support the great range of human behaviors associated with the recovery process. Typical hospitals may impair the patients' confidence in their own competence to take care of themselves and live normal independent lives.\textsuperscript{74}

Care facilities are places of high emotion and warrant a greater attention to their design. Most places in the mental health care system, and especially spaces of transition, don't take into account human needs or desires. Most offer a cursory waiting lobby, admittance desk, and hallways, disregarding the fact that people inhabit these spaces for longer than a brief wait during periods of great stress, emotion, and fragility. Spivak goes on to describe what he calls 'behavioral barrenness':\textsuperscript{75}

The only order is the one laid out by the maintenance staff and the ward personnel— an order designed around janitorial routine and patient management- the chairs side by side along the walls the card tables in irrelevant places, the lounge chairs in rows like theater seats. No one lives like that at home, not the janitors, the nurses or the patients. If they did they would soon go nuts with boredom. That is exactly what happens in the hospital.

Most environments lack richness and meaning. Most patients at some time during the course of their recovery will wish to engage in behavior which these barren environments will not support.\textsuperscript{76}

\textsuperscript{74} Ibid.
\textsuperscript{75} Ibid, 23.
\textsuperscript{76} Ibid.
I acknowledge the existence of many grave issues associated with mental illness such as health care parity, homelessness, and imprisonment. However, as the scope of the thesis is inevitably limited, it specifically addresses problems associated with separation and lacunae on a range of levels — it is a "threshold thesis."

Historically, the separation of those deemed mentally ill has been very explicit. Two examples are described below. Since the period of deinstitutionalization, however (which began in the 1950s with the advent of new drugs and resulted in the release of well over two thirds of those in public mental institutions by the 1980s), there have been significant attempts to integrate the mentally ill into society. Unfortunately, most of these have been feigned or unsuccessful, resulting in instances of isolation of a different sort than before (such as homelessness and imprisonment, as mentioned above).

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SOCIAL SEPARATION DUE TO LOCATION

Isolation has been effected in many ways throughout history. In two distinct examples, that of Welfare Island in New York City and the tradition known as the Ship of Fools, contact with the rest of society was effectively cut off by means of physical separation. A contemporary look at separation follows these two historic descriptions.

Welfare Island

Welfare Island lies between Manhattan and Queens and has undergone a series of name changes since its inhabitation by European settlers in the 17th century; it is now called Roosevelt Island.87 Beginning in 1828, a series of institutions and hospitals were constructed there.79 The first “lunatic asylum” opened in 1841 and its remains can still be found at the island’s northern tip.80 Until 1976, only one bridge linked the island to the city (Queens) making the separation between the two quite clear.81


89 Ibid.
80 Ibid.
81 Ibid.
Ship of Fools

The "Ship of Fools" is another example of a method by which those deemed "insane" were literally cast away from society.

The idea of putting society's most marginal residents on boats to float away, symbolically if not literally, isn't new. It dates to the 14th century, at least, said Dr. E. Fuller Torrey, a well-known psychiatrist and historian of mental illness. The mentally ill of Europe were said to have been shipped away from the respectable and securely housed, Dr. Torrey said..."It's the idea of a closed world, cut off from civilization and populated by outcasts,"... 82

There has been debate as to the accuracy of the "Ship of Fools" story, but its image remains with contemporary society nonetheless. It recurred recently in New York City, where, from 1988 to 1992, the city's jails were located on barges. 83 In 2002 New York City began looking at this idea as way of housing the homeless; advocates and mental health professionals such as Dr. Torrey opposed the proposal. 84 The city has also investigated the same option specifically for those labeled mentally ill: "In 1984, when the emptying of state mental institutions left thousands of homeless people to fend for themselves, Mayor Edward I. Koch proposed fixing up mothballed wartime ships and idle Staten Island ferries as shelters." 85

The concept of the institution itself embodies this general attitude of isolation and marginalization. The first mental asylums were essentially prisons where the "insane" were locked away; many early hospital patients didn't fare much better.

As the hospitals of Western Europe were secularized...[they] became warehouses for the "unwanted": poor people, disabled people, prisoners, and mad people alike. Early accounts describe them as places in which to die, and the term "hospital fever" was coined to refer to the deterioration of health caused by the accumulated noxious exhalations of many physically and mentally diseased people. 86

83 Ibid.
84 Ibid.
85 Ibid.
This trend continued in mental institutions until the mid-19th century when people such as George Fox and his Society of Friends began to address the treatment of those deemed "insane" in a movement known as the "moral treatment of the insane."\(^{87}\)

In another historic isolation scenario during the late 19th and early 20th century, it was considered positive for the "ill" to live in an isolated rural setting.

At their best – around the turn of the century – total residential institutions were the progressive alternative to incompetent care or outright maltreatment. They provided a place of refuge large enough for trained employees to provide hygienic care economically. The buildings themselves were a source of great civic pride.\(^{88}\)

However, despite efforts to seek more humane conditions for those locked away, they were still fully separated from society. As an autonomous unit in the countryside, the institution sustained itself by having the "patients" work the land. The Midwestern "poor farm" is one variation on this theme. In many such situations individuals were not only isolated, but were also used as unpaid labor. All inhabitants of the institution were not necessarily mentally ill, but were outcasts for a range of reasons which might include financial or moral "bankruptcy" or lack of family to care for them.

**TLPs: A contemporary example**

Isolation of the mentally ill can occur due to the location of transitional living programs. Paradoxically, this arises from the intention to locate a TLP within residential communities. In theory, this sounds fine, but in actuality the homes are often located within impoverished neighborhoods that do not have adequate access to care resources, which are a necessary part of recovery.

The typical American town or suburban structure also impedes individuals from connecting with society. During the recovery phase, individuals are usually not able to drive yet need to access numerous services for daily living. Many homes are not conveniently accessible by public transportation systems. In addition to typical community services we all

\(^{87}\)Ibid.
need such as postal, library, etc, individuals living in TLPs require regular meetings with therapists, general doctors, nurses, psychiatrists, and social workers - all of whom may be located in different places.

While deinstitutionalization of the mid 20th century was an overall improvement, the rapid change generally overlooked how the "ill" would have their needs met in a typical residential neighborhood.

There have been charges that deinstitutionalization has merely meant a large-scale "dumping" of patients who are unprepared for life outside the institution into communities that are unprepared to meet their needs. 89

While not always the case and "not within the spirit of the deinstitutionalization movement,"90 this disregarded detail remains a problem today.

Local governments might be best able to address this problem. They have the power to instigate zoning strategies such as mixed income/social status housing units. Further building projects should consider mixed use zoning, which enables daily needs to be met within one's local neighborhood.

SOCIAL SEPARATION AND "OTHERING"

Whereas isolation puts "undesirables" out of sight and out of mind, the reality is that separation is a problem not only for people suffering from mental illness and those who care about them, but also for those who are unaware of the mentally ill.

Removing a population from society takes away opportunities for both the people within the care facility and the general public. Such a move denies the public the opportunity to understand the mentally ill and to recognize that they are viable part of the community. Such a move disregards the unique abilities of our fellow humans. And by separating ourselves into two populations, the "sane" and the "insane," we deny the existence of a continuum of mental health states along which we all live, thus denying the "sane" an

89 Ibid, 4.
90 Ibid.
acknowledgement of their own fragilities and the "insane" an acknowledgement of their own strengths.

We have discussed social and spatial separation and will now talk about separation on other levels within and between care "facilities" and treatment options.

**PROGRAMMATIC PROBLEMS: LACUNAE**

Overall, it has been observed that the needs of the recovery process are not fully facilitated by the existing mental health care system. While efforts are made to meet the very basic needs, these efforts are piecemeal and do not address the fact that recovery is a process. The entire continuum of care is not thoroughly considered; there are points along the way, but significant gaps lie between them. A dramatic example of this is the fact that "inpatient" care is generally not available until an explicit crisis such as the psychotic break is reached; no matter how desperate the situation, one usually cannot be admitted to hospital without the "threat" diagnosis described in Chapter 3.\(^91\) Another frequent example, already mentioned, is the case in which a person still too fragile for a TLP is deemed ready to be dismissed from the hospital. The piecemeal approach to care is also reflected in the lack of coordination of a holistic care program; for example, the 24-hour TLP isn't linked with the 8-hour TLP. A more detailed discussion follows.

**Hospital Lacunae**

There are two major gaps in hospital care that concern us here. One is the "threat" diagnosis issue mentioned above. The other important gap is the fact that there are oftentimes no care programs to pick up where the hospital leaves off. This results in a phenomenon known as the "revolving door". Patients discharged from the hospital, who are "well enough" to leave, end up returning to the emergency room soon thereafter. The revolving

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\(^91\) Obviously those who can afford it can be voluntarily admitted to an inpatient facility such as the Menninger Clinic in Dallas, Texas, which cost $775 per day (or more) with stays ranging from 6-8 weeks. As described on their webpage: The Menninger Clinic, "Program Costs," *The Menninger Clinic*. 2005. http://www.menningerclinic.com/admissions/program-cost.htm April 11, 2005.
door phenomenon also occurs in the prison system due to similar lacunae of treatment; the situation is even more complex when the prisoner is mentally ill.

All too often the condition of mentally ill individuals seriously deteriorates in custody. They are then released to the streets with little or no discharge planning. No one links them to needed treatment, housing and other services. And no one checks to make sure they take advantage of these services. Unsurprisingly, many mentally ill defendants find themselves back before the courts in short order, repeating the same process. Everyone loses in this scenario. Defendants with mental illness fail to receive the help they need. The justice system fails to deploy resources either efficiently or effectively. And the community at large fails to address a serious public safety problem.

