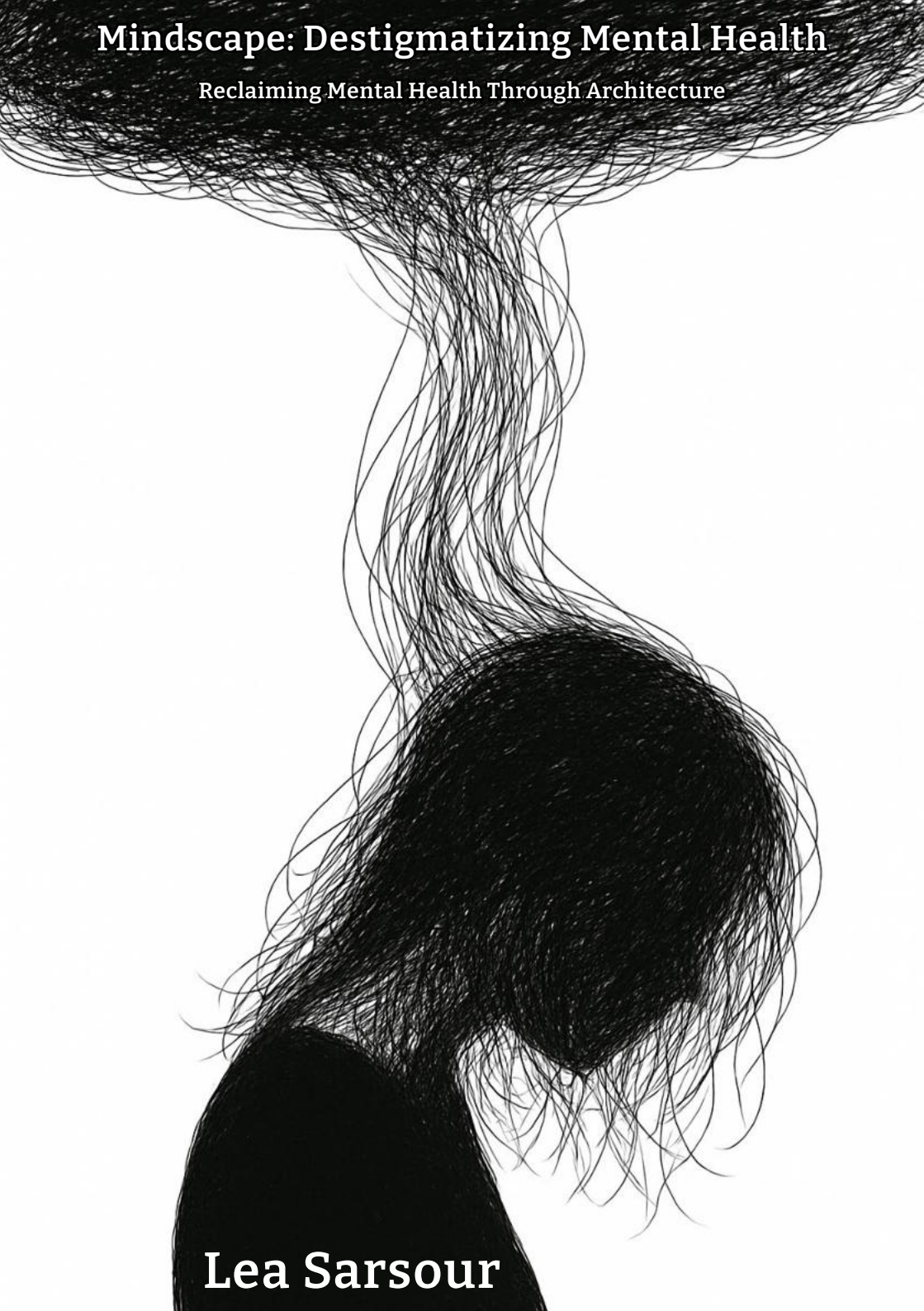
Mindscape: Destigmatizing Mental Health

Reclaiming Mental Health Through Architecture



Lea Sarsour

“ The greatest cruelty is our casual blindness to the suffering of others.”

–Anonymous

Artwork 1. Pinterest, accessed August 25, 2025, https://www.pinterest.com/pin/596234438206957172/.

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Destigmatizing Mental Health

Reclaiming Mental Health Through Architecture

Lea Sarsour

Final Project

[Pro]active Studio

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Architecture and Town Planning Program

Faculty of Architecture and Town Planning, Technion

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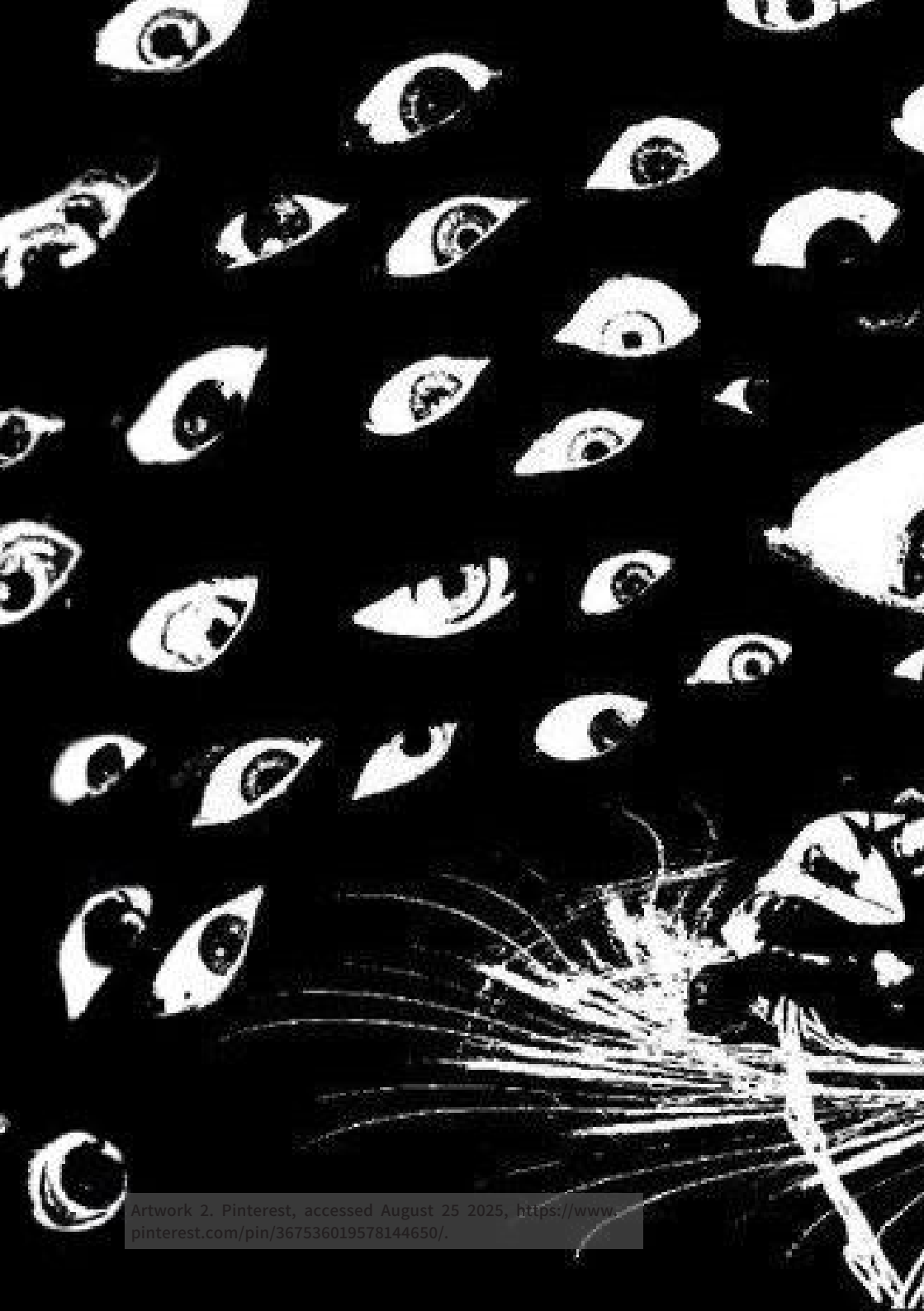

Artwork 2. Pinterest, accessed August 25 2025, https://www.pinterest.com/pin/367536019578144650/.

“*Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity*”

— The World Health Organization

Abstract

Mental health is a fundamental human right, yet it remains stigmatized, underfunded, and poorly integrated into urban development. While physical health services receive widespread prioritization, mental health continues to be treated as secondary, leaving many, especially marginalized communities, without essential support. This project explores the intersection of mental health and architecture, emphasizing how the built environment shapes psychological well-being, social connection, and emotional resilience.

Using Jaffa as a case study, the research examines how spatial design can mitigate the alienation experienced by its residents, particularly within the Arab sector, where systemic inequalities exacerbate mental health disparities. By analyzing Israel's existing psychiatric institutions, including psychiatric hospitals, rehabilitation centers, and balancing homes, this study identifies architectural patterns that either support or hinder mental health outcomes.

The proposed intervention reimagines urban spaces to align with Jaffa's cultural and social fabric while embedding mental health support into daily life. Through inclusive, community-oriented, and adaptable design strategies, the project challenges the traditional model of isolating mental health care within medicalized institutions. Instead, it envisions a city that integrates mental well-being into its fabric and serves as a replicable framework for other urban settings facing similar challenges.

This project calls for a fundamental shift in planning

The stereotypical psychiatric hospital room. https://www.shutterstock.com/image-photo/crazy-straitjacket-psychiatric-12801700

where mental health is not an afterthought but an essential component of city design. It underscores the urgent need for architectural frameworks that foster dignity, inclusion, and collective healing while dismantling outdated models of segregation.

Keywords: Mental health architecture, stigma, urban well-being, psychological resilience, spatial justice, healing environments, human-centered design.

Introduction

Introduction

This project examines the relationship between mental health, architecture, and urban design, focusing on marginalized communities in Israel. It explores how architectural design can either support or hinder mental well-being, particularly in societies where mental health remains stigmatized. Through theoretical analysis, cultural investigation, and architectural proposals, the project advocates for inclusive, accessible, and integrated design strategies that challenge conventional mental health care models.

The first chapter examines the relationship between mental health, stigma, and architecture, drawing on theories by Erving Goffman and Michel Foucault to explore how design can either reinforce exclusion or foster inclusion.

The second chapter focuses on the Arab sector in Israel, where mental health struggles are often concealed due to cultural stigma and societal pressure. Fear of social judgment discourages individuals from seeking professional help, reinforcing cycles of isolation and untreated conditions. This chapter highlights the need for culturally responsive architectural solutions that foster openness and accessibility.

The third chapter examines mental health institutions in Israel, analyzing the spatial characteristics and treatment models of psychiatric hospitals, rehabilitation centers, and balancing homes. It critiques how traditional institutional settings reinforce stigma by separating mental health care from daily life and proposes urban-integrated alternatives that promote community engagement.

The Architecture of Well-Being - HOK

The fourth chapter introduces Jaffa as a case study, exploring its historical, social, and cultural complexities. It examines the city's demographic shifts, socio-economic disparities, and the impact of gentrification on local communities. Central to this chapter is the identification of spaces of alienation—urban areas that evoke exclusion and disconnection due to their design, function, or history.

The final chapters presents the proposed intervention, developed through research and site analysis. It outlines strategies for transforming spaces of alienation into inclusive, healing environments by restoring historical structures, embedding mental health services into public spaces, using local materials to reinforce cultural identity, and fostering community engagement through participatory design. The intervention is framed as both an architectural and social initiative aimed at reducing stigma and integrating mental health into the urban fabric.

This project challenges the idea that mental health care should exist on the margins of society. It argues that architecture has the power to shape public attitudes, dismantle stigma, and create environments that support psychological resilience and social inclusion. By rethinking the relationship between mental health and urban design, it envisions a future where cities themselves become spaces of healing and collective well-being.

Artwork 3. Yanar, "Reflection art, Dark art illustrations, Deep art" (Pinterest image), accessed September 1 2025, https://in.pinterest.com/pin/1618549864284670/.

Chapter I
Mental Health, Architecture & Shame

Mental Health, Architecture & Shame

Mental Health

Mental health is a fundamental human right. Yet across the world, and acutely in Israel, it continues to be stigmatized, underfunded, and segregated from the environments where people live their lives. While physical health is prioritized in both discourse and infrastructure, mental health remains an afterthought. This neglect is not abstract; it is embedded in our cities, policies, and physical spaces.

In Israel, mental health concerns are rising sharply. Over 600 suicide deaths and nearly 7,000 attempts occur annually[1]. These numbers already exceed the annual rate of traffic-related fatalities. The trauma of the Gaza-Israel war from 2023 to 2025, along with the lingering effects of the COVID-19 pandemic, intensified psychological distress. Rates of PTSD, depression, and anxiety have surged, affecting close to 44 percent of the population.[2] Yet mental health services remain sparse, overburdened, and inaccessible. Psychiatric hospitals often operate at more than 110 percent capacity, forcing patients to sleep in hallways[3].

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1 נתוני אובדנות בישראל משרד הבריאות - gov.il, accessed March 15, 2025, https://www.gov.il/he/pages/suicide-data-il.

2 “PTSD, Depression, and Anxiety Nearly Doubles in Israel in Aftermath of Hamas Attack,” Columbia University Department of Psychiatry, January 9, 2024, https://www.columbiapsychiatry.org/news/ptsd-depression-and-anxiety-nearly-doubles-israel-aftermath-october-7-2023-terrorist-attack.

3 “Hospital Occupancy,” Centers for Disease Control and Prevention, September 13, 2023, https://archive.cdc.gov/www_cdc_gov/respiratory-viruses/data-research/dashboard/hospital-occupancy.html.

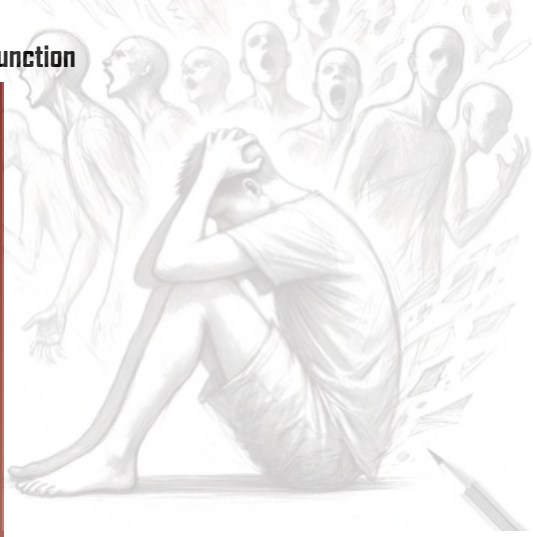
Five patients in the ward. Photo from one of the hospitals. https://www.ha-makom.co.il/post-galit-psy-hospital/

For many, professional care is out of reach, physically, economically, and emotionally.

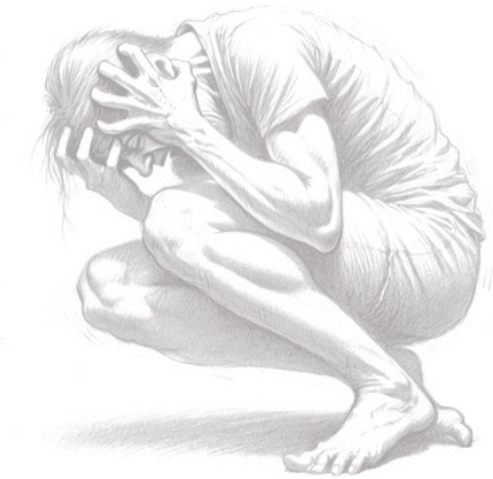
This crisis is deepened by societal stigma, which isolates those who are struggling. In many traditional and conservative communities, including the Arab sector, mental illness is often seen as a source of shame. It is not spoken about openly. The fear of social judgment discourages individuals from seeking help, creating a cycle of silence, deterioration, and exclusion.[4]

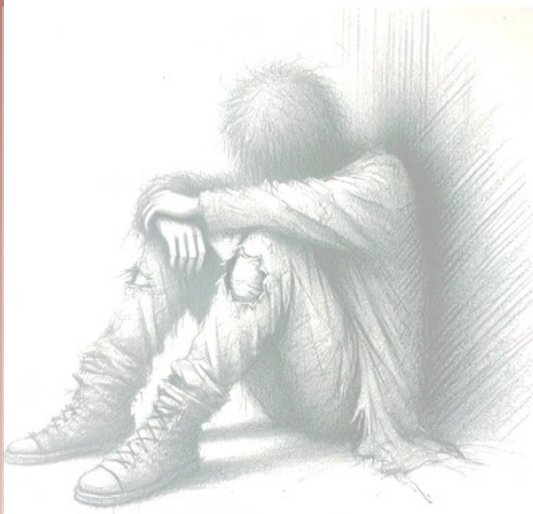
4 Abo-Rass, Fareeda, Sarah Abu-Kaf, and Ora Nakash. 2022. "Barriers to Mental Health Service Use among Palestinian-Arab Women in Israel: Psychological Distress as Moderator" International Journal of Environmental Research and Public Health 19, no. 19: 12557. https://doi.org/10.3390/ijerph191912557

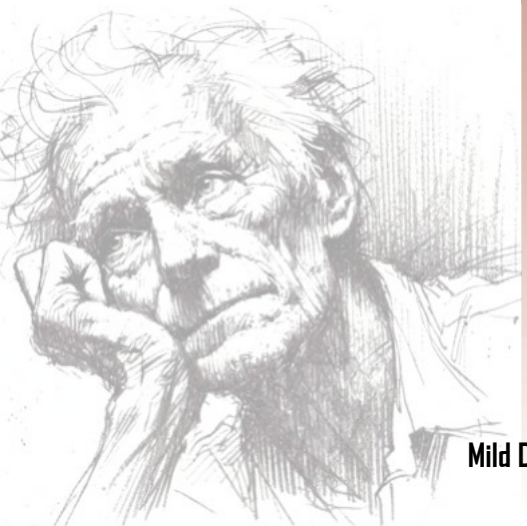
Inability to Function



Spectrum of Mental Disorders: From Mild to Severe







Mild Disruptions

However, stigma is not only cultural or psychological. It is also spatial. Architecture plays a critical role in reinforcing or dismantling the invisibility of mental illness. The placement, design, and symbolic language of mental health institutions reflect the values of the society around them. When psychiatric hospitals are hidden on the edges of cities, surrounded by fences and designed with rigid, institutional layouts, they communicate exclusion. These buildings send a message: mental illness must be managed, contained, and kept out of public sight.

This spatial exclusion has been shaped over centuries. This spatial marginalization is not unique to Israel; it reflects a long history of how societies have responded to mental illness. In his book **Asylums** (1961), **Erving Goffman** introduced the concept of the total institution. These are places such as psychiatric hospitals, prisons, and military bases where individuals are removed from society and placed under rigid systems of control. Goffman showed how these environments strip people of their autonomy, identity, and social relationships. Far from healing spaces, they become places of surveillance and dependency. Within them, individuals are defined not by who they are but by what they are diagnosed with.

Michel Foucault expanded this critique. In **Madness and Civilization** (1961), he traced the historical management of mental illness, beginning with medieval leprosariums and leading up to the rise of the asylum. Foucault argued that modern psychiatric institutions were not created out of compassion, but out of a need to control what society saw as irrational or dangerous. In **Discipline and Punish** (1975), he explored how architectural structures, from prisons to hospitals — shape behavior. These environments do not simply house individuals; they enforce order and control. They

Asylums Book Cover. Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates, Erving Goffman, 1961. Source: Anchor Books.

Prisoners Exercising (Prisoners' Round). Vincent van Gogh, 1890. Cover of Discipline and Punish: The Birth of the Prison, Michel Foucault. Translated by Alan Sheridan. New York: Pantheon Books, 1977. Source: Pushkin State Museum of Fine Arts.

were never just places of treatment. They were places of discipline.

Both Goffman and Foucault reshaped the way we understand mental health institutions. Their work revealed how these spaces reflect a deep-rooted cultural discomfort with vulnerability and psychological distress. They forced architecture to confront its own role in reinforcing stigma and exclusion. Their insights form a central foundation for this project — revealing how mental illness is not only treated clinically, but managed spatially, culturally, and politically.

This project addresses the following research question:

How can architecture transform spaces of alienation into environments that promote inclusion, connection, and mental well-being, while dismantling stigma?

This thesis takes that question as its starting point. Through the lens of architecture, it reconsiders how mental health is supported, where it is supported, and who has access to care. It rejects the logic of institutional isolation and instead proposes integration. Mental health support should not be pushed to the margins of the city. It should exist in the public realm, visible, accessible, and part of everyday life.

To support this vision, the project adopts a design framework based on two core concepts: care and cure. Cure refers to focused clinical intervention and recovery. Care refers to ongoing emotional support, social connection, and the feeling of being seen. These concepts are not separate. They must coexist. Architecture must make space for both. This thesis explores how that can be done within the urban fabric, not by building new institutions, but by transforming the environments we already live in.

Artwork 4. Mitch, “lost soul” (August 7 2023), Instagram, accessed 2025, https://www.instagram.com/p/CjxpiyUow9A/.

Chapter II
Concealment and Denial & The Arab Sector

The Arab Society in Israel

Arab citizens make up approximately 21% of Israel's population, including Muslims, Christians and Druze. They are distributed across villages, towns, and mixed cities such as Jaffa, Haifa, Lod, and Acre. While they are citizens of the state, Arab communities often experience deep structural inequality and marginalization. Public services such as healthcare, education, infrastructure, and transportation are typically underfunded or poorly maintained in Arab-majority areas.

In response to this neglect, many Arab communities have developed a strong sense of internal cohesion. These communities tend to function semi-independently, maintaining cultural, linguistic, and social self-reliance. Family plays a central role, and extended networks are deeply involved in everyday life. Personal identity is closely tied to communal reputation, and in such tightly woven communities, social standing is a shared responsibility rather than an individual concern.

Mental health challenges within this framework are rarely perceived as neutral or solely medical. Instead, they are filtered through layers of social perception and cultural expectations. A diagnosis, or even a visible emotional struggle, may be seen as a sign of weakness, instability, or failure to conform. It can jeopardize a family's standing, interfere with marriage prospects, or disrupt long-standing social relationships. Emotional suffering is often silenced, not only due to personal fear or denial, but because disclosure could threaten the social balance within a highly interdependent environment. What is hidden becomes normalized, and what is visible is carefully managed.

Even in moments of deep distress, individuals may suppress their emotional needs in order to protect their family's name. This silence is not rooted in apathy, but in a survival instinct shaped by collective memory and experience. The community's closed nature, along with its status as a minority, creates a unique tension between the need for help and the fear of social rupture. In such cases, mental illness becomes not just a private struggle but a communal burden, and visibility is traded for perceived stability.

Concealment and Denial in Minority Communities

This pattern is not exclusive to the Arab sector. Across many minority, conservative, and traditional societies worldwide, mental illness continues to carry a heavy stigma. In such groups, illness is often seen not as a neutral medical condition but as a moral or spiritual shortcoming. Concepts like strength, modesty, and resilience are often emphasized, while expressions of vulnerability may be met with discomfort or denial. These pressures make it difficult to discuss psychological challenges openly.

Seeking help is not only seen as unnecessary, but sometimes as shameful. Psychological care may be replaced with religious or spiritual responses, such as prayer or traditional healing. Families may minimize or hide emotional suffering to avoid reputational damage. Individuals, in turn, may internalize these views and deny their own needs in order to avoid social scrutiny. Fear of judgment, gossip, and exclusion acts as a barrier to honesty and care.

