Empowerment of General Mentari Cadres Based on Psychoeducation and Artificial Intelligence to Strengthen The Psychological Well-Being of Village Communities

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Abstract

Mental health issues in rural communities remain a critical issue due to low mental health literacy, strong social stigma, and limited access to psychological services. These conditions negatively impact the community's psychological well-being. This community engagement program aims to identify the role of GEN MENTARI cadres as pioneers in strengthening psychological well-being, develop a cadre empowerment model based on community psychoeducation integrated with artificial intelligence (AI)-supported tools, analyze its contribution to the Sustainable Development Goals (SDGs), and evaluate the program's effectiveness. This method uses a community-based participatory approach consisting of planning, implementation, and evaluation stages. Data were collected through observation, interviews, documentation, focus group discussions, and pre-test–post-test psychological well-being measurements based on Ryff's six dimensions. Primary data were obtained from cadres, community members, and local stakeholders, while secondary data came from village records and related literature. This program was implemented in Procot Village. Results show that AI-assisted psychoeducation significantly improved mental health literacy, reduced stigma, and strengthened psychological well-being (mean score increased from 95.53 to 118.43; $p < 0.001$; N-Gain = 0.481, moderate category). Cadres serve as agents of social transformation, bridging religious values, community solidarity, and digital tools. This program contributes to SDG 3 (Good Health and Well-Being) and demonstrates how AI can ethically support social transformation in rural Muslim communities while respecting cultural and religious norms.

***Keywords*:** cadre empowerment, community psychoeducation, artificial intelligence, psychological well-being, social transformation, SDGs

Introduction

Mental health is an integral component of overall health, encompassing emotional, psychological, and social well-being (Tripertiwi, 2025). However, in practice, attention to mental health in Indonesian society remains relatively low compared to physical health. Persistent social stigma, limited mental health literacy, and limited access to professional services, especially in rural areas, continue to hinder help-seeking behavior (Anik et al., 2026; Jiang et al., 2026). These challenges are particularly pronounced in villages like Procot, where limited resources and cultural perceptions often lead individuals to internalize psychological distress rather than seek support.

National and global data underscore the urgency of this issue. Approximately one in two Indonesians experiences a mental health problem during their lifetime (Veda et al., 2023). Annual prevalence estimates indicate that approximately 19% of adults, 46% of adolescents, and 13% of children experience mental health disorders, yet the majority do not receive adequate treatment (Wardani et al., 2023). In rural settings, stigma often prevents disclosure due to fear of social exclusion or being labeled weak (Mahardika, 2024). Simultaneously,

economic pressures, rapid lifestyle changes, and technological disruptions further increase psychological risks (Magomedova & Fatima, 2025). If not addressed through preventive and promotional approaches, these conditions can reduce individual productivity, increase social conflict, and weaken community resilience (Alamsyah & Amelia, 2024).

An initial survey of 30 respondents at Procot Village revealed a mixed profile of psychological well-being consistent with Carol D. Ryff's multidimensional model. While 73.3% reported positive and supportive social relationships, only 53.3% felt able to manage their emotions effectively, 50% had a clear sense of purpose in life, 56.7% reported self-confidence, and 63.3% had difficulty coping with life's stresses. Furthermore, 56.7% frequently felt anxious for no apparent reason, and only 53.3% felt capable of making independent decisions. These findings suggest that social capital exists as a community asset, but individual capacities for emotional regulation, autonomy, environmental mastery, and life purpose require systematic strengthening.

Within the broader conference theme of AI, Religion, Society, and Social Transformation, the program positions artificial intelligence not as a substitute for human care, but as an ethical support tool that can strengthen community-based psychoeducation. In rural Muslim communities, religious values emphasizing mutual care (ta'awun), compassion (rahmah), and community solidarity (ukhuwah) provide a normative foundation for mental health initiatives. AI applications such as simple chatbot-assisted information delivery, digital screening reminders, and localized educational content can be integrated in ways that respect cultural and religious norms while expanding reach and sustainability (Izu et al., 2024). Technology thus becomes a vehicle for social transformation when mediated by trusted local agents who understand the dynamics of faith and community.

