Dignified Design:
An actionable conceptual model informed by residents and staff in permanent supportive housing

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ABSTRACT: This study addresses a critical and timely issue—how the built environment can support dignity for individuals experiencing housing instability. Common definitions of dignity include autonomy, respect, self-determination, freedom, and equality. For people experiencing housing and health instability, everyday life is extremely stressful, and the built environment can play a critical role in supporting psychological and somatic regulation (Devlin 2018). Ajeen and colleagues (2023) found that many participants perceived that trauma-informed design updates for homeless shelter bedrooms increased their experiences of dignity and safety. For this study, a practice-embedded research team collected observations of use at various supportive housing sites, documented through photos and note-taking, and conducted semi-structured interviews and focus groups in two phases with a total of 115 resident and staff participants. The team inductively analyzed this large dataset of text and images using grounded theory methods. Analysis revealed that the experience of comfort, community, and control are deeply interdependent and together create a rich and layered sense of safety for participants. Key design attributes—categorized as sensory engagement, nested layers, and identity anchors—emerged as critical for creating an atmosphere of dignity, which significantly contributed to the overall experience of dignity for participants. Ultimately, the research resulted in a grounded theory model of Dignified Design, establishing a framework for architects, designers, and other creators of service-oriented spaces.

KEYWORDS: Dignity, Design, Housing, Wellbeing, Practice-embedded

INTRODUCTION

In the United States in 2024, 771,480 people experienced homelessness on any given night (United States Department of Housing and Urban Development 2024). Supportive housing is an affordable housing approach with dedicated supportive services for indiviudals with complex needs including histories of homelessness, disabilities, and chronic illnesses. They are places for sleep and bathing and also places to access services, such as occupational therapy, minor medical services, and peer counseling. The designed attributes of supportive housing impact people's experience of the services themselves because the built environment can play a critical role in supporting psychological and somatic regulation (Devlin 2018). Because people experiencing homelessness face disproportionately poor health outcomes, marked by accelerated aging, chronic physical and mental health conditions, and high mortality rates (Garcia et al. 2024), it is necessary for the built environment to attend to more than basic needs for residents to heal from co-occurring trauma and health conditions. However, the design of typical supportive housing and related service spaces frequently fail to uplift and dignify the human experience of the people living and working in these environments (Ajeen et al. 2023; Faerden et al. 2023).

This research began as an exploration of the concept of trauma-informed design (TID). "Trauma-informed design (TID) is the application of the principles of trauma-informed care (TIC) to the creation of the built environment: architecture, interior design, landscape design and user experience" (Bollo and Donofrio 2021). TID is particularly relevant for environments serving individuals experiencing homelessness, as trauma is a known precursor of houselessness (Fitzpatrick-Lewis et al. 2011). However, there are currently no existing TID frameworks that take a salutogenic lens, focus on the creation of environmental atmospheres, or identify an objective for design beyond minimizing triggers and re-traumatization.

Individuals experiencing homelessness are subjected to societal stigmatization and are at risk of having their sense of dignity diminished (Stevenson 2014). Dignity is recognized across the globe as an innate human right and a fundamental part of being human (Borowski 2022). Common definitions of dignity include autonomy, respect, self-determination (Ohls 2020), freedom, and equality (Pols 2013), while indignity is characterized as shame, dehumanization, and referring to people as "other" or objects (Moran and Salter 2022).

There is limited research on dignity and the built environment, though there are case studies in specific contexts, such as behavioral health (Faerden et al. 2023) and memory-care (Fleming et al. 2023). Dignity-adjacent research includes healing spaces and trauma-informed design. Scholars have provided ample evidence that biophilic design principles facilitate psychological and social benefits (Browning and Ryan 2020). Trauma-informed design incorporates design elements that support and facilitate a sense of safety to help regulate and heal multiple neurological functions (Owen and Crane 2022); Ajeen and colleagues (2023) reported that many participants perceived that trauma-informed design updates to homeless shelter bedrooms increased their experiences of dignity and safety. However, researchers have found that social service spaces often fail to facilitate and support dignity (Bittencourt and Amaro 2019). In fact, the built spaces that house social service programs often contribute to *indignity* through a lack of concern communicated by their architectural design (Gallagher 2004).