This dynamic becomes even more complex for communities that already feel excluded from broader society. For minority groups under political, cultural, or economic pressure, public

A drawing by a mentally ill person, from the "Enlightenment" ("Astanara") therapeutic assessment developed by Dr. Nabila Anaboussi following the October 7 attacks (Photo: Courtesy of Dr. Nabila Anaboussi)

"I hated the stigma around therapy... the stigma that stopped me from seeking help when my anxiety and depression were at their worst... I didn't want anyone to be in the position I found myself in – lonely, confused, and scared"

– Nour Abou Fayad[1]

1 https://al-rawiya.com/the-stigma-the-struggles-the-shame-an-interview-with-nour-abou-fayad/#:~:text=more%20I%20talked%20about%20it%2C,I%20found%20myself%20in%20%E2%80%93

dignity becomes a form of resistance. Admitting to emotional distress can feel like a form of vulnerability in a world where being perceived as strong is a form of survival. The fear is not only being misunderstood by outsiders, but being seen as weak within one's own community. Denial becomes a form of social self-preservation.

This silence has long-term consequences. Emotional pain that is not addressed does not go away. It lingers, accumulates, and eventually becomes chronic. Individuals may function in daily life while carrying enormous psychological burdens. Without support structures, mental health issues deepen into isolation, hopelessness, and long-term distress. When there is no space for expression, suffering is internalized and buried beneath the surface of everyday life.

The Arab Sector as a Case Study

In the Arab sector of Israel, these cultural dynamics are further compounded by the lack of accessible infrastructure. Even when individuals are willing to seek help, the physical and institutional systems fail to support them. Mental health services are limited in Arab-majority areas, and many psychiatric clinics and hospitals are located far away. Arabic-speaking professionals are underrepresented, making communication difficult and often uncomfortable. Public health campaigns are rarely translated or adapted to local cultural frameworks. These gaps reinforce the sense that the system is not made for everyone.

This is especially true for vulnerable groups, including women, youth, and elders. Arab women often experience heightened social pressure to remain emotionally restrained. Feelings of anxiety, depression,

or trauma are typically managed privately, hidden behind socially acceptable roles or channeled through physical symptoms. Elders may carry trauma from war, displacement, or generational poverty that was never acknowledged. Younger individuals, exposed to both modern ideas and traditional expectations, often find themselves caught between two worlds without the tools to navigate either.

The physical environment reflects this exclusion. In many areas, care facilities are not only distant but also feel disconnected from the community's cultural language. Their institutional appearance, rigid layouts, and foreign modes of operation make them feel unsafe or unwelcoming. Without spaces that are culturally familiar and emotionally intuitive, the built environment reinforces the invisibility of mental health struggles.

Shame and silence are shaped by what is visible and what is hidden, by what is accessible and what feels foreign. Architecture has the potential to either sustain that silence or begin to gently dissolve it. When designed with cultural sensitivity and emotional intelligence, physical space can offer more than treatment. It can offer permission. Permission to feel, to speak, and to heal.

Prof. Sami Hamdan:

"Research from recent years has shown that **more than 30%** of adolescents in Arab society reported **injuring themselves** multiple times, and often they could not explain why they did it. **Suicidal thoughts exist among about one third of young Arab men and women**."[1]

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1 "אובדנות בחברה הערבית - תנו לנו כלים להציל חיים," ynet, September 10, 2023, https://www.ynet.co.il/health/article/hj5fyaqc3.

המלחמה מעמיקה את המשבר הנפשי גם בחברה הערבית

"בחברה הערבית, מי שהולך לטיפול מתויג כמשוגע. מחרימים אותו"

כמו אצל היהודים, רבים מאזרחי ישראל הערבים חווים בשנתיים האחרונות פגיעות נפשיות קשות ותסמיני פוסט־טראומה ● נפגעי הנפש הערבים מפחדים מהרקטות, מזועזעים מטבח 7 באוקטובר וגם מהמצב בעזה, ומודאגים מפיטורים ורדיפות פוליטיות ● עם זאת, חלקם מסרבים לקבל טיפול: "חוששים מסטיגמה"

Mourners gather in the Arab town of Tamra in northern Israel on June 17, 2025, for the funeral of four family members killed in an Iranian missile attack. (Jamal Awad/Flash90).

Societal Stigma

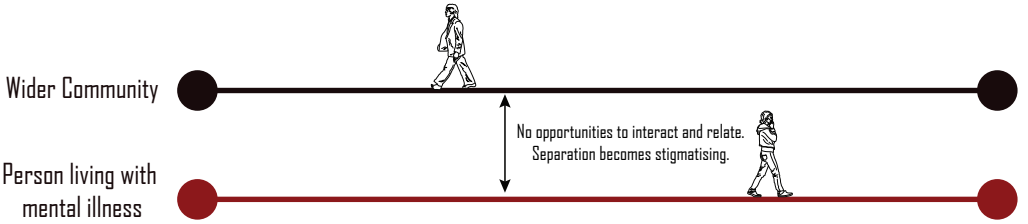
In Arab communities, awareness of mental health struggles does not always lead to seeking help. Many people recognize their pain, yet fear of judgment, shame, and social exclusion keeps them silent. Family honor and cultural expectations often make denial feel safer than disclosure.

This stigma discourages naming mental illness, pressures families to hide emotional suffering, and leaves many carrying distress in isolation. As one young Arab woman explained in an interview:

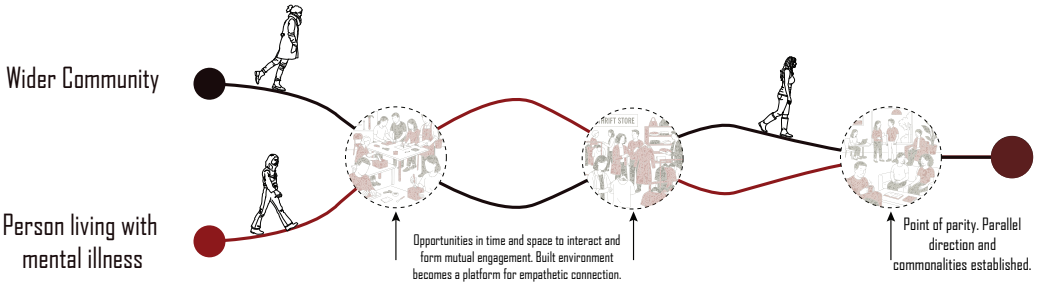
"*It was easier for me to say I had cancer than to say I was depressed. Cancer people understand. Depression makes you weak in their eyes.*" (Al Jazeera, 2020).

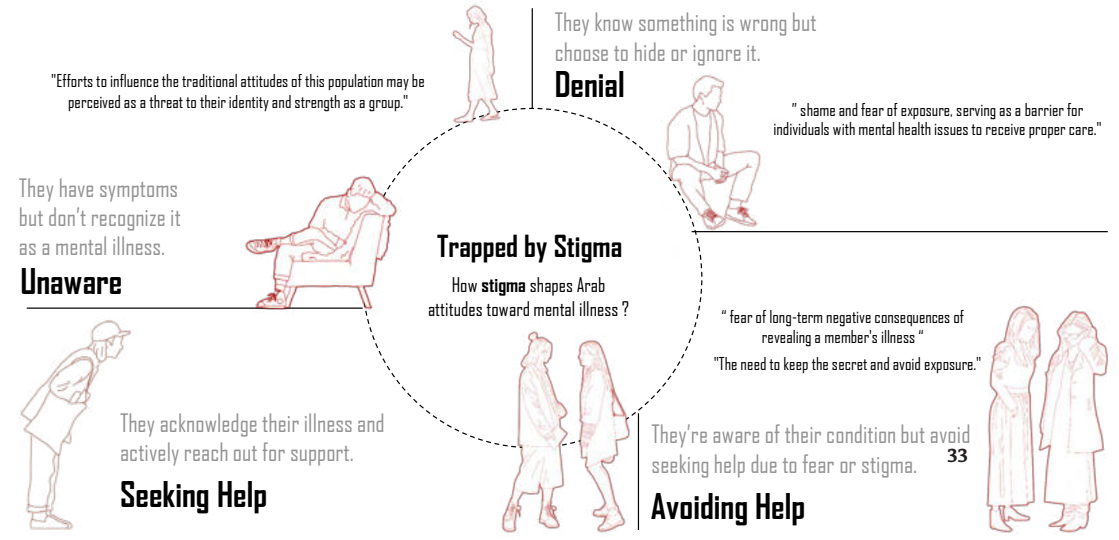
https://www.nami.org/education/barriers-to-mental-health-the-middle-eastern-experience/

Types of Stigma of mental illness



Reduction of stigma through contact





Chapter III
Mental Health Institutes in Israel

Mental Health Institutions in Israel: Spatial Distribution and Access

There are three primary types of institutions that form the core of Israel's mental health infrastructure: psychiatric hospitals, rehabilitation centers, and balancing homes. These facilities are meant to address different stages of care, from acute treatment to post-hospital stabilization. However, they often operate in isolation from one another, with limited integration or coordination. Many are difficult to access without private transportation, and few are designed with the user experience in mind. The architecture and spatial placement of these institutions continue to reflect an old-fashioned separation between health and society.

Rehabilitation approaches in Israel focus primarily on practical reintegration. Services include supported employment, assisted living, and structured day programs intended to stabilize individuals following acute psychiatric episodes. While valuable in principle, these services are inconsistently available and often delivered in improvised settings. Many facilities are housed in generic or reused buildings, lacking the therapeutic quality that recovery environments require. Cultural adaptation is minimal, and in Arab communities, these services are virtually nonexistent.

Mental health continues to be treated as a secondary concern within Israel's broader healthcare system. Psychiatric care is underfunded, understaffed, and largely disconnected from primary and preventative care frameworks. The Arab sector, in particular, is nearly invisible in mental health planning. There are almost no Arabic-speaking professionals in key positions, few services tailored to cultural context, and little effort to address language or gender-related access issues. Even when

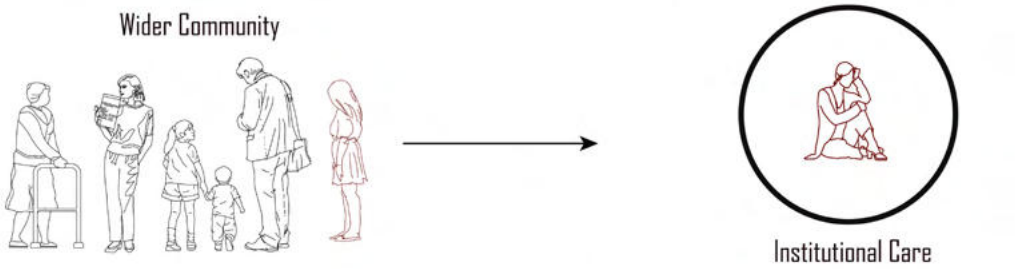
individuals in these communities overcome personal and cultural stigma, the physical and institutional barriers remain.

This landscape reflects more than just logistical failure. It communicates a message that mental illness, and especially the mental health of marginalized groups, does not belong within the normal flow of life. Care is hidden, both physically and socially. Until mental health services are fully integrated into the environments people live in, and until architecture reflects respect, trust, and accessibility, the system will continue to fall short of offering meaningful care.

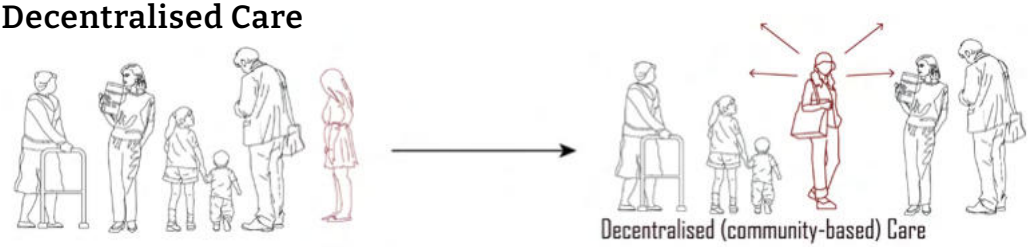
The spatial distribution of psychiatric institutions in Israel reveals deep structural disparities. Facilities are concentrated primarily in Jewish-majority and mixed cities, while Arab communities remain almost entirely unserved. Despite the significant presence of Arab populations across the country, there are no psychiatric hospitals located within Arab cities. This absence is not coincidental. It reflects a broader pattern of systemic neglect and a mental health system built around exclusion rather than inclusion.

Israel's mental health care system has traditionally been structured around institutional models. Most services are delivered through large psychiatric hospitals situated far from urban centers. These institutions follow an outdated logic of containment, built to isolate individuals experiencing mental illness from the rest of society. In contrast, decentralized care models aim to integrate mental health support into everyday environments, using community clinics, neighborhood-based services, and transitional housing to provide continuity and familiarity. While reforms have promoted the idea of community rehabilitation, the reality remains that institutional care is still prioritized in both planning and funding.

Institutional Care



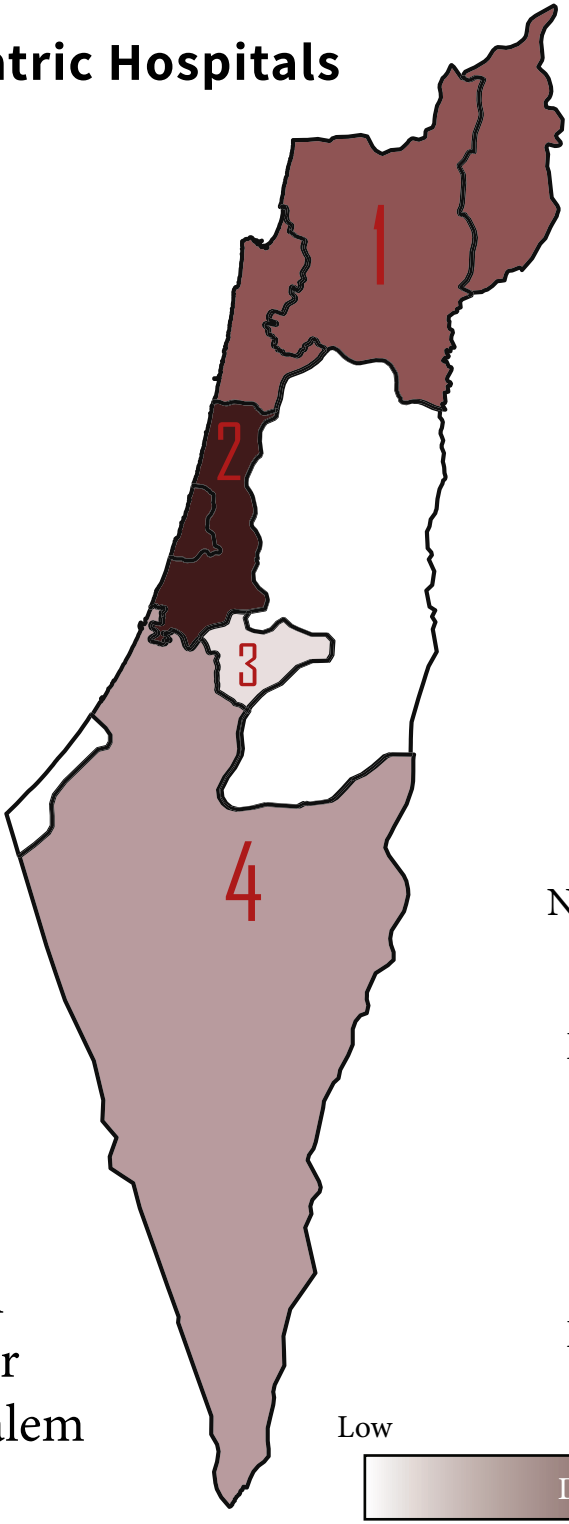
Decentralised Care



Types of treatments


Geha Hospital. Photo: Efrat Eshel

Psychiatric Hospitals



Number of hospitals

Jewish cities: 10
Percentage: 52.6%

Arab cities: 0
Percentage: 0%

Mixed cities: 9
Percentage: 47.4%

1- North
2- Center
3- Jerusalem
4- South

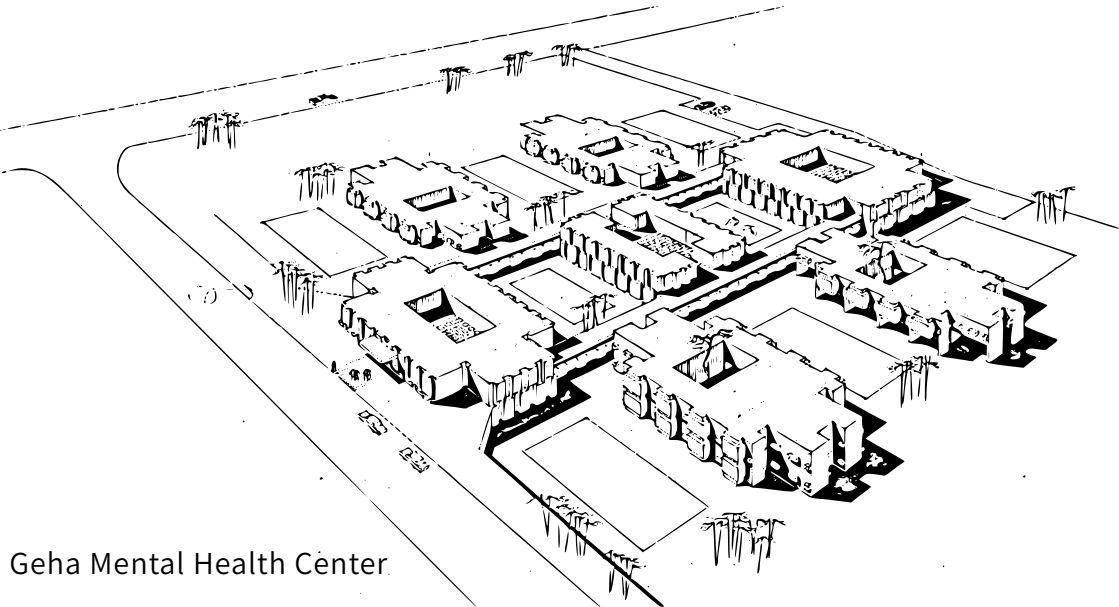
Low High

Density

Psychiatric Hospitals

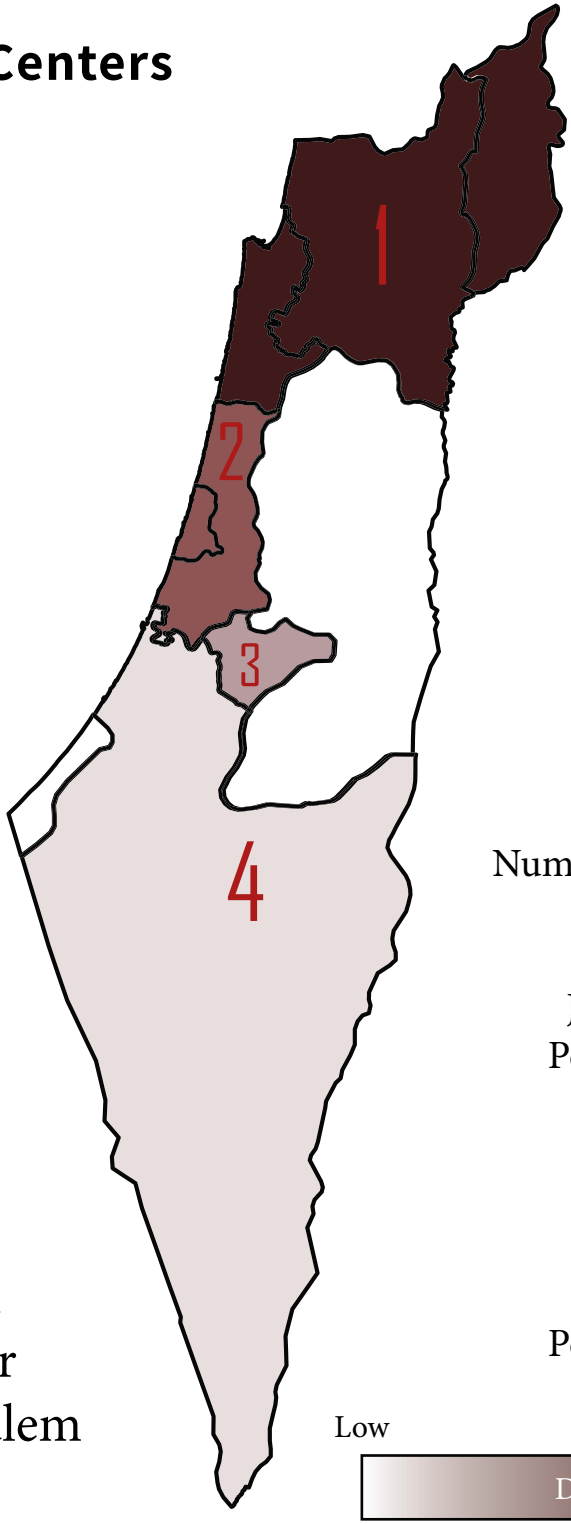
Psychiatric hospitals in Israel are typically built on the outskirts of cities, physically detached from everyday public life. Their typology is based on corridor and pavilion layouts, with long institutional wings, centralized staff stations, and high degrees of control. Facilities such as Geha or Abarbanel are often surrounded by fencing or open green zones that separate them from the surrounding context. Shared patient rooms, fluorescent lighting, and hard materials reinforce an atmosphere of surveillance and containment rather than healing. These spaces prioritize order over comfort and give form to the idea that mental illness should be hidden. Their architecture communicates exclusion, and their physical detachment from Arab communities only reinforces the inaccessibility of care.