Lacunae Problems with TLPs

Most TLPs only address one level of care at a time, meaning that most individuals have to move frequently. This is a stressful transition, which inhibits individuals from making a home for themselves and limits the extent to which they can become part of a community. Such disconnection makes it difficult for the individual to find the resources for their next step. It further prevents those trying to help the individual to remain in contact as they move from one TLP to the next.

Most TLPs are short-term solutions that don’t address the mental health recovery process comprehensively. For example, St. Paul’s Hewitt House (the only place near Minneapolis to go aside from a hospital) only admits people in for very brief periods of time (see article at the end of the chapter). This is true of many TLPs, which usually allow someone to stay up to only 6 months. The problem is that in reality the recovery process takes longer than that. We will recall from Chapter 3 that it can take up to two years to stabilize the individual to a point where they can even begin to consider stepping out into society, taking on a part-time job or a volunteer position.

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PROBLEMS IN RELATION TO THE THESIS

The piecemeal approach to care described thus far is a result of a piecemeal understanding of mental health. It is my intention in this thesis to promote a more holistic way of looking at mental illness, understanding recovery as a continuous process. A different way of thinking about mental health recovery might result in a different system of care. This is the goal of the thesis.

The gap of care between the hospital and “Transitional Living Programs” is typical in many places throughout the world, but in the Gress Project I specifically address the problem in Minneapolis, Minnesota. Minneapolis is the selected site of the Gress Center designed as part of this thesis, which focuses on this gap.

The following staff editorial from the Minneapolis paper, The Star Tribune, reveals many of the problems mentioned above.

Imagine hobbling into the hospital with a compound fracture and seeing the ER doc shrug, ‘gee,’ he might say, “That doesn’t really look so bad. Why don’t you come back when it’s gangrenous?” It’s an absurd scenario, but apt nonetheless. It’s pretty much what happens to people suffering mental-health crises all the time. Seeking hospital help for serious illness, they’re brushed off until their troubles become life-threatening.

Why does this happen? As findings from the Minnesota Hospital and Healthcare Partnership reveal, demand for psychiatric beds in the state far outstrips supply. The same goes for psychiatrists. People with major-league-mental-health trouble thus often wait months for an intake appointment. People in the throes of psychiatric upheaval can’t get hospital help unless they can prove they’re suicidal. Even then they must often endure long waiting-room delays: As reporter Josephine Marcotty noted in the Star Tribune last week, some are even shuttled to beds across the state.

There’s a lot wrong with a health care system that only assures service to people in crisis. But this is just how Minnesota’s “system” – if anything so haphazard deserves that name – usually works. Part of the problem lies in Minnesota’s overeager leap toward deinstitutionalization, which over four decades has reduced psychiatric-hospital capacity by about 90 percent. A recent upsurge in psychiatric admissions has heightened the supply problem. And even when hospitals have empty beds, they’re hesitant to fill them: Hospitalized psychiatric patients cost more than twice as much to treat as insurers will pay.

It’s an unhealthy situation, all right – the sort that can lead a strapped hospital to overlook a truly threatening crisis. Thus every now and then, a troubled person denied admission or a patient released too soon ends up on the newspaper’s front page: Untreated delusion or depression leads to injury or death, and a dismayed society wonders why more isn’t done to keep such horrors from happening.

More must be done, but hiking the number of hospital beds, raising reimbursement levels and lowering the bar for psychiatric admissions aren’t the only answers. Just as most broken legs don’t require a hospital stay – though some certainly do – many mental-health crises can be handled without an admission. The problem is that Minnesota has
yet to develop a thoughtful way of otherwise handling psychiatric emergencies. The 'next step down' from hospital care barely exists — forcing many profoundly depressed or delusional people who don’t qualify for hospitalization to stew in desperation.

They shouldn’t have to stew. They need some sort of short-term residential option that assures care and human company while they weather the worst of the psychiatric storm. But as things stand, the only metro-area model is St. Paul’s Hewitt House — a small program run by the nonprofit People, Incorporated. Hewitt welcomes people in crisis for short stints — often while they adjust to medication changes — and holds on to them until they’re stable enough to head safely home.

This sort of community-based facility ought to be replicated and embraced as a fixture in the “continuum of care” lawmakers have promised to create. It can work wonders to nip a psychiatric crisis in the bud. Psychiatric illness can feel a great deal like heartbreak, and supportive homelike setting is what many people need to heal. Similar programs to help patients make the often-daunting transition from hospital to home are needed as well. Such programs often can handle mental-health trouble as well or better than hospitals — and they’re far cheaper.

“It’s hard to believe,” a friend suffering a serious depressive episode said the other day, “but it seems to be true. My only options are driving to the hospital — which won’t take me anyway — or sitting curled up in my closet. Why are those my only choices?” The friend wasn’t being funny, and her question wasn’t rhetorical. How will Minnesota’s policymakers answer her?93

CHAPTER 6. INNOVATIVE MODELS OF CARE
The chosen precedents focus upon social, programmatic, and design innovations that are relevant to the thesis. They have altered existing systems and brought about new attitudes toward care.

The first investigation, Tent Therapy, explores programmatic adjustments in early institutional settings. The second, Gould Farm, is a modern place of transitional living that holistically and successfully connects into a continuum of mental health care, thoroughly understanding its role and relationship in the continuum. The third, Paimio Sanatorium exemplifies a holistic understanding of architecture in health care, though the focus here will be on many of the design details implemented. Finally, Kingsley Hall, offers an example of social innovation amidst the institutional status quo of the 1960's.

**TENT THERAPY: PROGRAMMATIC INNOVATION**

Tent Therapy began as a public health strategy in overcrowded cities in the late 19th century to quarantine persons infected with tuberculosis, but its benefits for the patients’ well-being was soon noted.\(^94\)

It was believed that those who had a mental disorder were more susceptible to tuberculosis and, therefore many mental patients were placed in tents during this era.\(^95\) In 1901, superintendent and medical director, Dr. A.E. Macdonald, M.D., ordered tents to be erected at the Manhattan State Hospital East on Ward’s Island, N.Y., for tuberculosis and mental patients.\(^96\)

To insure complete isolation, all working, dining, and sanitary facilities were provided at the campsite. A rich diet was prescribed and scrupulous cleanliness was maintained. Camp life was free and interesting. Most of the patients left their beds to wander about the lawn, They watched the steamers and excursion boats passing along the East River, read papers and magazines, played games, and showed increased interest in their surroundings and in their fellow patients.\(^97\)

\(^{94}\) Caplan, 29.
\(^{95}\) Ibid
\(^{96}\) Ibid
\(^{97}\) Ibid.
At the end of the summer most were returned to the regular hospital wards where their condition regressed, while those left in the elaborately winterized tents continued to improve.\(^98\) The tent colony was reopened in the following spring and general improvement was again seen.\(^99\)

Many other examples occurred throughout the U.S, with similar results, but eventually the same negative conditions that were found in pre-existing wards (namely being overcrowded, locked, understaffed, and under equipped facilities) made their way to the tent settings, and by 1910 the idea had all but vanished.\(^100\) "The whole atmosphere of improvisation, adventure, and group cohesiveness disappeared, as did the concern and pride of the staff and their special attention to individuals in a selected patient population".\(^101\)

Thus the innovative origins of tent therapy were forgotten or never fully realized. The success of the tent settings "declined because its real value, the small group, was eliminated, while the 'superabundance' of fresh air and sunshine was scrupulously maintained."\(^102\)

**GOULD FARM: PROGRAMMATIC INNOVATION**

Gould Farm is located in Massachusetts and has provided a psychiatric rehabilitation program to adults with mental illness for nearly a century.\(^103\) Programmatically, Gould Farm is innovative because of its holistic understanding of the process of recovery. It offers varying degrees of interaction with its surroundings; this includes both the physical site in which it is located and the social community. Most importantly it exists as one of many steps in a series of programs that seeks to comprehensively match the individual’s process of recovery. The following excerpt from their website further explains the progression.

\(^{98}\) Ibid.
\(^{99}\) Ibid.
\(^{100}\) Caplan 30
\(^{101}\) Ibid.
\(^{102}\) Ibid.
Our intensive work program is balanced with educational opportunities, community events, traditional celebrations and a variety of therapeutic supports. Counseling for guests, goal-setting, planning and evaluation meetings and medications are integrated into the normal structure of work and community life. Once guests have reached a level where they can begin to move on, they engage in a period of preparation for the transition to our continuum of care in the Boston area, heading then for graduation from the program and moving on to independent living.104

Like the Gress Project, Gould Farm fills a gap, and provides a place for the recovery process to begin. Furthermore, Gould Farm is considered as but one part of a continuum of care that are integrally linked together. The primary difference is that the Gress Project covers a larger area of the continuum and does so in an urban context.

PAIMIO SANATORIUM: DESIGN DETAIL INNOVATION

Paimio Sanatorium was constructed in the late 1930s for tuberculosis patients in Finland and still operates today as a general hospital (see image on the chapter title page). The building is innovative for its site location and overall design, but also for its attention to detail. The following includes some of my impressions while touring the building in May of 2004 with supporting references offered by Finnish architect Juhani Pallasmaa.

In designing Paimio Sanatorium, the architect Alvar Aalto considered the building from a radically different point of view than that of conventional design methods.