Research on the impacts of dignity on service providers is particularly limited, which is unfortunate because designing for the dignity of staff can directly impact the experience of dignity for residents and guests (Pless et al. 2017). Gallagher (2004) argued that the dignity of providers is not respected in "tangible ways" (592)—both within the built environment of service facilities and through organizational culture—and this lack of respect can impact the ability of providers to honor the dignity of service users. He illustrated this concept through an example of a nurse who connected the absence of a staff break room to feelings of indignity among providers, stating that "If we give our patients dignity then we need a little as well" (591).

Despite repeated recognition of the importance of the concept of dignity across multiple disciplines as well as the breadth of literature emphasizing the impact of the built environment on human flourishing, few studies seek to operationalize dignity through built environment design elements. The research presented in this paper considered the experiences of people with housing and health instability who seek services in permanent supportive housing. The grounded theory analysis of resident and staff perspectives lead to a conceptual model that builds on prior definitions of trauma-informed design as well as dignity. The resulting Dignified Design model, informed by cross-disciplinary research, provides a framework for increasing the potential for dignity in the built environment. The following sections describe the methods used for this study; explicate the grounded theory of Dignified Design; and provide an inventory of Dignified Design manifestations in supportive housing settings.

1.0 METHODS

This study used a grounded theory approach to discover a "unified theoretical explanation" (Corbin and Strauss 2007, 107) for the attributes of the built environment that best contribute to an atmosphere of dignity for residents and staff in affordable housing settings. Grounded theory allowed for multiple sources of data to be analyzed comprehensively and iteratively. The data collection activities of this study were organized into two phases. Phase I was exploratory, conducted at three supportive housing sites, and focused on generating knowledge to inform the real-time practice of trauma-informed design by firms engaged in architectural and design services. Following Phase I, the research team continued to interview residents and staff through project-specific pre-development and post-occupancy evaluation efforts, testing the ideas resulting from Phase I in real-life conditions. This lead to Phase II, which was supported by external funding and examined trauma-informed design using a qualitative comparative study research design at five supportive housing sites, including settings designed with trauma-informed principles and typical affordable housing buildings. The grounded theory data analysis was ongoing and included both phases of data collection.

Both phases of this study involved participants in supportive housing. As such, participants were recognized as particularly vulnerable and ethics concerns were of utmost concern. Data collection efforts were collaborative with the Center for Housing and Homelessness Research at the University of Denver, and the ethics were guided by academic standards. Participants were fully free and encouraged to critique their environments. To help ensure this, researchers requested that staff not be present during resident interviews and supervisors not be present during frontline staff interviews; this request was often honored. In Phase I, original designers/architects of the buildings in question were not present for the interviews, and in Phase II, the lead researcher was not involved in the design of any of the buildings.

1.1 Phase I

1.1.1 Sample and Recruitment

The data collection of Phase I took place from May to July 2019. Resident and staff participants were recruited from three supportive housing developments in Colorado. The study included 72 participants, including a voluntary sample of 56 residents and a purposive sample of 16 staff. Resident participants were compensated with US$20 gift cards to local vendors, and they signed consent forms prior to the interviews and focus groups.

1.1.2 Data Collection and Analysis

Phase I qualitative focus groups were approximately 60-90 minutes long and facilitated in person in English. Interviews were conducted using a semi-structured guide, which provided a core list of questions for interviewers who used prompts to further explore the experience of residents and staff in the built environment. Open-ended questions were used to elicit feedback on living and working in supportive housing settings and ideals for future housing/service

settings. Observational data were collected via semi-structured observations at the three housing sites. Data were captured in the form of note-taking and photographs of the environment.

Data analysis was led by one member of the research team with two research assistants. Researchers used initial coding to analyze data collected from focus groups conducted with residents and staff at the three sites. Researchers followed an inductive approach, allowing concepts to emerge from the data without a pre-existing framework or theory (Corbin and Strauss 2007).

1.2 Phase II

1.2.1 Sample and Recruitment

Phase II data collection took place from February to August 2024 in five supportive housing developments in Colorado, including three supportive housing settings designed with trauma-informed principles and two typical supportive housing buildings. A total of 59 participants were engaged in the research, including a voluntary and convenience sample of 42 residents and a purposive sample of 17 staff. Participants joined semi-structured interviews and focus groups inquiring about their interactions with and perceptions of living and working in the five study sites. Interviews were conducted in person in English and facilitated by two members of the research team. All interviews were audio recorded and transcribed with participant permission. Per the agreement with the University of Denver Institutional Review Board, researchers explained the study procedures and secured written consent from all participants. All participants were compensated with US$25 gift cards to local vendors.