Psychiatric Hospitals | Typology



Geha Mental Health Center

Rehab Centers



Number of rehabilitation centers

Jewish cities: 23
Percentage: 88.4%

Arab cities:0
Percentage 0%

Mixed cities:3
Percentage: 11.5%

1- North
2- Center
3- Jerusalem
4- South

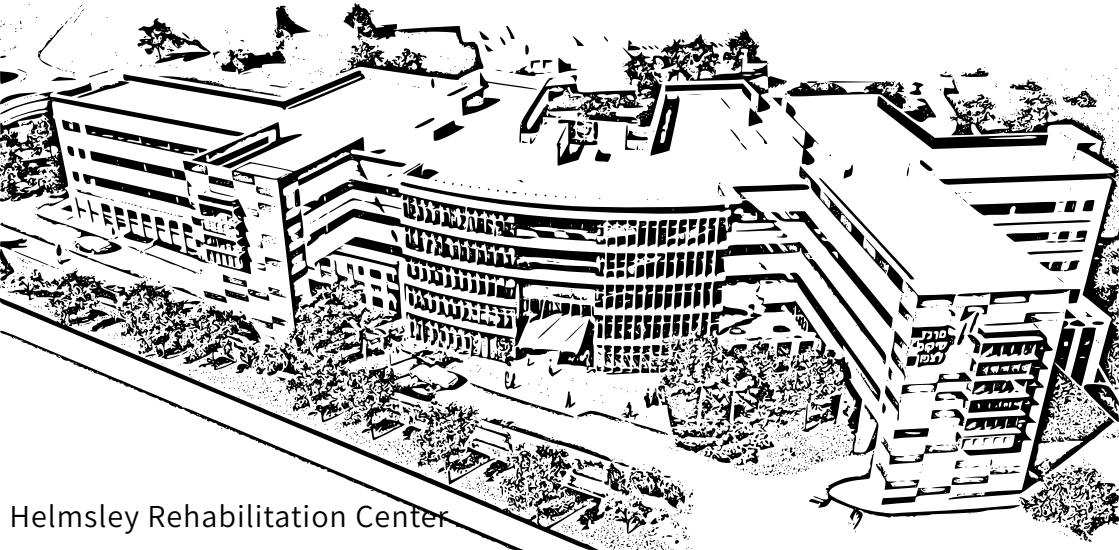
Low High

Density

Rehabilitation Centers

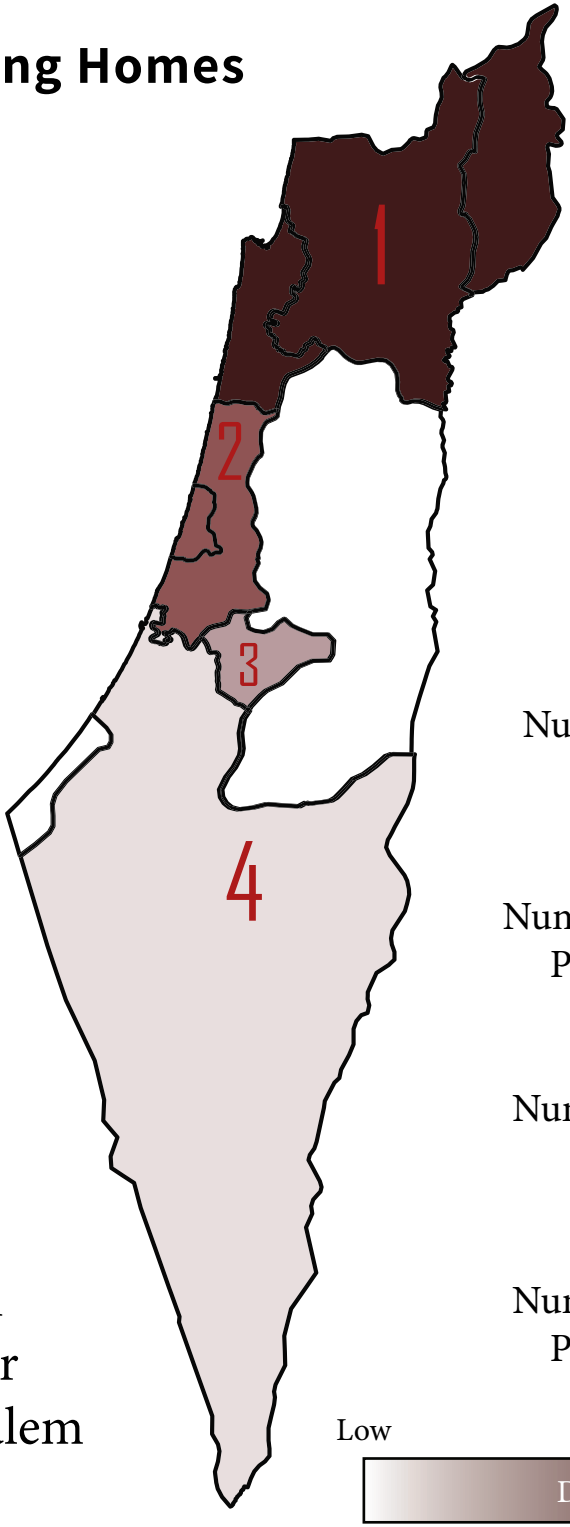
Rehabilitation centers serve as transitional spaces for individuals stabilizing after hospitalization. These include day centers, supported work programs, and residential facilities. Most are located in adapted buildings such as former offices or residential units. Their typology tends to be generic and utilitarian, with basic shared kitchens, bedrooms, and activity rooms. Interiors are rarely designed to support sensory comfort, privacy, or therapeutic experience. Although meant to promote social reintegration, their spatial qualities often convey impermanence and marginality. For Arab communities, their near-total absence is not only a logistical issue but also a spatial erasure — recovery infrastructure simply does not exist within reach.

Rehab Centers | Typology



Helmsley Rehabilitation Center

Balancing Homes



Number of Balancing Homes

Jewish cities:
Number of hospitals: 10
Percentage: 52.6%

Arab cities:
Number of hospitals: 0
Percentage: 0%

Mixed cities:
Number of hospitals: 9
Percentage: 47.4%

1- North
2- Center
3- Jerusalem
4- South

Low High

Density

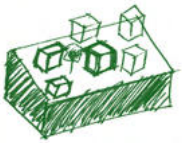
Balancing Homes

Balancing homes, are intended as short-term therapeutic residences for people transitioning between hospital and home. They are usually placed in standard apartments or institutional buildings, with minor spatial modifications. Communal areas, shared bedrooms, and structured daily routines define the experience. The typology is simple, emphasizing function over emotional or psychological support. While these homes are meant to offer stability, their design rarely considers the emotional needs of the residents. The absence of such homes in Arab communities further exacerbates the sense of disconnection. Without access to transitional care, individuals face higher risks of relapse or readmission.

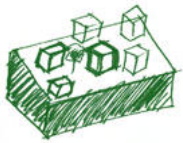
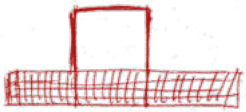
Balancing Homes | Typology

Balancing Home “A house in nature”

Architectural Elements

	Balancing Home
Connection to the city (Low-High)	
Fences/Walls (High-Low)	
Integration of Green Courtyards (Closed-Open)	
Building Height (High-Low)	
Underground Floors (More-Less)	
Community Integration (Low-High)	

Elements Adapted In The Proposed Design

	Psychiatric Hospital	Rehabilitation Center
		
		
		
		
		
		

Chapter IV
The Site | Jaffa

The Site

Choosing the site

The selection of a site was not a neutral act. It had to reflect the core themes of this thesis: spatial exclusion, cultural concealment, and the absence of mental health infrastructure in marginalized communities. Several locations were considered during the early stages of the project, including Arab towns, peripheral cities, and mixed urban areas. Each offered a relevant context, but lacked the layered social and architectural conditions necessary for this investigation.

Jaffa was eventually chosen for its complexity. It is a site shaped by historical displacement, demographic change, and ongoing cultural tension. It contains overlapping narratives of memory and erasure, presence and marginality. These contradictions are not abstract. They are visible in the built environment, in patterns of segregation, in the distribution of resources, and in the daily lives of its residents. Jaffa is not a neutral setting for this project. It is part of the subject itself.

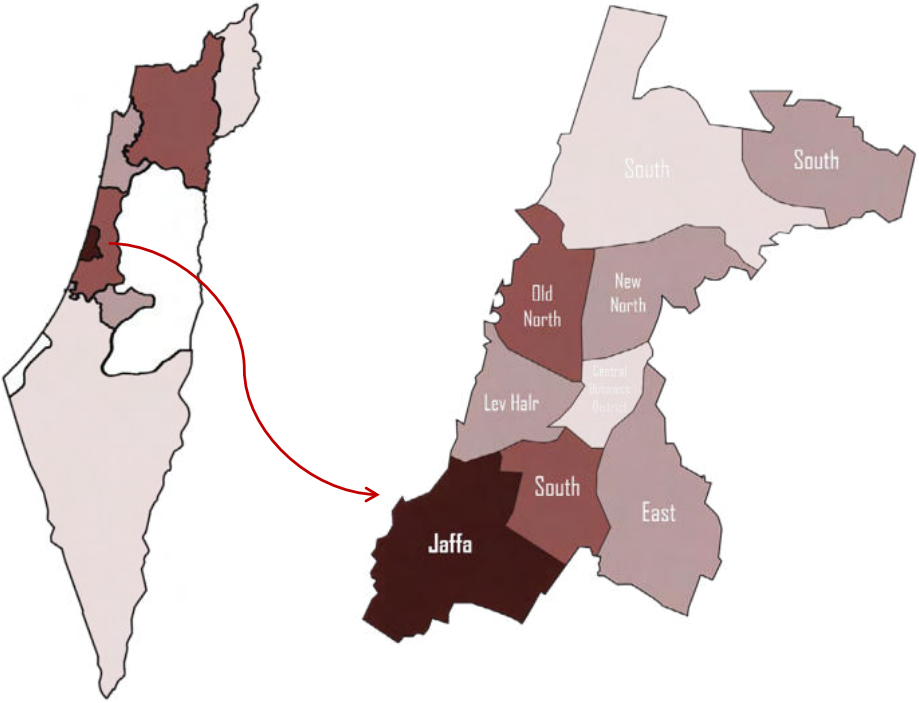
Jaffa: A Layered Urban Reality

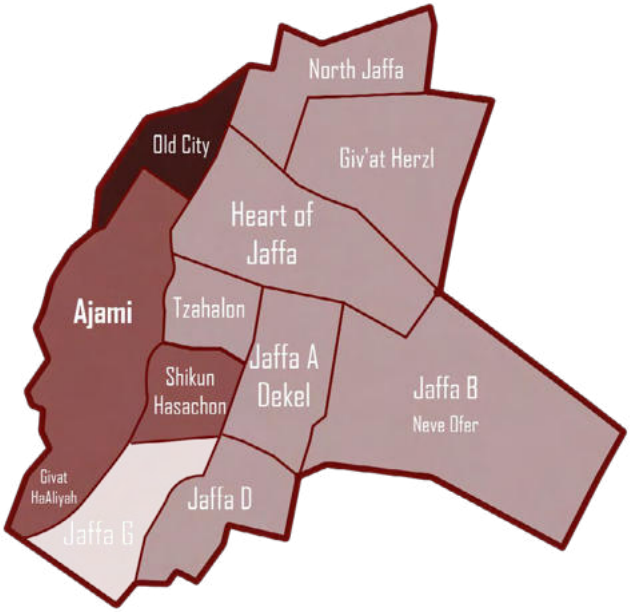
Jaffa is one of the most historically and politically charged sites within the Israeli urban landscape. Its layers are not only visible through architecture and street patterns but are embedded in everyday life. Once a central city with a thriving port, economy, and cultural scene, Jaffa held significant importance before 1948. It was known for its schools, hospitals, printing presses, and its role as a gateway between the country and the Mediterranean. This city was not a periphery. It was a cultural capital.

That reality changed rapidly following the events of 1948. The majority of the Arab population was displaced during the war. Those who remained were relocated and placed under military rule. The physical integration of Jaffa into the Tel Aviv municipality did not create unity but rather signaled a shift in control, ownership, and visibility. Arab residents were confined mainly to the Ajami neighborhood, which itself was placed under close surveillance. The urban fabric was no longer a shared resource but a mechanism of fragmentation.

In the decades that followed, Jaffa experienced waves of urban erasure and reinvention. The 1965 urban renewal plan introduced widespread demolitions, targeting what was labeled as “slum housing.” These demolitions disproportionately affected Arab families and made way for redevelopment projects that catered to wealthier, Jewish populations. Many of the new residents were not aware of the history beneath their apartments. Others were part of a growing gentrification process that reframed Jaffa as a place of heritage and tourism. Arabic street names disappeared. Public housing stock diminished. Investment came in the form of luxury development, not community infrastructure.

Today, Jaffa is framed in national discourse as a symbol of coexistence. This label conceals the structural inequalities that define it. While Jews and Arabs do share geographic proximity, they often live in separate realities. There are separate schools, separate informal economies, and vastly unequal access to housing, services, and resources. The urban environment reflects this divide. In places like the flea market district and the old port, gentrification is complete. Cafés and galleries line the renovated streets. In contrast, areas like Ajami remain underfunded and heavily policed. Property values rise, but Arab families face ongoing displacement.


South
South
Old North
New North
Lev HaIr
South
East
Jaffa


North Jaffa
Old City
Giv'at Herzl
Heart of Jaffa
Ajami
Tzahalon
Jaffa A Dekel
Shikun Hasachon
Jaffa B
Neve Ofer
Givat HaAliyah
Jaffa D
Jaffa G

This fragmentation extends into the healthcare system. While Jaffa does have general clinics, there is a visible absence of mental health infrastructure within the city, especially for its Arab population. Psychiatric care remains centralized, physically distant, and culturally inaccessible. Services are primarily conducted in Hebrew, often located outside the city, and are not designed with the lived realities of Jaffa's residents in mind. For Arabic-speaking individuals, particularly women and youth, seeking care involves navigating language barriers, social stigma, and a lack of local options. As a result, mental health struggles are often handled privately or not addressed at all.

The healthcare landscape in Jaffa reflects the same patterns visible in housing and planning: marginality, underinvestment, and cultural invisibility. There are no psychiatric clinics, no culturally adapted therapeutic services, and no architectural presence of mental healthcare in the neighborhoods where it is most needed. For the Arab community, care must be found elsewhere or improvised through personal networks. The absence is not simply institutional. It is spatial. It reveals who the city is built for, and whose needs remain unrecognized.

To speak about Jaffa's history is to speak about these contradictions. It is a city where trauma has been formalized into urban policy, where memory is selectively preserved, and where the everyday experience of Arab residents is shaped by both visibility and exclusion. It is not only a symbolic site. It is a living urban field where the architectural intervention of this thesis must respond to fragmentation, not erase it. The goal is not to idealize the past

A courtyard in a House in Jaffa/1916.

or to resolve political conflict. It is to understand how space can acknowledge complexity, carry memory, and create openings for presence where absence has dominated.

The People of Jaffa

Jaffa's population is diverse but deeply divided. Long-established Arab families, Jewish residents, and newer arrivals share the city physically, but rarely socially. What is often framed as coexistence is, in reality, a structure of separation shaped by history, policy, and planning.

The Arab community in Jaffa, has lived under pressure since 1948. Many were displaced during the war, and those who remained were relocated into areas like Ajami under restrictive conditions. In the decades that followed, they faced housing insecurity, minimal

Jaffa demonstration against Amidar. https://hadfnews.ps/post/81777.

public investment, and gentrification-driven erasure.

Today, Arab residents remain present but increasingly marginalized. Rising housing prices, tourism-driven planning, and luxury developments reshape neighborhoods without addressing local needs. Public services rarely accommodate Arabic speakers, and mental health support is especially limited.

Despite these conditions, the community maintains strong cultural and social networks. Informal systems of support fill the gaps left by institutions. To intervene in Jaffa is to understand these structures and recognize the people not as passive recipients of design, but as central actors in the city's layered and ongoing reality.

Jaffa| History

1918

Early 1900s – Ottoman Rule

Jaffa was an Arab-majority port city under Ottoman rule, known for citrus exports.

1948

1918–1948 – British Mandate

Under British rule, Jaffa saw rising Arab-Jewish tensions and violent unrest.

Post 1948

1948 – War and Aftermath

Zionist forces captured Jaffa. Most Arabs were displaced; remaining residents were confined to Ajami under military rule.

1950s

1950s–1970s – Merger and Marginalization

Jaffa was merged into Tel Aviv in 1950. The Arab community faced neglect, poverty, and forced urban changes.

1980s

1980s–1990s – Decline and Gentrification

Jaffa suffered from neglect but saw rising activism. **Gentrification** began, displacing low-income residents.

2000s

2000s–Present – Revival and Inequality

Tourism and development increased, but gentrification deepened economic gaps between Arabs and Jews.

Architectural Elements of Jaffa

The architecture of Jaffa has been shaped across centuries by cultural layering, migration, and adaptation to both climate and topography. This layering is visible in the smallest details of the residential fabric, where doors, windows, and courtyards are not only functional but deeply symbolic. They communicate identity, belonging, and memory, and together they form a language that is both intimate and collective.

Windows are one of the most recognizable features. Outward opening shutters frame the façades and establish a porous relationship between the home and the street. These shutters provide shade, control ventilation, and allow residents to choose between visibility and seclusion. Over time, their repetition across neighborhoods has created a rhythm that gives Jaffa its characteristic visual identity. Doors add to this language in even more personal ways. Each entrance carries a unique expression through size, ornament, or carving, turning thresholds into cultural statements. They mediate between the private interior and the public street, offering a moment of transition that feels at once protective and inviting.

Materiality further reinforces this sense of continuity. Stone, plaster, and wood are layered and re layered across generations, creating buildings that bear the marks of time and adaptation. Additions, repairs, and changes are not hidden but celebrated as part of the city's texture. The result is a built environment that feels lived in, responsive, and resilient, a constant reminder of the community's resourcefulness and ability to adapt without erasing

Medieval, Jaffa Street.
https://www.flickr.com/photos/96040147@N03/9380907833/

its past. This lived quality is what makes Jaffa's architecture both ordinary and extraordinary, carrying memory while also allowing for change.

Courtyards and thresholds form another essential layer of Jaffa's architecture. In many houses, recessed entrances and internal yards create distance from the street, offering privacy while also shaping spaces of encounter. These courtyards are both climatic devices, providing shade and ventilation, and social infrastructures, where families and neighbors gather in semi private comfort. Luxury houses with their "three opening" phenomenon, or smaller homes with modest windows above the door, all reflect this preoccupation with thresholds as places of negotiation between exposure and retreat.

At the scale of form and massing, Jaffa's architecture also responds to the natural landscape. Multi storey roofs accommodate the slope of the terrain, while double skin façades provide shade and regulate airflow. Elevated entrances create subtle separations between the street and the interior, reinforcing privacy but never cutting off connection. These gestures demonstrate how architecture in Jaffa has long balanced the need for openness with the equally pressing need for protection.

What makes Jaffa's urban fabric compelling is its balance between repetition and uniqueness. Certain patterns such as shutters, arches, courtyards, and stone layering repeat across neighborhoods, producing coherence and familiarity. Yet within this shared language, every door, every façade, and every courtyard carries its own variation, tied to the story of its residents.

Local Architectural Elements Of Jaffa. Diagram By: Rahaf Haskia

This interplay of common structure and individual identity is what gives the city its richness and its enduring human scale.

These architectural elements are more than aesthetic features. They influence how people move, gather, and connect. Courtyards become centers of community life, shaded arcades encourage chance encounters, and layered materials evoke continuity across generations. Together they create an atmosphere that feels rooted in place while remaining open to daily life.

In studying these details, the project finds strategies that inform its own design approach: an architecture that does not impose itself as foreign or institutional, but one that resonates with cultural memory and creates spaces of dignity, belonging, and healing.

Chapter V
Methodology

Methodology & Analysis Strategy

The concept of alienating spaces emerged clearly through conversations with residents of Jaffa, many of whom expressed a deep sense of disconnection from parts of their own city. One resident explained:

“There are places in Jaffa that we walk by, and even though they are in our neighborhood, they don’t feel like they belong to us. It’s clear they weren’t designed for us. They feel like they’re meant for other people, outsiders, so we avoid them. We feel pushed out of spaces that should be ours.”

This phenomenon aligns with the concept of ethnocentrism, where one cultural perspective is imposed as the dominant standard.

In White City, Black City: Architecture and War in Tel Aviv and Jaffa, Sharon Rotbard explores how Tel Aviv’s expansion often came at the expense of Jaffa’s historical and cultural identity. He argues that the narrative of Tel Aviv as the “White City” was deliberately constructed to overshadow Jaffa, the “Black City,” reinforcing patterns of urban marginalization and cultural erasure.

Recognizing these spatial and social dynamics is crucial in identifying “spaces of alienation” and developing architectural interventions that foster inclusivity and belonging.

Spaces of alienation

Spaces of alienation are urban areas that, through their design or function, create feelings of exclusion and disconnection among local communities. This project challenges the outdated model of isolating mental health care within medicalized institutions, advocating for an integrated approach where the city itself nurtures well-being. Urban design reflects societal values. Do we prioritize profit over people, exclusion over inclusion, neglect over care? Reimagining urban spaces is not just an architectural challenge but a moral imperative that fosters dignity, connection, and healing.

The intervention strategy identifies alienating spaces and transforms them into environments that reflect the identity, culture, and needs of Jaffa's citizens.

By designing spaces that resonate with the local community, the goal is to dissolve feelings of exclusion and foster belonging. These interventions will align with Jaffa's cultural fabric while integrating mental health support into the urban landscape, creating a more inclusive and restorative city.

Identifying Alienating Spaces

To locate such spaces, I established a set of parameters that helped frame and identify them. These criteria offer a methodology that can be applied to other sites as well, serving as a tool to guide future intervention strategies.

The Selected Parameters

Safety

This parameter considers how secure people feel in a space. Poor lighting, lack of visibility, or signs of neglect can make a space feel unsafe and uninviting. It also takes into account past incidents of violence or unrest that may have occurred in or around the space, which can leave a lasting emotional impact on the community.

Community Integration

This parameter addresses whether a space feels like part of the community's daily life. It includes signs of social presence, meaningful activity, and a function that serves local needs. A space that is underused, disconnected from local routines, or used primarily by outsiders often contributes to feelings of exclusion.

Human Scale

The proportions and layout of a space should relate to the human body. When the design feels too large or rigid, it can create psychological distance and discomfort.

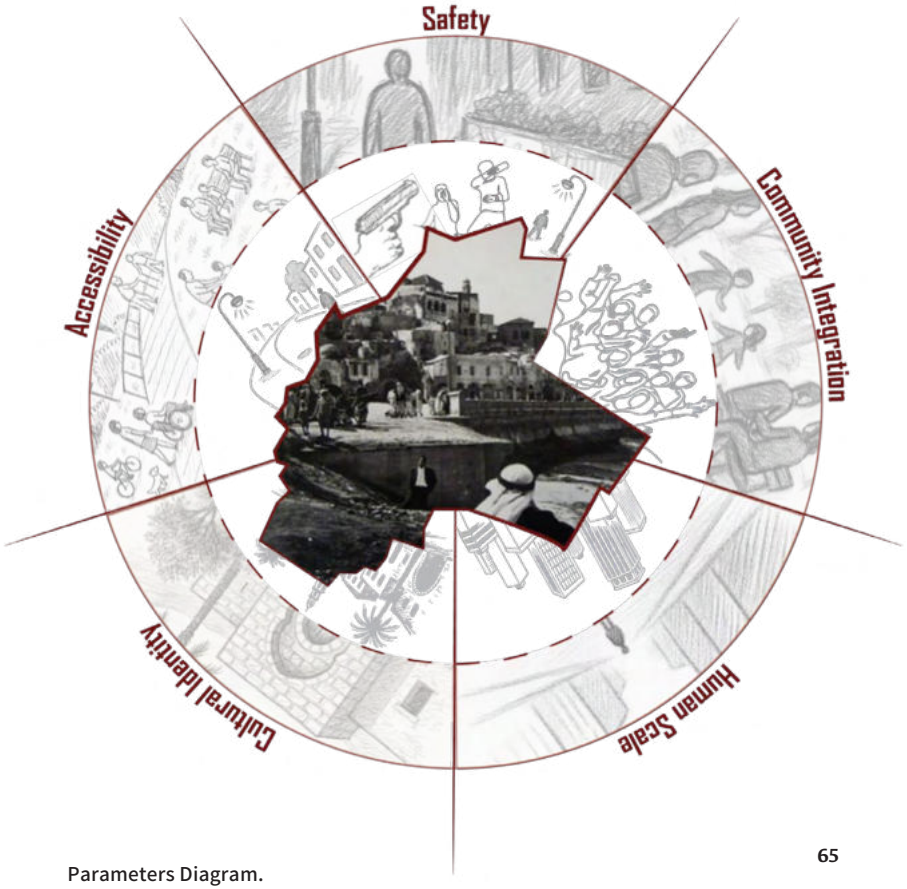
Cultural Identity

Spaces that reflect local culture, history, and materials help residents feel recognized and respected. This includes

architectural language, symbols, languages, and building materials that resonate with the community's collective memory. When these elements are missing, the space often feels detached and alien.

Accessibility

A space must be physically reachable and usable for all members of the community. This includes barrier-free design, clear signage, and inclusive layouts. When a space lacks these features, it can unintentionally exclude people with disabilities, the elderly, or those unfamiliar with the area.



Parameters Diagram.

