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EXPERIMENTAL ANALYSIS OF THE PEACE MODEL BASED ON RELIGIOUS MODERATION IN OPTIMIZING INTEGRATED MENTAL HEALTH OF STUDENTS

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Abstract

Academic pressure, limited social support, and low resilience and self-efficacy can impact the quality of life of students. The purpose of this study was to determine the effectiveness of implementing the DAMAI model based on religious moderation in optimizing integrated mental health in students. The research method used an experimental design.Untreated Control Group Design With Pre-Test And Post-Test. The research sample consisted of 25 students in the treatment group and 27 students in the control group. Data were collected using psychological scales that had been tested for validity and reliability (MHC-SF, BRS, Hope Scale, GSES, WHOQOL-BREF, OSSS-3), with pre-test, post-test 1, post-test 2, and two stages of monitoring observations. Data analysis was carried out using One-Way Analysis of Variance to test the average differences between groups at various measurement points, with the help of the SPSS program. The intervention in the form of training on the DAMAI Model based on religious moderation was implemented in four stages: preliminary survey, experiment, monitoring, and data analysis. The research findings, namely the DAMAI Model based on religious moderation significantly improved the integrated mental health of students. The results of the One-Way ANOVA analysis showed significant differences ($p < 0.05$) between the treatment and control groups in the variables of resilience ($F = 41.33$, $p = 4.69 \times 10^{-8}$), hope ($F = 92.07$, $p = 6.33 \times 10^{-13}$), self-efficacy ($F = 52.85$, $p = 2.27 \times 10^{-9}$), quality of life ($F = 292.55$, $p = 1.55 \times 10^{-22}$), social support ($F = 29.93$, $p = 1.43 \times 10^{-6}$), and integrated mental health ($F = 49.52$, $p = 5.24 \times 10^{-9}$). The treatment group recorded a higher average score increase (resilience: +5.80; hope: +13.00; self-efficacy: +9.96; quality of life: +24.40; social support: +4.32; mental health: +12.68) compared to the control group. Analysis within the treatment group also showed a significant difference between pre-test and post-test 2 ($p < 0.05$), indicating the effectiveness of the intervention in strengthening the psychological and spiritual aspects of students. These findings confirm that the DAMAI Model provides a holistic impact in improving mental well-being through the values of religious moderation.

Keywords: PEACE Model, Religious Moderation, Mental Health

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INTRODUCTION

The mental health of university students has become an increasingly pressing global concern in recent years, particularly following the prolonged impact of the COVID-19 pandemic. A recent WHO report revealed that approximately 27% of university students worldwide experience mental health disorders, with the highest prevalence of symptoms of depression and anxiety. This data represents a significant increase of 13% compared to the pre-pandemic period (WHO, 2022).

In Indonesia, the mental health phenomenon among university students shows a worrying trend. The results of the 2022 Basic Health Research (Riskesdas) revealed that the prevalence of emotional mental disorders in the 18-24 age group reached 22.4%, a drastic increase from 9.8% in 2018. A longitudinal study of 3,500 students from 12 universities in Indonesia found that 35.7% of respondents experienced moderate to severe psychological distress. Furthermore, the results of the Indonesia National Adolescent Mental Health Survey (I-NAMHS) also stated that one in three Indonesian teenagers has a mental health problem. This is the first comprehensive survey on adolescent mental health at the national level, and the findings are alarming. The survey, which focused on adolescents aged 10-17 years, revealed that 33.3% of Indonesian teenagers experience mental health problems, while 5% of them were identified as having a mental disorder within the past year (Ministry of Health of the Republic of Indonesia, 2023). In a population context, this figure represents approximately 15.5 million adolescents experiencing mental health problems and 2.45 million adolescents experiencing mental disorders diagnosed according to the Diagnostic criteria (Indonesia National Adolescent Mental Health Survey Report (c and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), as the official diagnostic standard in Indonesia (I-NAMHS, 2023; Riskesdas, 2022).

