

Therapeutic Environment as Silent Therapy in Supporting the Recovery Process at the Recovery Centre in Malaysia

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ABSTRACT

The pervasive reliance on pharmacological interventions and structured group therapies in Malaysian recovery centres frequently overlooks a fundamental dimension of holistic healing. Patients often reside in sterile, institutional spaces, creating a profound disjuncture between their internal need for solace and the external environment's unresponsiveness; this oversight, one might argue, severely impedes genuine, sustained recovery efforts. Existing scholarship generally treats therapeutic environments as a mere backdrop for clinical practice, seldom conceptualising the physical and social surroundings themselves as an active, potent therapeutic agent. This conceptual paper undertakes a critical analysis of extant literature, examining how carefully curated physical and relational surroundings might function as a discernible form of silent therapy. The paper argues that a thoughtfully designed environment actively promotes self-regulation, offering clients a sense of autonomy often profoundly eroded during the addiction cycle. Furthermore, it posits that specific environmental elements foster non-verbal communication and support deep emotional processing, often bypassing common therapeutic resistances inherent in verbal modalities. Finally, the analysis suggests such settings can subtly, yet powerfully, reinforce a client's emergent identity beyond their addiction, rather than simply containing or managing their symptoms. This re-framing urges policy makers and facility designers alike to fundamentally reconsider recovery centres as dynamic, restorative ecosystems, capable of profound influence.

Keywords: Therapeutic environment, Silent therapy, Recovery centres, Malaysia, Environmental psychology

INTRODUCTION

Malaysia's addiction recovery apparatus faces a quiet crisis. Despite considerable investment in structured programmes, relapse rates remain stubbornly high, a persistent whisper of systemic inefficiency. We build walls, erect fences, impose schedules—all in the name of healing—yet often ignore the very fabric of the spaces where recovery is meant to unfold, a baffling oversight. The standard recovery centre, with its often Spartan aesthetics and rigid functionality, frequently feels more like an internment facility than a sanctuary for profound personal reconstitution; this stark reality begs a harder look at how we conceive of therapy beyond the consultation room. Why do we so readily pour resources into clinical interventions while treating the physical container of healing as an afterthought, an inert shell? It appears we have fixated on direct, explicit therapeutic modalities, overlooking the subtle, pervasive influence of the environment itself. This curious blind spot leaves us with an incomplete picture of effective recovery. The tacit messages conveyed by architecture, light, sound, and communal arrangements are powerful, yet routinely disregarded; their omission arguably constitutes a grave disservice to those striving for sobriety. How does a soul mend in a space that feels utterly devoid of soul? This paper contends that the prevailing emphasis on overtly clinical approaches, while perhaps necessary, has unfortunately overshadowed the deep, almost subconscious, therapeutic potential embedded within the very design and ethos of the recovery environment itself, a phenomenon we propose to call 'silent therapy'.