Environment

Healing

Yaffo Community Mental Health Center

Mahmoudiya Mosque

The Containers House

Peres Center for Peace & Innovation

Cultural Detachment

Alienating

Selected Site as the case study

Potentia

Arab-Jewish Community Center

Old Jaffa House

Old Jaffa Port

Clock Square

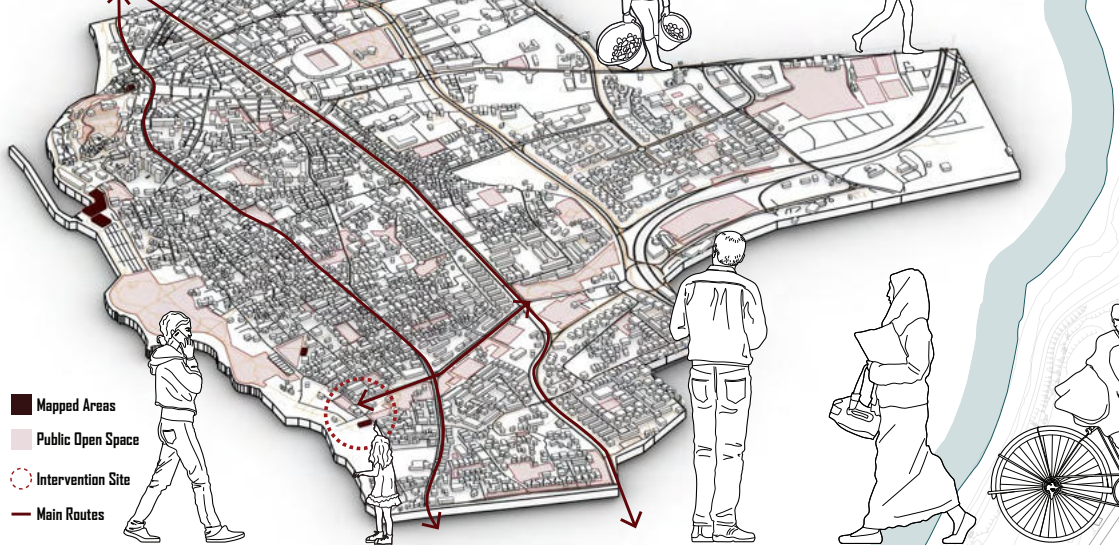
Belonging / Cultural Embeddedness

al Alternative for the

Potential Sites

Using these parameters, I mapped a series of spaces across the city that showed signs of alienation but also the potential to be reimagined as places of visibility, accessibility, and belonging. Each site was evaluated through safety, community integration, human scale, cultural identity, and accessibility, creating a clear framework for comparison.

The mapping revealed sites with different strengths and weaknesses. Some offered strong visibility along main streets but lacked cultural identity or intimacy. Others were embedded in neighborhoods and carried traces of local culture, yet suffered from poor accessibility or safety concerns. A few connected well to open landscapes and natural light, but risked remaining detached from everyday life.



From this process, a pattern emerged: the most promising sites balanced openness with protection and civic presence with community intimacy. At the same time, the most alienating sites demonstrated how mismatched relationships between space, scale, and social life create exclusion and discomfort. For this project, I deliberately chose the most problematic of these sites, with the aim of restoring it and showing how even the most neglected environments can be transformed into opportunities for civic healing.

In this way, the mapping exercise became both an analytical tool and a design strategy. It clarified which spaces in the city hold the greatest potential for transformation, while also proving that architecture can repair and reintegrate areas once marked by alienation.

Chapter VI
Intervention

Site Selection

Site A

The process of choosing a site for intervention began with identifying the kind of space this project was searching for. The aim was not simply to locate an available or vacant lot, but to find a space that reflects the themes at the core of the thesis. This included physical and symbolic disconnection, social marginality, and the absence of public care. The ideal site needed to exist in a state of tension, a place marked by abandonment, misalignment, or silence, yet with the potential to be transformed into a space of collective meaning and support.

Several candidate sites across Jaffa were selected through a combination of urban analysis, site visits, historical research, and spatial observation. Each one was studied based on its physical condition, level of integration into its surrounding context, and the presence or absence of public life. Some were still in use but no longer served their original communities. Others had lost clear function or visibility altogether. While different in form and history, all the selected locations shared an atmosphere of neglect or redefinition.

To structure this selection process, I placed the sites within a conceptual framework that measured two key conditions: their level of cultural connection and their potential for spatial healing. This comparison revealed the distinct nature of each site. Some were heavily embedded in the city's daily life, such as the clock tower square or areas around the old port. Others, including community centers and institutional buildings, maintained a presence but were limited in accessibility or symbolic reach. A small number of spaces, however, stood out for their complete detachment from

both their immediate surroundings and the broader urban fabric.

Among these, Site A gradually emerged as the most relevant location for this project. Situated near the Peres Center for Peace, the site is positioned along the coastline, close to high-profile landmarks, yet remarkably isolated. It lacks clear entry points, functional programming, and connection to everyday activity. The site sits between important institutions and residential areas but remains unused and undefined. It appears present on the map but is absent from lived experience.

This contradiction is precisely what gave the site its power. Its physical openness and formal ambiguity reflect the themes explored throughout the thesis, particularly the experience of being visible but unacknowledged, present but unsupported. The site's layered context, proximity to water, and distance from the city's active social life created an opportunity to engage with the ideas of erasure, presence, and healing in a direct and spatial way.

The methodology behind this selection was not only analytical, but narrative. It involved identifying conditions that align with the thesis goals and understanding how each space participates in the city's larger dynamics of inclusion and exclusion. Site A was chosen not for its neutrality, but for its relevance. It becomes the ground for a design proposal that seeks to reconnect what has been held apart, including space, memory, and care.

Peres Center. Picture By Yohan Zerdoun.


Lamed Bet Ajiel High School
Jabalia Mosque
Abu Nasser Restaurant
Playgrounds
Peres Center for Peace and Innovation
Cemetery

The History

To understand why this site became an alienating space, I began by analyzing its history and found that it was once a key medical institution, contributing significantly to Jaffa's well-being.

However, as healthcare infrastructure shifted, many older institutions were abandoned or repurposed. Over time, gentrification and urban restructuring led to the demolition or alteration of several original buildings, further disconnecting the site from its historical identity.

The site, formerly Donolo B Hospital, holds historical significance but has lost its connection to the community. By restoring key elements and integrating public mental health services, this intervention aims to reclaim its relevance and foster inclusivity.

Jaffa's traditional architecture emphasizes integration with the city's movement and topography, using human-scaled designs, local materials, and natural shading to create an inclusive, climate-responsive environment.

In contrast, modern developments such as the Peres Center depart sharply from this tradition, favoring larger scales and different material choices. This contrast underlines the need for culturally sensitive design that fosters belonging and connection rather than displacement.

Tel Aviv-Jaffa, Donolo B' Hospital, 1956, Source: Israel State Archives.

The Chosen Site | History

Quarantine station

1930s

Built as a quarantine station under British rule, it later became Jaffa's main government hospital, but it was one of many small, underfunded facilities in the 1950s

Hospital

1962

Added a tumor detection clinic but struggled with limited resources and outdated equipment

Demolition

1980

Wolfson Medical Center opened after years of neglect and poor conditions forcing the closure of Donolo

Peres Center

2009

Peres Center for Peace and Innovation was built on the former hospital site removing Jaffa's last trace of its old public hospital

Healthcare | Hospitals Of Jaffa

Jaffa's hospital history reflects its diverse cultural and social development. The Sha'ar Zion Hospital, established in 1891 by the B'nai B'rith organization, was the first Jewish community hospital in the country. The Jaffa Mission Hospital, founded by the Church Missionary Society in the late 19th century, served the local population. The Al-Dajani Hospital, established in 1933, became a key private medical center. The Government Hospital of Jaffa operated as a major public health institution until its closure in 1980, following the opening of the Wolfson Medical Center in Holon, which remains a primary medical facility serving the wider region today. These hospitals collectively shaped Jaffa's medical landscape, though today, most of the original institutions no longer operate, marking a significant shift in the city's healthcare infrastructure.

The Entrance to the Government Hospital in Jaffa, 1933–1948. Collections/Photograph Collections/Palestine Information Office (PIO) Photograph Collection.

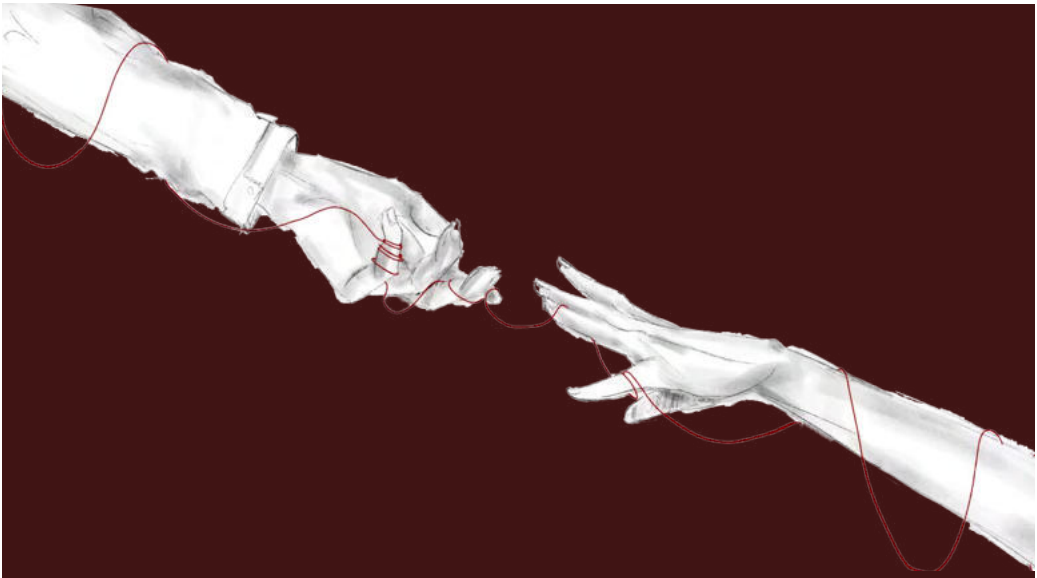
A nurse sitting with two women on a sea-facing balcony at the hospital in Jaffa, 1933–1948. Collections/Photograph Collections/Palestine Information Office (PIO) Photograph Collection.

A mother carrying her young child to the hospital in Jaffa as a nurse welcomes them, 1933–1948. Collections/Photograph Collections/Palestine Information Office (PIO) Photograph Collection.

The Government Hospital in Jaffa, 1933–1948. A mother and her children near the hospital entrance. Collections/Photograph Collections/Palestine Information Office (PIO) Photograph Collection.

Map of Tel Aviv-Jaffa (left), 1956, Source: Israel State Archives.
Donolo B' Hospital (right), 1956, Source: Israel State Archives.


1956



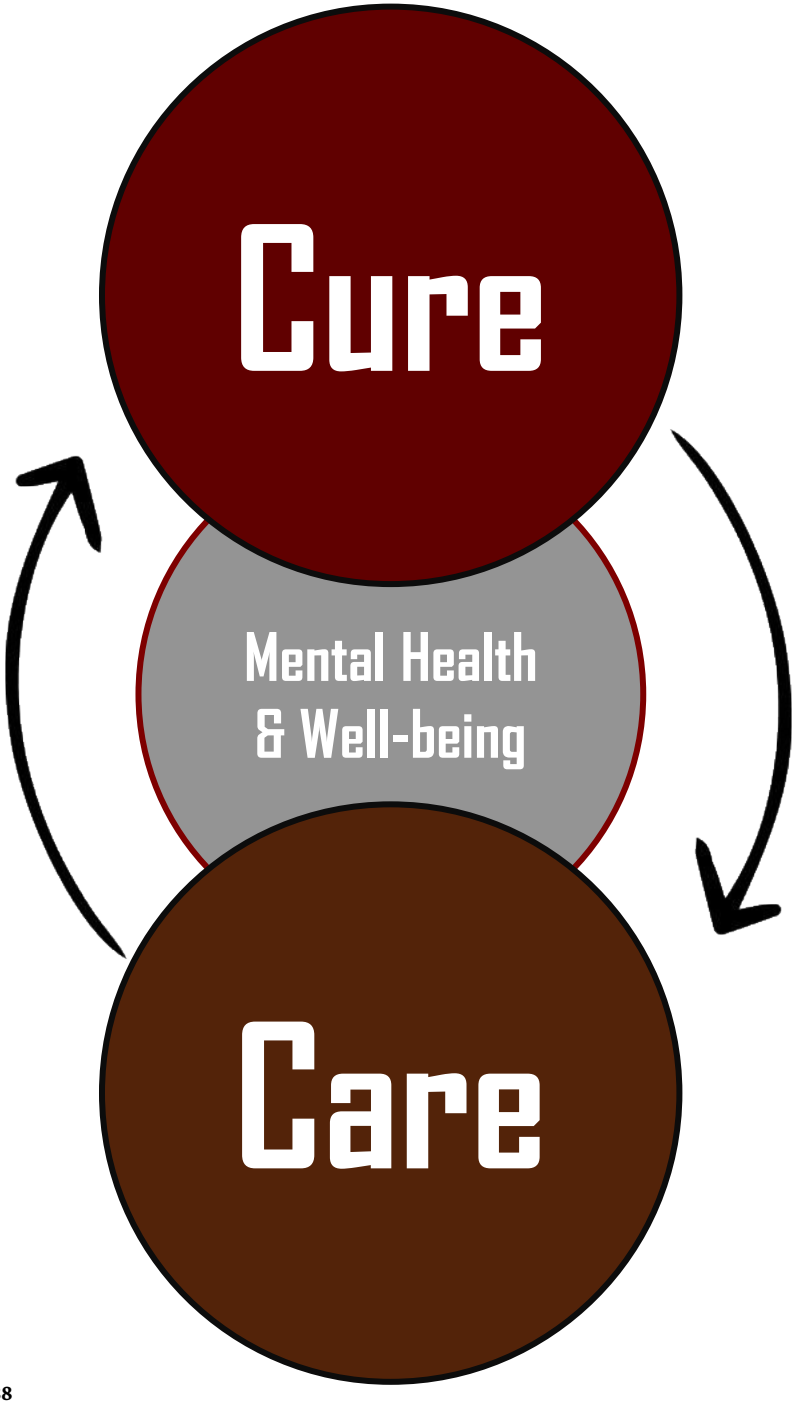
Chapter VII
Intervention and Design Solutions

Methodology of the Intervention

The intervention begins with a rejection of the traditional model of mental health care as isolated, hidden, and institutional. Instead, the space I wanted to design is one that is fully connected to the city, visible, accessible, and open to all. Rather than standing apart from the everyday life of Jaffa, the project seeks to weave mental health support into the fabric of the urban environment, making it a natural and welcoming presence rather than a stigmatized periphery.

The design takes inspiration from the style of a small village: a place that holds everything for everyone, where diverse needs can coexist within a shared framework. Just as a village provides spaces for gathering, working, resting, and healing, this intervention creates a holistic environment that integrates care, culture, and community. By doing so, it challenges the idea that mental health spaces should be confined to specialized institutions. Instead, it proposes a model of inclusion, a setting that restores dignity through visibility, fosters belonging through accessibility, and ensures that mental health is recognized as a collective condition supported by the city itself.

Small Village Sketch. Pen line PNG Designed By from https://pngtree.com/freepng/free-png-vector-diagram-countryside-village_872281.html?sol=downref&id=bef


Cure
Mental Health
& Well-being
Care

Methodology of the Intervention: Care and Cure

As part of the design process, two guiding terms emerged that shaped both the analysis and the architectural decisions in this thesis: care and cure. While these terms exist in broader theoretical and medical discourse, they are used here in a specific and personal way. They serve as conceptual tools for understanding how spaces function emotionally and socially, and for imagining how mental health architecture might offer something more than containment.

Cure, in the context of this work, refers to spaces and systems that treat mental illness as something to be corrected or resolved. It describes an approach focused on diagnosis, stabilization, and clinical control. Their architecture reflects a goal of managing risk and reinforcing order. The result is an experience of distance, impersonality, and often silence.

Care, in contrast, refers to an ongoing, relational form of support. It focuses less on outcomes and more on presence. Care allows for vulnerability and change. It encourages trust, softness, and recognition. In architectural terms, it involves attention to sensory experience, cultural familiarity, emotional safety, and adaptability. A space that embodies care does not simply house treatment. It invites healing. It makes room for the complexities of living with and through mental distress.

This distinction was not part of the project from the beginning. It emerged through critical engagement with the research, especially when reflecting on what current institutions failed to provide. As the project developed, these terms became practical tools for shaping the spatial logic of the proposal. They guided decisions about what kinds of spaces were needed, how they should relate to

one another, and what emotional responses they might generate.

The care and cure framework also revealed the gap between how institutions are designed and how people actually experience mental health. Most existing facilities operate almost entirely within the logic of cure, without acknowledging the human need for continuity, identity, and cultural safety. Without spaces designed with care, silence and suffering are reinforced rather than relieved.

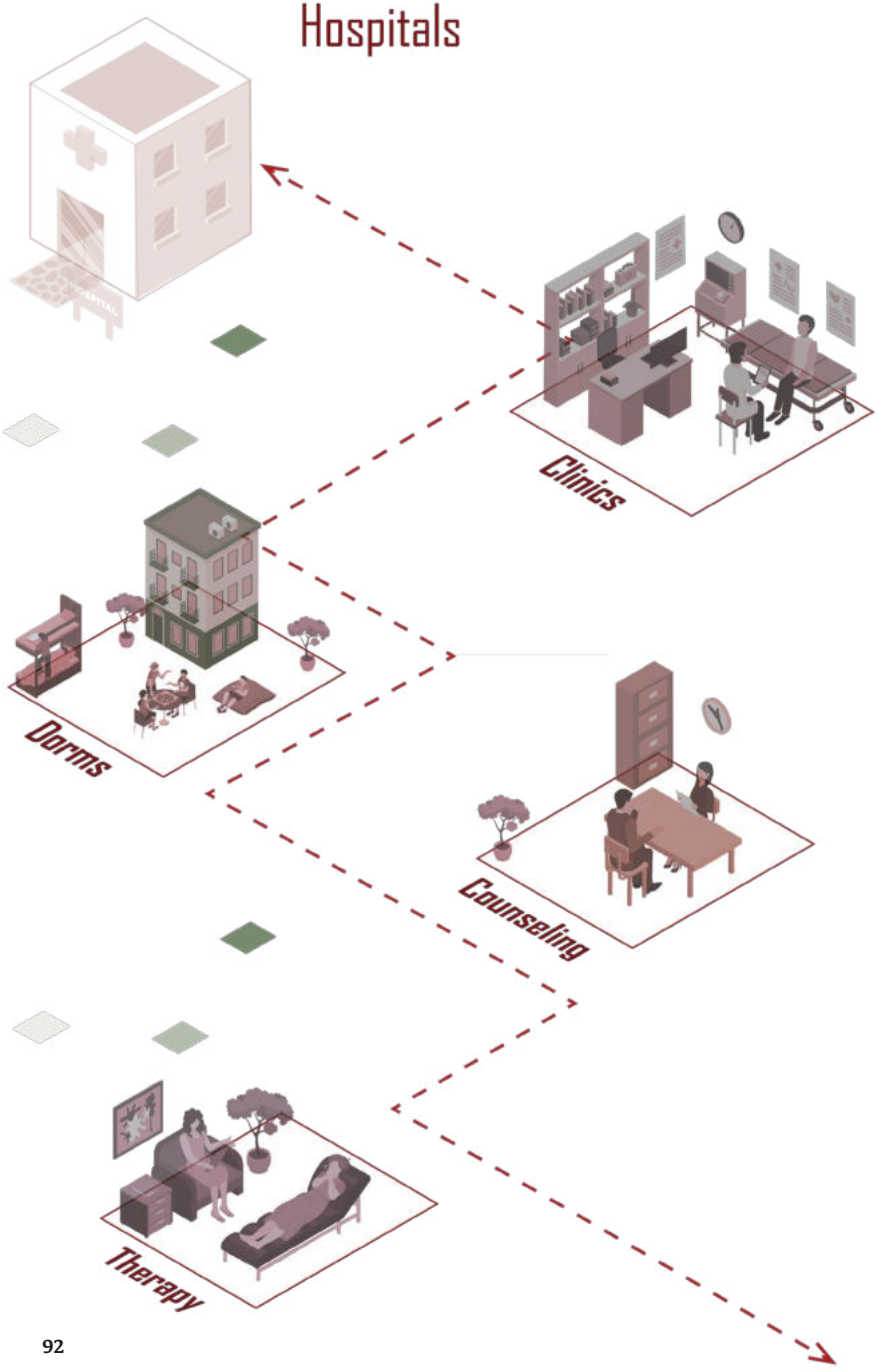
In this thesis, care and cure are not treated as opposites but as complementary modes. Both may be needed at different times and in different ways. Some individuals may require structure and containment. Others may need softness, familiarity, and trust. The architectural task is to create an environment that accommodates this complexity without defaulting to the institution. Zones are arranged in a progression from public to private, allowing gradual transitions and intuitive circulation. Cure is held as a protected core within the larger envelope of care, offering privacy without isolation. Light, material warmth, and openness are used as design tools to support dignity and presence, replacing the rigid and clinical signals of traditional facilities.

By building with care rather than only for cure, the project redefines mental health space as a civic condition rather than a hidden service. It imagines environments that are not feared or avoided, but integrated, respected, and recognized as part of everyday urban life.

Mother and daughter hugging; Shutterstock ID 220380457; PO: TODAY.comBlend Images / Shutterstock / Blend Images

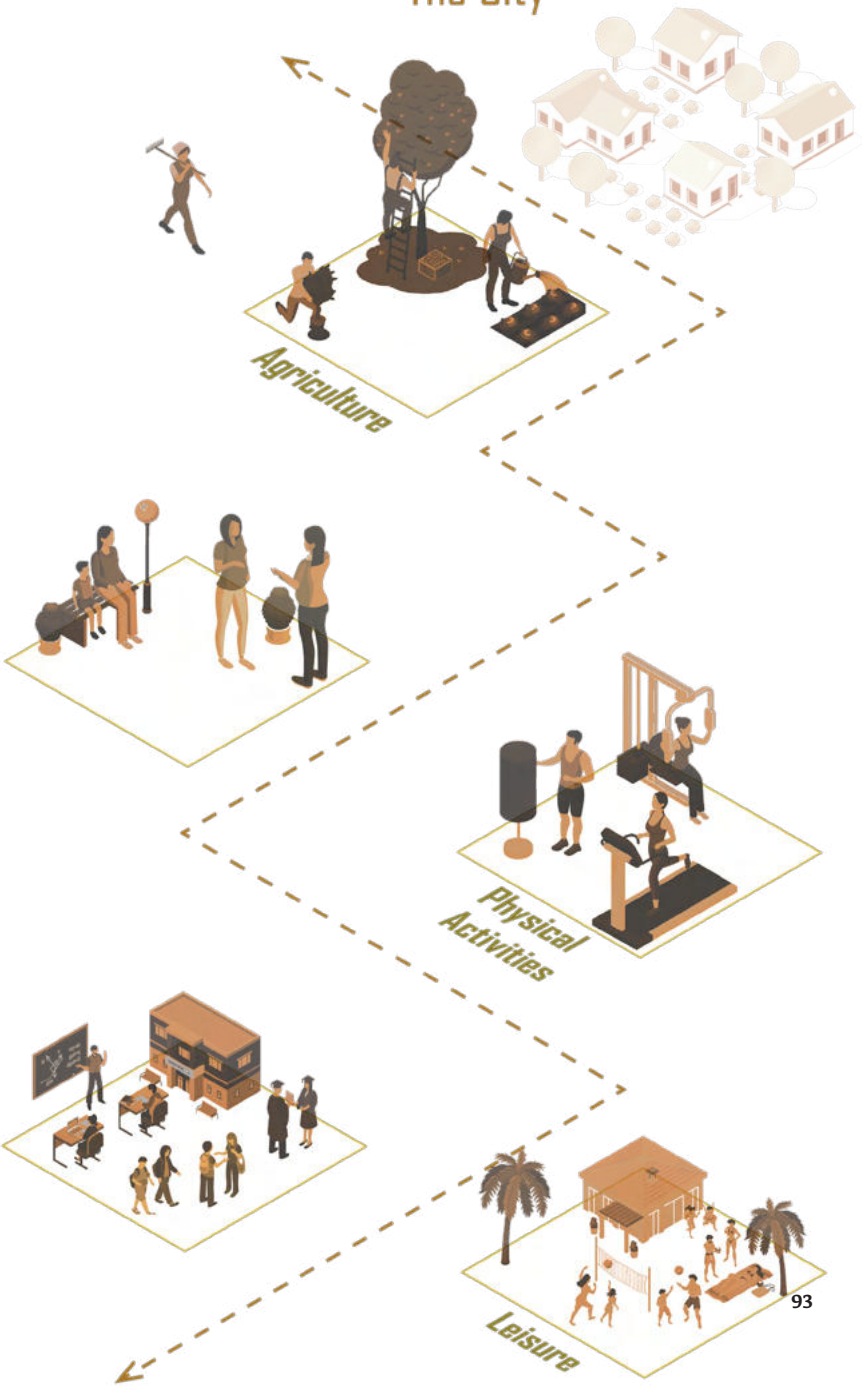
A place of Cure

Hospitals



A place of Care

The City



Design Strategy and Spatial Implementation

The design strategy translates the framework of care and cure into spatial form. The aim was not only to provide functional efficiency, but to create an environment that is emotionally legible and culturally rooted. The intervention transforms a site of disconnection into one of openness, continuity, and dignity.