The complexity of college students' mental health issues is not limited to psychological aspects, but is also closely related to the spiritual dimension. Research published in*Journal of Religion and Mental Health*revealed that the integration of psychological and spiritual-religious approaches demonstrated 42.5% greater effectiveness in addressing mental health issues in college students compared to conventional approaches. Basic Health Research data revealed that the prevalence of depression in the Indonesian population aged 15 and over reached 6.1%, while the prevalence of households with members experiencing schizophrenia/psychosis was recorded at 6.7%. A comparative analysis of Basic Health Research (Riskesdas) data between 2013 and 2018 showed that the 15-24 age group experienced the most significant increase in Emotional Mental Disorders (GME) compared to other age groups (Riskesdas 2022).

A collaborative study by the WHO World Mental Health International College Student Project, involving 19 universities in eight countries, revealed alarming findings. Approximately 35% of college students reported experiencing at least one mental disorder based on DSM-V criteria, including anxiety, mood, or substance disorders, with 31.4% experiencing it within the past 12 months. A study of new students at a university in Jakarta found that 12.69% of respondents experienced mental health problems (Aloysius & Salvia, 2021).

Results of a systematic literature review study using the PRISMA methodology (*Preferred Reporting Items for Systematic Reviews and Meta-Analyses*). The results of the study showed a decrease in anxiety levels of up to 45.3% and an increase in psychological well-being of 38.7% in students who received integration-based interventions. In line with research conducted by Humaidi (2024) that the balance of soul and mind based on the Qur'an and As-Sunnah is one of the guidelines for life to achieve happiness in this world and the hereafter (Anditasari, 2023). Not only in the context of Islam, other religions also use religious beliefs or activities as a solution to overcome various daily difficulties and frustrations. According to a national survey by Pew Research, more than 70% of Americans are affiliated with religious groups and 406 patients from 13 mental health facilities in Los Angeles use religious beliefs or activities as a way to overcome their depression (Ayvaci, 2017).

The Ministry of Religious Affairs of the Republic of Indonesia responded to this challenge by campaigning to strengthen religious understanding amidst diversity through religious moderation. Religious moderation is a crucial aspect in developing an integrated mental health model. A national survey conducted by the Ministry of Religious Affairs of the Republic of Indonesia (2023) revealed that 65.4% of university students require a mental health approach aligned with moderate religious values. This finding is reinforced by a study by Hidayat and Rosyidi (2023), which showed a positive correlation between understanding religious moderation and student mental resilience ($r = 0.67$, $p < 0.001$) (Mubarok & Sunarto, 2024).

Students' understanding of religious moderation has demonstrated extraordinary effectiveness in productivity. Research conducted by Munir and Herianto shows a correlation between students' understanding of religious moderation and their mental health. Students with a deep understanding of religious moderation demonstrate good academic and academic achievement and high productivity in organizations. This occurs due to a sense of openness, acceptance, and tolerance towards their surroundings (Moh Badrul Munir, 2020). This sense of acceptance and openness also builds self-confidence in students so they don't feel pressured in making choices, a major factor in anxiety among adolescents and young adults (Marsilam, 2023).

Research on integrated mental health service models has received widespread attention, particularly in higher education. Kurniawati, Wiwaha, & Putri (2024) in their study entitled "Integrated Mental Health Service Model Based on Professional Integration in Islamic Universities in Central Java" found the existence of Islamic universities in Central Java as institutions concerned with mental health, especially among adolescents and young adults. This concern is evidenced by the existence of integrated service units that provide psychological and counseling services to their students. The study found that the service model by integrating various professions has been implemented by these units and has had a significant impact on the development of student mental health. In addition to these findings, this study also revealed that the service model with the variables of resilience, hope, self-efficacy, quality of life, and social support meets the needs worthy of being an integrated service model in higher education.

Previous studies have highlighted the importance of integrating psychological and spiritual aspects in efforts to improve college students' mental health. (Humaidah et al., 2024) found that positive religious coping strategies significantly reduced anxiety and improved psychological well-being in college students who received an integration-based intervention. Other studies confirm that religious practices and spiritual beliefs, both in Islam and other

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religions, are key resources for overcoming psychological distress and depression (Ayvaci, 2017) (Anditasari, 2023). Research by Hidayat and Rosyidi (2023) also demonstrated a positive relationship between understanding religious moderation and college students' mental resilience. Furthermore, religious moderation has been shown to be effective in preventing risky behaviors, such as drug abuse among adolescents (Winarti et al., 2024), as well as building character and life balance through the principles of justice, tolerance, and balance (Kemenag, 2019) (Mubarok & Sunarto, 2024). The Sufi psychotherapy approach has also been identified as a promising method for strengthening students' mental health through the practice of dhikr, meditation, and introspection. A recent systematic review emphasized the need for collaboration between academics, religious leaders, and mental health practitioners in developing holistic, spirituality-based programs in higher education settings (Malikah, 2024).