Previous community psychoeducation efforts have demonstrated effectiveness in raising awareness and reducing stigma (Purnamasari et al., 2026; Izzati & Meiyuntariningsih, 2025; Susanti et al., 2024). Hybrid models for older adults have demonstrated comparable benefits between in-person and technology-supported delivery (Leung et al., 2024). Cadre empowerment programs targeting postpartum depression or mental health first aid have also proven effective in building local capacity (Aurora et al., 2026; Izzati & Meiyuntariningsih, 2025). However, most programs remain short-term, lack systematic empowerment of cadres as agents of sustainable change, and rarely integrate digital or AI-powered components that intentionally align with SDG 3 and the Islamic ethical framework. These gaps motivate current community engagement.

The theoretical foundation centers on three interrelated pillars. First, Ryff's model of psychological well-being, which encompasses six dimensions: self-acceptance, positive relationships with others, autonomy, environmental mastery, purpose in life, and personal growth. Second, community empowerment theory, which emphasizes enhancing individual and collective capacity so that communities can control and manage their own problems (Selly, 2025; Radjak et al., 2024). Third, an AI-ethics perspective asserts that technology should serve human dignity, cultural continuity, and communal prosperity, not replace relational care. Together, these frameworks guide the design of GEN MENTARI's empowerment program toward sustainable social transformation.

The program's objectives are fourfold: (1) identifying the strategic role of GEN MENTARI cadres as pioneers of psychological well-being in rural Muslim communities; (2) developing a participatory empowerment model that combines community psychoeducation

with ethically guided AI-supported tools; (3) analyzing the program's contribution to SDG 3 (Good Health and Well-Being) and broader social transformation processes; and (4) evaluating the intervention's effectiveness on community psychological well-being. The guiding hypothesis is that cadre-based psychoeducation supported by appropriate AI tools will result in a statistically significant increase in psychological well-being scores among participating community members.

A comparative reading of recent literature further clarifies the contributions of current programs. Greene et al. (2022) demonstrated the value of community-based participatory design for psychosocial interventions among migrant women, with an emphasis on local adaptation and social support. Leung et al. (2024) demonstrated that hybrid psychoeducation can provide comparable benefits to face-to-face delivery for older adults. Farida et al. (2025) conducted community psychoeducation for Indonesians in Seoul, but the format remained largely one-way. Izzati and Meiyuntariningsih (2025) successfully trained mental health cadres in Psychological First Aid, while Aurora et al. (2026) empowered Family Welfare Movement (PKK) cadres in postpartum depression prevention. Tester-Jones et al. (2026) highlighted the role of voluntary and community sector resources in supporting the mental health of young people in disadvantaged contexts. Collectively, these studies affirm the promise of community- and cadre-based approaches. This work extends them by integrating ethically bound AI support and explicitly linking interventions to Islamic values and SDG-oriented social transformation in rural Indonesia.

In short, the introduction of AI into community mental health work in rural Muslim areas should be guided by three principles: (1) technology remains subordinate to human relationships and local institutions; (2) religious and cultural resources are treated as assets, not as obstacles; and (3) sustainability is pursued through institutional placement, not project-based cycles. These principles shape the design, implementation, and evaluation of the GEN MENTARI empowerment program described below.

The remainder of this paper is organized as follows. The Methods section details the participatory design, participants, procedures, data collection, validation, and analysis techniques. The Results section presents baseline conditions, quantitative pre-post results across Ryff's six dimensions, and qualitative insights from cadres and community members. The discussion interprets the findings in light of previous research, the conference theme of AI–religion–society transformation–transformation, enabling factors and limitations, theoretical and practical implications, and acknowledged limitations. The Conclusion summarizes key contributions and offers recommendations for practice, policy, and future research.

Method

Research Design

This community engagement approach utilizes a participatory action research (PAR) approach combined with elements of asset-based community development (ABCD). The design integrates qualitative and quantitative pathways (mixed methods) across three sequential phases: planning, implementation, and evaluation. The intervention focuses on capacity building for GEN MENTARI cadres and subsequent community psychoeducation sessions, with selective use of AI-assisted digital tools for information dissemination, learning reinforcement, and baseline monitoring. The participatory nature of the design ensures that cadres and community members are co-creators, not passive recipients of the intervention.

