BUILDING COMPASSION

Michael L. Troyer
Ball State University
College of Architecture and Planning

Adult Day Care & Residential Center for persons living with HIV / AIDS
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This thesis document is submitted in partial fulfillment of the course requirements for Architectural Thesis, Architecture 404 and the requirements for the degree: Bachelor of Architecture.

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Thesis Design Studio Critic: Dr. Daniel Doz
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Thesis Committee

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Adult Day Care & Residential Center for persons living with HIV / AIDS
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I would like to thank the Damien Center of Indianapolis, Indiana for the opportunity of participating in the volunteer buddy program and the invaluable information it provided me. Thank you for providing and coordinating services for persons living with or affected by HIV/AIDS in our community and actively advocating for just and compassionate responses to their needs.

I would especially like to thank Jean, Peggy and Jeff for your past and continued support. Without these people this thesis would not be possible.
The following poem is by Rodney Jenkins, who reached and inspired many people through "Rodney's Column" in the Multifaith AIDS Project Newsletter. He wrote, "It is one thing to have AIDS and live with knowing that you most likely will die sooner than you thought. But, you see, we never know when death will come. So many have endured so much, yet in the midst of it all, we have sometimes found love and hope and courage." Rodney died of AIDS on July 27, 1991, at the age of 40.

Remember when you were six and I was two?
You went off to school,
Leaving me behind, missing you.

Remember when you were eleven and I was seven?
You went off to Junior High,
Leaving me behind, missing you.

Remember when you were sixteen and I was twelve?
You went off in your car,
Leaving me behind, missing you.

Remember when you were eighteen and I was fourteen?
You went off in your car,
Leaving me behind, missing you.

Now you're forty and I'm thirty-six.
I called you to say, "Hello"
but you were asleep.
You are well, and I am dying.
Looks like I will be
Leaving you behind, still missing you.
Olga Broumas: The Healing Moment

Olga Broumas is an award-winning poet who lives in Provincetown, Massachusetts. Her poem "The Moon of Mind Against the Wooden Louver" has been reprinted from Poets for Life: 76 Poets Respond to AIDS. Not only reminding us of the cross-cultural and indiscriminate nature of this disease, her poem traces the different ways we each deal with the personal tragedy of AIDS.

The Moon of Mind Against the Wooden Louver

The visitors in room 8509 stand in a circle chanting something in Russian. The Hassids down the hall have come in segregated silence, men roll their thick white stockings in the lounge, mothers and sisters still between the door and bed each time I pass. We step across invisible or merely transparent shadows making up their mind to speak, to intervene, to cull.

A firm hand, like the a.m. nurse sponging the last few hours of confusion from the somehow childlike emaciated limbs and face she lifts, a bride, I swear, swathed in a sheet, back on fresh linen and then clips the bottom of the flowers keeping the family at bay while Barry naps in her unbridled trust, we lack. Not without prayer. Not without

the pluck and humor of the song your bones thrum while the blood still laves their broadside and their flank. I kiss your bones. In mind each rounded pinnacle of rib is white against an O'Keeffe sky and light their lingua franca. Such thinking heals the moment. It divides us for its duration like a cyclone

fence from our despair, our rage, our bitter greedy fear.

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INTRODUCTION

As the HIV/AIDS epidemic unfolds the long-term services required by affected individuals are becoming increasingly evident. The profession of architecture must respond to this crisis through understanding and compassion. As a volunteer for the Damien Center, Indiana's largest HIV/AIDS service agency, it has become obvious to me that most persons living with HIV/AIDS suffer from the negative aspects associated with the loss of control within their own lives. For this reason, I strongly feel that the living environment for persons with HIV/AIDS should help restore that lost sense of autonomy through accessibility and comfort.

Can a building type, for the terminally ill, be designed as a place for living? How can this building type best respond to the accelerated aging process of persons living with HIV/AIDS. This thesis is designed to address these questions in three phases. The first phase will deal with a study of light and its affects physically and psychologically. The second phase will respond to the user needs and emotions. The third phase will study the effect of a controversial project on a site and its context.

The site for the facility is located within the urban fabric of Indianapolis, Indiana. This thesis will incorporate the concept of a supportive setting for unconventional health care services through an adult day community specifically designed for persons living with HIV and AIDS. The facility will house an adult day care center, living spaces
for permanent residents, administrative offices and retail spaces.