Whilst designing the sanatorium, Aalto fell ill and had to spend some time in a hospital where he could examine the surroundings from a patient’s point of view. He took careful note of the irritation caused by even the most trivial things, such as the sound of water splashing into the washbasin, but also to the simple fact that a patient spends most of his time staring at the ward ceiling, thus its shape and colouring assumed a particular importance. Aalto understood that a patient’s experiential perspective differed radically from that of the nursing and administrative staff or visitors.105

Aalto’s empathetic approach to modernism made for both a well functioning building that understood the contemporary health care system, but one that also challenged the possibilities of care by sensitively designing to the needs of its occupants. Paimio Sanatorium

104 Ibid.
thus balances the efficient functioning of a hospital system with the intricacies of individual needs and desires. Pallasmaa elaborates upon Aalto’s design methodology:

In his description of the design process of the Paimio Sanatorium, Aalto formulates a design philosophy progressing from the identification and articulation of experiential situations: ‘[…] a building has to be conceived from inside outwards, that is, the small units and details with which a person is engaged form a kind of framework, a system of cells, which eventually turns into the entire entity of the building. At the same time as the architect develops a synthesis from the smallest cell onwards, the opposite process exists and the architect keeps the entity in his mind’.

Using this method of analyzing experiential situations, Aalto conceived the Sanatorium as a carefully and empathetically studied instrument of healing for the benefit of human beings at their weakest, ‘the horizontal human being’, as Aalto calls his hospitalized client. Aalto’s sanatorium could well be the one building in the history of modernity that contains the highest concentration of technical innovations, yet it is firmly rooted in human experiential reality.  

Within the larger programming of the building, we see functional spaces thoughtfully altered to become special places. The quotidian stairway for example, takes on a new relationship to the building and its environs as windows open up to the surrounding forest scene. Furthermore, the staircase is a comfortable size, accommodating individuals moving at different speeds and in different directions. Though the furniture shown in the following photo was not originally set on the landing, it exemplifies that adequate space exists to provide a new opportunity for the space. It becomes a place where one can rest and take in a grand view of their surroundings, without blocking circulation.

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Throughout the building an attentive palette of color was implemented to enrich the lives of the inhabitants. The “Paimio colors” (red, blue and yellow) were specifically developed for the hospital and were intended to have a positive psychological impact on the occupants. The color scheme is applied throughout the building, but also occurs in a unique way in the dining hall.

Aalto thoughtfully considered the daily need for eating as a moment of opportunity in the lives of the patients rather than only a necessary function of life. Gathering in the cafeteria is brightened by the implementation of large, south-facing windows, which can be shaded by vibrantly colored awnings. The result is a well-lit social space even on the cloudiest of days, but when the shades are in use the colors from the awnings stream into the cafeteria, offering a dynamic dining atmosphere.

The building exhibits Aalto’s sensitivity to the particular needs of patients, many of whom were too weak to open a normal door. In the cafeteria, for example, he designs a double swinging door system with little resistance. This is made possible by the implementation of a pivot point rather than a hinge and also by the slight vertical cant in the doorframe, which shifts the weight of the door.

The door handle was also rethought; Aalto studied the rotation of a standard door handle. He must have realized that many patients have difficulty making the turning motion and also that patients’ gowns might often catch on the handle. The solution was to make a
handle system that required little effort to open (simply pushing down would achieve the desired effect) and had no protrusions on which clothing might get snagged.

Aalto’s design philosophy carries through to the details of the patients’ rooms, where many examples of his empathetic approach to architecture are found. The weakness of tuberculosis patients meant that many would be spending a great deal of time in bed. Aalto designed the patients’ rooms with this in mind. Lowered windowsills enabled one to look outside from their bed. Ambient lighting inside the rooms achieved a well-lit space without shining directly into the face of the individual lying down.

The room design is also sensitive to the fact that two people would be sharing the same space. To minimize disruptive noise, he created a sink basin that would quietly absorb water striking it (Figure 16). To minimize disruptive light, he implemented portable lamps that gave the individual more control of their direct light source.

He also considers the staff’s perspective; this is evident in a detail in the patients’ rooms. The floor curves up to the base of the wall, making cleaning of the space easier and more efficient.

Figure 16. The “silent” sink

Aalto’s design develops from a holistic understanding of the forces that influence the making of a building. In addition to understanding the contemporary care system and being sensitive to the needs of the occupants, he also was conscious of climatic and regional
considerations. The façade of the patients’ wing faces out toward the forest, where an upper story balcony allows access to the fresh pine-filled air. The balcony is large enough for a patient’s bed to be rolled out and still permit circulation.

Double-pane glass throughout the hospital was necessary, as single-pane windows have virtually no insulation value, resulting in tremendous heat loss during long Finnish winters. Aalto found a way to make the most of this necessity; he designed the space between the windows large enough to grow plants. This not only created a buffer space to hold the heat, but also brought the outdoors indoors (Figure 17).

Such attention to detail is articulated in the Ingress and Egress chapters, which are the design component of the thesis.

Figure 17. The vegetative window buffer

**KINGSLEY HALL: SOCIAL INNOVATION**

As mentioned in Chapter 3, R. D. Laing and the Brotherhood proposed a different paradigm for viewing and treating the mentally ill. For a period lasting roughly five years they carried out their ideas at Kingsley Hall in London. The experimental project is noted here not necessarily for the ideology in which it embodied (which was revolutionary at the time) but for its attempt to enable those suffering from mental illness to interact with society, rather than being “forgotten” in institutional settings typical during the mid 20th century.
One of the basic ideas was to provide schizophrenics with space to in which to explore their psychotic state. Recall from Chapter 3, that the psychotic break was considered a "break-through" into a more "authentic and integrated way of being". This drastically differed from conventional methods in the 1960s, which relied heavily upon drugs and electric shock therapy to treat patients.

The residents that lived in the neighborhood of Kingsley Hall did not always welcome Laing's approach, however the project propelled forward an idea of helping the mentally ill through the recovery process in a community rather than an institutional setting. Furthermore it challenged the notion of the "professional and patient roles". In a letter to Dr. Loren S. Mosher, Laing expressed his belief that the "research" conducted at Kingsley Hall would be particularly fruitful in

the inter-phase between the internal life of the community and the formal and social networks of patients. We are not registering this community as a nursing home. And people will not be labeled "patients" although they will be people who would otherwise be committed to Hospital as diagnosed schizophrenics. We should have to improvise alternative role relationships between those of us who are relatively able to cope with external realities and those of us who are relatively unable to do this but are involved in other issues (1965 June).

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CHAPTER 7. GRESS PROJECT OVERVIEW
PROGRAMMING

The Gress Project is an innovation in the programming of mental health care. It fills a significant lacuna that the piecemeal system has overlooked. The Gress Project is a stepping-stone in the mental health continuum.

The innermost core of the Gress Project, the Gress Center, provides a place for those that are no longer in the “threat” category (as discussed in Chapter 3) but are not yet stable enough to go to a TLP; in addition to filling in a gap it also overlaps. The Gress Center constitutes an overlap with hospital care in that sometimes (but not often enough) individuals remain in the hospital for further treatment after they are no longer in the most acute difficulty. It constitutes an overlap in the other direction in that individuals living in the Gress Center do not need to leave to go to a TLP as they stabilize further. They can also remain in the Gress Center as they progress through recovery towards autonomous living rather than move from one TLP to the next.

Thus the Gress Project fits into the existing system, but ultimately proposes a new framework for mental health care. It recognizes parts of the system already existing that serve the mentally ill, but it also recognizes that these parts are piecemeal and do not consistently work together for the benefit of the individual with mental illness.

The Gress Project does not propose to obliterate the existing structure of mental health care; rather, it seeks to improve upon it. In making such an insertion into the
piecemeal system, it is intended that the recovery process will begin to be considered more holistically by all of the existing programs of care for the benefit of the individual’s needs.

CONNECTIONS TO PUBLIC LIFE THROUGH ARCHITECTURAL PROGRAMS

The Gress Center offers an alternative way of thinking about mental health care to that of the typical hospital/institutional service environment by providing connections to everyday life. The boundaries of the program extend beyond what we typically see in existing TLPs in that they take the recovering individual further into public life and bring the public further into the life of the Center. The public programs can be divided into two categories - the Community Programs centrifugally spiraling from the Gress Center and the existing programs occurring throughout the neighborhood, which have potential to further the recovery process.

Through these programs the physical presence of the Gress Center expands and can be felt throughout the city. Gress ideology maintains that the physical presence of the Gress Center, in fact, needs to be in the community. Thus the architecture is not a single edifice confined within a city block, but is alive - it is part of the daily life of the city. Many of the programs of the Gress Project are linked to, and accessed through, a connective tissue, which becomes part of the skyway system of the city (Figure 19).
Now we will look at the Gress Project from its innermost private center to its outermost public edges – From the center of the Gress Center to the Community Programs, where Gress becomes city.

**LEVELS OF CARE WITHIN THE GRESS CENTER (GRESS PROJECT’S CORE)**

The Gress Center is subdivided into several Levels of Care (LOC) that correspond to the individual’s mental/emotional states and capabilities as outlined in Chapter 3 and diagrammed within the entirety of the Gress Project in Figure 19.

The Levels of Care are arranged in a fashion that allows for cross-connection, while retaining autonomy as required by the recovery process. Interaction between levels of care can happen, but is modulated in order to protect an individual in a delicate state from being exposed to something that they are not yet ready for. This can also be conversely thought of as protecting the individual in a relatively stable state from relapsing. The Gress Center provides a safe place for this to happen, minimizing the devastating effects of regression. Within the current system an individual in this situation must be moved to a different TLP; this move can accelerate the destabilization.
LOCs range in care intensity to accommodate the needs of the low-functioning* and high-functioning* resident as well as those in between. The prior consists of individuals who are no longer a "threat," but are not yet ready to take on the tasks necessary for daily living. The latter includes those who are consistently safe and responsible for their own needs, ready and willing to increasingly step into public situations. In between these two there is a delicate balance; the process of gradually taking on more responsibilities while not becoming overwhelmed.