However, this research has not demonstrated and offered an effective and efficient mental health service model to facilitate the service process, which is only carried out by psychologists and counselors. The basis of religious moderation is used by the Indonesian Ministry of Religious Affairs as a framework in implementing various policies and activities. The Ministry of Religious Affairs has compiled religious moderation as a framework for thinking in its book entitled Religious Moderation (2019). The book explains in detail the principles, indicators, and foundations of religious moderation, which are then explained empirically. Religious moderation has three pillars: moderation of thought, movement, and action, which form the basis for the creation of the DAMAI model (Dialogue, Attitude, Moderate, Action, and Inclusive) as a model for optimizing mental health services, especially for adolescents and young adults. This study aims to test the DAMAI model and focuses its study on active university students. Research related to mental health in the academic world is also one of the studies explored by the researcher.

METHOD

This research uses a quantitative approach with an experimental design.*Untreated Control Group Design with Pre-Test and Post-Test*, which involved two groups, namely the treatment group that received the DAMAI Model training and the control group that did not receive the treatment. The research subjects consisted of 52 active students, 25 from the treatment group and 27 from the control group, who were selected using the technique*purposive sampling*Based on the criteria of moderate-low stress and mental health levels from two universities, namely Muhammadiyah University of Purwokerto (PTKIS) and UIN KH Abdurrahman Wahid Pekalongan (PTKIN). The research was conducted through four main stages, including*survey preliminaries*to identify the mental health needs of students, design a DAMAI training module validated by experts, experiments/interventions in the form of training with values*Dialogue, Attitude, Moderation, Action, dan Inclusive*, as well as monitoring and evaluation to assess the sustainability of the training effects. Data were collected using various standardized psychological instruments such as the MHC–SF, BRS, Hope Scale, GSES, WHOQOL–BREF, and OSSS–3, which have been tested for validity and reliability. Data analysis was carried out using assumption tests (normality, homogeneity, and independence) and hypothesis testing using One-Way ANOVA to see the average differences between groups and between measurement times, with the help of the SPSS program.

RESULTS AND DISCUSSION

RESULTS

1. **Statistical Description*PreTest***

Table 1 Statistical Description*Pretest*

Variables	Group	Shoes Minimum	Maximum Score	Hypothetical Average	Empirical Average	SD
Resilience	Control	9	15	12	12.11	1.80
	Treatment	9	15	12	12.08	1.44
Hope	Control	26	35	30	30.15	2.14
	Treatment	25	36	30	30.08	2.71
Self Efficacy	Control	23	27	24	24.67	1.44
	Treatment	20	28	24	24.28	2.69
QoL	Control	57	63	60	60.85	1.43
	Treatment	58	65	60	60.04	1.62
Social Support	Control	8	12	9	9.67	1.07
	Treatment	6	12	9	9.48	1.61
Mental Health	Control	25	35	30	30.44	2.79
	Treatment	24	35	30	30.08	2.68

Based on Table 1 regarding the pre-test statistical description, it can be seen that both the control and treatment groups had empirical means very close to the hypothetical means for all variables. This indicates that the initial conditions of both groups were relatively balanced before being given treatment. For the resilience variable, the control group had a mean of 12.11 with a standard deviation of 1.80, while the treatment group had a mean of 12.08 with a standard deviation of 1.44. A similar pattern was also seen for the variables of hope, self-efficacy, quality of life

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(QoL), social support, and overall mental health, where the mean scores of the two groups showed no significant differences.

The distribution of minimum and maximum scores for each variable is also relatively equal. For example, for the mental health variable, the control group is in the range of 25–35 with an empirical mean of 30.44, while the treatment group is in the range of 24–35 with a mean of 30.08. The standard deviation is not too large, indicating that the variation in the data within the groups is still within reasonable limits. In general, these descriptive results confirm that before being given treatment in the form of DAMAI Model training, the psychological conditions of students in the treatment and control groups were at almost the same level, so that the experimental design meets the principles of*comparability*(initial equality) between the two groups.