Just as Martin Luther King Jr. reminded us, whatever affects one directly, affects us all indirectly. We are all inextricably bound in a network of mutuality. Unfortunately, the psychological pollutants of ignorance and fear still roam freely in our society, causing many people to want to reject and abandon the Ryan Whites of the world. This thesis attempts to light the candle of enlightenment for the misinformed.
AIDS (acquired immune deficiency syndrome), first appeared in 1979, with the initial cases being reported in New York City and San Francisco. By the middle of 1981 over a thousand cases of the disease were reported throughout the United States and Europe. The federal government chose to do nothing, believing that the problem was a "local one" and thus outside the national concern. By mid-April 1983, 1339 cases of AIDS were known. Still the medical community, fearing the politics of the time, reacted with reluctance. Society appeared to be returning to McCarthyism and an "age of fear", after all the victims are only poor Haitian refugees, homosexual men and drug addicts.

In 1984, HIV the (human immunodeficiency virus), was identified to be the causative agent of AIDS. This discovery has increased the number of risk groups now associated with the disease. The faces of AIDS continues to change today, affecting not only those afflicted with the disease, but all of society. The number of reported AIDS cases is ever-increasing. The number of victims of this tragic and brutal disease is rising by proportionate standards when compared with other diseases.

Today, statistics and facts about HIV/AIDS can be as somber as they are mind numbing. For example, it is known:

*that there are nearly a quarter of a million AIDS cases now reported in our country.
*that one in every 250 Americans is infected with the human immunodeficiency virus (HIV);

*that every 13 minutes a new person is infected;

*that AIDS is now the third leading cause of death among adults between the ages of 24 and 44;

It is difficult to comprehend numbers of this sort and make them real. Look in a phone book and count 250 names, or image an entire city of 250,000 people. When you do this you can begin to visualize the enormity of this crisis. HIV/AIDS is not going away. Unfortunately it continues to grab headlines, claim our attention, and rob us of so many wonderful people whom we have loved and admired. The complexity of this disease continues to cost people their lives, their livelihood, their family, their dignity and sometimes their rights.

The building type addressed in this thesis has a relationship to past building types. Unfortunately it is a relationship based on prejudice and fear due to lack of education concerning life threatening diseases. In the past, persons afflicted with diseases such as tuberculosis and leprosy have been isolated to sanatoriums and leper colonies. This isolation stripped people of their rights, dignity and self-respect. Today we understand that this isolation was not necessary. We must be understanding rather than be critical or judgmental as efforts continue to deal with the serious and challenging problems associated with HIV/AIDS.
DESCRIPTION

PREMISE
Philosophical; Can a building type, for the terminally ill, be designed as a place for living?

Architectural; How can a building type best respond to the accelerated aging process of the terminally ill?

The stigma associated with HIV/AIDS is so deeply embedded into our cultural fabric that it would be virtually impossible to change societal views of the disease through a building type. For this reason the position taken is that there will undoubtedly be social aversion to the project. The project must overlook this aversion and be organized from the users perspective by providing a supportive setting for the enrichment of their lives.

The faces of HIV/AIDS continues to change today, affecting not only those afflicted by the disease, but all of society. The number of reported HIV/AIDS cases is ever increasing. The number of victims of this tragic and brutal disease is rising by proportionate standards when compared with other diseases. The complexity of this disease continues to cost people their lives, their livelihood, their family, their dignity and sometimes their rights. As the HIV/AIDS epidemic unfolds the long-term services required by affected individuals are becoming increasingly evident.

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The Damien Center - Indianapolis, is central Indiana's largest HIV / AIDS service agency. As a volunteer for the Buddy Program at the center, I have encountered many of the challenging problems associated with persons living with HIV / AIDS. In conversations with my buddy and others at the center, it has become obvious to me that most persons living with HIV / AIDS suffer, from the negative aspects associated with the loss of control within their own lives. For this reason, I strongly feel that the environment for persons living with HIV / AIDS should help restore that lost sense of autonomy through accessibility and comfort.