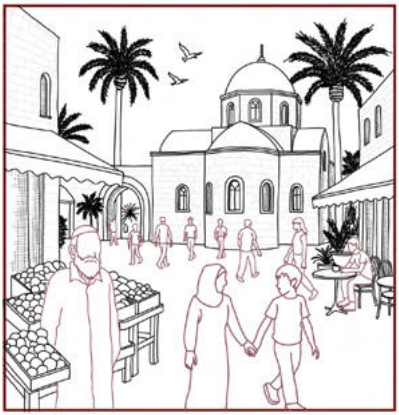
Three guiding principles shape this transformation: integration, layering, and presence. Rather than repeating the detached and inaccessible qualities of conventional institutions, the design opens the site to the city while embedding traces of the existing urban fabric. Circulation paths follow natural axes and topographic shifts, making orientation intuitive and fluid. Terraces and courtyards create points of pause, offering sunlight, fresh air, and everyday gathering.

Connectivity is emphasized both at the scale of the site and within buildings. Spaces are not divided by rigid walls or sealed corridors, but linked through soft thresholds. These transitions are spatial and emotional, guiding people through public, semi-public, and therapeutic areas without reinforcing stigma. Users determine their own level of engagement, moving freely between privacy and community.

The diagrams illustrate this layered strategy. At the urban edge, the project anchors itself in local identity and creates a civic presence. At the center, the scale shifts to that of a small village, fostering community for residents. Toward the sea, the architecture opens into a transparent civic front, welcoming the wider public while maintaining views of the horizon.

Urban Edge

Anchoring the project in local identity, strengthening the connection with the city, and creating a welcoming civic presence.



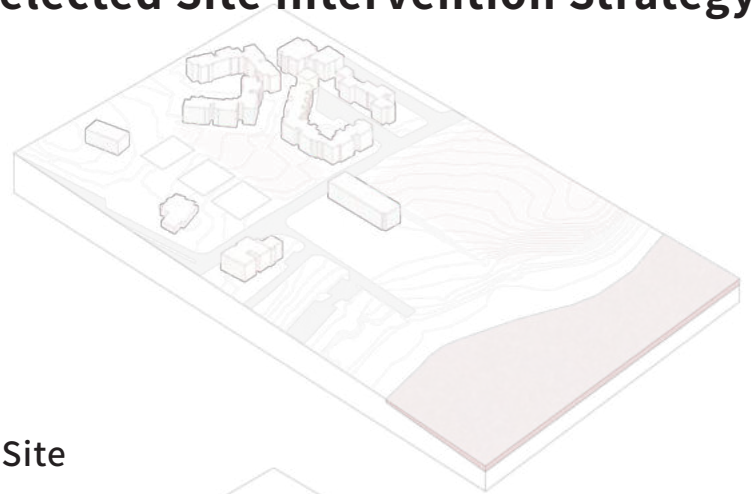
Village Core

Fostering community and continuity for residents through a village-like scale that combines living, workshops, and shared spaces.

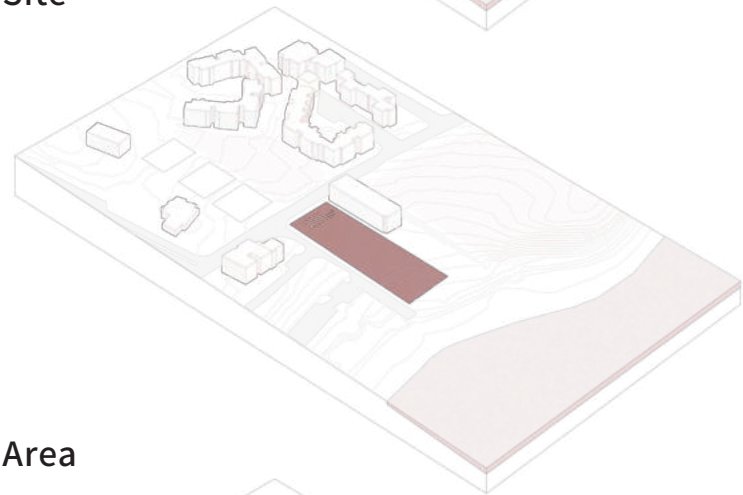
Sea Front

Opening the project toward the horizon, preserving sea views, and inviting the wider public into a transparent civic setting.

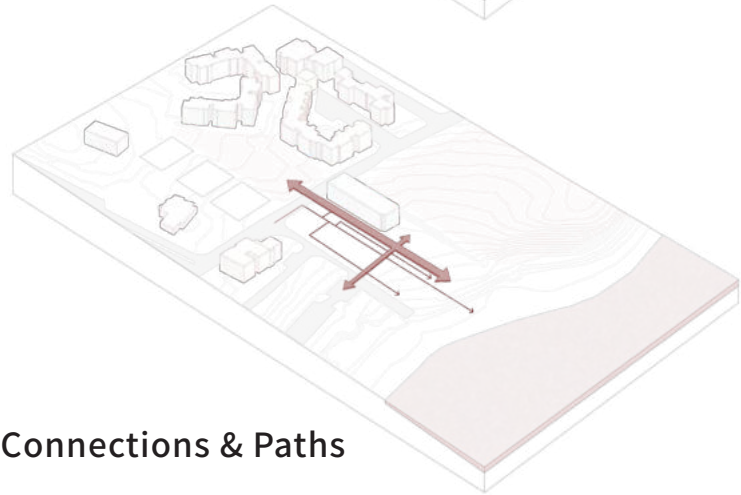
Selected Site Intervention Strategy



Site



Area



Connections & Paths

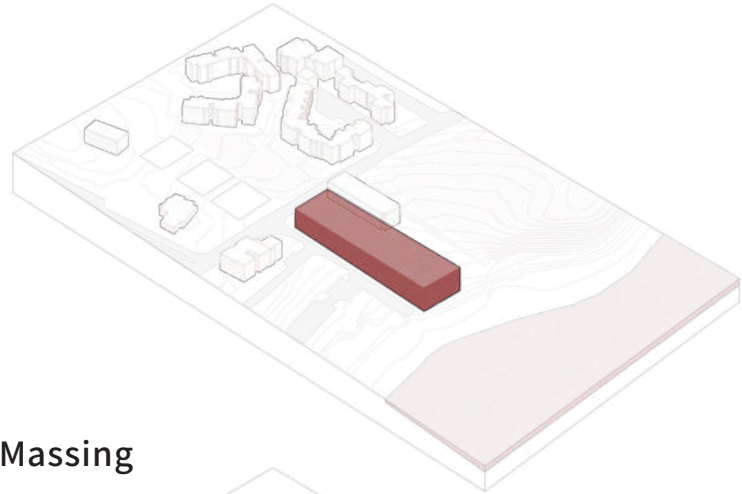
Methodology of the Intervention

The design strategy was shaped by a close reading of the site and its spatial conditions. The intervention takes place on a plot of 2,111sqm, defined today by two main circulation axes that are disconnected from the surrounding street. The proposal preserves these existing axes while transforming them into organic, inviting connections that welcome people into the site and allow for smooth movement across it.

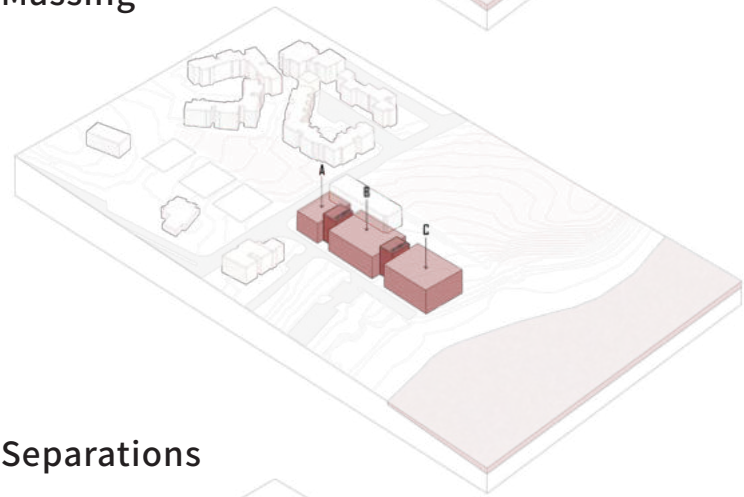
The design process began with a single large mass, which was then divided into three distinct volumes to create hierarchy and variety, ensuring that different users could find spaces suited to their needs.

Each zone was given its own architectural character. Zone A, closest to the street, adopts a local building style so it feels familiar within its urban context and inviting for passersby. Zone B takes on the atmosphere of a small village, containing the residential program and generating a sense of belonging and community for its inhabitants. Zone C is shaped as a modern, glass-like structure intended for public and shared uses, oriented to preserve wide views toward the sea and to emphasize the site's relationship with its coastal edge.

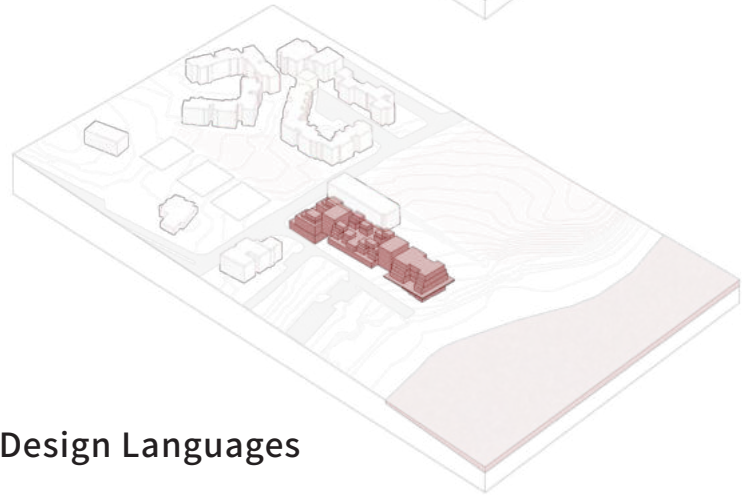
Biophilic strategies are embedded throughout the intervention. Green elements, natural light, and open air are woven into the buildings and outdoor areas, turning the site into a restorative landscape. Openings were carefully introduced to bring natural ventilation, enhance comfort, and strengthen connections with the topography. This gradual use of thresholds creates a clear hierarchy, helping visitors orient themselves while keeping the atmosphere open and humane.



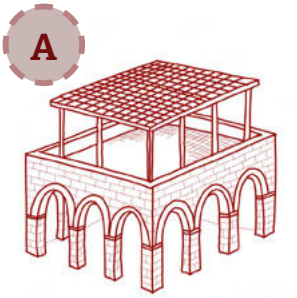
Massing



Separations

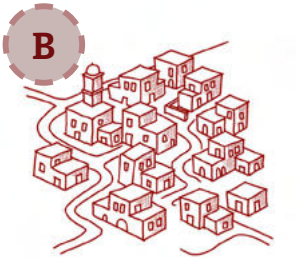


Design Languages



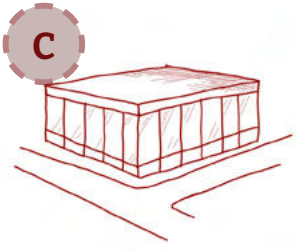
Local

Zone A reflects Jaffa's local style with stone and arches, creating a familiar and inviting edge that blends into the city.



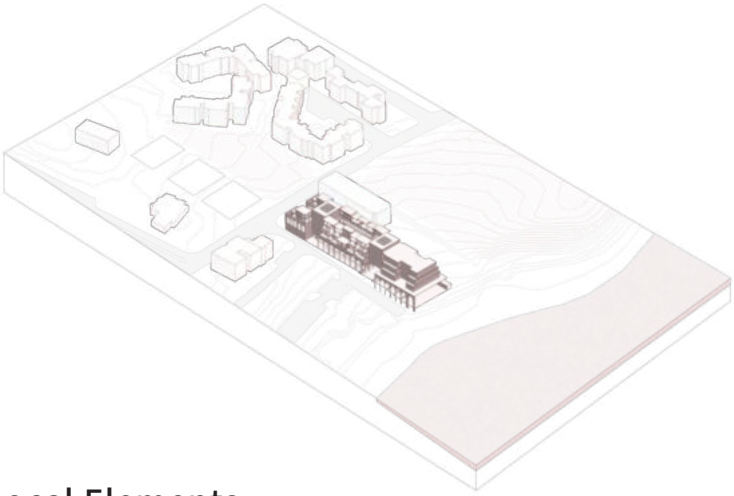
Village

Zone B resembles a small village with clustered residential units and shared spaces, fostering community and a sense of belonging.



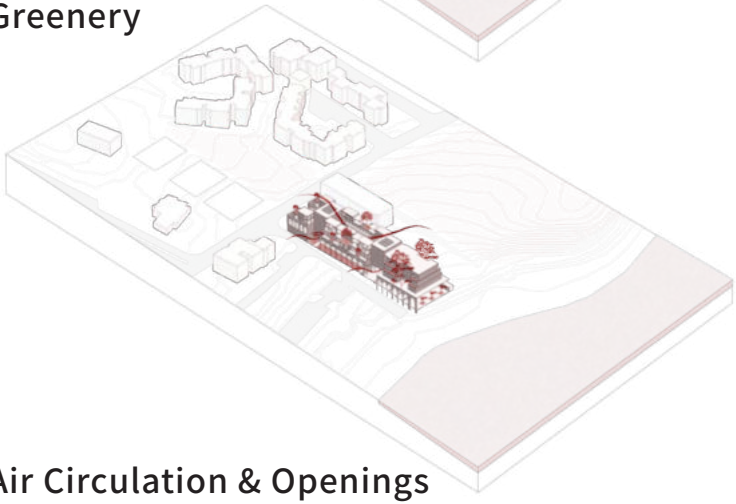
Modern

Zone C faces the sea with a modern glass design, maximizing openness, views, and shared public use.

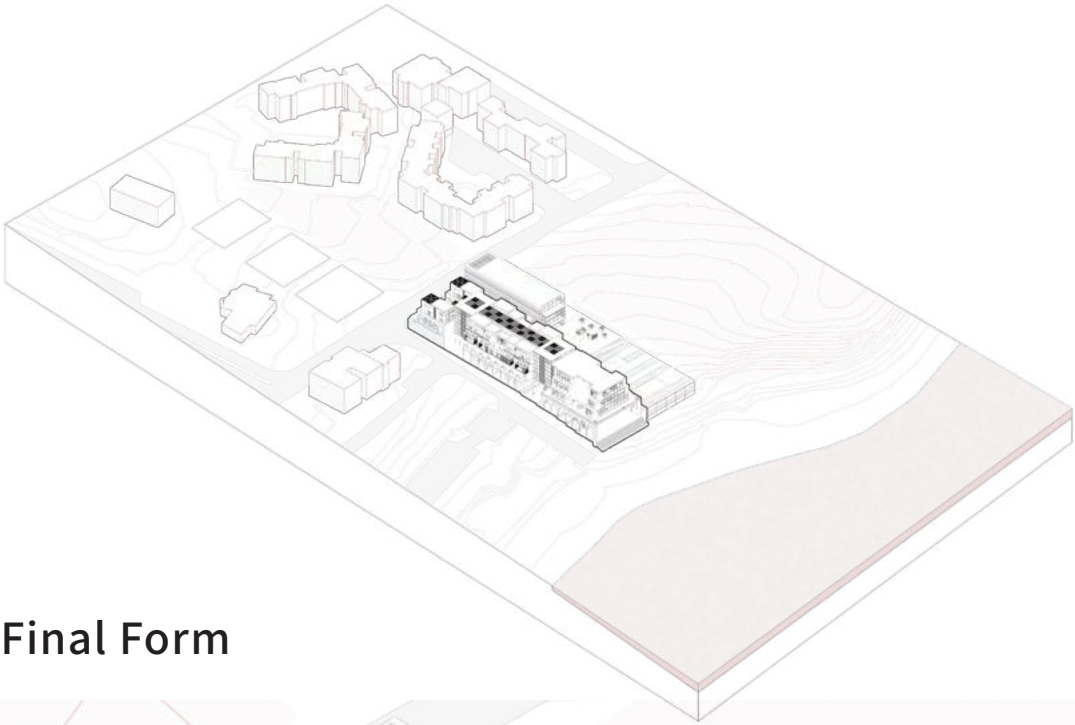


Local Elements

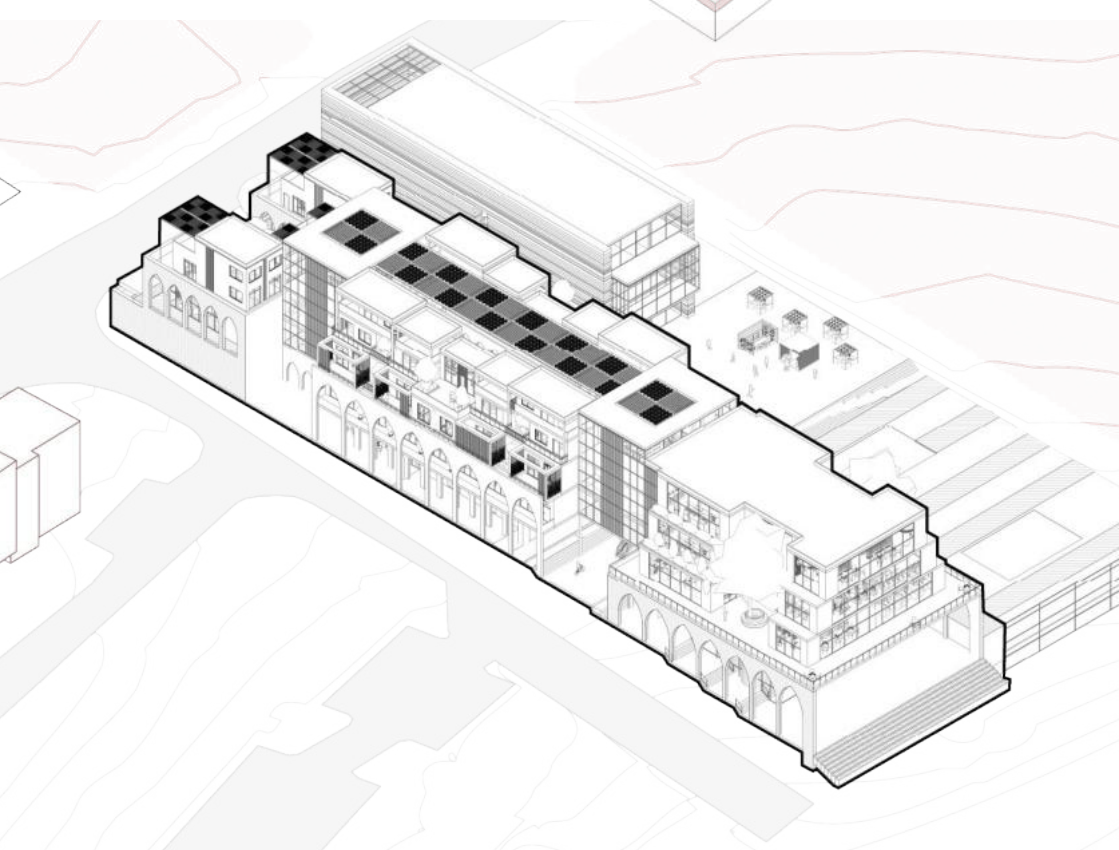
Greenery

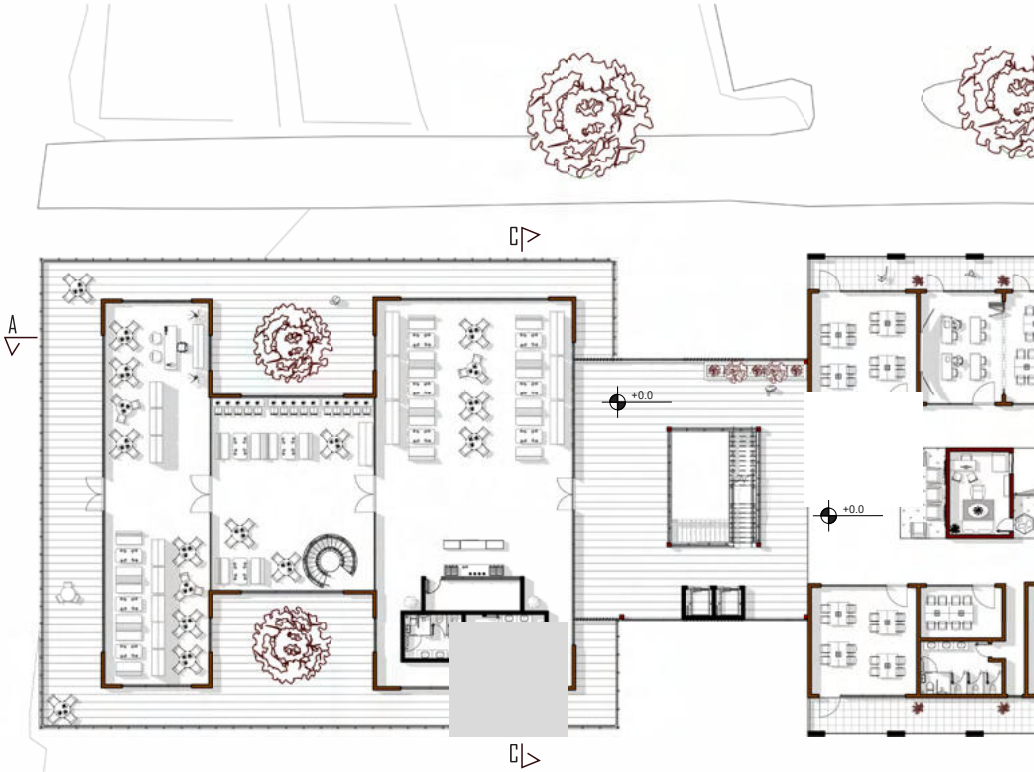


Air Circulation & Openings



Final Form





Ground Floor Plan +0.0


B
B
A
+0.0
+0.0
+0.0
-1.5
-5.5

1st Floor Plan +4.0


8.0%
+4.0
+3.5
+5.5
+2.5

Functions

Functions

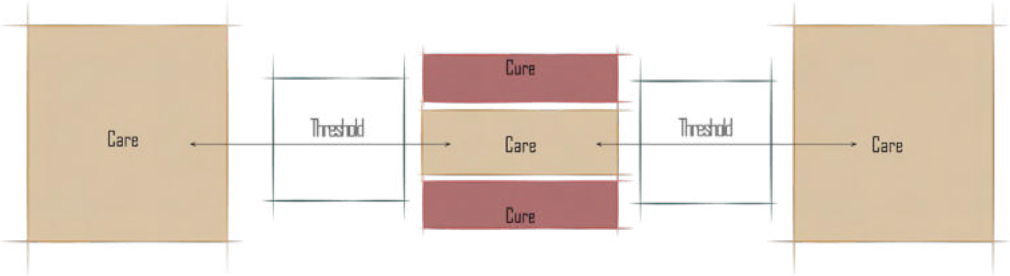
The program of the building is organized to balance care and cure as complementary layers. Public and community-oriented functions, such as a library, café, workshops, and gathering spaces, represent care by fostering openness, belonging, and everyday wellbeing. Within and beneath these layers lie the clinical and therapeutic functions of cure, including counseling rooms, treatment areas, and residential units that provide privacy and support when needed. By embedding cure within care, the building ensures that medical and therapeutic spaces are always held by an environment of trust, dignity, and cultural familiarity, transforming treatment from an isolated act into part of a wider continuum of life.