LITERATURE REVIEW

The concept of a "therapeutic environment" has long haunted the periphery of recovery discourse, often invoked as a desirable ideal rather than scrutinised as an active therapeutic agent (Ulrich, 1984; Verderber & Moore, 2017). Early proponents, particularly within psychiatric contexts, certainly recognised the potential of asylum design to either soothe or agitate, though their understandings were frequently rudimentary, rooted more in intuition than empirical rigour (Scull, 1977). Modern scholarship has moved beyond such rudimentary notions, yet a persistent conceptual ambiguity clouds what "therapeutic" truly signifies in this context. Is it merely the absence of harm, or something more proactively beneficial? This question, unfortunately, rarely receives the dedicated theoretical interrogation it demands. Some researchers champion a distinctly clinical view, arguing that the environment's primary function is to support professional interventions, making it a mere stage for the real work (e.g., Focht & Rhee, 2012). They contend that carefully arranged furniture or natural light, while pleasant, cannot supplant the skilled therapist or the efficacy of evidence-based programmes. This perspective, though practical, feels decidedly limited. It reduces the environment to a passive container, ignoring its constant, often subliminal, communication with its inhabitants. One might argue that such a view risks fostering complacency, permitting drab or uninspiring spaces to persist so long as clinical outcomes are ostensibly met. Yet, other voices present a far more expansive interpretation. They assert that the physical and social milieu holds an intrinsic, dynamic capacity to shape behaviour, mood, and even neurochemistry (Kaplan & Kaplan, 1989; Heerwagen & Orians, 1993). These scholars, often drawing from environmental psychology and biophilia hypotheses, posit that exposure to nature, restorative views, or even simply non-institutional aesthetics can significantly reduce stress, improve attention, and foster a sense of psychological safety – all elements absolutely vital for individuals navigating the turmoil of addiction recovery. One might suspect that ignoring these subtle, pervasive influences is akin to prescribing medication without considering its taste or texture; the delivery mechanism matters just as much as the core ingredient. Consider the debate surrounding sensory input. A significant body of work suggests that environments rich in natural light, calming colours, and access to green spaces can profoundly impact patient well-being (Ulrich et al., 2008). However, the precise mechanisms through which these elements operate remain somewhat contested. Is it purely physiological—reduced cortisol levels, improved circadian rhythms—or is there a significant psychological component, where such environments signal safety, normalcy, and hope? While studies often correlate these environmental factors with improved patient outcomes (e.g., better sleep, reduced agitation), few manage to disentangle the direct environmental effect from the myriad other variables at play in a recovery setting. This makes robust causal claims difficult, leaving space for critics who dismiss these factors as mere 'comforts' rather than essential therapeutic components. A critical eye reveals that many studies, while well-intentioned, often conflate "patient satisfaction" with "therapeutic efficacy," a dangerous slippage in an area as sensitive as addiction recovery. It seems plausible that a comfortable client is not necessarily a recovering one. Furthermore, the social dimensions of the therapeutic environment present their own complexities. Recovery centres are inherently communal spaces, and the physical layout dictates much about how these communities form and function. Some argue for open, communal areas that encourage interaction and peer support, seeing these as extensions of group therapy (Keesler & Witkin, 2007). Others caution against excessive openness, fearing a lack of personal space might trigger anxiety or undermine individual reflection, particularly for those whose past experiences include trauma or a strong need for solitude (Cohen & Friel, 2011). The architectural design—corridors, common rooms, private quarters—can either subtly foster connection or inadvertently promote isolation. It certainly appears that a well-intended design could inadvertently create unintended barriers to genuine interpersonal engagement, leading to a superficial camaraderie rather than profound, mutual support. This tension between fostering community and respecting individual boundaries is a persistent design conundrum, one with no easy answers. The ideal arrangement, one might assert, remains a constantly shifting target, dependent on the specific client population and their unique needs. The question of client autonomy within the environment also warrants critical examination. Traditional institutional settings, by their very nature, often strip individuals of control, imposing rigid schedules and limiting personal choices. While some structure is undoubtedly necessary in addiction recovery, environments that offer opportunities for choice—even small ones, such as controlling room lighting or choosing a quiet corner for reflection—have been associated with improved self-efficacy and a greater sense of personal agency (Rodin, 1986). Yet, many recovery centres, particularly in Malaysia, still operate under a paternalistic paradigm, where the environment is designed for control and containment rather than empowerment. This approach, though perhaps rooted in a desire for order, risks inadvertently perpetuating the very powerlessness that often fuels addiction. The argument here is not for unfettered freedom, but for a thoughtful integration of choices that allow

clients to gradually reclaim their agency within a safe, structured context. The challenge, of course, lies in balancing safety and structure with meaningful opportunities for self-direction, a tightrope walk few institutions manage with true finesse. Finally, the cultural specificities, particularly within the Malaysian context, often get overlooked in global literature. Most studies on therapeutic environments originate from Western paradigms, implicitly assuming universal applicability (e.g., Ulrich, 1984; Kaplan & Kaplan, 1989). However, collectivist cultures, distinct religious sensibilities, and differing notions of privacy and community might necessitate radically different environmental configurations for optimal therapeutic effect (Abdullah & Hamzah, 2014). For instance, the role of prayer rooms, communal dining, or even the layout of gender-segregated spaces might carry profound symbolic and psychological weight that a purely Western design framework would miss entirely. A failure to consider these deep-seated cultural expectations arguably renders many well-intentioned 'best practices' from elsewhere somewhat inert or even counterproductive when applied locally. It suggests that a onesize-fits-all approach to environmental design in recovery centres is not just simplistic, but potentially harmful, missing the complex interplay of cultural norms and psychological well-being. The existing body of knowledge, therefore, while rich in general principles, often falls short when confronted with the particularities of local contexts, creating a stark void where tailored research ought to be. This critical gap demands redress.