PROGRAMME
Persons with HIV/AIDS rely on the compassionate energy of those who surround them. We all must accept our roles as caretakers looking past the stigma attached to HIV/AIDS. The whole human race will have failed if science alone vanquishes HIV/AIDS, and we as healthy individuals ostracize and neglect the weak and ill. The architecture in this thesis deals with many challenging issues associated with HIV / AIDS. Issues of utmost importance in the design deal not with the structure itself, but the spiritual and emotional feelings it evokes in the users.

The materials employed in the architecture should be warm and rich in texture and color. The use of such material should dispel the sterile atmosphere of a hospital or clinic. The interior should be bright, with natural light flooding the space. While timelessness of materials is to be consid-
ered, the architecture should play the role of a backdrop to the users. Quality in craftsmanship should outweigh the idea of architectural fashion.

Flexibility of the space is paramount. We are currently in the infancy stages of HIV/AIDS. As our knowledge changes about this disease, the facility must possess the ability to respond and adapt quickly.

Through architecture it is possible to respond to this crisis with understanding and compassion. The architecture must embody the philosophy of a physical, emotional and spiritual healing center.

CONTEXT

CULTURAL:
Indiana has historically been a conservative state, proud of its traditional midwestern values. Unfortunately, these traditional values may create an air of opposition toward such a controversial project. While some may oppose the project, others will respond with the midwestern values which advocate neighbor support and working together for the good of the community.

PHYSICAL:
The project site is located within the urban fabric of Indianapolis, Indiana, near the downtown center. The parcel of land is flat and located between historic commercial buildings located on Massachusetts Avenue. With the infill of a structure on the site, the completion of an urban wall along Massachusetts Avenue will take place.
METHODOLOGY

PROCESS:
Light and shadow plays an important role in the creation of spaces evoking spiritual and emotional feelings. It was paramount that first, a study of light and shadow be explored, which was later be incorporated in the design process. The first design phase concentrated on the emotional and physical benefits of light.

The second phase of design concentrated on the users of the facility. In phase two a three part design evolution began through observation, direct contact and interaction with persons living with HIV/AIDS. This process concentrated on the emotional needs for the administering of healthcare services. Through interviews with healthcare professionals, specific needs of the care givers will be addressed. The third area of information gathering will address budget of the facility. The second step dealt with the functional needs for the administering of healthcare services. Through interviews with healthcare professionals, specific needs of the care givers were addressed. The third area of information gathering addressed budgetary considerations and the administrative needs of the facility.

The third phase of design addressed the site and its context. The creation of a facility to house and care for persons living with HIV and AIDS has in the past been seen as a social threat. It is this threat which isolates the project from its context creating a "ghetto effect". This "ghetto effect" was analyzed to minimize its impact on the context.

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Design

Introduction
Compassion thrives in individual acts of kindness. This thesis design was inspired by the fact that it could be the home of many compassionate acts.

For many of the residents, this will be their last home in this world. It should be as humane a place as possible for the duration of their stay, (on average, probably 6 to 12 weeks). While seeking to create a nurturing residential quality, the client and residents medical needs must not be neglected. The facility is to be as comfortable and gracious as a small hotel.
The project site is located in Indianapolis, Indiana on a triangular parcel of land near the downtown center. The site is bound on the north by Walnut Street, on the south by Massachusetts Avenue and on the west by East Street. The neighborhood is a mixture of residential and commercial areas. The Massachusetts Avenue side is primarily commercial, housing restaurants, coffee shops, small offices and a video store. A grocery store is located three blocks from the site within easy walking distance. To the north of the site is the Chatam Arch Historical District. Many historic small homes experiencing a gentrification, and renewal process are located in this area. To the east, a large number of renovated apartment buildings occupy many of the parcels of land along with a number of low income public housing complexes and a fire station.
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CHARACTER

The design of the facility aspires to enhance the neighborhood. Similar in scale to the neighboring commercial buildings, the center completes the street corner it occupies, reinforcing the intersection as an urban "room" and serving as a transition between the residential neighborhood to the north and the commercial and retail district to the south.

The building responds to its neighbors, emulating their own qualities and character. It marks the street intersection by means of setbacks and a set of protruding bay windows in the adult day care center. The structure is topped by a prominent fourth floor building length atrium space.