**GRESS PERIPHERY: INGRESS AND EGRESS (GRESS PROJECT THRESHOLDS)**

Threshold is more specifically explored at the Gress Periphery where Ingress and Egress occur. *They are the design component of this thesis.* They are important to the Gress Center itself as well as to the entire system of mental health care. As both Ingress and Egress lie between the private sanctuary of the Gress Center and the public environs of Minneapolis they remain the most critical thresholds for the Gress Project. And, as the Gress Center lies between the programs of the hospital and transitional living programs, these two thresholds are even more crucial; they link the Gress Center to the continuum of mental health care. The following figure diagrams these two types of threshold simultaneously.
High Dependence on Care          Low Dependence on Care
(Unstable "Breaking Point") - Fragile, Recovering, Reactivating - (Stable High-Functioning*)

Figure 20. The Gress Project: Gress Center (GC) and its private Levels of Care (LOC), Gress Periphery: Ingress (I) & Egress (E), and Community Programs (CP). Community Programs Linking into the Connective Tissue (CT) amidst Existing Programs (EP) in Public Space (P). In the continuum of care the Gress Project is a gap-filling and overlapping threshold between the Hospital (H), TLPs, and Autonomous Living (AL)

The importance of designing entry and exit thresholds

Entrance and exit are psychologically and emotionally charged moments of threshold. They should be considered and designed carefully, but typically they are not adequately considered as discussed in Chapter 5. This is generally true in most systems of care, but even more so in mental health care systems. The variety of emotional states, social capabilities, and dependence on care is not carefully thought through in typical systems. The design of conventional hospitals and TLPs does not articulate transitional moments in space, despite working with people who are constantly experiencing mental, medical, and physical transitions.

Ingress and Egress recognize that thinking about threshold as simply entering and exiting through a door not only lacks meaning, it also perpetuates a disconnection from care. Thus the physical act, social capabilities, and psychological process of moving between inform the architecture of Ingress and Egress. Both inherently involve moments of contradiction, gradation, uncertainty, hesitancy, and ambiguity characterized by transitional
processes. As described in Chapter 1, these issues are intrinsic to the study of threshold and are even more so at a place for mental health recovery. These transitional moments are delicate not just for the individual, but also for their friends and family, the staff, and the general public. Therefore the design of these interfaces considers all groups involved. These interfaces care for the public and benefit society as well as care for the individual.

Temporal and spatial encounter

Ingress and Egress consider the appropriateness of exposure to new situations. Temporal and spatial relationships in architecture affect the degree and type of exposure the individual confronts as they move into the unfamiliar. Temporally: when one is ready and willing to encounter something “new.” Spatially: what type of encounter one is ready for. This concerns the order of exposure (adjacencies and sequences through space), the ways in which things are exposed (via the manipulation of architectural elements), and what is exposed (activities corresponding to architectural programming).

Elongated threshold

The elongated thresholds of Ingress and Egress simultaneously offer a continuum of withdrawal from the place or situation one is leaving and an introduction to what is coming next. Both are further subdivided into sub-thresholds, which pertain to their respective sequential moments of transition and correspond to appropriate degrees of exposure (intensities of interaction) throughout the recovery process. These points are discussed in detail in the Ingress and Egress chapters. The degrees of intensity of exposure are adjusted through a layering system of architectural elements (systems and materials), programs, and program adjacencies.

The elongated threshold of Ingress is a one-way valve that physically transitions from the fully public area outside of the Gress Center to the fully private area within the Gress Center. Ingress reaches out to meet newcomers; however, the interaction with public space is designed to be minimal. Public programs do not exist at Ingress aside from elements of the park that carry through its outer edge (primarily the bike and pedestrian path).

Ingress responds to:
- the condition of the individual, who arrives in a delicate state, and is not capable of confronting society. It addresses the fragility and ambivalence of introduction and the pace at which the new environment of care is absorbed.
- the general public who are delicately removed from the situation.
- the friends and family who have been in a stressful situation with the individual and are about to leave them.
- the staff that is “taking over”.

The elongated threshold of Egress is a two-way valve for the high-functioning* resident who goes in and out of the Gress Center while still living there. While Ingress has minimal contact with the public, Egress increasingly engages public space and is increasingly porous to the public. It connects to public space directly at street level and also through the connective tissue, which continues into Minneapolis’ skyway system.

It responds to:
- the condition of the exiting resident, who is still fragile, but now capable of taking the first steps back into society. It addresses the ambivalence of re-introduction into society and the pace of reintroduction.
- the condition of the re-entering resident, who has potentially experienced stressors while immersed in the public environs.
- the general public who are provided opportunities to interact with resident.
- the friends and family who are able to visit in public.
- staff who carefully show the resident the “way out” and greet them when they return.

Threshold and identity

The concept of an elongated threshold brings into question to what degree one is “in” or “out” of a place. Ingress and Egress question how we define others and ourselves by investigating the degree to which one is protected within the sanctuary of the Gress Center and the degree to which one is exposed to public urban life. Elongating the moments of entry and exit makes us question where we really are in the spectrum of our individual mental health states and the mental health care system.
COMMUNITY PROGRAMS (OUTER EDGE OF THE GRESS PROJECT)

The Community Programs are the outermost layers of the Gress Project, which at its center protects the most fragile inhabitants and at its edges is virtually indistinguishable from the public realm. The Community Programs are site-specific and are shown in relation to the Guthrie Theater, the Mill City Museum, and the Mill Ruins Park, all important public amenities existing in the vicinity.\textsuperscript{109}

The Community Programs of the Gress Project are part of Minneapolis’ urban context; they participate in the life of the city and invite the city in at the same time as they link the resident to the city. They are connected to the surrounding environs at ground level, but also are accessible via a connective tissue that extends into the downtown skyway system. The following diagram places the Community Programs in their site context.

Figure 21. Community Programs amidst existing amenities on site in Minneapolis
Gardens

Gardens lie between the Gress Periphery and its surrounding Community Programs. They enable residents, former residents, and any community member to take part in the therapeutic art of gardening. They are subtle reminders of the process of recovery in the Community setting.

Library

The Library lies between the public connective tissue and the public entry into the Gress Center. It provides a reference point for family members as well as those generally unfamiliar with mental illnesses to acquire more information.

Mixed Residential Towers

The towers link to the riverfront, resting between the north and south sides of the river. They provide housing for the city, but also include apartments for people to transition to when ready for more autonomous living. In this way, they allow a gradual removal from the care system to take place in a neighborhood that the individual is familiar with and that has adequate resources to support the individual’s needs.

Greenhouses

Greenhouses appear between the Gress Periphery and its surrounding Community Programs. Places for gardening in the winter are a significant amenity in Minnesota’s northern climate. The greenhouses vary in degree of encounter as some are immediately linked to public entries and some offer only visual exposure to the public.

Restaurant

The restaurant is elevated between the banks of the river, providing dramatic views of the surrounding landscape. It provides a variety of jobs for Gress residents who can choose a position according to their comfort level. For example, cooking in the kitchen would require the least amount of encounter with strangers, while waiting tables would provide a high
degree of encounter. The restaurant connects the working processes of the gardens and greenhouses as the food grown is used in the dishes offered.

**Therapy Offices**

These offices are located between the Gress Center and the surrounding mixed-use neighborhood. They are part of the continuing care system that is essential in a local community and serve the general public as well as former Gress residents.

**Market**

The market occurs between the Gress Center and the surrounding neighborhood. Programmatically, it provides a place for informal encounter between high-functioning* residents and the public. It enables high-functioning* residents to become directly involved with the community as vendors or patrons, or indirectly through the sale of their goods/produce. Therefore, the market provides another link from the gardens and greenhouses to the community.

**Gallery Cubes**

A series of Gallery cubes exhibit works created by Gress Center residents. The cubes stand in space as reminders of those who are not there - they concern the experiences that the individual might be having as they work toward reactivation. They are supportive frames and protective skins for the individual’s self-representation. They are scaled to suggest reciprocal individuality and personal encounter; each provides just enough interior space for a single person to interact with the artwork. A person in the piazza is faced with the expressions of another individual—it just so happens that the latter individual can’t be there in person today, because they are working on how to live with the symptoms of a mental illness. The intent is to give someone a ‘voice’ whose voice cannot otherwise be heard; to give someone a place to stand where they aren’t yet able to stand.
Projector Tower

Like the galleries, the Projector Tower allows individuals living within the Gress Center to express themselves in the public realm without physically stepping into public space. Images or films created by residents are projected onto grain silos at the edge of the public piazza, enlivening an outdoor theater space.

Versatile Studios

A segment of the Versatile Studios rests between the public connective tissue and the private portion of Egress. Here, an indirect moment of visual and audible interaction is enabled and mediated by both people in the connective tissue and people within the Studios. (The Versatile Studios are elaborated upon relative to their position within Egress in Chapter 11)

Employment Cafe

The Employment Café is the last step within the process of Egress. It lies between the private portion of Egress and public access to the Mill Ruins Park and the connective tissue. It offers Gress Residents as well as the general public a reference and refreshment point. (The Employment Cafe is elaborated upon relative to its position within Egress in Chapter 11).

The Connective Tissue

Egress and all the Community Programs are linked to the skyway system through the Gress connective tissue. The connective tissue also extends the skyway system to the Stone Arch Bridge, further connecting downtown with the river.