1.2.2 Data Collection and Analysis

Researchers used semi-structured interview guides and probed to elicit deeper feedback. Residents and staff were asked about their perceptions of living and working at the study sites with attention to experiences of safety, comfort, connection, health, and engagement with other services and systems. Observational data was also collected at the five study sites. A semi-structured note-taking protocol prompted researchers to record first impressions of the building as well as specific design features in each space that mapped onto early iterations of the trauma-informed design affordances (safety, comfort, connection, and choice) and design attributes (nested layers, sensory boundaries, and identity anchors). Researchers took photographs of indoor and outdoor environments at the five sites.

Interview transcripts were analyzed using an iterative process led by two members of the research team who were assisted by a research assistant. Researchers organized initial codes by categories of responses based on questions from the interview guide, recording the chunks of data that emerged into a shared spreadsheet. During this process, team members used memoing to capture notes on initial codes and emerging themes. Applying an axial coding process, the themes were printed out and posted to a wall to construct a map of connections (Saldaña 2013). This enabled the team to study and further refine conceptual relationships through a physical process of clustering ideas and defining the nature of relationships between concepts, including links to findings from Phase I (Charmaz 1996). Through a selective coding process, a central theoretical idea emerged, which linked to the other identified categories and revealed a core narrative that tied together the most significant findings from previous cycles of analysis (Saldaña 2013).

2.0 RESULTS

2.1 Atmosphere of Dignity: Comfort, Community, Control, and Safety

Interviews with residents and staff revealed that the most defining outcomes in housing settings related to the human experiences of comfort, community, control, and safety. Findings showed that the idea of safety was the most fundamental of these experiences and often served as the culminating experience of comfort, community, and control. Further analysis found the concept of safety was deeply interdependent with the presence of comfort, community, and control. This suggested that the experience of safety was dependent on the presence and quality of the other affordances, and together they shaped one's perception and experience of safety.

Comfort was associated with the ability to be physically, psychologically, and socially at ease. Participants described comfort in terms of sensory richness, the ability to form connections with their surroundings, and opportunities to contribute to their environment. Activities like gardening, caring for a neighbor's plants or pets, and communal cooking exemplified this engagement.

*Communit*y emerged from positive connections with self and others, including neighbors, staff, family, and pets. Participants described layered relationships, which ranged from involuntary (e.g., shared spaces with neighbors) to voluntary (e.g., social groups around shared interests). Spaces that fostered both formal and informal connections enhanced one's sense of belonging to the greater community.

Control was linked to the ability to make authentic and autonomous choices about engagement with the space and people in the space. Elements that provided variety and adaptability allowed participants to navigate the environment according to their changing needs, reinforcing a sense of agency and empowerment.

Safety relates to an individual's physical and psychological well-being and peace of mind as well as that of loved ones and the communities with which individuals identify. Safety is also tied to the security of participants' possessions and their sense of ownership and belonging to home. The analysis revealed that the experience of safety was defined along a spectrum. When participants described a diminished experience of comfort, community, and/or control, there was a lower-grade experience of safety; conversely, when describing an elevated experience of comfort, community, and/or control, there was a higher-grade experience of safety.

2.1.1 Atmosphere of Dignity: Quality Informs Degree of Safety

The experience of low-grade safety was captured in the following comments: "No, I don't feel safe here," "[This place] is less safe due to all psychological disorders," "[This place] is not as safe as it should be," "I feel safer not talking to people here," and "I feel safe in my apartment when I can lock the door but nowhere else." The experience of high-grade safety was expressed in participant comments such as "there are no places in the building that feel unsafe," "I feel safe—when I ask for help, I get it," "They really look out for you here," "I have good neighbors," "I feel good and comfortable everywhere in the building," and "There is no place I really feel safe, but I do here."