METHODOLOGY

This study, a purely conceptual exploration. Instead, it pursued a rigorous, albeit interpretive, approach rooted deeply in conceptual analysis and an extensive library-based literature review. The ambition here was to construct a robust theoretical synthesis, building a coherent argument from fragmented, often disparate, pieces of existing scholarship; this necessitated a careful, almost forensic, examination of primary and secondary texts, rather than a mere cataloguing of existing findings. The core aim was to articulate the environment's role in addiction recovery—specifically within the Malaysian context—not as a passive backdrop, but rather as an active, pervasive 'silent' therapeutic agent, a notion that clearly demands profound engagement with theoretical frameworks rather than superficial empirical data. The methodology essentially unfolded as a multi-stage process of critical textual engagement. It commenced with a broad, systematic search across major academic databases—Scopus, Web of Science, PubMed, and PsycINFO—using a carefully curated set of key terms: therapeutic environment, recovery centre design, addiction treatment architecture, environmental psychology and addiction, healing spaces, and Malaysia addiction recovery. This initial sweep regrettably yielded a vast, often unwieldy, array of articles, reports, and book chapters, many of which were tangential at best. Crucially, the process was far from mechanical or automated. Rather than simply extracting isolated data points, each identified text underwent an initial, rapid screening to assess its immediate conceptual relevance to our central premise: the environment as an active, rather than merely benign, therapeutic force. Many articles, while discussing 'environment,' treated it merely as context, a logistical concern, or a source of aesthetic pleasure, thus failing this initial stringent conceptual filter; these were, quite unceremoniously, discarded from further consideration. The subsequent, more demanding stage involved an intensive, iterative reading of the literature that had passed the initial conceptual hurdle. Here, we applied a critical hermeneutic lens, striving not just to comprehend what authors explicitly stated, but also why they advanced particular arguments, and perhaps more importantly, what their frameworks failed to adequately consider or account for. This was an inherently qualitative sifting process, where theoretical propositions were continually weighed against alternative perspectives, and inconsistencies or logical lacunae were actively sought out and scrutinised. For instance, theories proposing universal environmental benefits (e.g., biophilia's innate human connection to nature) were consciously juxtaposed against arguments for deep cultural specificity in environmental perception and response, creating an intellectual friction that proved invaluable in refining our own emergent conceptual model. We ruthlessly discarded outdated theories that lacked contemporary empirical backing or were unfortunately predicated on now-discredited psychological models, opting instead for those exhibiting greater explanatory power and contemporary relevance, even if they themselves remained subjects of ongoing scholarly debate. This entire exercise was never about achieving a facile consensus; it was about identifying and exploring productive intellectual tensions that could yield new insights. Furthermore, the rigorous selection criteria prioritised works that either directly theorised the therapeutic effects of specific environmental attributes or offered compelling empirical evidence that could be plausibly re-interpreted through a silent therapy framework. Articles focusing exclusively on pharmacological interventions or purely behavioural therapies, devoid of any substantial engagement with spatial, aesthetic, or social environmental factors, were systematically excluded from the analysis. The unwavering emphasis remained on studies from environmental psychology, architectural psychology, healthcare design, sociology of

health, and critical social theory that explicitly addressed the intricate interplay between built form, social dynamics, and psychological well-being within diverse health and recovery contexts. This necessitated consciously seeking out truly interdisciplinary perspectives, those capable of enriching our understanding far beyond the often restrictive confines of a single academic discipline. The final, crucial step involved the synthesis: mapping the conceptual connections between these disparate bodies of knowledge to forge a cohesive argument. We sought to identify recurring themes, underlying assumptions, and emergent patterns that collectively spoke to the environment's subtle, often subliminal, non-verbal influence on the recovery trajectory. This iterative mapping allowed us to move beyond a mere descriptive catalogue of environmental elements towards a far more sophisticated, nuanced understanding of their function as active therapeutic agents. For example, rather than simply noting that natural light is generally perceived as beneficial, we critically probed how it might specifically contribute to a client's sense of normalcy, reduce agitation, or improve mood, thereby connecting it to established theories of circadian rhythm regulation and affective well-being. The entire process was akin to assembling a complex intellectual mosaic, where each piece of scholarship, no matter how seemingly small or disparate, contributed to a larger, more coherent picture of environmental healing. This intellectual heavy lifting permitted the formulation of novel theoretical propositions regarding the environment's under-recognised capacity for silent therapy, a concept that remains stubbornly under-theorised and tragically under-implemented within Malaysian recovery contexts. This conceptual work, one might argue, provides a vital, indeed essential, foundation upon which future, more robust empirical investigations might finally stand, guiding them towards truly impactful interventions.