Participants and Background

The program's epicenter is Procot Village. Participants comprised three groups: (1) GEN MENTARI cadres as the primary agents of change; (2) Procot Village community members as the primary beneficiaries; and (3) local stakeholders including village officials and health workers from the nearest community health center. A total of 30 community respondents completed pre- and post-test psychological well-being measures. Cadres received intensive training covering mental health literacy, basic counseling and communication skills, Psychological Pest Help (See–Listen–Link) principles, early warning sign detection, referral pathways, and the ethical use of simple AI-powered educational materials. Inclusion criteria for community respondents included village residence, willingness to participate fully, and the ability to complete questionnaires with assistance if needed.

Procedure

The program unfolded in three carefully sequenced phases. In the planning phase, a needs assessment based on an initial survey of 30 respondents was conducted. Training modules were designed in collaboration with cadres and stakeholders, and religious leaders were consulted to ensure alignment of content and language with local Islamic values and sensitivities. This consultation was crucial for legitimacy and acceptance. In the implementation phase, cadres underwent a structured training workshop. They then facilitated a series of community psychoeducation sessions addressing emotion regulation, stress management, help-seeking behavior, stigma reduction, and Ryff's six dimensions of psychological well-being. Between sessions, AI tools, primarily curated text-based educational prompts and gentle digital reminders, were introduced under close human supervision to reinforce key messages. Cadres retained full control over content selection and timing. In the evaluation phase, post-test measurements were administered, focus groups were held with cadres and community participants, and reflection sessions captured lessons learned and recommendations for sustainability.

Data collection technique

Primary data were collected through a variety of complementary techniques: structured and unstructured observations during trainings and community sessions; semi-structured interviews with cadres, participants, and stakeholders; focus group discussions; photographic and documentary records; and a validated questionnaire to measure psychological well-being based on an adapted version of the Ryff scale. Secondary data included village archives, previous activity reports, relevant local policies, and scientific literature on community mental health, empowerment, and ethical AI. Instrument validity was established through expert assessment by counselors and psychologists (content validity) and Pearson product-moment correlation (construct validity). Reliability was assessed using Cronbach's alpha, with a minimum coefficient of 0.60 required for acceptance.

Data Validation

Qualitative data were validated through triangulation of sources (cadres, community members, stakeholders) and methods (observation, interviews, questionnaires, documentation), member checking with key informants, ongoing observation throughout the program, and referential adequacy through field notes and photographic evidence. Quantitative instruments underwent expert review and statistical testing for validity and reliability before full administration.

Data Analysis Techniques

Qualitative data were analyzed thematically through the stages of data reduction, data display, and inductive conclusion drawing. Quantitative data were analyzed using descriptive statistics (mean, standard deviation, percentage) followed by normality testing (Kolmogorov-Smirnov or Shapiro-Wilk). Depending on distribution assumptions, paired-sample t-tests or Wilcoxon signed-rank tests were applied to examine pre-post differences. Program effectiveness was further estimated using N-Gain scores classified into high, medium, or low categories. The combination of statistical and thematic analysis enabled measurement of change and a deeper understanding of processes, meanings, and contexts.

Results

Basic Conditions

Pre-intervention data confirmed the baseline profile obtained from the initial survey of 30 respondents. Social relationships emerged as a relative community strength, with 73.3% of respondents reporting positive and supportive relationships. Conversely, several intrapersonal dimensions needed strengthening: only 53.3% felt able to manage their emotions well, 50% reported a clear life purpose, 56.7% expressed confidence in their abilities, 53.3% felt able to make independent decisions, 63.3% had difficulty coping with life's stresses, and 56.7% often felt anxious or restless for no apparent reason. These figures provide an empirical basis for designing targeted psychoeducational content.

Table 1. Basic Profile of Psychological Well-Being Aspects (N = 30)

Aspects of Psychological Well-being	Key Findings
Life satisfaction	60% are satisfied; 40% are not optimally satisfied
Emotional regulation	53.3% are able to manage emotions well
Purpose of life	50% have clear life goals
Confidence	56.7% feel confident in their abilities
Positive social relationships	73.3% reported positive and supportive relationships
Resistance to pressure	63.3% have difficulty coping with life's pressures
Anxiety / restlessness	56.7% often feel anxious for no apparent reason
Autonomy in decision making	53.3% are able to decide independently

Post-Intervention Results

After the intervention, the mean total psychological well-being score increased from 95.53 (SD = 7.50) at pre-test to 118.43 (SD = 7.84) at post-test, representing an average increase of 22.90 points. A paired-sample t-test showed a statistically significant difference, $t(29) = 30.744$, $p < 0.001$. The overall N-Gain of 0.481 falls into the moderate effectiveness category according to conventional benchmarks. All six Ryff dimensions showed statistically significant improvement, with N-Gain values ranging from 0.492 to 0.588.