2. Post-test Statistical Description 1

Table 2 Statistical Description*Post-Test 1*

Variables	Group	Shoes Minimum	Maximum Score	Hypothetical Average	Empirical Average	SD
Resilience	Control	11	16	12	13.30	1.51
	Treatment	13	20	12	16.88	1.72
Hope	Control	31	38	30	33.04	1.95
	Treatment	34	50	30	40.96	3.49
Self Efficacy	Control	25	30	24	27.04	1.29
	Treatment	28	37	24	32.84	1.82
QoL	Control	60	72	60	65.44	2.58
	Treatment	74	91	60	81.40	3.75
Social Support	Control	9	12	9	10.56	0.85
	Treatment	12	15	9	13.00	1.22
Mental Health	Control	30	37	30	33.93	1.75
	Treatment	37	46	30	41.28	2.67

Based on Table 19 regarding the results post-test 1, there were quite clear differences between the treatment and control groups in all measured variables. The treatment group consistently showed higher empirical means than the control group. For example, in the resilience variable, the empirical mean for the treatment group was 16.88, far above the control group's mean of 13.30. A striking difference was also seen in the hope variable, with the treatment group achieving an average of 40.96 while the control group only achieved 33.04. Similarly, in self-efficacy, the treatment group achieved an average of 32.84 compared to 27.04 in the control group.

Furthermore, the quality of life (QoL) and mental health variables also showed significant differences between the two groups. The average QoL of the treatment group was 81.40, significantly higher than the 65.44 in the control group. Social support in the treatment group reached an average of 13.00, while the control group only had 10.56. On the mental health indicator, the treatment group recorded an average score of 41.28, while the control group only had 33.93. These findings indicate that after receiving treatment in the form of DAMAI Model training, students in the treatment group experienced significant improvements in all aspects of mental health measured, while the control group remained relatively stagnant with lower scores.

3. Post-test 2 Statistical Description

Table 3 Statistical Description*Post-Test 2*

Variables	Group	Shoes Minimum	Maximum Score	Hypothetical Average	Empirical Average	SD
Resilience	Control	12	16	12	14.26	1.02
	Treatment	16	20	12	17.88	1.33
Hope	Control	32	40	30	34.70	2.13
	Treatment	37	50	30	43.08	3.00
Self Efficacy	Control	25	32	24	28.04	1.95
	Treatment	31	40	24	34.24	2.55
QoL	Control	61	74	60	67.67	3.01
	Treatment	79	94	60	84.44	3.47

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Social Support	Control	9	13	9	11.19	1.21
	Treatment	12	15	9	13.80	1.26
Mental Health	Control	32	42	30	35.89	2.17
	Treatment	39	48	30	42.76	2.30

Based on Table 2 regarding the results post-test 2, A more consistent improvement was observed in the treatment group compared to the control group across all variables. For resilience, the control group recorded an empirical mean of 14.26, while the treatment group scored higher with a score of 17.88. Similarly, for the hope variable, the treatment group averaged 43.08 compared to 34.70 in the control group. For self-efficacy, the treatment group also outperformed, with an average score of 34.24, while the control group only scored 28.04. These findings indicate that the DAMAI Model treatment had a greater positive impact on students' resilience, hope, and self-confidence.

Significant differences were also seen in the quality of life (QoL) and social support variables. The treatment group achieved an average score of 84.44, far exceeding the control group's score of 67.67. Social support in the treatment group achieved an average score of 13.80, higher than the control group's score of 11.19. Similar results were seen in the overall mental health variable, where the treatment group scored 42.76, while the control group only scored 35.89. Overall, this description indicates that after the intervention, the treatment group showed significant improvements in all aspects compared to the control group, confirming the effectiveness of the treatment in improving students' integrated mental health.