At the same time, the project was envisioned as a place for all, offering something for everyone across different needs and circumstances. It is not only a setting for recovery but also a civic hub where daily life can unfold, where community can blossom, and where mental health is understood as part of shared urban experience rather than a hidden condition.

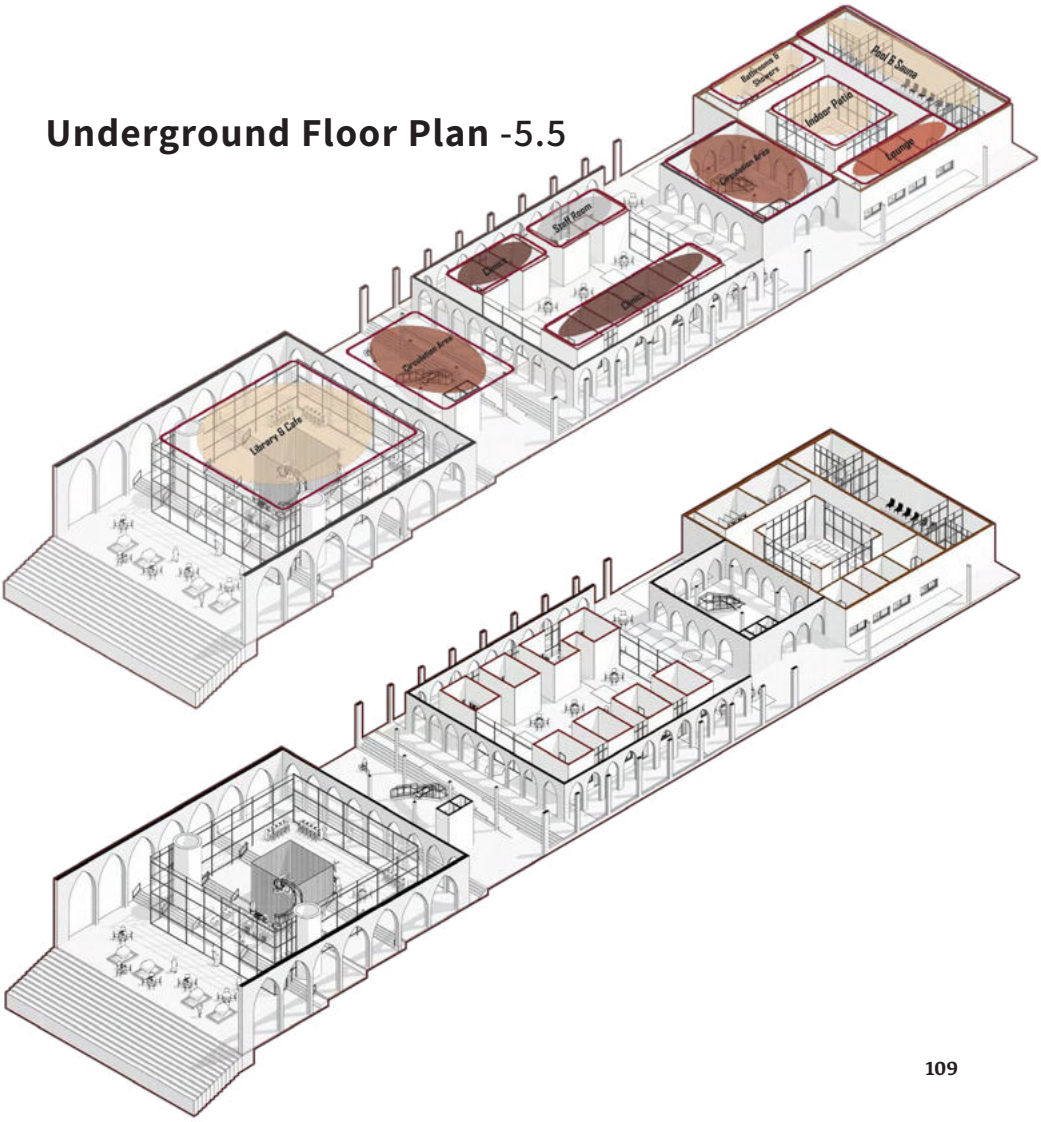
"One of the marvelous things about community is that it enables us to welcome and help people in a way we couldn't as individuals."

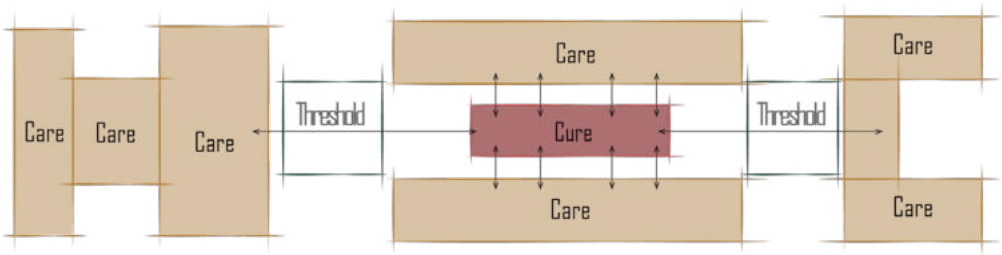
– Jean Vanier[1]