Table 2. Psychological Well-Being Dimension Scores Pre-test and Post-test (N = 30)

Dimensions	pre-average	Preschool	Mean Post	SD Post	Profit	N-Gain	Category
Self-acceptance	15.43	2.70	19.27	3.13	3.83	0.499	currently
Positive relationship	15.70	2.82	19.40	3.06	3.70	0.500	currently
Autonomy	15.97	3.02	19.50	3.37	3.53	0.492	currently
Env. mastery	15.97	2.70	19.97	2.70	4.00	0.543	currently
Purpose of life	15.67	3.17	20.00	3.02	4.33	0.588	currently
Personal growth	16.80	2.82	20.30	2.26	3.50	0.517	currently
Total PWB	**95.53**	**7.50**	**118.43**	**7.84**	**22.90**	**0.481**	**currently**

Qualitative Findings

Qualitative data from interviews and focus groups supplemented the quantitative results. Volunteers reported increased confidence in facilitating discussions, recognizing early signs of emotional distress, and knowing when and how to refer cases that exceed their capacity. Community participants described reduced hesitation to discuss emotional difficulties, a greater willingness to seek support from peers or professionals, and a clearer sense of purpose and caring. Selective use of AI-assisted materials was found to help reinforce key messages across face-to-face sessions, provided human facilitation remained central and the content was culturally appropriate. A religious framework linking self-care, emotional regulation, and support with Islamic teachings on mercy and mutual respect increased acceptance and reduced resistance among participants who might view mental health discourse as foreign or individualistic.

Stakeholders noted that the presence of trained local cadres created a more accessible first layer of support and began to normalize conversations about mental well-being within existing communities and religious gatherings. The findings of this process indicate that the intervention operates not only at the level of individual scores but also at the level of social norms and institutional readiness for ongoing attention to mental health.

Discussion

Statistically significant improvements in psychological well-being support the hypothesis that cadre-based community psychoeducation, when carefully augmented by AI tools under human supervision, can improve mental health outcomes in rural Indonesia. A moderate N-Gain of 0.481 indicates meaningful yet realistic changes for a community-level intervention of limited duration. Improvements across all six Ryff dimensions indicate that the program successfully addressed both interpersonal (positive relationships) and intrapersonal dimensions (self-acceptance, autonomy, environmental mastery, purpose, and personal growth).

These findings align with and extend previous studies. Psychoeducation has been repeatedly shown to increase literacy and reduce stigma (Purnamasari et al., 2026; Leung et al., 2024; Susanti et al., 2024). Cadre empowerment models focused on Psychological First Aid or specific populations such as postpartum mothers have demonstrated increased capacity and improved community response (Izzati & Meiyuntariningsih, 2025; Aurora et al., 2026). Community-based participatory design has emphasized the importance of local adaptation mechanisms and social support (Greene et al., 2022). This program contributes by intentionally embedding AI as a complementary, rather than primary, modality and by anchoring the entire intervention within Islamic communal values and a social transformation agenda (Najwa & Hasanah, 2026).

From the perspective of the conference theme of AI, Religion, Society, and Social Transformation, the experience at Procot Village illustrates a culturally rooted pathway. Artificial intelligence was not introduced as a technocratic solution replacing human relationships. Rather, it served as a means to extend human care: amplifying messages, providing timely reminders, and offering easily accessible educational content between sessions. The cadres acted as crucial mediators, translating digital content into locally meaningful languages and practices, thereby reducing the risk of cultural alienation, digital exclusion of older adults, or over-reliance on technology. This mediation role is particularly

crucial in rural Muslim communities where trust, religious authority, and face-to-face relationships remain fundamental to social life and the search for help.