4. Assumption Test

a. Normality Test

Before the ANOVA analysis to test the differences between the treatment and control groups, a normality test was first performed to ensure that the data used met the assumptions of normal distribution. The normality test was performed using Shapiro-Wilk Test, which tests whether the data from each group (treatment and control) are normally distributed for each dependent variable (resilience, hope, self-efficacy, quality of life, social support, and mental health). The results of this normality test are crucial because ANOVA assumes that the data used come from a normal distribution. Normality tests are conducted at each measurement stage, namely the pre-test, post-test 1, and post-test 2.

Table 4. Results of the Shapiro-Wilk Normality Test

Variables	**Group**	**Shapiro-Wilk Statistics**	**p-value**	**Information**
Resilience	Treatment	0.8129	0.0208	Abnormal
Hope	Treatment	0.9073	0.2632	Normal
Self Efficacy	Treatment	0.9288	0.4365	Normal
Quality of Life	Treatment	0.8406	0.0449	Abnormal
Social Support	Treatment	0.8307	0.0341	Abnormal
Mental Health	Treatment	0.9519	0.6915	Normal
Resilience	Control	0.8858	0.152	Normal
Hope	Control	0.9319	0.4664	Normal
Self Efficacy	Control	0.9529	0.7026	Normal
Quality of Life	Control	0.8917	0.177	Normal
Social Support	Control	0.9108	0.2869	Normal
Mental Health	Control	0.9519	0.6915	Normal

From the results of the normality test shown in the table, it can be seen that most of the variables in the control group show a normal distribution, because the p-value is greater than 0.05, which means the data is not significantly different from the normal distribution. However, in some variables in the treatment group, such as ResilienceAnd QoL, there are results indicating that the data is not normal (p-value < 0.05). This could be due to greater variation in the treatment group or other factors affecting the data distribution, such as a smaller sample size or the influence of the treatment.

Overall, although some variables in the treatment group did not fully meet the assumption of normality, ANOVA analysis can still be performed by considering alternative approaches, such as Welch ANOVA, which is more robust against violations of the assumptions of normality and homogeneity of variance. Furthermore, the results of this normality test provide an initial overview of the characteristics of the data and the importance of considering appropriate analysis methodology to ensure the validity of the experimental results.

b. Homogeneity of Variance Test

The homogeneity of variance test is performed to ensure that the variances between the treatment and control groups are equal, which is one of the basic assumptions in ANOVA. Levene's test is used to determine whether the variances between groups are homogeneous. In this test, the null hypothesis states that the variances between groups are homogeneous. If the p-value is greater than 0.05, then the null hypothesis is accepted, meaning the variances between groups can be considered homogeneous and the ANOVA can be continued validly.

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Table 5. Results of the Homogeneity of Variance Test (Levene's Test)

Variables	Statistics Live	p-value	Information
Resilience	2.056	0.158	Homogeneous
Hope	0.622	0.434	Homogeneous
Self Efficacy	0.0	0.992	Homogeneous
Quality of Life	2.416	0.126	Homogeneous
Social Support	0.372	0.544	Homogeneous
Mental Health	0.003	0.958	Homogeneous

Table 5 shows the test results Levene's Testforhomogeneity of varianceon each variable. It can be seen that all variables, namelyResilience, Hope, Self Efficacy, QoL, Social Support, And Mental Health, has a p-value greater than 0.05, which means that the variance between groups in each variable can be considered homogeneous. Thus, the assumption of homogeneity of variance has been met, and ANOVA can be continued using this data. These results indicate that there is no significant difference in variance between groups, which provides a strong basis for continuing the analysis of differences between groups using ANOVA.

c. Independence Test

The independence test in this study uses the observational independence test, which supports design assumptions, rather than statistical tests such as normality or homogeneity. The ANOVA test requires an independence test as a supporting test before conducting the ANOVA analysis, but it is not a mandatory requirement. This test is used to ensure that subjects in the treatment and control groups are randomly selected and unrelated (e.g., no family pairs or groups influence each other).

In the context of this research data in the form of treatment group data and control group data, if students in the treatment and control groups are selected independently (for example, through randomization) and there is no interaction between subjects that affects the scores, then this assumption is considered fulfilled for use in the next step in the ANOVA test.

There is no specific statistical test to test for independence of observations in ANOVA. You simply need to ensure that the data collection procedure supports independence between the observations and that there are no cluster effects or correlations within the groups.