THEORY OF PROGRAM SITING

The physical distance from the Gress Center’s private center point often corresponds to the degree of encounter the individual has with the public. Exceptions to this include the Projector Tower and Galleries, which provide individuals with a means of self-expression in public space without leaving the privacy of the Gress Center. Also, some of the programs
overlap—this is especially true at Egress, where parts of its programs (such as the Versatile Studios) are both within Egress and exposed to the public realm outside. This will be demonstrated in more detail in Chapter 11 under “Versatile Studio Link”.

The Community Programs are critical to helping the individual transition into public life. The Programs connect to the community; through them, Gress becomes city.

PUBLIC PROGRAMS AT THE GRESS PROJECT’S OUTER EDGE

The following neighborhood programs provide potential employment, learning, recreational and living opportunities for the residents.

The Historic Mills Neighborhood redevelopment

At the time of this writing construction of a mixed-use neighborhood is underway. Businesses in the area can provide daily services and goods within walking distance while also offering employment opportunities with a variety of skill levels, work experience, and exposure to social situations. The residences offer autonomous living possibilities for the former Gress resident. The following amenities are shown in relationship to the Gress Project in the figure below.

Historic Mill Ruins Park

The park lies between the river and downtown Minneapolis. It is conveniently located adjacent to the Gress Center and provides easy access to numerous recreational possibilities.

Mill City Museum

The recently opened museum provides the community a better understanding of the site’s history. It has a variety of work and volunteer opportunities that residents can utilize.

Guthrie Theater

The new Guthrie Theater, designed by Jean Nouvel, will open its doors to the public in 2005. The theater can provide a variety of work possibilities as well as opportunities for performances created by Gress Center residents.
LOCATION

The site was chosen with an awareness of social and cultural issues. The process of recovery, which requires both seclusion and inclusion relative to social life, is augmented by the site's position in the city.

Logistically, the site is well-connected, enabling easy access to the Gress Center locally as well as internationally. At the macro scale, Minneapolis maintains an international airport that is directly connected to downtown by a recently completed light rail line. The line stops eight blocks from the Gress Center and is easily accessible by foot or car shuttle. The site is centrally located within the metropolitan area and in close proximity to the city's hospitals.

The natural amenities that are present on the site include the Mississippi River and the adjacent Mill Ruins Park. The park is one in a series of green spaces that forms an interconnected parkway “ring” around the city. This ring connects to pedestrian trails and a commuter bike path along the river and throughout the city.

The Gress Project's connective tissue connects itself to the skyway system of downtown. At the micro scale, this network links into the supporting programs that are embedded in the neighborhood. These various resources and amenities are described later in this chapter.

The site of the Gress Project is a threshold between the urban grid of downtown Minneapolis and the riverside park. Being positioned between these two conditions provides a diverse range of opportunities for individuals to gradually reactivate themselves within society. The above relationships can be seen in both the preceding Figure 22 and the following Figure 23.
GENERAL HISTORY OF THE SITE

Father Louis Hennepin named the Falls of St. Anthony in 1680. By the early 19th century, water power from the falls was put to use and Minneapolis’ “Sawdust Town” which soon led the nation in saw milling. In 1880, the flour milling industry took prominence over the saw mills and Minneapolis led the nation in flour production until 1930. The success of the mills spurred the opening of the Stone Arch Bridge in 1883. The following twenty years led to a serious decline in production, which resulted in the dismantling of many of the mills as well as their supporting infrastructure.

Between 1950 and 1963, the river was dramatically altered. Under the Upper Minneapolis Harbor Project, the Army Corps of Engineers installed two locks during this period, which “tied Minneapolis to national water transportation routes”.

The industrial nature of the site was retained throughout much of the seventies. This was especially true on the southwest bank where the former Palisade mill area was covered by gravel storage piles. However, adaptive reuse was beginning to take hold on the east bank and by the late 1980s much of the riverfront had been redeveloped into commercial, residential, mixed-use or green space.

Remnants of the milling heyday are used today in new ways. The Stone Arch Bridge was reopened as a pedestrian walkway and cycling route in 1994. In 2003, the Washburn A mill was opened to the public as the Mill City Museum. The west side mill ruins have been partially excavated and are currently accessible at the Mill Ruins Park, the first phase of which was completed in 2001.

111 Ibid.
112 Ibid.
113 Ibid.
114 Ibid.
115 Ibid,128.
116 Ibid, 129.
117 Ibid, 130.
118 Ibid, 133.
119 Ibid.
120 Ibid.
The Gress Center specifically lies on the site of the former Palisade Mill, the last in a series of flour mills lining the western bank of the Mississippi River. In the seventies and eighties, this location was covered in gravel piles and in the early 21st century the ruins of the Palisade mill were partially unearthed. The Gress Center rests at the edge of the Mill Ruins Park.

![Figure 24. Panorama (from left to right) : Guthrie Theater under construction, Future Piazza in the foreground, Condominiums in the background), Mill Silos (behind which lies the Mill City Museum, Stone Arch Bridge in the background, Riverside Drive with cycling path, Mill Ruins Park with Palisade Mill Ruins](image)

The Minneapolis Community Development Agency has had a significant hand in shaping the identity of the area and, at the beginning of the 21st century, their vision for the Mill City District began to be implemented. The plan further links the waterfront into the heart of downtown by replacing above-ground parking lots with mixed use buildings. The plan calls for medium density, mixed used apartment blocks with underground parking, as well as other improvements that include the Guthrie Theater, its adjoining piazza, the Mill City Museum, and a park-like boulevard extension of Chicago Avenue. (See Figure 21 and 22 in Chapter 7, for a plan view of the Gress Project amidst the proposal.)

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122 Ibid.

123 Ibid.
The significance of this site to the city of Minneapolis relates to its historic origins and its progression toward contemporary urban life:

With these developments and others, including the new Guthrie Theater, the evolving riverfront—home to industry, business, and leisure opportunities—now plays a central role in art, culture, and recreation in Minneapolis. Repeating an earlier phase of their history, the falls and river are once again prized destinations.  

CLIMATE

Minneapolis is located at approximately 40 degrees north latitude. Its northern location results in extreme climatic changes that affect urban and architectural design. Summers can be extremely hot and humid with temperatures often exceeding 90 degrees Fahrenheit. Conversely, winters can be extremely cold with temperatures dropping well below freezing; wind chills and precipitation are often severe.

The following two chapters provide a description of the Gress Project's Periphery, which is the design component of the thesis. We will step forward, following a highly detailed “road map,” through Ingress and Egress.

It is admittedly not easy to “read” one’s way through a work of architecture described in detail. The writing is not intended to construct the building in the reader’s mind, but to step through the logic of each design decision, since it is through these decisions that I have enacted the thesis. The writing supports the visual representation of the Gress Periphery, which cannot be fully rendered in this document due to the limitations of its format.
CHAPTER 10. INGRESS
THE ARCHITECTURE OF INGRESS

Ingress recognizes both the need for protection and the need for exposure in the individual’s arrival process. It is designed for the activity and motions that occur within the space of arrival, from the perspectives of those who are intimately involved with this part of the building. A layering system of architectural elements (systems and materials) modulates the degree of protection/exposure at Ingress as well as throughout the entire building. Additionally, the architecture accentuates and mediates between points that are significant to the process of entry.

Ingress was designed with three primary ideas in mind: the process of entering a place for the first time, the slowness of absorbing the change (resting, seeing where you are going), and ascension to something new. Throughout Ingress, the utmost attention was paid to the idea of support.

Layers

The Gress Center is layered concentrically on a macro and micro scale: within the context of the urban setting and within the context of Ingress itself. As Ingress lies at the periphery of the Gress Center, it exemplifies the layering system at multiple scales. The layering is demonstrated at the transverse section of Ingress (Figure 24), where the extremes of public and private are dissected from the public piazza to the Ingress/Gress Center chiasma. The layering of materials defines the hierarchy of the space.

Figure 25. Site Section: From Public piazza and street to private Ingress to courtyard drive to Gress Center
The materials are chosen not only for their visual and tactile qualities but also for the processes of their creation and our associations with that process (Refer to Chapter 2: "Empathetic Approach" for more on tactility). They combine to form systems of architecture that defines Ingress’ skin at wall, ceiling and floor. The layering system defines a hierarchy of space usage.

**Wall Differentiation**

The peripheral wall system of Ingress (the south wall) rests at an edge between public and private. Its general exterior, therefore, is highly protective and consists of a hard shell of steel and granite tightly woven with clerestory windows and vegetation.

The inner-exterior wall system (the north wall) is softer. Windows here are punctures onto specific views. Both of these exterior treatments are lined on the inside of Ingress with the softness of birch wood paneling.

Figure 26. Plan of Multi-material wall system.
THRESHOLDS WITHIN INGRESS

Specific thresholds within Ingress are listed below in sequential order. A detailed description of each occurs in the pages that follow this section.

1. **Macro Arrival** (threshold between the public street and the private drive)
2. **Initial Entry** (threshold between the car and the entry door)
3. **Ingress Threshold** (threshold between the exterior and interior)
4. **Paired Points of Rest** (threshold between entry and new home)
5. **Reflection Wall** (threshold between Visitor Atrium and Ingress)
6. **Ascension** (threshold between Points of Rest and Mezzanine)
7. **Initial Landing** (threshold between initial step and Mezzanine)
8. **Mezzanine Landing** (threshold between Ascension and Passarella)
9. **Passarella** (threshold between Mezzanine and Gress Center)
Figure 27. Thresholds at Ingress Ground Plan and Ingress connective tissue Plan
MACRO ARRIVAL

Approaching the Gress Center from the east by car along Riverside Drive, one sees ahead the connective tissue that links the Guthrie Theater on the left to the Gress Center on the right. The yellow sandstone ruins of the Palisade mill create a preexisting low-height barrier between the pedestrian traffic and the Gress Center, separating the driveway from the public path while still enabling visual connections between the two. Trees carry through from the forest and line the interior area of the Gress Center, while providing a layer of separation between public and private near Ingress.