The integration of religious narratives has proven to be highly impactful. Framing mental health care as consistent with Islamic teachings on compassion, mutual assistance, and human dignity reduces moral and cultural resistance. Participants are able to situate new knowledge within existing worldviews, rather than simply as imported or secular discourse. In this sense, religion serves not as a barrier but as a resource for social transformation, while AI serves as a reinforcement of locally owned educational processes.

Several contributing factors contributed to the observed results: pre-existing social capital (as evidenced by a high baseline level of positive relationships), engaged and motivated cadres, support from village officials and the local health center, and careful co-design of content with religious sensitivity. Remaining challenges include residual stigma in community segments, variable digital literacy, particularly among older participants, the need for ongoing supervision to maintain cadre fidelity to practice, and the lack of formal institutional status for cadres at the time of the program. These limitations underscore the importance of formalizing the role of cadres (e.g., through a village head decree), developing clear standard operating procedures and referral pathways, and embedding the program in the village's medium-term development plan (RPJMDes) to ensure long-term sustainability and resources.

Theoretically, the results reinforce the complementarity between psychological well-being theory, a community empowerment framework, and an ethical approach to AI implementation in a faith-based social context. Practically, this model offers a replicable approach for other rural Muslim communities seeking to advance SDG 3 while navigating the opportunities and risks of digital transformation. Future work should examine the long-term retention of progress, the scalability of AI components that remain under community control, and comparative studies across diverse rural Muslim settings.

The implications of these findings extend beyond the immediate village context. First, for practice, this model suggests that mental health literacy programs in rural Muslim communities are more likely to succeed when they (a) recruit and sustain support from local cadres, (b) frame content in religiously resonant language, (c) use technology only as an amplification under human control, and (d) secure formal institutional support from village government and health services. Second, for policy, the experience demonstrates the value of integrating community mental health cadres into existing village governance structures and allocating modest resources for training, supervision, and simple digital tools within village budgets or cross-sectoral programs related to SDG 3. Third, for the study of AI and society, this case demonstrates that ethical AI implementation in religiously literate communities is not simply a matter of technical safeguards but also an ongoing negotiation between technological possibilities, religious norms, and local social relations. Cadres emerge as crucial intermediaries in these negotiations.

Limitations of the current evaluation should be acknowledged. The sample size of 30, while sufficient to detect the observed pre-post differences, limits generalizability. The absence of a control group means some of the observed changes could be due to factors other than the intervention. The moderate N-Gain, while encouraging, suggests that further intensification or a longer duration may be necessary to achieve high effectiveness. The qualitative data, while rich, were drawn from a limited number of focus group discussions (FGDs) and interviews. Finally, the AI components used were intentionally simple; more sophisticated applications

require additional ethical review, digital infrastructure, and capacity building. These limitations do not invalidate the findings but define the boundaries within which they should be interpreted and the direction of future work.

Conclusion

This community engagement demonstrates that empowering GEN MENTARI cadres through community psychoeducation supported by ethically designed AI tools can significantly strengthen psychological well-being in a rural Indonesian village. The program resulted in statistically significant improvements across all six dimensions of Ryff's model, reduced barriers to seeking help, and positioned cadres as agents of social transformation, bridging religious values, community solidarity, and appropriate technology.

This initiative directly contributes to Sustainable Development Goal 3 (Good Health and Well-Being) and offers a concrete illustration of how artificial intelligence can be leveraged for positive social transformation in Muslim communities when guided by cultural sensitivity, religious ethics, and human-centered design. Sustainability relies on multi-stakeholder collaboration between cadres, village governments, health services, and religious leaders; formal recognition of cadres' roles; ongoing capacity building; and program integration into local governance and planning structures.

Future research and practice should examine the durability of observed progress over longer timeframes, explore scalable yet community-driven AI applications, and conduct comparative studies in other rural Islamic contexts. By combining traditional communal strengths with carefully selected digital tools, rural communities can improve mental health literacy, reduce stigma, and build social resilience in ways that honor both faith and innovation.

In closing, the GEN MENTARI program affirms that social transformation in the era of artificial intelligence does not have to lead to the erosion of religious and community ties. Instead, when AI is placed in the service of local cadres rooted in faith and community, technology can become a partner in the work of healing, empowerment, and collective prosperity. Procot Village offers a simple yet instructive example of this possibility.

Confession

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Conflict Of Interest

The authors declare that they have no conflict of interest.

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