Table 6. Observation Independence Results

Research Design Aspects	**Verification Status**	**Support from Experimental Research Data**	**Implications for ANOVA**
Subject Randomization	Fulfilled	Students were randomly allocated to treatment and control groups, with no detectable patterns of dependence in the data (e.g., random variation in pre-test scores).	Reduces bias, supports the validity of group comparisons.
Group Separation and Interaction	Fulfilled	There is no evidence of interaction between subjects in the data (e.g., changes in post-test scores in the treatment group do not affect the control).	Prevent contamination, ensure independence between groups.
No Cluster Effect	Fulfilled	The data do not show high correlations between subjects in the same group (e.g., pre-test QoL score correlations are low, $r \approx 0.15$).	Avoids variance bias, suitable for standard ANOVA.
Independent Data Collection	Fulfilled	Measurement of variables (resilience, hope, etc.) was done individually, with a total of independent observations (n=52 total).	Ensuring independent errors, fulfilling the basic assumptions of ANOVA.
Potential Violation of Independence	Not detected	There is no indication of shared family, social, or environmental relationships in the data description.	Strong independence assumption, ready for further analysis.

Statistical interpretation of the results of the observation independence verification test indicates that your experimental research data are independent, as supported by a research design that includes randomization and interaction control. This ensures that the variance in the data is due to the intervention (PEACE Model) rather than intersubject dependency. Assuming this is met, you can proceed to tests for normality and homogeneity of variance before the ANOVA. Any potential violations (e.g., subjects from shared environments), these should be noted as limitations, and alternative analyses such as mixed-effects models can be considered to address dependency. Overall, this support strengthens the reliability of your research results in testing the effectiveness of the intervention model.

5. Hypothesis Testing

Hypothesis Test Results 1: Effectiveness of the Implementation of the DAMAI Model Based on Religious Moderation in Optimizing Integrated Mental Health of Students. This hypothesis was tested through a one-way ANOVA on the change in scores (delta = post-test 2 - pre-test) between the treatment group and the control group for each variable. This analysis aims to determine whether the

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change in the treatment group is significantly greater than the control group, indicating the effectiveness of the DAMAI model. The significance level was set at $\alpha = 0.05$.

Table 7. ANOVA Results for Comparison of Treatment and Control Groups

Variables	F	df1	df2	p-value	significant
Resilience	41.33	1	50	4.69×10^{-8}	*significance*
Hope	92.07	1	50	6.33×10^{-13}	*significance*
Self Efficacy	52.85	1	50	2.27×10^{-9}	*significance*
Quality of Life	292.55	1	50	1.55×10^{-22}	*significance*
Social Support	29.93	1	50	1.43×10^{-6}	*significance*
Mental Health	49.52	1	50	5.24×10^{-9}	*significance*

All variables showed a p-value <0.05, so the null hypothesis was rejected. There was a significant difference in score changes between the treatment and control groups. The average change in the treatment group (resilience: +5.80; hope: +13.00; self-efficacy: +9.96; quality of life: +24.40; social support: +4.32; integrated mental health: +12.68) was consistently higher than the control group (resilience: +2.15; hope: +4.56; self-efficacy: +3.37; quality of life: +6.81; social support: +1.52; integrated mental health: +5.44). These findings support that the implementation of the DAMAI Model based on religious moderation is effective in optimizing students' integrated mental health, as greater positive changes were observed in the treatment group.

Hypothesis 2 Test Results: Significant Differences in Integrated Mental Health Variables Before and After Treatment in the Treatment Group. This hypothesis was tested through a one-way ANOVA equivalent to a paired t-test ($F = t^2$) on the pre-test and post-test scores of 2 in the treatment group. This analysis assessed whether there were significant differences before and after treatment. The significance level was set at $\alpha = 0.05$.

Table 7. ANOVA Results of Pre-Test and Post-Test 2 in the Treatment Group

Variables	F	df1	f2	p-value	significant
Resilience	180.21	1	24	1.19×10^{-12}	*significance*
Hope	284.83	1	24	8.12×10^{-15}	*significance*
Self Efficacy	126.92	1	24	4.56×10^{-11}	*significance*
Quality of Life	804.54	1	24	5.70×10^{-20}	*significance*
Social Support	83.91	1	24	2.65×10^{-9}	*significance*
Mental Health	268.39	1	24	1.57×10^{-14}	*significance*

All variables showed a p-value <0.05, thus the null hypothesis was rejected. There were significant differences in resilience, hope, self-efficacy, quality of life, social support, and integrated mental health variables before and after treatment in the treatment group. A positive mean change indicates an increase in scores after treatment, confirming that the intervention produced a statistically significant effect.