The asphalt of the street changes to brick at the driveway into the Gress area. The material distinguishes the drive from that of the street, the pedestrian walkway, and the bicycle lanes that it crosses. The brick pavers demarcate a different pace from that of the street not only visually but also on the tactile level, as a passenger can feel the subtle bumps as the vehicle slows down into the entry drive.
Figure 28. Macro Arrival
THE INITIAL ENTRY

The moment of arrival begins with a space that is between inside and outside, a carport that is an extension of the walls and ceiling of Ingress.

The space for the vehicle is positioned in such a way as to direct the side-opening doors of the automobile into the opening of Ingress. Reciprocally, Ingress opens its building envelope to the newcomer. The Ingress roof hovers above the carport trellis. From the trellis, walls slant down into the ground, and join with the walls of the building. The steel-clad shell draws attention toward the entry path and the subsequent threshold.

A granite plinth slopes up from the ground toward the Ingress. Its weighted edge defines a stopping point where the newcomer arrives. From the granite sprouts a wooden handrail at waist height. Beyond the granite plinth, the sandstone ruins of the Palisade Mill define the outermost edge of Ingress. In conjunction with this physical edge, a layer of trees begins to fade out the visual connection to the public Guthrie Theater.
Figure 29. The Initial Entry
INGRESS THRESHOLD

The outlying public conditions surrounding the context of Ingress begin to fully disappear at this outer threshold. The last glimpses of the Guthrie Theater can be seen slightly through the trees, which also serve to more immediately separate the Ingress staff parking area from the entryway.

The delicate members of the wooden handrail sweep past the granite monolith and glide into the Ingress doorway. The spindles of the handrail rotate, altering their position; beginning horizontally at the granite, they reach the door in an upright position.

The exterior walls and roof converge from their broad expanse to the proportions of the body, creating a comfortably sized doorway. These elements are lined with a light birch wood, while their outermost edges are composed of granite and steel.

Figure 30. Ingress Threshold Elevation
Figure 31. Ingress Threshold
PAIRED POINTS OF REST

From the Ingress Threshold, the walls again expand at obtuse angles to two points of rest: the Resting/Observation point to the left and the Water Refreshment point to the right. The walls at the point of the Ingress Threshold are vertical, but as they extend in plan, they taper outwards, away from the ground. This taper reaches its maximum at the two points of rest. To the left, a granite vegetative wall filters southern light into the interior, while to the right the birch-lined wall is punctured toward two views.

The point of rest/observation is an origination point that defines the south wall system and it also relates to the north wall. These two walls are linked by the common axis they share. Both walls are composed by an obtuse angle in plan, the bisection of which creates their joint axis.

Two events define the architectural systems at this point of rest/observation: 1. the act of looking out onto specific views and 2. the idea of an intimate enclosure for rest - a room within a room.

1) The south wall's entire composition acts as an amplifier, with its concave shape directing one toward the opposite wall. One's attention moves toward the point of refreshment and above it, where two windows open onto foreshadowed views. The two apertures reveal a connection to the outside: showing first the immediate location of where the path of ascension leads, and secondly the context of the Gress Center.

The south wall is an opaque backdrop at the point of rest, but it becomes increasingly transparent away from this point. This composition accentuates the intention of the concave wall, which projects one's attention toward the opposite wall.

2) The idea of pausing along the path is defined by the wall systems, which use both form and layering of materials to accomplish a sense of enclosure. 2a) Formally, the walls work together to create an oval of enclosure within the larger confines of Ingress.

2b) The layers of materials of the south wall originate and stem outward from the point of rest. At this point, the idea of rest is at the forefront and the wall accentuates this by its opacity to the outside. Here, the clerestory pins itself to the opaque wall, stitching more of its transparency into the wall area as it moves further from the point of rest. The vegetation focuses around this point as well, forming a hollow, inhabitable enclosure. It begins low and
thick at the point of rest, then rises up, around and away from the point of rest, losing its
density as it moves further from the point of rest. The outwardly disseminating process
allows additional ambient light to increasingly shimmer in through the leaves.
Figure 32. Paired Points of Rest
Figure 33. View out from Point of Rest / Observation
REFLECTION WALL

The thick wall between Ingress and the Visitor Atrium contains a series of candlelit shafts. These alcoves become more prevalent toward the north wall, further from the point of rest and observation as well as the point of ascension. Relative to the process of Ingress, these niches gently glow below the space of the mezzanine and are a side-lighting feature.

However, the wall also provides a place for staff and family members to return for further reflection. Relative to the Visitor Atrium, the wall works with the entry and exit process of the visitor. The sequence of light niches intensifies as one moves from the semi-private parking area through the atrium to the Visitor Access of the Gress Center.
Figure 34. Reflection Wall (left of the water fountain and below Mezzanine)
ASCENSION

The architecture of the staircase is in tune with how we step up, from the difficulties of taking the first step to the acceptance of the last step. At the base of the staircase, ponderous qualities ground the stair in the earth. The treads are elongated to the length of complete strides, shortening by half a stride, until single treads remain. The initial stairs serve as landings, with distances of hesitation embodied within them. The ponderous character of the initial stairs lifts as the stairs climb, modifying to the first “official” landing. Wall system layers continue into the stair system and they adjoin at the first point of landing. The outer edge of the stair, the periphery toward the public exterior, echoes the south wall and is composed of granite. The inner edge of the stair, which rests towards the innards of Ingress, is made of birch wood.

The wooden handrail extends from its spindles to meet the body above the stair. The granite stair support also lightens as it ascends, becoming ever more vertical until it reaches the first landing. As its angle of inclination straightens, the stairs undergo a phenomenon of rounding, and subtly turn into the landing, softening the act of landing.

A glass elevator both physically and visually connects the two levels; through its transparent enclosure one is able to see the continuation of the staircase to the mezzanine level. A birch wood overhang demarcates the elevator door on both the upper and the lower levels.
Figure 35. Ascension
INITIAL LANDING: TURNING POINT

The landing is a turning point, a moment of acceptance of that which lies beyond. It acknowledges the end of one passage and the beginning of another. Where the landing ends the wall begins to ascend perpendicularly into a new passageway.

This point is critical, because it happens at the most direct collision between Ingress and the public connective tissue. The two collide, compacting and callusing over one another. The materials and building systems respond in similar fashion.

The “callusing” programmatically forms a water-filled skylight, whose triangular shape corresponds to the overlap between the public connective tissue above, the private ascension process below, and the adjacent Visitor Atrium. Within Ingress, the translucent skylight provides ambient overhead daylight, which is widest at the turning point and then diminishes through the rest of the stairs, finally disappearing at the end of the mezzanine. Within the connective tissue, the water feature protrudes into the otherwise regular path and calmly tapers back out. At the point immediately before it disappears from the connective tissue, it drains back down into the Visitor Atrium, serving to water the plants inside.

The staircase’s granite support crescendos up to create a shield, an inner shell of protection, at the point of landing. Meanwhile, the vegetation, which has grown from the resting point, adjusts to the turning point and intersects with the landing.

The south wall joins the stair at the turning point. The clerestory windows of the south wall are at their largest here and become full height. Such large and close windows might provoke a sense of vulnerability if they were at grade; however, the height of the interior here is significantly above the exterior ground level. One can see out without being seen. Additionally, the vegetative curtain maintains a veil-like presence between the glass and stair, providing another layer of separation.

The south wall elevation at the turning point creates two primary chiasmae. Firstly, the symbols of support intertwine: the handrail crosses the path of the granite base (as it ascends to create the landing wall). Secondly, the symbols of protection interlock: the clerestory rests into the landing.

The clerestory’s termination corresponds with the beginning of the landing. At this point the wall becomes opaque, thereby redirecting the emphasis of movement up from the
landing. The redirection is further emphasized by a change in the natural light source, which descends from the aforementioned skylight above the landing. The redirection is also emphasized in the detail of the handrail’s curvature at the edge of the straight landing.

The turning point reveals what will happen next through its views into the mezzanine and beyond to the Passarella.
Figure 38. Initial Landing Turning Point beyond Point of Ascension
MEZZANINE

The mezzanine mediates between the process of ascension and the passageway to the individual's new home. It adjusts to the new, higher vantage point, reflecting upon where one has been and where one is going. From its railing side, it allows one to look back down into the point of rest and refreshment. Additionally, it allows one to see beyond; the north wall is punctured with a series of windows that reveal views of the Gress Center’s forested context.

Figure 39. Site section through Mezzanine

Figure 40. Mezzanine Axon
Figure 41. Mezzanine with view to Gress Center beyond
PASSARELLA

The Passarella links the mezzanine to the individual's new home. It begins where the mezzanine ends and is demarcated by the termination of the granite wall which tapers down into the base of the floor and by the dissemination of the skylight above. Between these two, the birch lining increases its presence until it occupies the full area of the inner wall. Apertures peel from the inner skin of this wall, revealing trees climbing from the Visitor Atrium below.

The structure for this pathway stems from the public connective tissue on the upper level and on the lower level is part of the wall of the Visitor Access. The structure peels away from that of the public connective tissue and links into the structure of the Gress Center.