RESULTS

Recovery is, at its heart, a reclamation of self, a difficult, often painful, journey back to agency. Yet, many recovery environments inadvertently undermine this fundamental process, trapping individuals in spaces that enforce passivity. Consider the ubiquitous institutional corridor—long, impersonal, offering no private corners, no real choice; it screams control, not liberation. Our conceptual analysis reveals that environments acting as silent therapy subtly reintroduce a sense of personal control, offering clients small, yet profoundly meaningful, choices within their physical surroundings. This isn't about chaos; it's about empowerment. A room with adjustable lighting, for instance, or a communal area with flexible seating arrangements, allows an individual to tailor their immediate space to their mood, fostering a micro-exercise in decision-making that counteracts the ingrained helplessness of addiction (Rodin, 1986). The subtle permission to rearrange one's immediate environment—to choose a window seat, to draw the curtains, to select a quiet nook for reflection—serves as a constant, non-verbal affirmation that one's preferences matter, that one's presence shapes the space, rather than merely inhabiting it. Such deliberate design choices, often dismissed as mere amenities, are in fact quiet revolutions, chipping away at the learned helplessness and fostering the emergent self-efficacy so vital for sustained sobriety. The environment thus becomes a constant, gentle tutor, teaching self-determination. The conventional view of pleasant surroundings often stops at comfort or aesthetics, a woefully incomplete understanding of their deeper impact. Our conceptual exploration reveals that sensory elements—light, sound, texture, smell—function as powerful, pre-cognitive regulators of the nervous system, essentially performing 'silent therapy' at a biological level. Harsh fluorescent lights, for instance, can elevate stress and disrupt circadian rhythms; conversely, natural daylight synchronises internal clocks and has been linked to improved mood and sleep patterns (Ulrich et al., 2008). This is not just about feeling good. It is about recalibrating a dysregulated system. The inclusion of natural elements—a small garden, a view of trees, even potted plants—taps into an innate human biophilia, reducing physiological stress markers and fostering a sense of calm (Kaplan & Kaplan, 1989). A quiet space, free from jarring noises, allows the overstimulated brain to rest, process, and heal. The gentle murmur of a water feature, or carefully curated, non-intrusive ambient sound, might even serve to dampen anxiety and facilitate introspection, creating a soundscape for inner peace. These sensory landscapes, often overlooked in the clinical rush, are in effect a continuous, subtle pharmacological intervention, gently guiding the client's internal state towards balance and repose. Their impact is profound, yet often unacknowledged. Recovery is a paradox: intensely personal, yet deeply communal. Effective silent therapy environments recognise this duality, designing spaces that thoughtfully balance opportunities for connection with essential provisions for solitude. A common room that feels perpetually exposed, or dining halls too vast and noisy, can overwhelm those struggling with social anxiety or simply needing a moment of internal quiet. Conversely, an environment lacking any inviting communal zones might inadvertently foster isolation, hindering the vital peer support networks that underpin long-term recovery (Keesler & Witkin, 2007). The careful delineation of spaces—private rooms,

semiprivate nooks, and larger, flexible common areas—allows individuals to choose their level of engagement, responding to their fluctuating emotional needs. These physical boundaries become metaphors for psychological boundaries, teaching clients to manage their interactions and protect their inner world, while still accessing community. A well-designed recovery centre, then, becomes a miniature ecosystem of social interaction, enabling the organic growth of supportive relationships without forced conviviality, honouring both the extrovert's need for connection and the introvert's need for quiet introspection. It is a delicate dance, really. The most potent silent therapy environments reflect and affirm the cultural identity of those they serve. A universal design template, often imported from Western contexts, can feel alienating, sending subtle messages of otherness to Malaysian clients. This is not a trivial concern. When a space feels culturally incongruous—lacking familiar aesthetics, traditional motifs, or provisions for specific religious practices for example, dedicated prayer spaces, gender-segregated areas—it creates a subtle, yet persistent, dissonance (Abdullah & Hamzah, 2014). Such environments, rather than affirming, can inadvertently undermine a client's sense of belonging and cultural pride, essential ingredients for identity formation during recovery. Incorporating local architectural elements, indigenous materials, familiar patterns, and thoughtful provisions for cultural and religious practices transforms a generic institution into a culturally resonant healing space. It signals respect, understanding, and an acknowledgement of the client's holistic identity beyond their struggle with addiction. The environment thus acts as a cultural mirror, reflecting back a sense of rootedness and belonging, a silent affirmation that "you are home, and you are valued," which is a powerful, often overlooked, therapeutic message. This critical reflection of self within the surroundings supports a stronger, more integrated recovery.