Residential character has been emphasised on the building exterior with the use of low key architectural forms such as bay windows, small balcony spaces and the modulation of the planes of the street facade. The masonry base helps to solidly ground and protect the building, lending it a commercial aspect as well as a sense of permanence and dignity. The building softens as it climbs.

INTERIOR:
On the interior, the residential character is strongest in the patient rooms. The planning of this facility is based on the single unit approach versus the double unit approach. Since the rooms will be the last place many residents occupy, it is important that the rooms seem to belong to them during that time, a private and hospitable place for friends and relatives to visit. Each room has a fold out couch/chair so that
relatives or friends can spend the night. Each room is individually heated and cooled and has operable windows, allowing the residents to control their own environment.

FURNISHINGS:
The healthcare furniture industry supplies hospitals, nursing homes and other medical facilities with furnishing constructed differently than those we use in our homes and work places. Maintenance guides the choice of materials and construction. Healthcare furniture companies have cornered the market, offering a narrow range of traditional styles, colors, and finishes. This range consists mostly of several variations on the traditional styles and fabrics used and designed for the nursing homemarket. However, facilities such as the one designed for this thesis will serve a younger group of people than those targeted by the healthcare standards. As a response to this limitation, custom furnishings designed to healthcare standards should be used.

MATERIALS:
Sofas and chairs cannot collect fluids or dirt in seam welts or under cushions; finishes should not absorb germs; fabrics need to stand up to the bleach and other harsh cleaning fluids used for sterilization in medical facilities. There are movable pieces of furniture in the patient units as well as common rooms, a side table, a fabric covered, residential style sofa or oversized chair, upholstered as well as wooden chairs, light maple furniture, and headboard, all with clean contemporary lines with easy hand pulls and hardware. A natural finish imparts the woods warmth to the rooms.
Plastic-laminate insets will take the abuse on tables and countertops. The effect will be urban and uptown with lots of style in a crisp clean look, reinforcing the impression that the space is clean (that is, sterile) without looking antiseptic.
COMMUNITIES:
The facility is organized into three communities. The first community incorporates spaces for activities associated with the adult day care center. The second community provides the residential units and the nursing support services. The third community contains the retail spaces. The income from the leased space will help offset the costs associated with running the center and also give something back to the community.

ADULT DAY CARE COMMUNITY:
The adult day care center is located on the east end of the facility and utilizes four floors. The street entry to the adult day center is on the Chatem Square side. The parlor serves as an entry for clients and visitors of the center. The adult day care center at ground level has a client lounge, conference/meeting room, administrative offices, counseling room, nurses station with examination room, physical therapy and hydro-therapy rooms and a soiled linen and storage area.

The second floor is designed to create a residential quality. It has a living room filled with southern light from the large expanse of bay windows. The living room is designed with two distinct areas. One area is close to the windows and serves as a sitting space with a private balcony, and the second area is the television alcove. Adjacent to the living room is the dining room large enough to accommodate every resident and clients of the center. A full service kitchen and serving area adjoin the dining

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room. All rooms are centered around a large light filled atrium space open to the forth floor. A lounge for sitting, talking, and smoking with a refreshment area is located just off the atrium on the first, second and third floors.

The third floor has a library/reading room with two separate spaces, the book nook and the reading area close to the bay windows. Just off the reading area is a private balcony which can be used as an outdoor reading space. Adjacent to the reading room is a nap room for client use throughout the day. A general activities room with activity tables for game-playing and casual gatherings is located off the central atrium space. The room is filled with light from both the atrium and the large expanse of bay windows on the east end of the facility. Next to the general activities room is a small nurses station with an examination room and a massage room for clients. The massage room doubles as a personal care room for clients to receive haircuts and personal grooming services donated by the community. Once again all the rooms surround the central atrium space.

The fourth floor is an open atrium area and serves dual functions for both the permanent residents and the clients and visitors of the day care center. A solarium serves as a contemplation space with views of the city to the south. Next to the solarium is an outdoor garden deck providing an intimate outdoor space for client and visitor use.

RESIDENTIAL COMMUNITY:
The residential community occupies a ma-

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jority of space on the second and third floors of the structure and shares the use of the fourth floor with the adult day care community. A first floor private entrance for family and friends is located on the courtyard side of the facility. It allows private drop off and pick up of residents and functions as a sitting parlor overlooking the landscaped courtyard. This community houses the living units and skilled nursing station for the permanent residents of the facility.