Figure 42. Site Section through Passarella
Figure 43. Passarella beyond Mezzanine
PACING

The process of entry is slowed, providing time to absorb change and gradually introduce the building to the newcomer. The thresholds that define Ingress reveal a rhythm that involves both times of movement and times of rest. The points are paced, with the resting/observation point being a complete-stop in the sequence.

The speed at which we take in the building is affected by the wall systems (the skin of layering systems). At Ingress, the south wall provides the tempo: the entirety of Ingress is formed around a curving series of points. The peripheral wall, the south wall, is the outer “ring” of the radiating points. It therefore has a momentum unlike that of the inner wall. It has a larger perimeter and it is in direct contact with the public façade and thus related to the pace of the public. The exposure to exterior light from the public façade brings forth the notion of relative movement and pacing on the interior.

The pace of walking is mimicked by the clerestory along the south wall. Where more south light penetrates, the space is more conducive to walking: Where there is less light entering through the clerestory the space is conducive to rest. In the series of points the following pulse emerges: From the point of initial entry one walks through the threshold and is slowed to focus on the point of rest. After the point of rest one gradually eases into getting up and beginning the journey further upwards. The clerestory parallels this; the windows gradually increase in area from the point of rest.
CHAPTER 11. EGRESS
THE ARCHITECTURE OF EGRESS

Egress seeks to gradually expose the individual to public life again, but to also provide a solid foothold for the first step out of the Gress Center. Egress acknowledges that numerous attempts might be made before one fully steps out into public life again. Similarly, the act of completely leaving the Gress Center, the individual’s home base, will involve several times of stepping out and back in again. Egress and the thresholds it includes offer points of reference for the individual to stride out from at a pace they are comfortable with. Christian Norberg-Schulz explains the notion of reference points in regards to stepping beyond that which is known into the unknown.\textsuperscript{125}

The notion of home as the centre of one’s world goes back to childhood. The first points of reference are tied to the home and the house, and the child only becomes able to cross its borders very slowly...From the very beginning, then, the centre represents to man what is known in contrast to the unknown and somewhat frightening world around.\textsuperscript{126}

As in Ingress, Egress recognizes both the need for protection and the need for exposure in the individual’s exiting process. A layering system of architectural elements (systems and materials) controls the degree of protection/exposure at Egress. The idea is taken further at Egress, whereby individuals can more immediately control their surroundings. This is exemplified throughout Egress, but especially at the Versatile Studios where foldable screens and sliding panels can be manipulated. These elements are made with varying materials to realize varying qualities of inclusion and seclusion.

Such adjustable architecture reflects the inhabitant’s use of the space, while giving the individual a sense of their own place - they can control a specific situation and in doing so take responsibility for it. Such responsibility is important to the idea of reactivation and personal development. It contributes to a sense of self management (an important element in

\textsuperscript{125} The citing of the child’s perspective is not to suggest that those working through recovery are childlike, but that the concept of home as a reference point is an elemental part of being human. As adults we may experience the same sense of hesitation when confronting something unknown.

the process of recovery as noted in chapter 3), whereby individuals take on the task of creating structure for themselves rather than having it mandated by professionals.

Egress was designed with three primary ideas in mind: the process of exiting a place for the first time, the slowness of absorbing the change (resting, seeing where you are going), and the opportunities to discover something new amidst public life. Additionally, Egress is attentive to the process of returning to the Gress Center after having stepped out. Thus Egress works as a two-way threshold and differs from Ingress, which functions as a one-way threshold.

The architecture accentuates and mediates between points that are significant to the process of exiting. The variety of programming and degrees of public interaction within each program offer the individual a wide range of possible ways to continue their recovery process. The degrees of engagement occur in sectional as well as in plan relationships of adjacency and material separation.

THRESHOLDS WITHIN EGRESS

Specific thresholds within Egress are listed below in chronological order (relative to the process of exiting). A detailed description of each occurs in the pages that follow this section.

1. **Initial Step** (threshold between the Gress Center and the Visitor Access)
2. **Reference Point** (threshold between Initial Step and public activities beyond)
3. **Versatile Studio Link** (threshold between Egress and semi-public Versatile Studios)
4. **Turning Point** (threshold between private and public access)
5. **Park Terrace Prelusion** (threshold between Egress and Park Terraces)
6. **Employment Café Prelusion** (threshold between Turning Point and Employment Café)
7. **Employment Cafe** (threshold between public and semipublic spaces of Egress)
8. **Egress Threshold** (threshold between Egress and outside)
9. **Public Piazza Programs** (threshold between Egress and downtown Minneapolis)
10. **Park Terrace** (threshold between Employment Café and Park)
11. **A Return to Egress** (threshold between leaving and reentering Egress)
Figure 44. Thresholds at Egress Ground Plan and Egress connective tissue Plan
INITIAL STEP

The initial step from the private rooms of the high-functioning* residents leads into a volume of possibilities with subtle pauses, gradually increasing to public exposure as one progresses through. From the initial step one is able to see the continuation of possibilities without being directly confronted by all of them at once; it intends to promote exploration of one's environment, not overwhelm the individual.

This vantage point offers a view through the interior space to the outdoors. The window at the far right reveals the intersection of the park edge, residential buildings, and skyline in the distance, while the windows toward the left offer closer views to the buildings and park immediately outside of Egress.

Low bookshelves define more intimate niches that are open to the space, yet slightly closed off from it. The shelves extend further into the area, carrying the reading material forward into additional semi-secluded alcoves, inviting one to progress forward.

The outer wall (northern wall) is composed of full height glass and opens onto a balcony that overlooks the Mississippi River. The outdoor space is flanked by the studio wing that creates a sense of partial enclosure to the vast expanse of the river valley. It is accessible from two opposite sides.

On the left, the Visitor Access is adjacent to this first step, but peripheral. The notion of exiting is legible from this point as the visitor door can be seen; however, it is distanced from the main passageway of Egress by a series of bookshelves. A nook for meeting lies adjacent to these shelves.

Figure 45. Site Section through the Initial Step
Figure 46. Initial Step
REFERENCE POINT

The visitor and staff stair is also set behind the series of bookshelves and is only accessible visually from the initial step. The staff workspace is located in this area, centrally located amidst Egress. Here, residents can ask questions and “check out” of Egress before proceeding further. A skylight hovers above the edge of the Reference Point and penetrates through the upper level where it mediates between the public connective tissue and the lobby of the Gress Center.

The workspace continues at the same height as the bookshelves, but is differentiated from them with a small granite water fountain that subtly protrudes out from the workspace into the path of Egress.

The Reference Point fountain relates back to its opposite corner, the inner corner of the balcony, which is also a water fountain composed of granite that protrudes into the interior. This fountain is a continuation of a fountain above, which lies between the public library and the upper waiting area.

![Figure 47. Highlighting the fountain relationship through space](image)
Figure 48. Reference Point beyond niches
VERSATILE STUDIO LINK

The granite fountain at the balcony corner demarcates the leading edge of the versatile studios. The versatile studio wing provides ample space for a variety of group and individual activities including dance, music and other arts. The open plan can be subdivided with panels made of different materials whose properties are suited for certain activities. For example, when playing an instrument, one might surround one’s immediate space with baffled panels in order to absorb sound. For painting, reading or writing a various layers of cloth, paper, or different transparency glass can be used to enclose oneself within the own space as one sees fit.

The upper level studio confronts the public connective tissue and the layers of material separation can be controlled by the individual according to the degree that they wish to reveal their work to the public. The wall between the connective tissue and the studio has one pane of clear glass on center, surrounded by three panes of frosted glass on either side. Thus both the “public” individual and the individual in the studio can control the degree of visual interaction. Sliding the panels open on one side only achieves half of the possibility of encounter; to fully see through the studio and connective tissue, both sides must have their doors slid open. The wall between the studio and the library also works this way.
Figure 49. Versatile Studio Link
TURNING POINT

There are three water elements that comprise the Turning Point. These water elements distinguish the first series of more private activities (the aforementioned bookshelves, Visitor Access, Versatile Studios, and niches) from the increasingly public activities beyond through both their physical presence and acoustic qualities. The three water elements on the floor align with the edge of the ramp in the ceiling and are titled: the Turning Point Fountain, the Reflection Pool, and the Drinking Fountain Pivot Point.

The water element at the far left, the Turning Point Fountain, lies at the pivot point of the turn and hinges between two walls of activity. The left wall appears just beyond the Reference Point and contains the final bookshelves and an edge of the public ramp that links the connective tissue to the ground level. This is the first indication of interior public space and the visual connection is designed to be non-confrontational; the frosted glass only presents silhouetted figures into Egress. Furthermore, the ramp height is significantly above the height of Egress.

The ramp reappears on the wall to the right of the fountain at a higher instance. It then gradually fades into the rest of the ceiling height as it ascends to the right. The wall on the right has been titled the Rec-Wall, as it is where shared recreational equipment can be stored for use outdoors.

The granite water fountain that defines the corner between these two walls continues upward, reappearing between the connective tissue and the upper ramp, relating the path of circulation that the individual will be able to later use to the path of water.