Furthermore, analysis revealed that when there were clear security features (such as automated locks, abundant surveillance, strongly enforced guest protocols, secured entry, security guards, and/or visual partitions at the front desk) coupled with a limited reporting of comfort, community, and control, staff and residents did not describe feeling safe. Elements of safety and security without comfort, community, and control aligned with reports of stress, paternalism, exclusivity, and distrust, exemplified by responses such as "I don't even get a say in who visits me" and "They treat us like prisoners." Absence of one of the core elements (for example, no sense of community) impacted the experience of safety in a negative, diminished way as noted above. This finding implies that to experience a deep sense of safety, individuals must have access to meaningful experiences of comfort, community, and control as well.

Residents experiencing low-grade safety reported feelings of loneliness, a sense of languishing or "simply surviving," a heightened awareness of substance use, and a cynicism about life and future opportunities. Participants expressed habituation toward low-grade safety, noting that despite their conditions, they can "survive" and "get through the day," and the challenges they face force them to develop strategies to cope and move through life. Individuals reporting low-grade safety also spoke of having few elements of comfort in community spaces, little to no sense of community or social network to rely on in the building, and limited opportunities for control or agency outside of their apartments.

2.2 Design Attributes: Sensory Engagement, Nested Layers, and Identity Anchors

Through analysis of qualitative interviews and building observation data, key design attributes emerged as critical for supporting the affordances for comfort, community, control, and safety toward an atmosphere of dignity.

Sensory Engagement attributes include elements offering gentle sensory stimuli, which were reported as supporting self-regulation and reducing stress. These environments avoided institutional sterility, incorporating features like natural materials, noise modulation, and clear sightlines. Participants talked about working in the garden, enjoying the sun in a window-filled room, sitting by the fireplace, and rocking in the terrace swings.

Nested Layers include varied spatial options that support individual preferences and evolving needs over time. Features such as cozy seating nooks, spacious laundry rooms, and varied seating arrangements offered flexibility for different levels of engagement and comfort. Residents and guests described ideal spaces providing opportunities to sidle at the periphery of a community space as well as seats more centrally located in the hub of activity.

Identity Anchors are elements that reflect a diversity of local identities and histories, fostering a sense of belonging and attachment to place. Residents and staff talked about personalizing features such as shelves outside unit doors for displaying items, cultural representation through art and murals, and spaces for rituals and routines such as smoking in the gazebo or taking the dog out. These experiences play a significant role in cultivating belonging and combating isolation.

2.2.1 Design Attributes: Consequential Elements

Analysis of the observational data, contextualized by the interview analysis, revealed discrete features across the three categories of design attributes that were perceived and cited as promoting the atmospheric experience of dignity (*Figure 1*). Notably, these elements do not fall exclusively under a single category, as there is complexity in the function and role of each element. For example, the inclusion of Living Systems (such as a collection of native plants in a lobby) may promote both Sensory Engagement and an Identity Anchor to the regional location of the building.

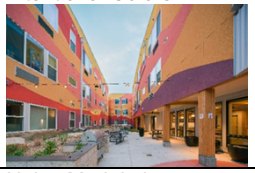
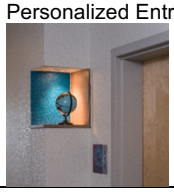
Sensory Engagement			
Clear Sightlines 	Enriched Lighting 	Intentional Colors 	Living Systems 
Natural Materials 	Natural Ventilation 	Noise Modulation 	
Nested Layers			
Accessible Front Desk 	Active Security Measures 	Approachable Entryways 	Attn to Neglected Spaces 
Dedicated Staff Space 	Diverse Common Areas 	Hearth-like Places 	Multiple Pathways 
Thoughtful Proportions 	Varied Outdoor Spaces 		
Identity Anchors			
Charismatic Places 	Clear Wayfinding 	Furnished Apartments 	Personalized Entrances 
Resonant Art 			

Figure 1: Consequential Elements of Dignified Design

2.3 Intersection of Atmosphere of Dignity and Design Attributes

The iterative grounded theory analysis process revealed a relationship between the atmosphere of dignity and the design attributes. Staff and residents reported experiencing lower-grade safety in spaces lacking natural light and views of the outdoors ("There's no windows…it's just dark"); long, stark hallways ("It feels like The Shining" and "The hallways are never ending"); lacking clear visual access across spaces; and/or institutional materials, such as acoustic ceiling tiles, tile flooring, stark white walls, and fluorescent lighting ("It feels like a prison"). More generally, residents commented on community rooms "having nothing to do" or that the building "sucks all of your good energy."