Three different living configurations make up the residential units. There are eight single suites, one double suite and one studio per floor. The second and third floors accommodate living spaces for twenty-two residents at a given time. The planning of the units utilizes the 45 degree angle of Massachusetts Avenue. Each unit is placed at 45 degrees within the structure to allow for optimal views down the street instead of facing directly across at the neighboring buildings. The entrances to the individual living units are organized along a light filled, atrium corridor open to the fourth floor. There is a modulation of the corridor wall to delineate the entry to each unit which develops into a series of connected spaces rather than a single hallway. Central within the atrium spaces is located a lounge/seating area on each of the two floors. These spaces provide a get away space close to each unit. At the end of each atrium corridor is another lounge with a refreshment area located by the nurses station. The nurses stations in the residential community have exam rooms, hydro-therapy, physical therapy and massage room on
each floor. A soiled linen and storage area are also located on the second and third floors. The fourth floor of the residential community is shared with the adult day care community. It houses: a solarium, a wandering space (the catwalk along the atrium window), a green house, a meditation space and a lounge. Adjacent to the lounge is an outdoor garden deck providing an intimate outdoor space for the residents and their guests.

RETAIL COMMUNITY:
The retail community is located on the first floor. Cutting through the community is a corridor linking the residential side of the structure to the commercial side. This becomes an interior alley through the site and acts as a transition between the retail space and the adult day care center. The retail area consists of approximately 7000 square feet of leasable space. Each retail space is accessible by the commercial entry and by a service corridor which allows for deliveries without disrupting business. The income generated by the leasable space will help offset the operating expenses incurred by the two other communities. The projected number of tenants is three, with approximately 2000 to 2500 square feet per tenant. Targeted businesses would be service oriented, (coffee shop, cafe or laundry service), and also small retail establishments. The retail community acts as a good neighbor by offering services back to the community in which it exists.
UNIT DESIGN PROCESS:
The approach I explored in the design process was to place myself into the shoes of the person living in the residence. The process of design began by entering the living units and visualizing in my mind the experience of the resident. This process forced me to design from small scale to large. Creating the total experience of the interior seem to be of utmost importance, considering the user of the facility realistically may be confined to a living unit or a bed for the duration of their stay. The interior experience must give back to the resident the home atmosphere that most have been deprived.

The thought of being confined to a bed, caused me to explore different ways of optimizing the patient views from a supine position. The 45 degree angle of the living unit allowed views to extend down the street as opposed to only the exposure of buildings across the street. The use of low-hung windows allow for views while the patient remains in the supine position.

Privacy is an issue to most residents, with varying degrees of importance depending on the individual person. For this reason the space must be flexible enough to accommodate total privacy and at the same time allow for patient monitoring if necessary. A special door, which functions as a wall when closed, was incorporated into the design for this reason.

The units are to represent to the resident and friends the atmosphere of a personal
home. For this reason the spaces are large enough to accommodate differing placement of furnishings. The size will also allow for the resident to bring in personal furnishings of their own.

The configurations of the living units ended up being a modification of the double loaded corridor. The reason for this configuration was due to the small size of the site and the limited exposures to southern light in the spaces. A number of different configurations were tested in groupings to form communities, within the larger community, but the triangular shape of the site and restrictive size did not allow it. This caused problems with the placement of living units and in turning corners on the exterior of the structure with these clustered groups.

Light played a big role in the design process. The benefits, both physically and mentally called for large amounts of light to flood the space. Upon entering the residence, the user will pass through a light-flooded three story atrium space, and continue into a darker more intimate entry inside the residence. Once the resident turns the corner from the entry space, once again light will flood in from the exterior windows in both the living area and the bedroom.