1 https://www.goalcast.com/quotes-about-community-coming-together/

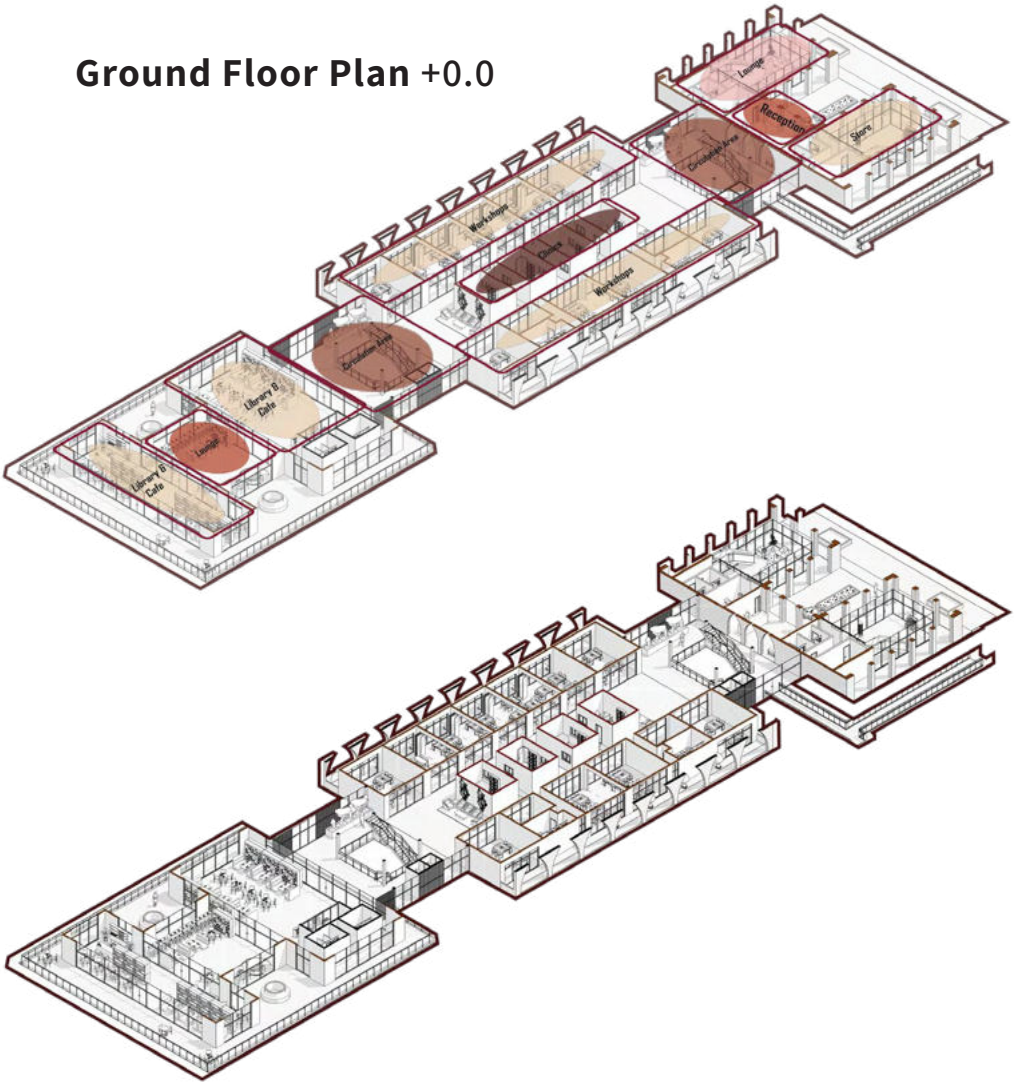


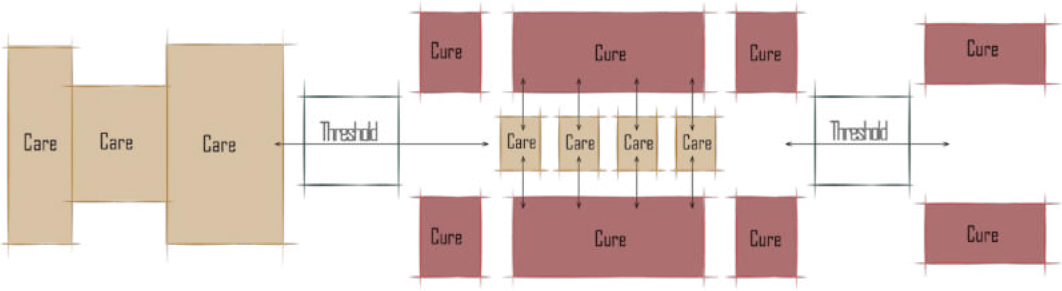
Underground Floor Plan -5.5



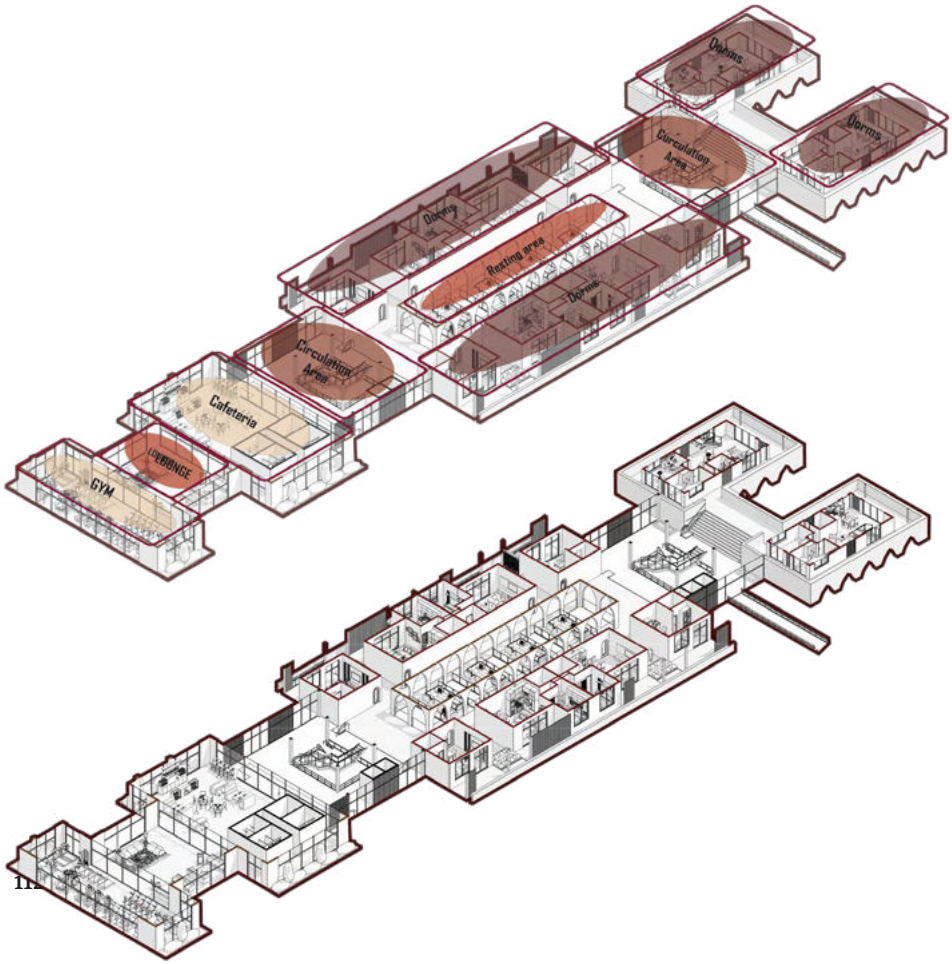


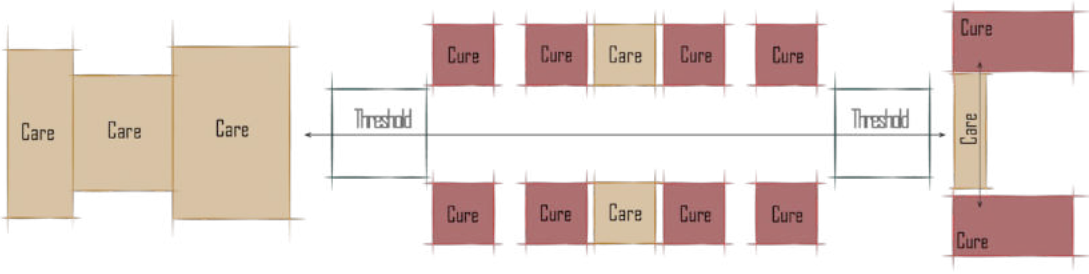
Ground Floor Plan +0.0



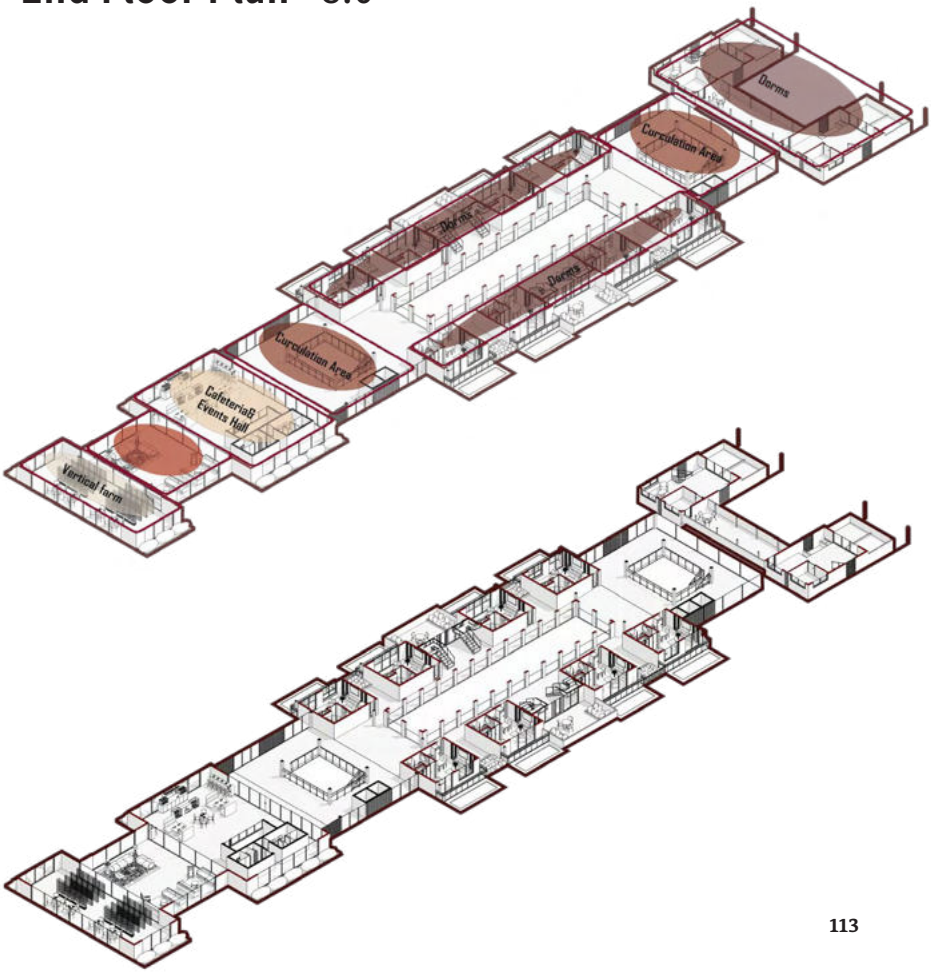


1st Floor Plan +4.0

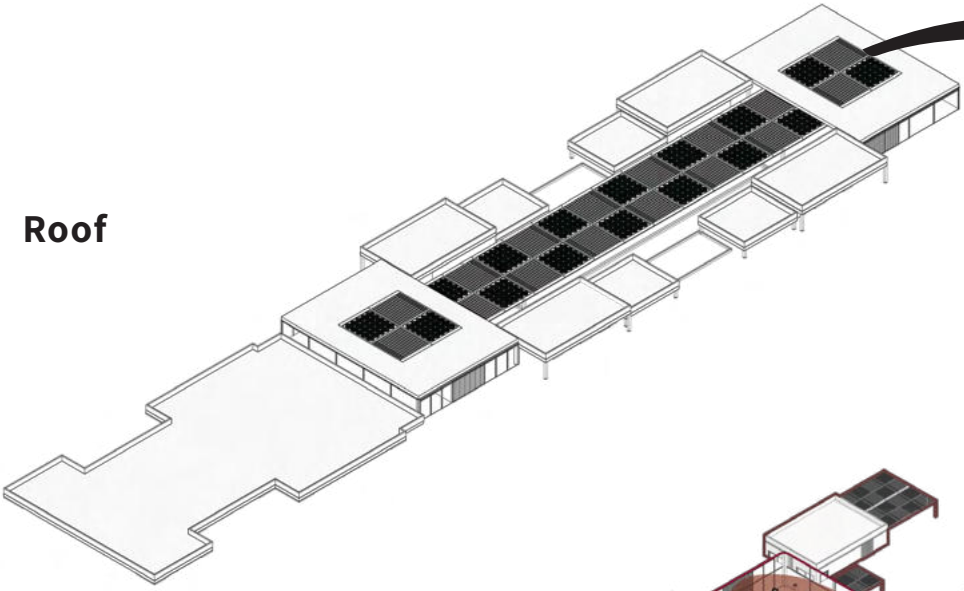




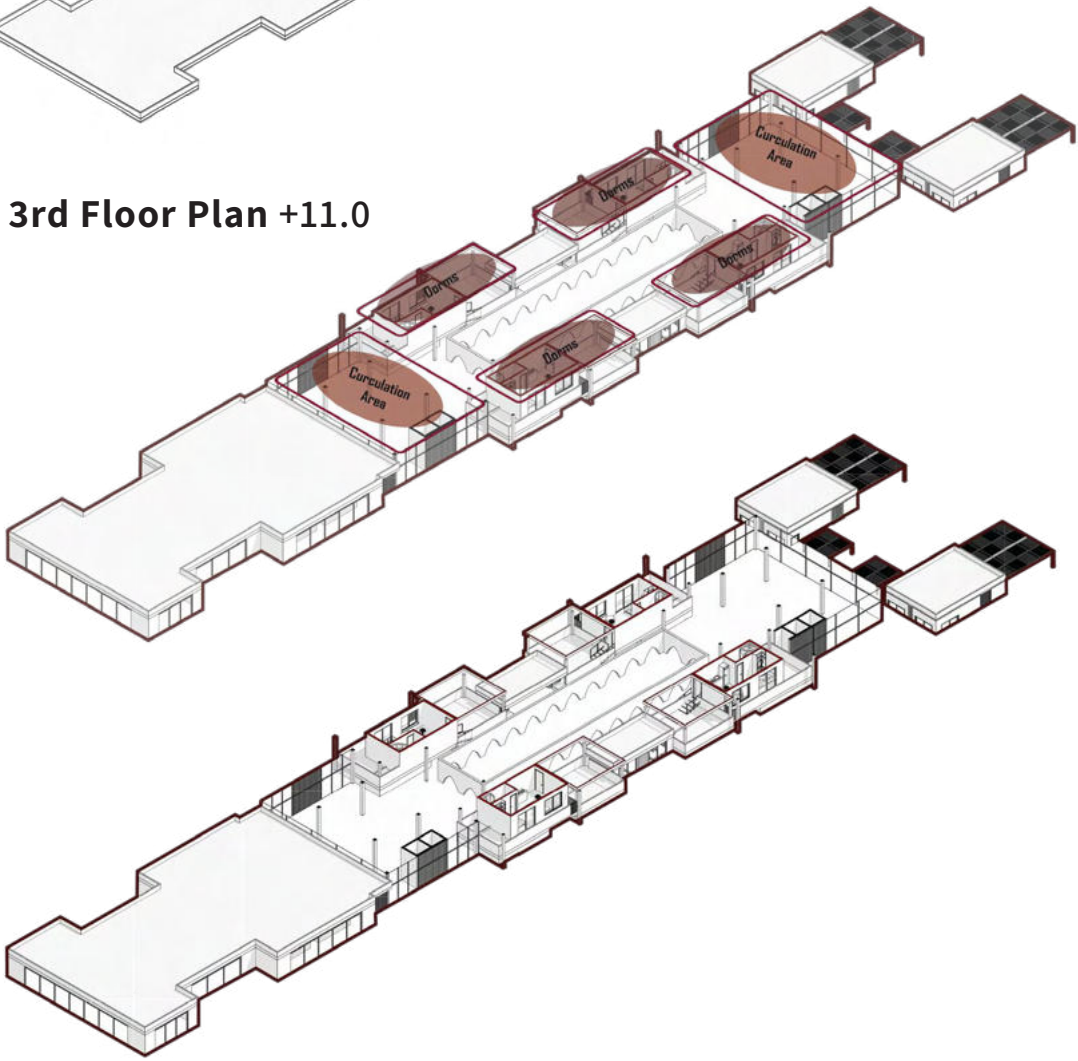
2nd Floor Plan +8.0

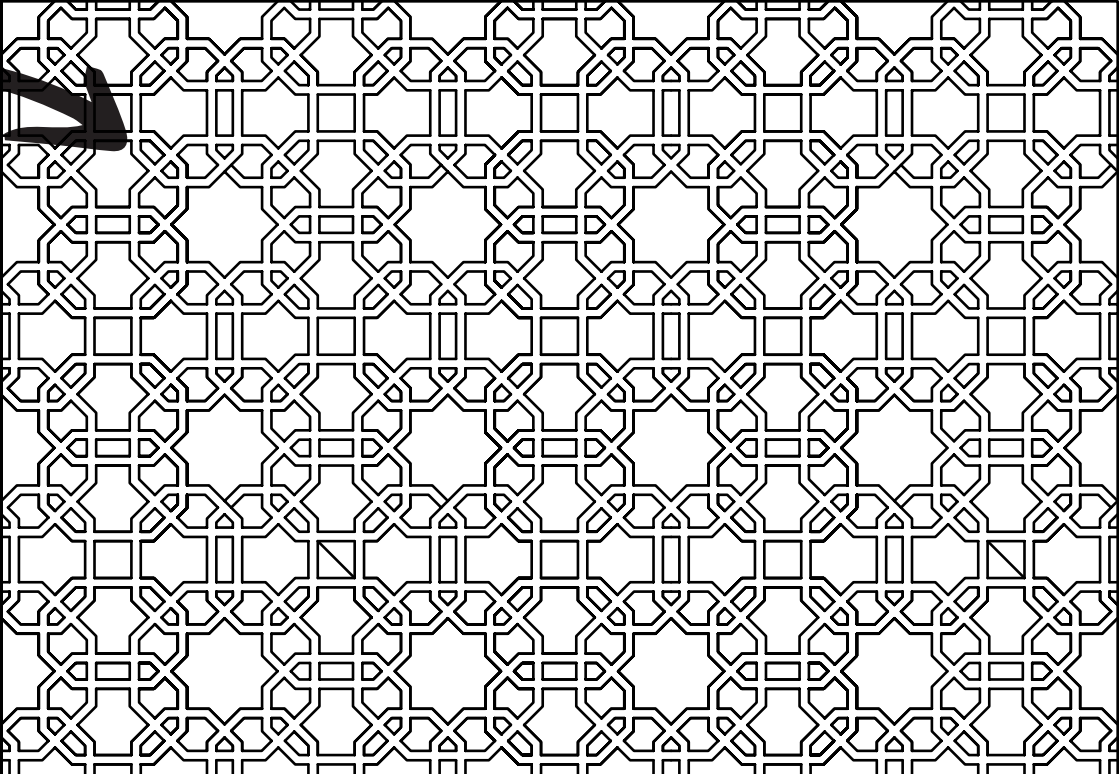


Roof



3rd Floor Plan +11.0





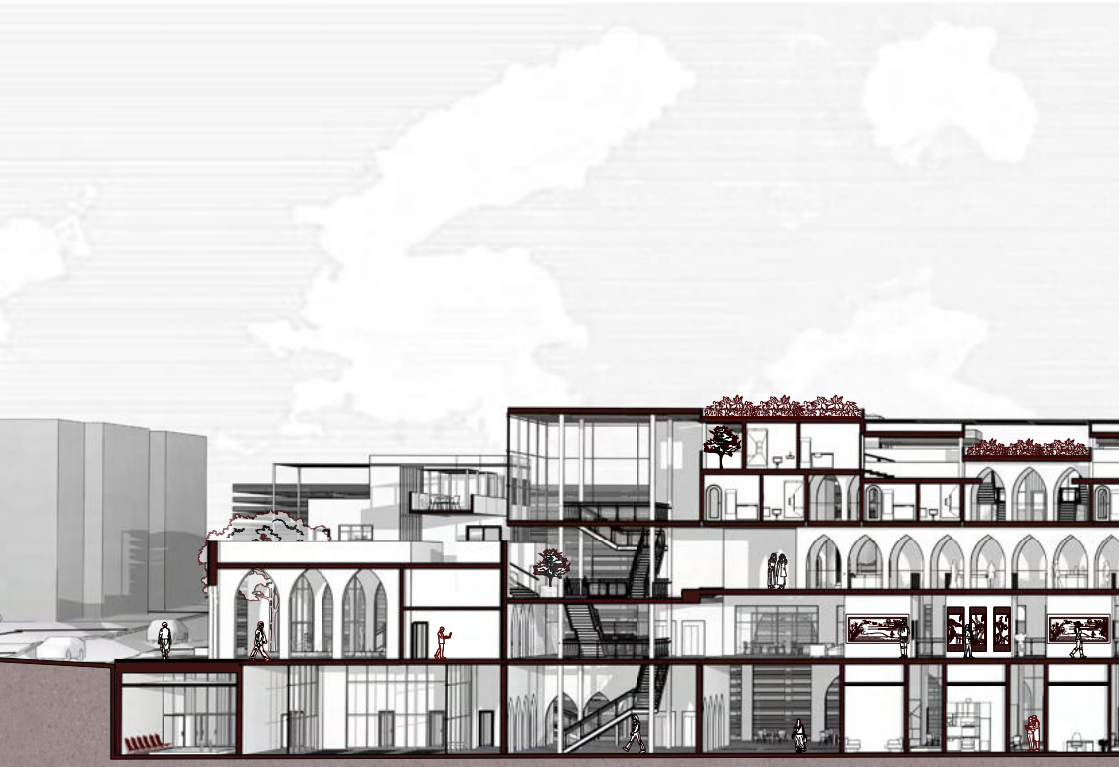
Mashrabiya and Shading

Instead of enclosing the central area of the residential part, the roof is left open to bring in natural air and sunlight, enhancing comfort and improving the overall user experience. Shading elements, inspired by the local tradition of mashrabiya in Jaffa, filter the light while maintaining airflow, tying the design to both cultural memory and the local climate.

This reinterpretation of a familiar element grounds the project in its context, softening the architecture and making it feel less institutional. In the middle, shaded seating areas create a communal core where residents can pause, relax, and socialize, transforming what could have been a closed corridor into an open, restorative environment that reflects both local heritage and contemporary needs.

Section A–A

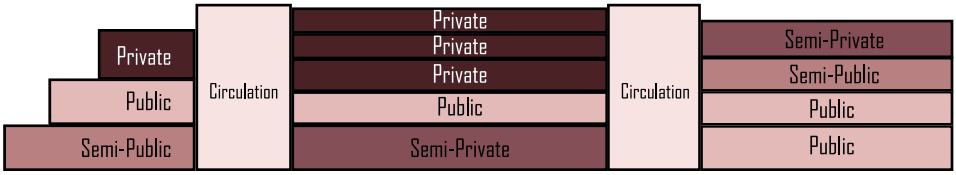
In the first section, the relationships between spaces and the overall movement through the building become clear. The cut illustrates how circulation weaves across the project, connecting public, residential, and therapeutic areas into a continuous flow. It also highlights the way the architecture engages with the topography, using changes in level to create natural transitions between programs. The distribution of functions across the section demonstrates how the building balances openness and protection, civic presence and private retreat, while always remaining anchored to the site's landscape.



Section A-A

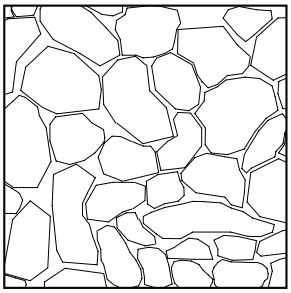
Privacy

In the first section, the relationships between spaces and the overall movement through the building become clear. The cut illustrates how circulation weaves across the project, connecting public, residential, and therapeutic areas into a continuous flow. It also highlights the wa

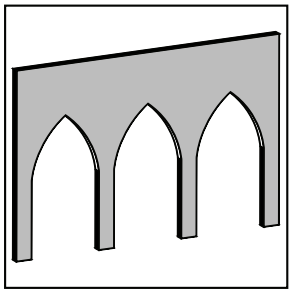


Elevation

The elevation reveals the close connection between the building and the site's topography, showing how the massing steps naturally with the terrain. Local elements such as stone façades, arches, and shaded openings are integrated into the design, rooting the



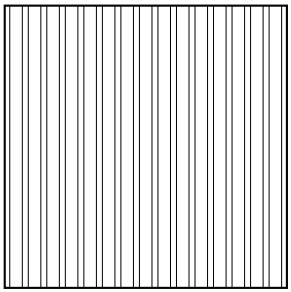
Local Stone



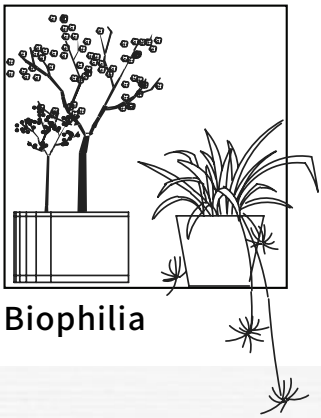
Arches

Northen Elevation

project in the architectural language of Jaffa. At the same time, the elevation makes visible the clarity of circulation, with pathways and transitions expressed cleanly across the façade. Together, these qualities demonstrate how the project blends contextual sensitivity with a legible and welcoming spatial structure.



Louvers

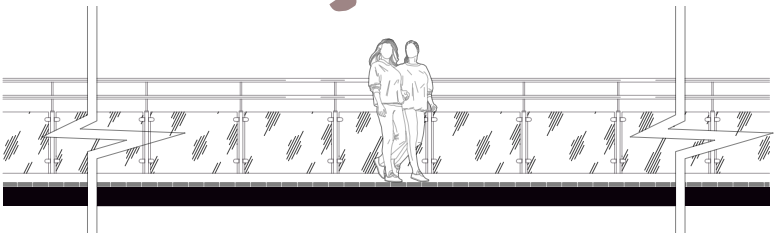


Biophilia

Section B-B

This section highlights the graduality embedded in the design, ensuring that the building does not overwhelm either the site or its users. The stepped massing and transitions create a gentle progression between spaces, supporting intuitive movement and comfort. The section also makes clear the relationship between the building and the yard in front of the Peres Center, showing how open areas and built forms are tied together into a coherent whole. It further emphasizes how circulation is organized to be clear and continuous, allowing users to move easily while maintaining visual and spatial connections with the surrounding landscape.

Section B-B



Section C-C

This section highlights the bridges that connect the proposed building with the Peres Center, as well as new links from Peres to the street on the ground floor, creating a level of accessibility that the existing structure lacks. By doing so, the design makes full use of the Peres Center as part of the intervention and strengthens its role within the urban fabric. The section also reveals the interior organization of the proposed building, where open and unroofed spaces allow natural sunlight and ventilation to flow through. This integration of light, air, and circulation ensures that the environment feels open and restorative rather than closed or institutional.

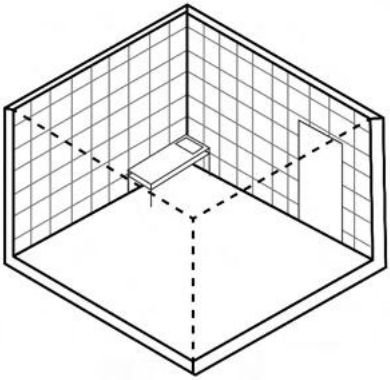
Residential

The residential units in this project challenge conventional ideas of institutional accommodation. Instead of isolating those in need of rest or recovery in clinical wards, the intervention offers spaces of presence, flexibility, and dignity. These units are intended for individuals experiencing mental health distress, burnout, or crisis, as well as staff and temporary visitors who support the site's overall care structure. While designed primarily for young adults, the spaces remain open to a wide range of users seeking a temporary pause from their everyday environment.

The architecture is structured around the principle of choice. Residents decide how much privacy or interaction they prefer at any time. Each unit includes a private balcony for light, air, and personal connection to the outside, while every floor provides shared lounges, kitchens, and quiet common areas. These communal spaces offer support and interaction but always remain optional, ensuring that community is offered rather than imposed.

The units are arranged to avoid the repetition and rigidity of institutional housing. Their organization follows residential logics more often found in apartment living than in medical facilities. Interiors are simple and soft in tone, grounded in warmth rather than clinical signaling.

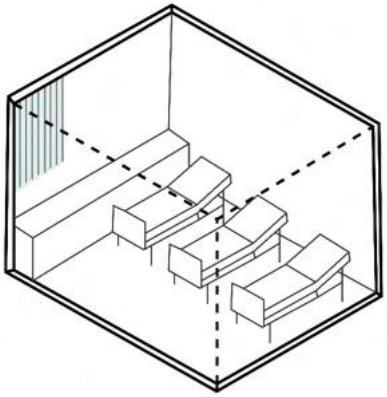
Circulation is intuitive, linking residents to terraces, communal areas, and therapeutic programs, creating an atmosphere of calm retreat while keeping every resident within reach of support.



Standard Psychiatric Room Design

Isolated | No sunlight

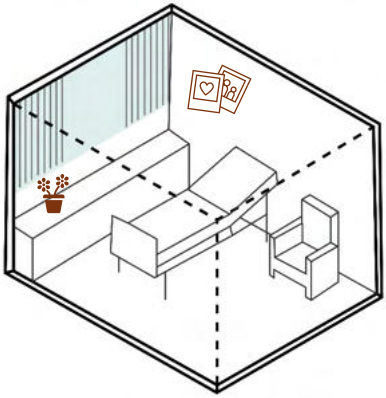
The most common psychiatric hospital room. Isolated, windowless, and lacking natural light.



Modern Room Design

Shared | Unsafe | Natural Sunlight

The current hospital standard. Several patients share one space with only a small window, offering little privacy or comfort.



Ideal Room Design | Flexible

Comforting | Safe | Natural Sunlight

A supportive environment with natural light and safe proportions. Adaptable space gives residents choice between privacy and connection.

Typology A

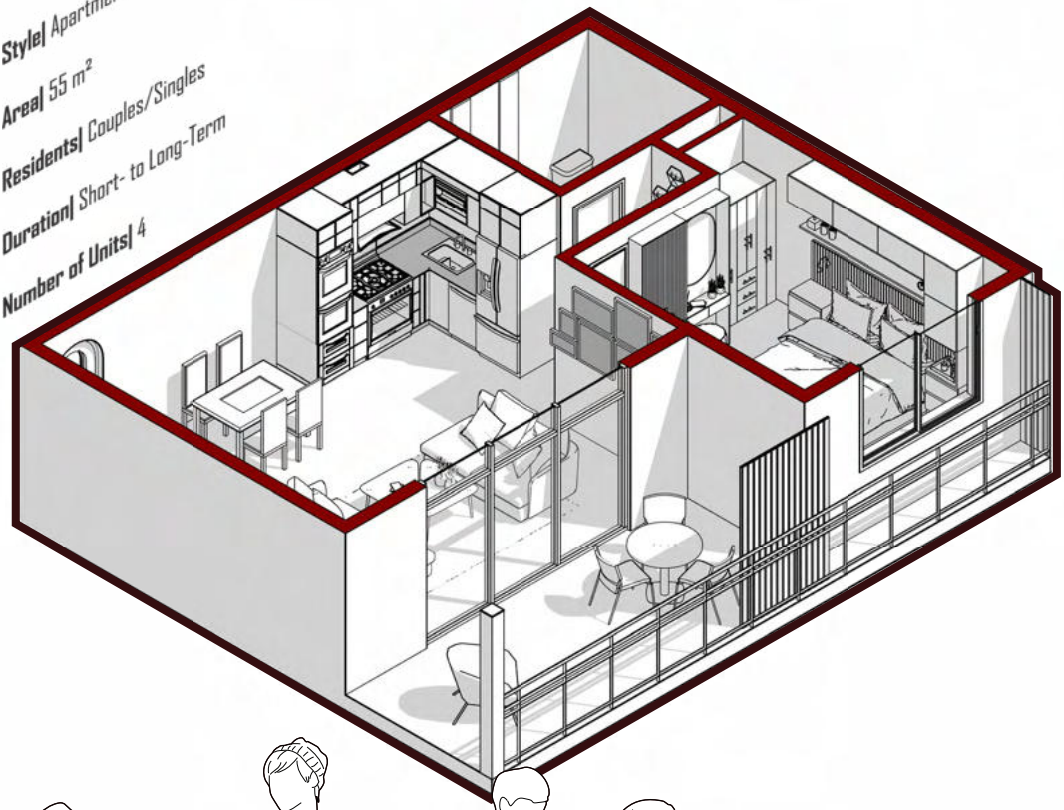
Style| Apartment

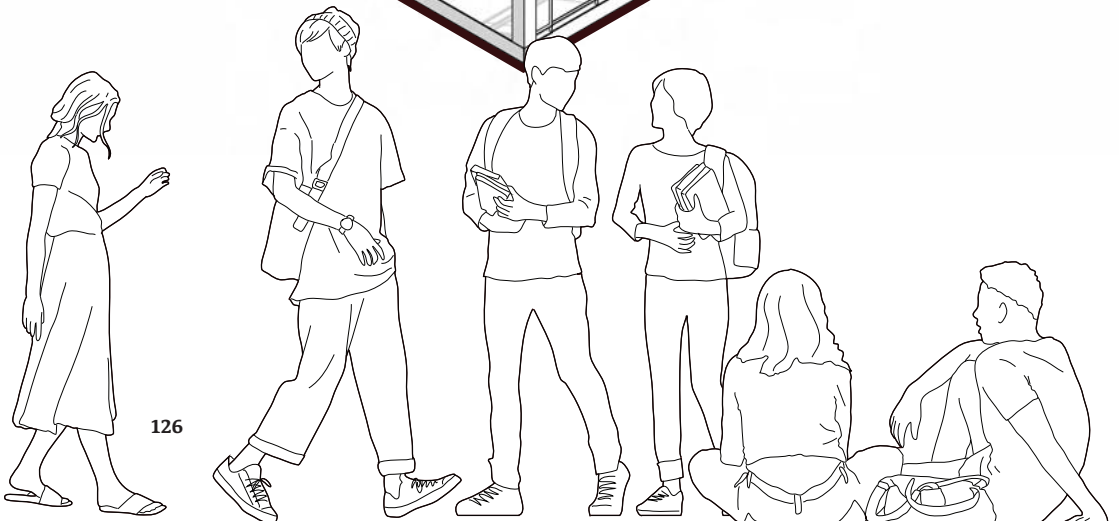
Area| 55 m²

Residents| Couples/Singles

Duration| Short- to Long-Term

Number of Units| 4





Typology A

Style| Apartment

Typology A offers a residential model that challenges conventional ideas of institutional accommodation. Instead of isolating those in need of rest or recovery in clinical wards, the apartments provide presence, flexibility, and dignity.

Each unit measures 55 square meters and accommodates singles or couples for both short and long term stays. With only four units, the scale remains intimate and personal, supporting recovery without detachment from everyday life.

The architecture is structured around the principle of choice. Every apartment has a private balcony that connects residents to light, air, and the outdoors, while shared kitchens, lounges, and quiet rooms are available on each floor. These communal spaces allow for comfort and interaction but remain optional, ensuring that community is offered rather than imposed.

The design avoids institutional repetition by following the logic of housing rather than medical infrastructure. Interiors are simple and warm in tone, creating an atmosphere that is calm and neutral. Circulation is intuitive, linking apartments to terraces and common areas without forcing contact.

Typology A demonstrates that mental health housing can feel like home, offering dignity, autonomy, and a gentle connection to the wider care structure.

Typology B

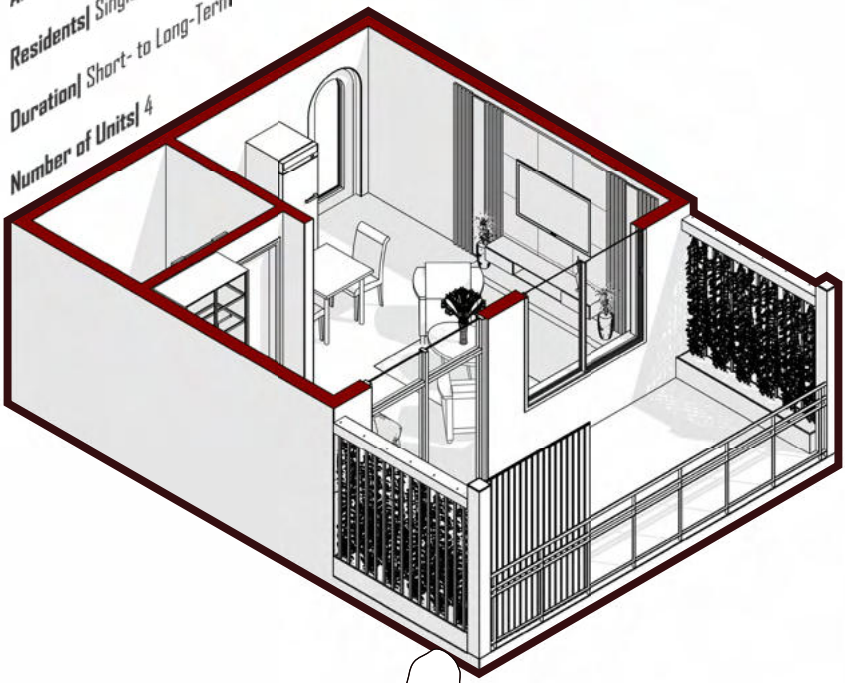
Style| Studio

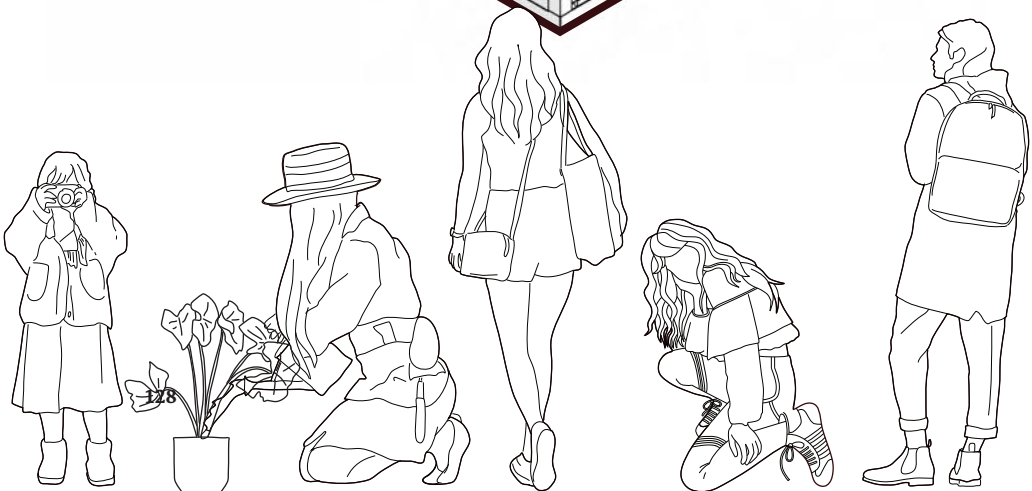
Area| 30 m²

Residents| Single

Duration| Short- to Long-Term

Number of Units| 4





Typology B

Style| Studio

Typology B introduces a studio-style residence designed for individuals seeking a private and self-contained living environment. Each unit measures 30 square meters and is intended for single residents who may require either short or long term stays. With only four units, the scale remains intimate, ensuring that residents are supported without being absorbed into an institutional atmosphere.

The studios are compact yet complete, offering a personal retreat with a clear sense of autonomy. Each includes its own balcony for light, air, and an immediate connection to the outside. The interior is arranged simply, with a calm palette and warm finishes that emphasize neutrality rather than clinical efficiency. This quiet domesticity creates a restorative setting where the individual can pause, rest, and recover on their own terms.

While self-contained, the studios remain connected to the wider life of the project. Shared kitchens, lounges, and terraces are located nearby, giving residents the option to join collective spaces without obligation. The circulation system makes these common areas accessible but not imposed, allowing every resident to define the level of interaction they need at any point in their recovery.