On the other hand, participants who reported higher-grade levels of safety described elements of comfort and beauty in their buildings ("It's gorgeous in here"), a sense of community and personal connections to their neighbors and staff ("I like the staff…and I have friends here"), and feelings of choice and control ("I get a say in what I do and when I do

it"). Those experiencing higher-grade safety also reported better coping mechanisms, improved health management, a stronger sense of hope and agency, greater intrinsic motivation, and an enhanced ability to think about and plan for the future. Importantly, the analysis found that participants in the three trauma-informed buildings from Phase II of the research reported greater comfort, community, and control overall and a higher-grade experience of safety than participants in the two control group sites not designed with a trauma-informed lens.

2.4 A Conceptual Model of Dignified Design

The conceptual model of Dignified Design generated by this research (*Figure 2*) posits that a combination of design attributes—sensory engagement, nested layers, and identity anchors—contributes to interdependent experiences of safety, control, comfort, and community. These exeriences, in aggregate, create an atmosphere of dignity, which, in combination with a supportive external environment (including the urban and systemic context of neighborhood amenities and transportation network) and being treated with respect by others (including housing staff and service providers), results in an experience of dignity for people facing housing instability. By describing these design attributes and analyzing their impacts on participant experiences, this model offers a scalable approach to advance this evidence-based practice in housing and social service settings.

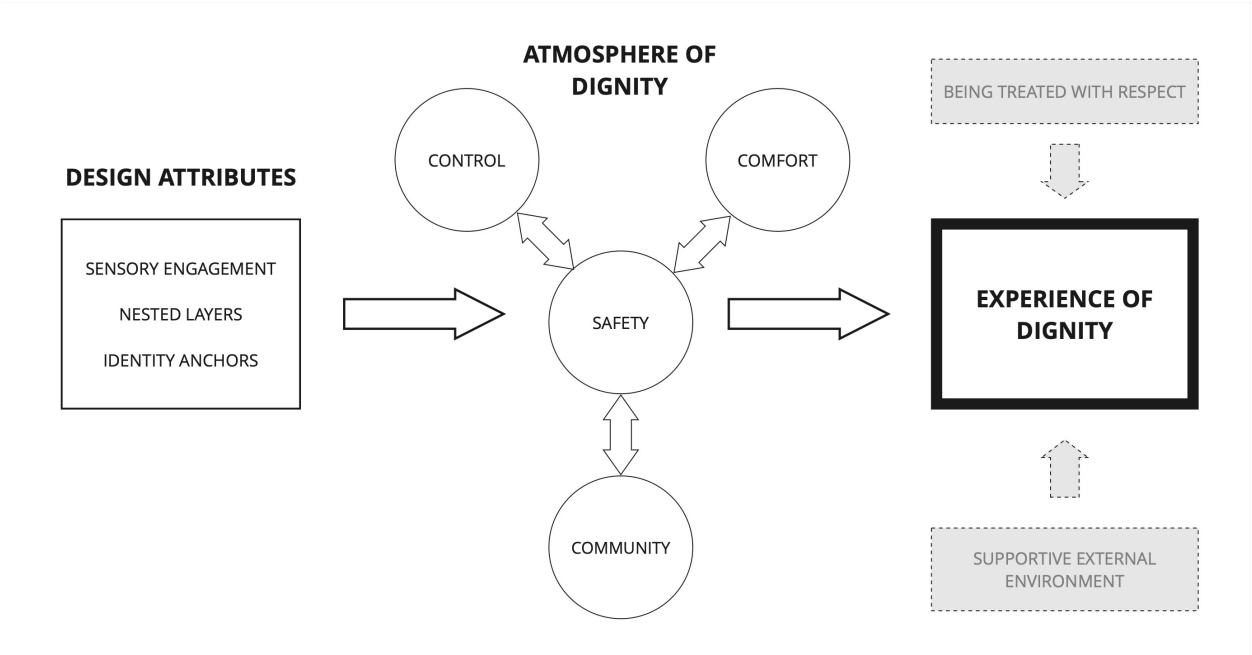


Figure 2: Conceptual model of Dignified Design

3.0 DISCUSSION

The objective of designing for dignity can be an indeterminate target, as evidenced by myriad interpretations of the concept (Borowski 2022; Ohls 2020; Pols 2013) and limited research on the application of dignity in the built environment (Faerden et al. 2023; Fleming et al. 2023). This has made dignity challenging to measure as an outcome and difficult to put into practice. This conceptual model of Dignified Design establishes a framework for architects, designers, and other creators of service-oriented spaces—a core set of values and concepts to guide practice, connecting the atmosphere of dignity to the factors influencing dignity in design. For practitioners and researchers, the model breaks down the conceptual complexity of dignity into a series of more realizable affordances and attributes. Further, the design elements provide structure for achieving the intended values and affordances.