DISCUSSION

The preceding conceptual analysis unveils a profound, yet persistently undervalued, truth of the therapeutic environment itself functions as an active agent, a silent therapist in the arduous journey of addiction recovery. So what does this mean for the practicalities of operating and designing recovery centres, particularly in a context like Malaysia? It means, quite simply, that our current models, heavily skewed towards direct clinical interventions, are likely operating with one hand tied behind their back, overlooking a pervasive, continuously influencing force. The prevailing narrative, which casts environments as merely passive containers, fundamentally misunderstands their potential to either accelerate or impede healing. Our first conceptual finding, the architecture of autonomy, suggests that the meticulous crafting of spaces to offer micro-opportunities for personal control carries far more weight than previously acknowledged. It is entirely possible that the high relapse rates observed in some centres, despite seemingly robust programmes, are not solely attributable to individual client factors or clinical programme deficiencies. Instead, they might also be a function of environments that inadvertently perpetuate learned helplessness, denying clients the very experiences of selfefficacy they so desperately need to rebuild their lives. If a client is constantly told where to sit, when to eat, and has no say over their immediate surroundings, how can they realistically be expected to exert control over the far more complex urges of addiction outside those walls? This hints at a deeper, systemic issue: a therapeutic paternalism embedded in the very bricks and mortar of our institutions, unknowingly suffocating the nascent autonomy required for lasting recovery. We are, arguably, designing for compliance, not for genuine empowerment, and the outcomes reflect this profound misdirection. Expanding on this, the sensory scapes argument posits that the immediate sensory inputs—light, sound, texture—are not mere comforts, but powerful neuro-regulators. This interpretation challenges the dismissive attitude sometimes accorded to aesthetics, suggesting a direct, physiological impact often mistaken for subjective preference. The pervasive use of harsh artificial lighting, the incessant hum of air conditioning, or the lack of natural views in many Malaysian centres might not just be unpleasant; they could be actively hindering the recovery process by perpetually triggering stress responses and disrupting restorative sleep cycles. One might speculate that the chronic physiological stress induced by such maladaptive environments exacerbates cravings, impairs cognitive function, and generally undermines a client's capacity for emotional regulation, thereby rendering them more vulnerable to relapse. This re-framing elevates environmental design from an architectural concern to a public health imperative, implying that investment in thoughtfully designed, naturally integrated spaces is not a luxury, but a fundamental component of effective treatment. It is, perhaps, a less glamorous intervention than a new drug, but no less potent. The social geography of support highlights a persistent tension between fostering community and respecting individual space. We discovered that environments that fail to provide a flexible continuum—from inviting communal areas to genuinely private retreats—risk alienating a significant portion of their clientele. Forcing interaction upon an emotionally fragile individual, or conversely, isolating a client who desperately needs

connection, can be profoundly counter-therapeutic. This demands a critical re-evaluation of current designs. Are common rooms genuinely conducive to authentic interaction, or are they merely large, undifferentiated spaces that encourage superficiality or withdrawal? Are individual rooms truly private, or do thin walls and incessant noise negate any sense of personal sanctuary? It is entirely possible that some existing designs, despite noble intentions, inadvertently cultivate an atmosphere of performative camaraderie rather than genuine, empathic peer support. This problem is particularly acute in cultures where public decorum often masks private struggles; a well-designed space should offer quiet invitations to both open up and retreat, based on genuine need, not institutional dictate. Finally, the critical importance of cultural resonance in environmental design cannot be overstated, especially within Malaysia's multicultural context. A recovery centre that feels alien to its inhabitants, one that ignores local architectural traditions, indigenous materials, or religious practices, sends a subtle but potent message of cultural invalidation. This is more than mere aesthetics as it impacts identity. When an individual is already grappling with a fragmented self-image due to addiction, encountering an environment that negates their cultural heritage can deepen feelings of displacement and further erode their sense of belonging, both to the facility and to their broader community. This finding directly challenges the notion of universal design principles, urging instead a localisation of environmental aesthetics and functionality. For Malaysia, this implies an integration of Islamic design principles, traditional Malay aesthetics, and an understanding of Chinese or Indian cultural needs where appropriate, creating spaces that feel inherently Malaysian rather than imported. This is not merely an act of cultural sensitivity as it is a profound therapeutic intervention, affirming the client's cultural identity as a stable anchor in the turbulent waters of recovery. Ignoring this would be a tragic misstep. The concept of 'silent therapy' therefore pushes beyond superficial architectural considerations, demanding a deeper engagement with the psychological, social, and cultural functions of space. It suggests that a truly effective recovery centre is not merely a place where therapy happens, but a place that is therapeutic, continuously, ubiquitously. The failure to recognise and deliberately engineer these subtle environmental influences represents a significant lacuna in contemporary addiction treatment models. We must move past the idea that the environment is merely a backdrop; it is, quite literally, part of the fabric of recovery, shaping perceptions, regulating emotions, and subtly guiding individuals back to wholeness. Ignoring its pervasive influence means we continue to miss a powerful, omnipresent ally in the fight against addiction. The implications for training, policy, and facility investment are substantial, urging a paradigm shift towards a more ecologically informed approach to healing.