Typology B therefore combines independence with proximity to community. It is designed for those who benefit from privacy while still being within reach of shared support. By embedding these small-scale studios into the urban fabric, the typology resists the logic of isolation and reframes mental health housing as a continuum of choice, access, and dignity.

Typology C

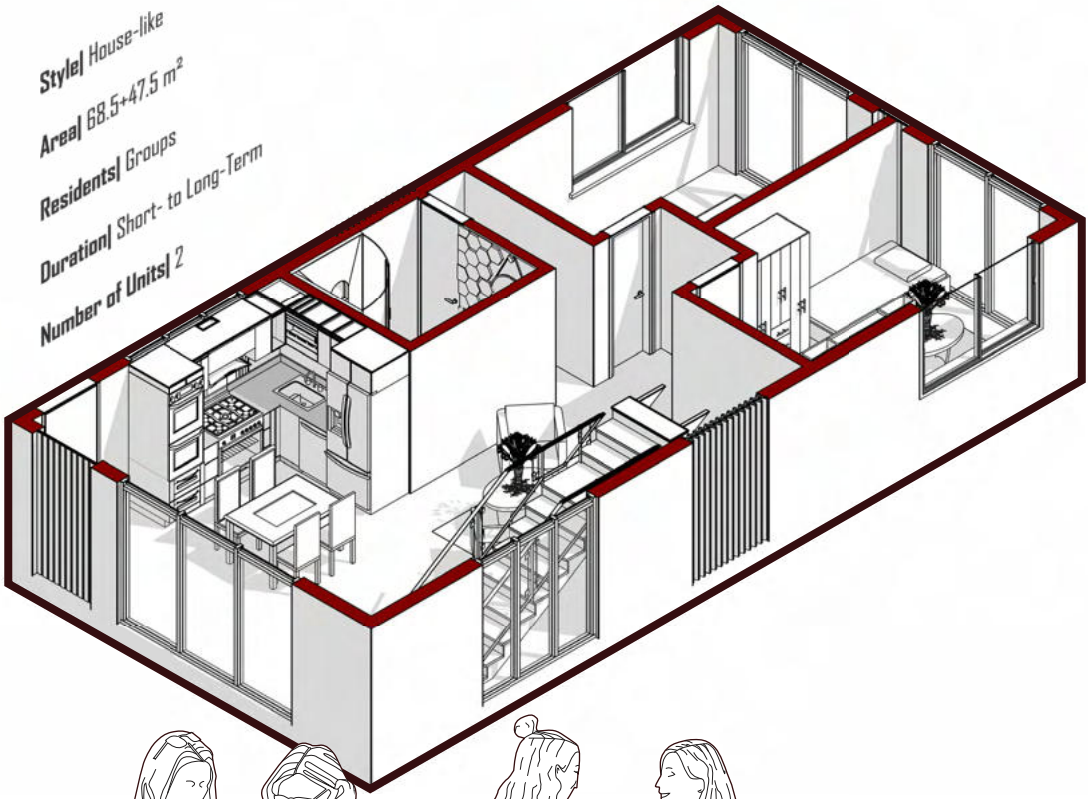
Style| House-like

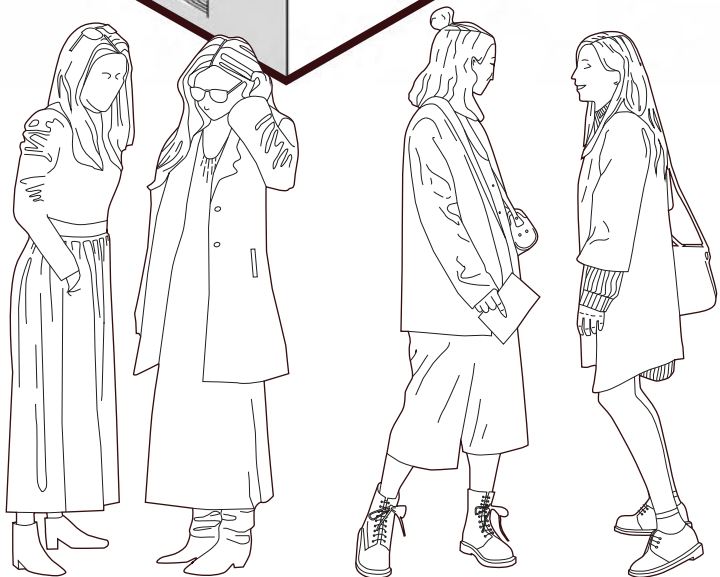
Area| 68.5+47.5 m²

Residents| Groups

Duration| Short- to Long-Term

Number of Units| 2





Typology C

Style| House-like (2 floors)

Typology C is conceived as a house-like residence, designed for small groups who benefit from living together in a more domestic and collective arrangement. Each unit is larger than the apartments and studios, measuring 68.5 and 47.5 square meters, and offers the scale and character of a home rather than a facility. With only two units in total, the typology maintains intimacy while supporting shared living as a meaningful part of recovery.

The house-like form fosters familiarity and companionship. Residents share kitchens, dining areas, and living spaces that encourage daily routines to unfold collectively, while bedrooms remain private to ensure individual retreat is always possible. This balance between group life and personal space allows residents to experience both care and autonomy in everyday rhythms.

The interior atmosphere follows the same principles of warmth, calm, and material softness as the other typologies, but here the emphasis is on togetherness. Spaces are designed to host meals, conversations, and informal gatherings, creating opportunities for peer support and collective healing. Outdoor terraces and gardens extend the domestic environment beyond the walls, linking the houses to the wider network of communal and therapeutic programs.

Typology C is particularly suited for groups whose recovery process is strengthened by shared presence and companionship. By offering a residence that feels like a real home, it challenges the separation often associated with mental health housing and proposes a model where group living becomes a source of stability and belonging.

Typology D

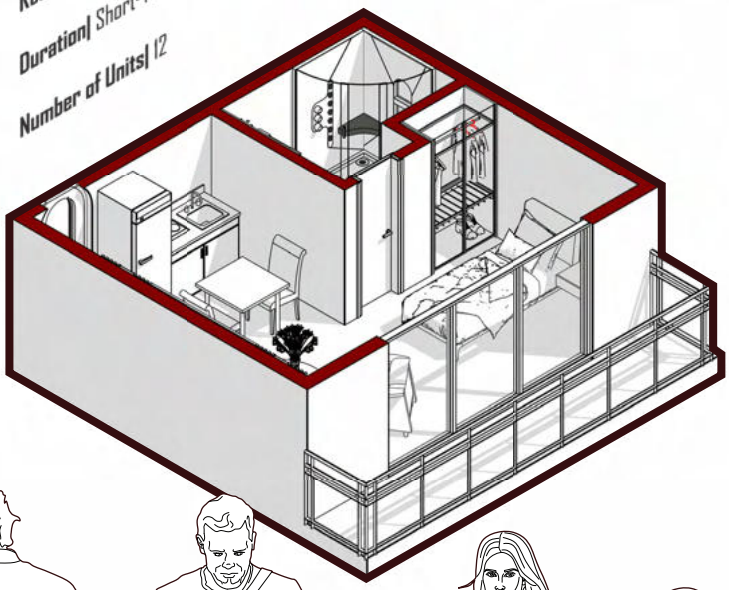
Style| Hotel-Like

Area| 25 m²

Residents| Single

Duration| Short-Term

Number of Units| 12



Typology D

Style| Hotel-Like

Typology D takes inspiration from the hotel typology, offering compact, efficient rooms designed for short term stays. Each unit measures 25 square meters and accommodates a single resident. With twelve rooms in total, this typology responds to moments of acute need, providing immediate access to rest and recovery without the long admission processes often associated with institutional care.

The design emphasizes simplicity and comfort. Each room is private and self-contained, offering a secure place to retreat. Interiors are modest in size but carefully finished with a warm palette, ensuring that even in their compact form they avoid any sense of clinical sterility. Balconies and openings provide light and air, reinforcing dignity and autonomy for every resident.

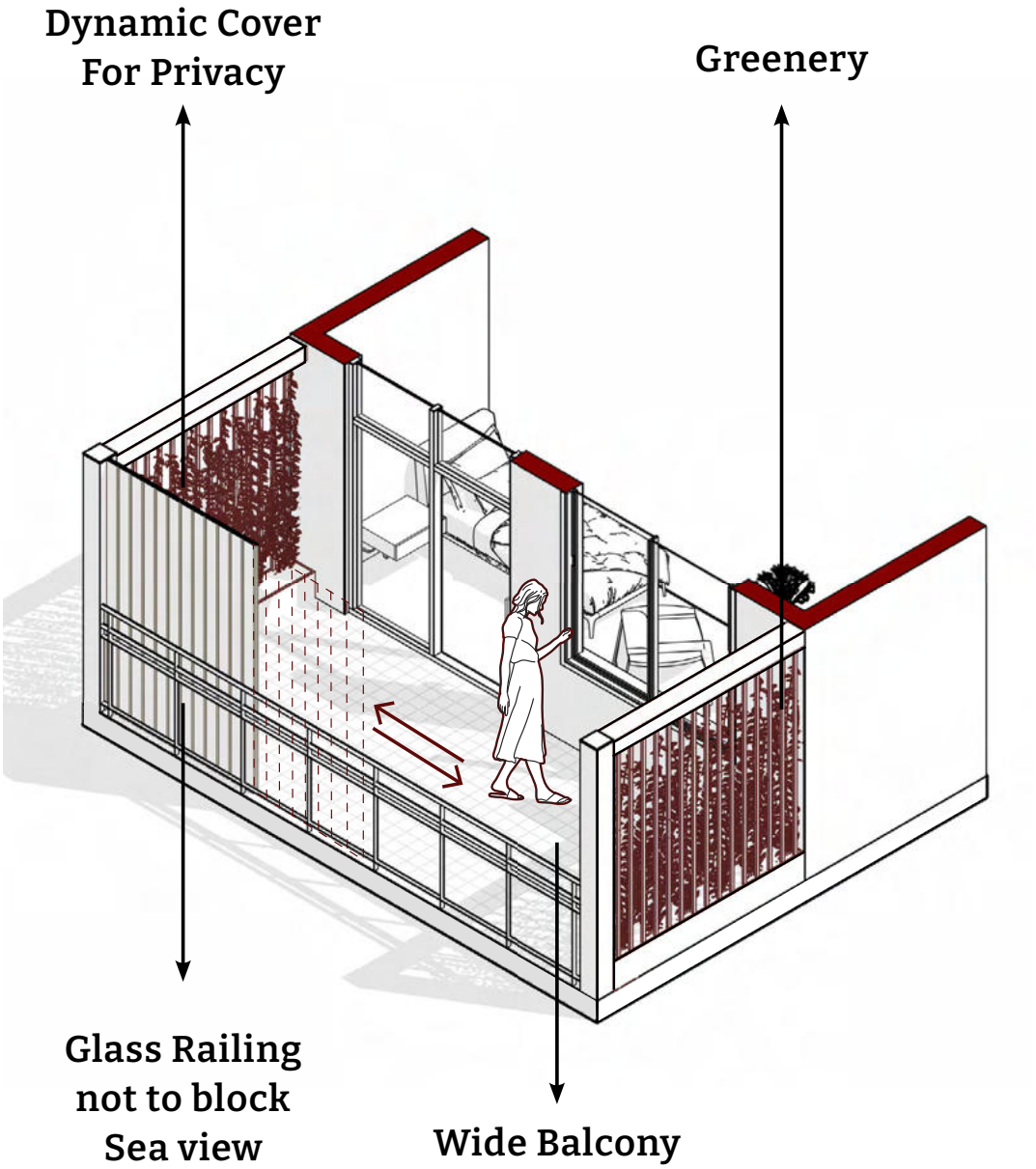
Although the scale is smaller and more transient than other typologies, Typology D remains embedded within the wider fabric of the project. Shared lounges, dining areas, and gardens are positioned nearby, allowing residents to step out of their rooms and connect with others if they choose.

Typology D is intended for those whose circumstances require short stays: individuals experiencing burnout, crisis, or temporary dislocation who need immediate shelter in a non-stigmatized setting. By adopting the logic of the hotel, it reframes short term recovery not as confinement, but as hospitality.

Biophilic Elements

Based on my research into healing environments, biophilic elements were carefully integrated throughout the project to support recovery and wellbeing. Natural light, open air, and greenery are not treated as additions but as essential parts of the spatial experience. They appear in circulation routes, courtyards, and communal areas, creating a rhythm of openness and connection with the environment.

Balconies, as shown in the diagram, are one example of this approach, giving every resident direct access to sunlight, fresh air, and outdoor views. These daily encounters with natural elements reduce the sense of confinement and help restore balance in moments of stress. The intention was to create a building where nature is present at every scale, from the smallest sitting area to the overall massing, so that the atmosphere always feels restorative and humane.


Dynamic Cover
For Privacy
Greenery
Glass Railing
not to block
Sea view
Wide Balcony

Final Thoughts

This project is not just an architectural proposal but a framework for identifying, analyzing, and transforming spaces of alienation into inclusive, healing environments. By developing a structured methodology of analysis and intervention, it provides tools that can be applied beyond Jaffa, offering a replicable model for other urban contexts facing similar challenges.

The intervention strategies introduced include the identification of alienating spaces, restoration of historical elements, integration of mental health services into public areas, and fostering of community engagement. These strategies are designed to be accessible and implementable by architects, urban planners, policymakers, and community leaders. Mental health is not a standalone issue but is deeply tied to urban design, cultural identity, and social integration.

By embedding mental health care into the everyday urban fabric rather than confining it to isolated institutions, this project challenges conventional models and advocates for cities that actively promote emotional well-being, inclusion, and social connection.

Ultimately, this project serves as a practical and adaptable framework that can be applied in any city by those committed to creating spaces that foster collective healing and belonging. Through this shift, architecture becomes more than a physical construct. It becomes an active agent in reshaping social narratives, dismantling stigma, and building a future where mental health is supported, not hidden.

Artwork 5. Rihito Takarai, Only the Flower Knows (manga image, extra chapter), accessed September 1 2025.

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Images Credit

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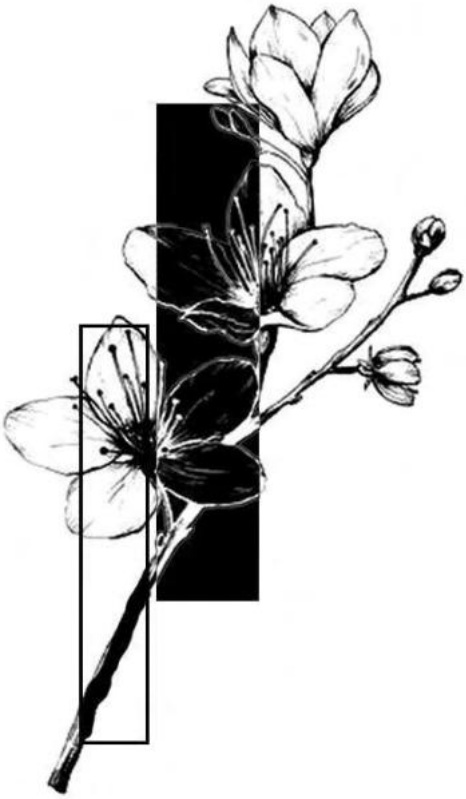

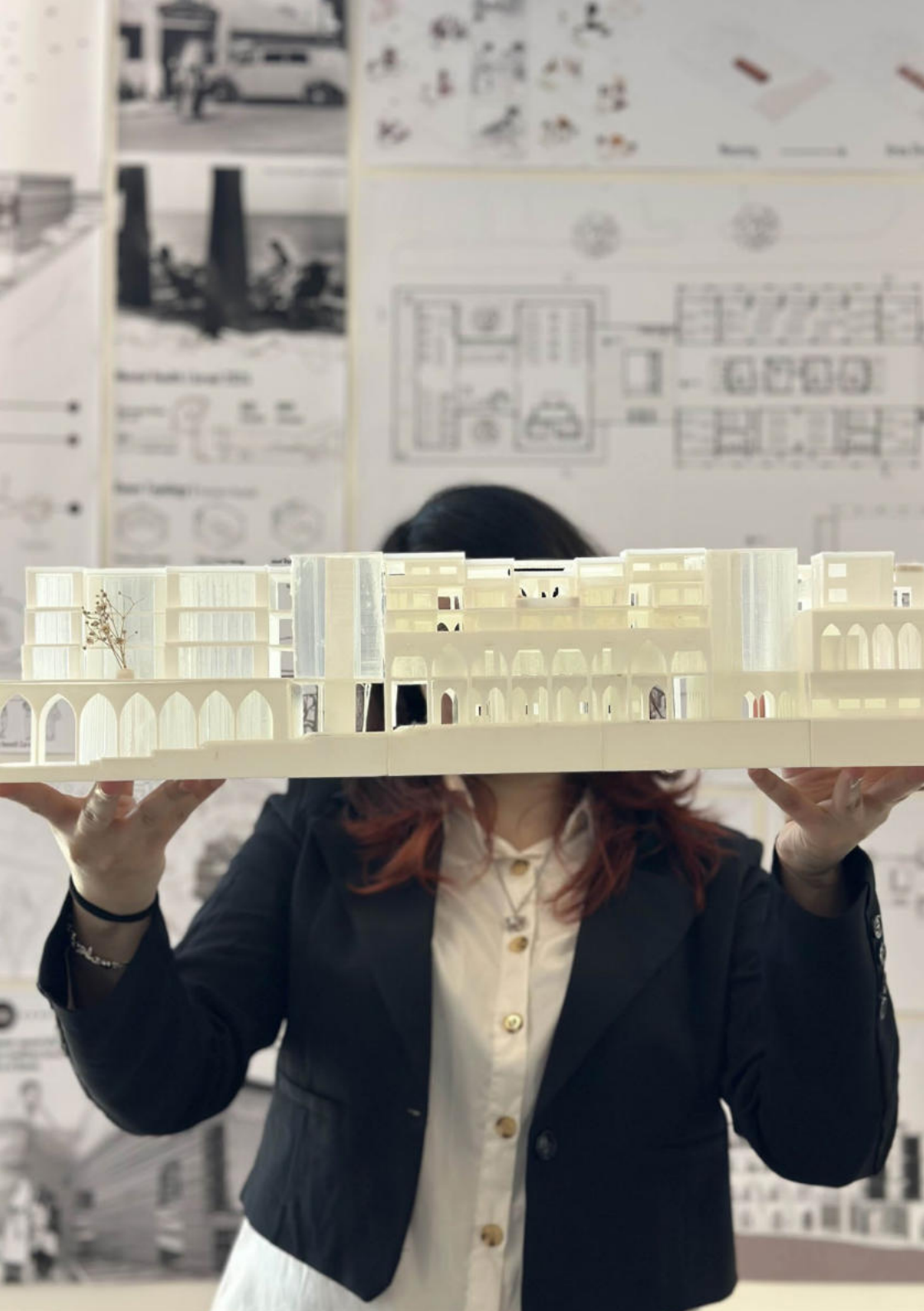


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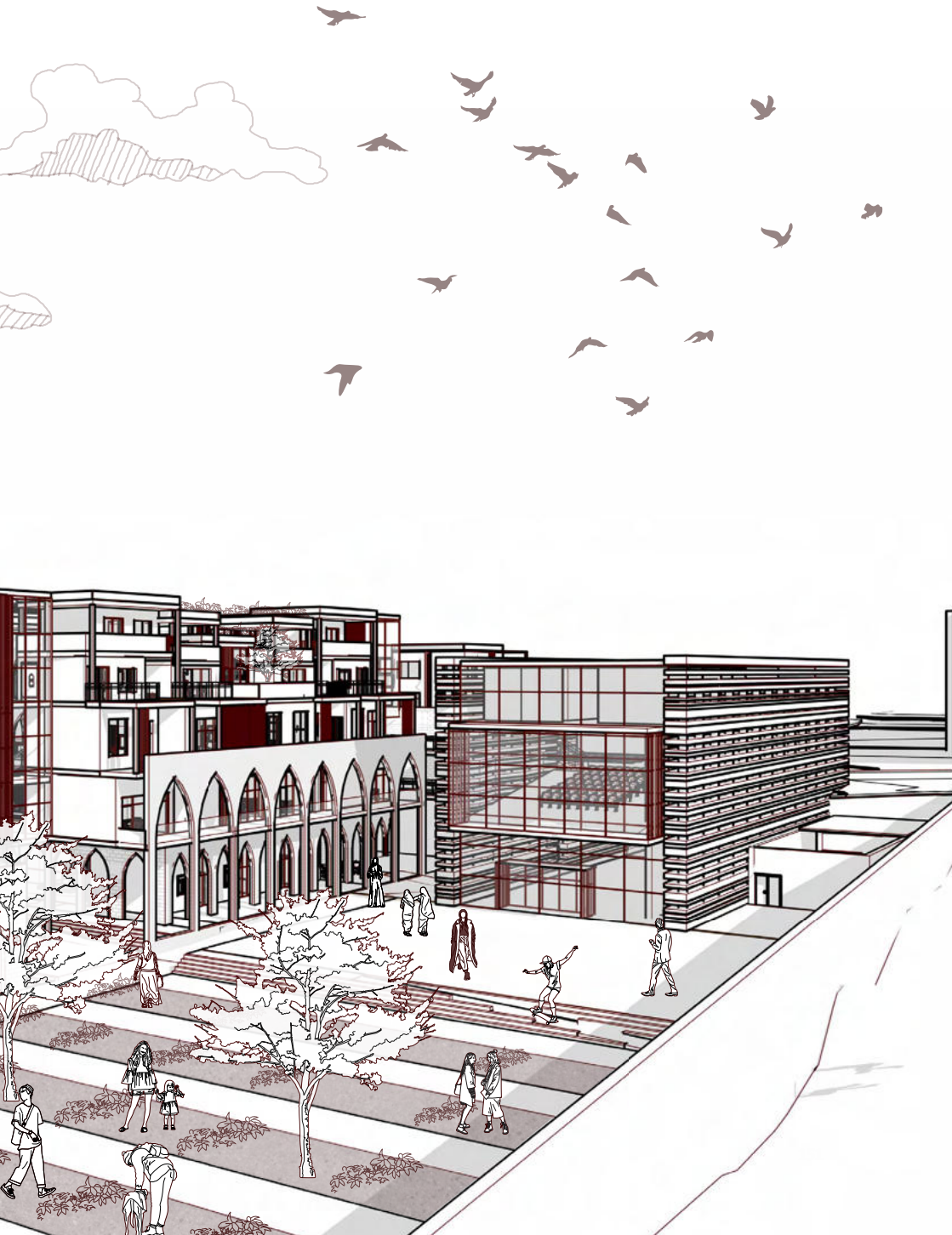

“The greatest cruelty is our casual blindness to the suffering of others.”

Growing up in an environment where mental health was stigmatized, I witnessed how architecture can either foster belonging or deepen feelings of isolation. Spaces are not neutral; they shape emotions, dictate inclusion, and define who is seen and who is left behind.

This project reflects my belief that architecture must play an active role in promoting well-being. Through the lens of Jaffa, a city marked by displacement, gentrification, and cultural fragmentation, it explores how urban design can either heal or alienate. Special attention is given to the Arab sector, where mental health disparities remain significant and often overlooked.

The intervention presented in this work focuses on transforming spaces of alienation, urban environments that disconnect and exclude, into inclusive and healing spaces. By embedding mental health support into the city’s fabric rather than isolating it, the project envisions public spaces that encourage connection, dignity, and resilience. Rather than hiding mental health care in distant institutions, this research challenges the stigma that separates the mentally ill from society and proposes a model where they are fully integrated into the everyday life of the city. Architecture can be a tool of exclusion, but it can also be a force for change, shaping a reality where mental health is no longer hidden but openly supported.

This project challenges the outdated notion that mental health care should exist on the fringes and offers a vision for cities that heal.