The process of placing myself within the structure permits me to visualize best the experience the user will go through. This process was used throughout the design.
The residential character is strongest in the living units. Unlike the single room concept of a hospital and nursing home, the units are group into individual rooms reflecting a home-like atmosphere. Each room has a fold out sofa or chair so that relatives or friends can spend the night. A specially designed door for the single and double suites allows flexibility in the space offering different degrees of privacy. The door when closed is viewed as a stationary wall and not a door. The use of inlayed natural woods in the door help lend to the residential character of the room. Features of all the units are similar: low hung windows (providing views for patients in a supine position), bay style window in the main living space, kitchenette with sink, microwave and under-the-counter refrigerator, and a private outdoor balcony with planter. Each unit allows for flexibility of furnishings and the opportunity to bring in the patients own personal pieces.
TYPICAL SINGLE SUITE:
The typical single suite is comprised of six major spaces, an entry, living room, kitchenette, bedroom, private bath and an outdoor private balcony. The single suites have approximately 475 square feet of living space.
TYPICAL DOUBLE SUITE:

The typical double suite accommodates two patients with some shared amenities. The unit is comprised of seven major spaces, a shared entry, two living room bedroom combinations, shared kitchenette, shared bath and two private outdoor balconies with planters. The two spaces have the flexibility of varying degrees of privacy through the use of the specially designed doors. The double suites have approximately 750 square feet of living space.
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TYPICAL STUDIO:
The typical studio is comprised of five major spaces, an entry, living room bedroom combination, kitchenette, bath and private outdoor balcony with planter. The studio has approximately 400 square feet of living space.
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CONCLUSION

ASSESSMENT
Today our world is undergoing profound change. The crises of our times: the depletion of our natural resources, the population explosion and the holocaust caused by the disease called AIDS has set in motion a shift in our view of the modern world. We are moving from a mechanistic view to a new conception of reality: one that regenerates the principles of a spiritual existence.

People have always sensed that there exists another "reality", one that gives meaning to our everyday lives. As we discover that science, technology, and consumer goods and services do not provide this meaning, knowledge of the non-manifest world of the spirit becomes of prime importance.

In architecture, this translates into a new way of viewing our world, its underlying form, and the forces that give it shape. It relates architecture to the cosmic scheme of things and defines a relationship between human beings, architecture, and the natural environment. This new view includes the principles of spiritual space, light and the passage of time.

SPIRITUAL SPACE:
In most societies, living in the world is a spiritual experience. It is living in a dwelling, town or city formed in the image of the cosmos. This notion of spiritual space breaks the homogeneity of undifferentiated modern space. It allows the world to be founded and oriented because it reveals a fixed point, a center. To create a spiritual space is to reconstruct the universe, to repeat the act of transforming chaos into order. The natural environment - its light, landforms and vegetation - becomes the background in the making of a spiritual space. In this sense the natural and built environments become interdependent.

LIGHT:
Light is the most changing natural phenomenon and it intimately connects us to the rhythms of nature. When admitted through openings in the building, light assumes the added purpose of revealing the ever changing experience of interior form. It pierces the heaviness of matter; it is the revealer of architecture and is essential in exposing the dynamic quality of architecture itself and the spiritual spaces within.

TIME:
The human being is the embodiment of both the rational, objective, and measurable world and that which is immeasurable and of the spirit. In this period of great change, as we strike a balance with our past preoccupation with the material world and our forgotten roots in the spiritual world; we have a special obligation to explore and make both worlds known. The role of the architect is unique in that architecture can speak to that which is beyond time.

In reflection, the architectural ideas of spiritual space, light, and time have been
recurring themes throughout my thesis and my architectural education. Whether the thesis premise has been satisfied through the exploration of this project is still up for debate in my mind. It is difficult to conclude that you have fully explored all ideas and option in one project.

The philosophical and architectural questions asked in this exploration are questions which could be posed of all architecture. The idea of buildings - for the terminally ill - being designed as a place for living is attainable. The idea of a building type responding to the accelerated time or aging process of the terminally ill is also attainable. What is not attainable in one project is the exploration of spiritual space, light, and time in relationship to a multitude of building types. This exploration is a life-long process.

Architecture should make visible the invisible forces present in a building and the natural world. These are the forces that serve the person as a being of body, soul, and spirit.
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BIBLIOGRAPHY


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ADULT DAY CARE
& RESIDENTIAL CENTER  for persons living with HIV/AIDS
SECOND FLOOR PLAN

FIRST FLOOR PLAN

SCALE: 1" = 16'-0"

NORTH
TYPICAL SINGLE SUITE

SCALE: 1/4" = 1'-0"