CONCLUSION

The present conceptual inquiry has argued for a radical, and indeed overdue, re-evaluation of the recovery environment, positing its profound capacity to function as a powerful, albeit often unacknowledged, silent therapy. The pervasive failure to recognise the environment as an active, continuous therapeutic agent represents a significant oversight in prevailing addiction recovery paradigms, particularly within the Malaysian context. We have painstakingly laid bare how physical and social spaces, through their deliberate design and inherent ethos, profoundly influence client autonomy, neuro-physiological regulation, social engagement, and the critical formation of cultural identity. This is not a trivial matter; rather, it strikes at the very heart of what constitutes genuinely effective and sustainable healing. Our exploration unequivocally demonstrates that ignoring these subtle, yet persistent, environmental messages is akin to attempting to navigate a ship while wilfully ignoring the powerful currents and prevailing winds; the journey inevitably becomes far more arduous, riddled with unseen obstacles, and the ultimate destination remains frustratingly uncertain. The traditional, perhaps overly zealous, focus on explicit, verbal therapies, while undoubtedly possessing its own vital importance, has inadvertently created a conceptual blind spot, preventing us from fully grasping the omnipresent, formative influence of the spatial context itself. It becomes starkly clear that a truly well-designed recovery centre does not just house therapy in designated rooms; it is therapy, operating continuously and ubiquitously, constantly reinforcing positive behaviours, subtly regulating emotional states, and gently, persistently guiding individuals towards a reconstituted and healthier sense of self. The implications, therefore, are profound, demanding a fundamental shift in perspective. For future research, a specific, empirically-driven investigation is not merely suggested, but urgently required. Subsequent studies should quantitatively assess the direct impact of specific environmental variables—such as carefully calibrated access to natural light, the deliberate inclusion of flexible communal spaces, or the thoughtful integration of culturally resonant design elements—on measurable recovery outcomes. These outcomes might include objective measures like client-reported self-efficacy, physiological stress markers (e.g., salivary cortisol levels), and, most critically, longitudinal relapse rates within Malaysian

recovery centres. This would ideally necessitate a quasi-experimental design, carefully comparing centres that have demonstrably integrated silent therapy principles into their architectural and operational design with those operating under more conventional, institutional models. We absolutely must move beyond mere correlation to establish robust causal links, thereby providing the irrefutable evidence base necessary for informed policy development and practical implementation. The potential benefits of wholeheartedly embracing silent therapy are not merely abstract theoretical constructs; they are tangible, offering a cost-effective, sustainable, and deeply human addition to conventional treatment modalities. A thoughtfully designed environment fosters an intrinsic motivation for healing, systematically reducing an over-reliance on external controls and significantly enhancing the client's innate internal resources for coping and thriving. If we, as a society and as practitioners, continue to ignore the pervasive, subtle power of these spaces, we risk perpetuating a deeply entrenched cycle of insufficient recovery, squandering precious human and financial resources and, most tragically, consistently failing those individuals who desperately seek a genuine, sustainable path to sobriety. The ultimate cost of such ongoing neglect, both in terms of individual human suffering and broader societal burden, is simply too high to bear. We must, therefore, fundamentally transform our understanding of healing environments, elevating them from the periphery of concern to the very core of our addiction recovery strategies, for the sake of true, lasting change.

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