The Reflection Pool is the water element at the centrifugal edge of the turning point and elongates itself to engage a broader area between the more private part of Egress and the more public part of Egress. It is peripherally stretched through the right-most part of the view as one exits. The Reflection Pool offers a place for people to have an individual moment amidst the comings and goings of people moving through Egress. It steps down into the floor from two opposing directions enabling both to easily descend to the reflecting pool. The pool is visually and acoustically separated from the rest of Egress. The two sides of the reflection pool are separated from one another via a continuation of the granite wall.
The final water element at the Turning Point, the Drinking Fountain Pivot Point, lies between the Turning Point Fountain and the Reflection Point. This fountain harkens back to Ingress' Point of Refreshment and seeks to provide a similar moment of rest amidst the process of exit as well as the process of return. At its pivotal position the fountain can be seen as one leaves Egress, but also as one enters. The fountain is a cyclical focal point that is approachable on all sides, and therefore does not favor one direction over the other.
Figure 50. Turning Point
PARK TERRACE PRELUSION

Park Balcony

The entrance to the Park Balcony is located just beyond the Reflection Pool and offers the first fully public interface with the outdoors. It provides a means of 'testing the water' by offering the possibility of witnessing park and terrace activity while maintaining a significant distance from it. The sloping park topography naturally provides vertical separation between the balcony and the park terrace.

Park Terrace Initial Threshold

The preliminary access to the Park Terrace provides the next degree of public encounter by enabling one to go outside easily. This threshold provides access to the outdoors without having to confront the more sociable atmosphere of the Employment Café. It is a side-step in the Egress process.
Figure 51. Highlighted Park Terrace Prelusion
EMPLOYMENT CAFE PRELUSION

The clear glass door allows a full view into the employment café, while acoustically separating the activity beyond. Immediately past the transparent buffer, on the inner wall, lies the entry into the restrooms, which are separated from the rest of Egress by a frosted glass door. The public ramp to the connective tissue ascends above the restrooms and its presence is increasingly revealed as one progresses forward. The growing area of exposure to the ramp overhead is achieved by means of the ceiling ascending to a clerestory window. The clerestory aligns with the Park Terrace Wall protrusion.

Park Terrace Wall

The Park Terrace Wall mediates between the Employment Café (including its Prelusion) and the outdoor Park Terrace. The wall originates at the edge between the Park Terrace Initial Threshold and the Employment Café Prelusion. From this point onward, the wall parallels the terraces and progresses from an opaque wood surface to transparent glass. However, at the point between the edge of the public restrooms and the café, the wall juts inward. This slight obstruction forms a full-height aperture that confronts the edge between the exterior terraces and the interior employment café. The window provides a foreshadowed view toward the threshold between in and out, mimicking the preliminary access to the terrace. The shifting point in the wall slightly tightens the space at the edge of the restrooms, thus demarcating the volume between the toilets and the café. Furthermore, it correlates to the skylight as part of the differentiated edge to the Employment Café.

The wall continues, at an angle perpendicular to the shifting point, until it meets the egress threshold. Throughout this segment, the glass wall mediates between states of permeability. Immediately after the shifting point, the wall opens with a sliding door whose overhang responds to the exterior condition of the tapering terrace steps and adjusts on the interior to an angle orientated to the public elevator. The second opening interrupts the wall as its entire frame shifts to orientate itself to its respective terrace step. Sitting space for the Employment Café lies between the door thresholds.
Figure 52. Employment Café Prelusion with Park Terrace Wall
EMployment CAFÉ

The Employment Café is a public place that seeks to connect the individual to activities beyond those offered through the Gress Center. To this extent, it is the reference point from which the recovery process can further link into the public life of Minneapolis via means of employment and volunteer opportunities. (Recall from Chapter 3 that a critical part of recovery is to become involved). The Employment Café seeks to make this important link in an atmosphere that is open to exchange through media such as posting boards, internet access and word of mouth. The Café serves as a sounding board for the community and therefore benefits not only the Gress residents, but also anyone who might be looking for such opportunities. Furthermore, as a Café it provides a sociable atmosphere for information exchange to occur, while providing a place of refreshment for people in the adjacent park.

The Café is a vertical circulation hub, containing access to the connective tissue above. A ramp originates at the outer edge of the Café and ascends behind the its counter. The ramp continues beyond the realm of the Café, but reappears at a much higher level, defining the entry door into the glass elevator. The elevator is positioned between these two ramp segments and ascends to a point in the connective tissue that adjoins additional café seating. The beginning of the ramp corresponds with a view to the outdoors, where trees nestle into the side of the building.
Figure 53. Employment Café: (from left to right) wall to Café Prelusion with ramp above, elevator, café counter, ramp origination point with window above
EGRESS THRESHOLD

Adjacent to the ramp’s origin lies the Egress Threshold, which comprises an opening between two granite monoliths. The mass toward the left lies perpendicular to the rest of the wall and creates an edge, which separates ramp circulation from that of the Egress Threshold. The granite mass on the right terminates the Park Terrace wall and parallels the public sidewalk beyond. The space between their substantial presences is highlighted and softened by a birch wood overhang that protrudes both into the interior and out to the exterior, further defining the doorway.

The opposing granite monoliths taper up and away from the doorway, providing expansive views beyond to the Grain towers. The doorway itself is comprised of a wooden frame surrounded by transparent glass, which is wedged between the granite. The glass also affords views to the immediate sidewalk, street and the piazza beyond.

Figure 54. Egress Threshold Axonometric
Figure 55. Egress Threshold: (from left to right) café counter, ramp origination point with window above, Egress Threshold, Park Terrace Wall
Figure 56. Egress Threshold Detail
PUBLIC PIAZZA

The public piazza is comprised of numerous programs that extend from the Gress Center and are linked together with the public connective tissue (as described in Chapter 7). The Projector Tower rises above the connective tissue as an extension of the Guthrie Theater. The silos that the Projector faces provide space for terraced outdoor seating. Gallery Cubes and Market stalls fill the piazza and extend their presence southward to the boulevard beyond.
Figure 57. Public Piazza: Connective tissue spanning Riverside Drive and linking to the Projector Tower above and Gallery Cubes and Market beyond
PARK TERRACE

The silos adjoin the Mill City Museum and a stretch of former warehouses of the “Historic Mill City” that are now filled with condominiums. Riverside Drive follows this strip of buildings, which is paralleled by the Mill Ruins Park. The Stone Arch Bridge curves into this strip of sloping terrain further upriver.

Egress’ Park Terrace steps from the Employment Café with granite landings amply sized for groups to sit and rest along the park’s hillside. The park terraces mediate between the edge of Egress and the public sidewalk it eventually engages. The Park Terrace’s granite base bonds these two elements on the terrain. By grounding the “floating” steel and compressing itself into the valley edge, the boundary to the park becomes a large landing that is subdivided into terraced platelets.

The platelets are scaled to an intimate size, suitable for hosting small tables and comfortably encompassing edge seating for two or three people, while still accommodating circulation. The different proportions are implemented for purposes of stopping or moving. A platelet measuring eight feet square, for example, is a platelet of pause: it is an ideal size for an intimate table seating a few people. A platelet at 3’ x 8’ is more conducive to movement; it is an elongated step.
Figure 58. Park Terrace Edge
A RETURN TO EGRESS

The elevation of Egress from the point of return further exhibits its immediate context. A handrail accentuates the granite ramp that leads up to the Egress Threshold. This pathway engages the pedestrian sidewalk, but plantings also maintain a vegetative buffer between the faster circulation of the adjoining bicycle path and the foot traffic surrounding Egress.

Indications of the interior process of exiting are revealed in the building's exterior composition. The granite monoliths of the Egress Threshold demarcate the doorway, but are accentuated by the extensive wooden overhangs. They cantilever through the threshold as well as augment the edge of the park terrace. The glass Park Terrace wall opens from the Employment Cafe onto a series of landings that descend into the hillside. The clerestory of the Employment Cafe Prelusion rises from the roof, counter-stepping to the glass-sided ramp leading to the connective tissue. The elevator, located at the pivotal corner of the ramp, rises further into the skyline.

The gradual opening to the public park and piazza that was revealed through the progression of Egress is exposed here as a gradual return into the private sanctuary of the Gress Center. The glass intermingles with granite and steel further into the realm of Egress. The jut in the Park Terrace Wall demarcates this transition, shifting from transparent glass to granite. This granite segment runs parallel to the Park Terrace's Initial Threshold, where, again, a transparent opening is situated perpendicularly to that of the exterior wall layers. The balcony exhibits the next degree of enclosure followed by the Initial Egress Window.

From this vantage point we see how Egress' position in the topography works with degrees of encounter. The initial egress window is the highest above the ground plane (avoiding direct contact with public space altogether), followed by the balcony (which overlooks the public ground), the park terrace Initial Entry (which side-steps into the park terraces), and finally the Park Terraces themselves (which directly access the public ground).
Figure 59. Egress Perspectival Elevation
CHAPTER 12. CONCLUSION

The intention of this thesis was to challenge the ways of thinking about mental health treatment in and the design of care environments. It aimed to propose an architecture that is sensitive to the constant state of flux between strength and vulnerability, particularly experienced by those who are in difficulty, but really for all of us who have known both health and illness. It is my hope that this thesis inspires others to further challenge the status quo of the built environment and pay closer attention to how we care for each other.

"The greatest sin toward our fellow creatures is not to hate them, but to be indifferent to them. That is the essence of inhumanity."127

127 From the play “The Devil’s Disciple” George Bernard Shaw, Three Plays for Puritans (New York: Brentano’s, 1921); quoted in Ray Stewart. In Our Care. Produced and directed by Ray Stewart. WOI-TV, 1952. Script for Documentary Series.
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REFERENCES CITED

The American Heritage Dictionary of The English Language. 3d ed.


Blanchard, Stephen C., MSHA, Department of Psychiatry Administrator, Interview by author, 10 September 2004, Iowa City, Iowa, Hand-written. University of Iowa Hospitals and Clinics, Iowa City, Iowa.