The conceptual model of Dignified Design arose from initial research on trauma-informed design with a basis in trauma-informed care. In addition to this overlap, there are connections between Dignified Design and neuroscience (Owen and Crane 2022); biophilia (Browning 2020; Sternberg 2018); environmental psychology (Kuo and Sullivan 2001); and public health (Schroeder et al. 2021). There are also links to interdisciplinary theoretical persepctives. Both Dignified Design and Maslow's Hierarchy of Needs (1943) illustrate the relationship between environmental conditions and more internalized human experiences toward the apex experience of optimal existence, defined as "self-actualization" by Maslow's model and "dignity" by the Dignified Design model. The theory of Social Determinants of Health (Wilkinson and Marmot 2003) establishes that the health and wellbeing of individuals and communities are significantly influenced by an array of mezzo- and macro-level conditions—including neighborhood and the built environment, social and community context, economic stability, healthcare access and quality, and education access and quality—all of which

must be considered in the design of environments intended to respond to the holistic needs and realities of its inhabitants.

3.1 Moving from Trauma-Informed Design to Dignified Design

Formal definitions and frameworks of TID focus on outcomes related to individual's needs in the moment with an emphasis on minimizing triggers and re-traumatization. This research revealed dignity as a key aspect of long-term well-being for people experiencing housing insecurity. When describing environments that deeply satisfied their needs, residents and staff frequently cited concepts closely linked to dignity, such as self-worth, social value, and self-determination. This was represented through participants' comments around "hope for life and the future," "being able to live a real life," "getting to do the things I love," and "having something to call your own." Further, they described the stigma of homelessness as it related to "respect," "being a human too," and "how people treat you." This finding centered *dignity* as an overarching theme describing the ideals of a full and valued existence. Furthermore, it shifted the lens of design from a narrow and pathogenic focus on trauma to a more aspirational, salutogenic orientation toward dignity. Figure 3 illustrates how Dignified Design is distinct from and builds on the existing tenets of TID.

Trauma-Informed Design	Dignified Design
Foundation in TIC	Multidisciplinary foundation (including TIC)
Pathogenic	Salutogenic
Undefined relationships between affordances	Defined relationships between affordances
Individual attributes	Synthesis of attributes toward cohesive atmosphere
Goal of minimizing triggers and re-traumatization	Goal of promoting overall wellbeing through dignity

Figure 3. Comparison of Trauma-Informed Design and Dignified Design

3.2 Limitations

This study has limitations to be addressed, rectified, and expanded on in future work. Firstly, the conceptual model and its components do not offer instructions for carrying out a Dignified Design approach on a project. This underscores an area for future research and an opportunity to manualize a process outlining the key components for carrying out this approach. Secondly, there is discussion in the literature about the limitations of evaluating human dignity with some scholars claiming that a qualitative methodology may be too limited, as there is no guarantee that researchers understand dignity better than participants (Barclay 2016). However, it seems evident that the theory must be grounded in the unique and first-hand expertise of end users, and the grounded theory approach of this study relied on end-user interviews defining both the actual and ideal built environment experience. Therefore, the robust results from this study argue for the use of a qualitative methodology to explore this topic, adding to recent scholarship supporting this approach (Ajeen et al. 2023; Faerden et al. 2023).

CONCLUSION

The conceptual model of Dignified Design provides a framework for designers and providers of service-enriched housing settings. The model posits that a combination of affordances—safety, comfort, community, and control—and design attributes—sensory engagement, nested layers, and identity anchors—contribute to an experience of dignity for people facing housing instability. The qualitative research methods of this study utilized a robust grounded theory analysis in which the voices of both residents and staff guided model development. Given ample evidence that the built environment can influence an experience of indignity for people facing housing and health instability, designers bear a responsibility to make decisions that enhance the experience of dignity in these settings.

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