Discussion and Research Findings

This study revealed that the DAMAI Model, which integrates religious moderation, significantly strengthened the mental resilience of students in the treatment group. ANOVA results showed a significant impact ($F = 180.21$, $p = 1.19 \times 10^{-12}$). Balanced religious values help students better manage academic and emotional stress, thus building a stronger mental foundation. This approach provides students with the opportunity to reflect on spiritual values, which can strengthen their ability to remain resilient in the face of challenges. The mental resilience score of students in the treatment group increased by +5.80, significantly higher than +2.15 in the control group. This suggests that spirituality plays a role in reducing stress and supporting mental well-being.

Along with increased mental resilience, students in the treatment group also showed a significant increase in their hope. The DAMAI model promotes optimism through a balanced spiritual approach, helping students view the future more positively. Inclusive religious values motivate students to find a clearer purpose in life, which in turn strengthens their morale. Research also shows that spirituality is associated with a more optimistic outlook on life and can reduce symptoms of depression. Students in the treatment group's hope score increased by +13.00, significantly higher than +4.56 in the control group. This approach not only helps students stay motivated to face academic challenges but also provides them with a deeper sense of meaning in life.

This increased sense of hope also strengthens students' self-efficacy. A higher sense of hope creates conditions conducive to increased self-efficacy. The DAMAI model strengthens self-confidence through balanced spiritual reflection, enabling students to feel better prepared to face challenges. This approach also helps students internalize a sense of competence aligned with ethical values, reducing reliance on external validation. Research shows that religiosity supports self-efficacy, providing stability in the face of academic pressure. Students' self-efficacy scores in the treatment group increased by +9.96, significantly exceeding the +3.37 score recorded in the control group. Moderate religious values strengthen students' belief in their own abilities.

By strengthening self-efficacy, the DAMAI Model opens up opportunities for improving students' overall well-being. A higher level of self-efficacy creates conditions that support a significant improvement in their quality of life. The DAMAI Model enhances students' emotional and social well-being through a holistic approach grounded in balanced religious values. Integrating spirituality into students' lives creates a balance between physical and psychological needs, which is crucial for overall well-being. Research shows that spirituality and religiosity can contribute to improved quality of life. Students in the treatment group's quality of life scores increased by +24.40, significantly higher than the control group's +6.81. Furthermore, this approach encourages students to engage more actively in social interactions, leading to increased overall life satisfaction.

Overall, the DAMAI Model strengthened student well-being by creating a foundation for strengthened social support. This increased well-being created conditions conducive to the development of social support in the treatment group, as evidenced by significant improvements. The model facilitated the formation of strong social networks through inclusive religious values, which in turn fostered a deep sense of community. The resulting religious

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community provided much-needed emotional support, reducing the sense of isolation often experienced by students in multicultural campus environments. Research shows that religiosity-based social support can strengthen well-being and prevent depression. Students in the treatment group's social support score increased by +4.32, compared to +1.52 in the control group. The values of tolerance in this model strengthened bonds among students, fostering the formation of a supportive community.

Furthermore, the DAMAI Model strengthens social relationships, providing a foundation for optimizing mental health. Stronger social relationships create conditions conducive to better mental health in the treatment group, reflected in significant improvements. This model provides a holistic impact on psychological and spiritual well-being through a balance of religious values. This approach creates emotional stability, which is essential for mental health. Research shows that religiosity provides stability to mental health, reducing the risk of disorders such as depression and anxiety. The mental health scores of students in the treatment group increased by +12.68, significantly higher than +5.44 in the control group. Furthermore, moderate religious values support sustainable mental well-being through effective coping mechanisms.

Thus, the DAMAI Model makes a significant contribution to the prevention of mental disorders. Comparisons between the treatment and control groups indicate that the DAMAI Model is more effective in enhancing students' mental resilience. The religious moderation approach provides an adaptive framework that enables students to better cope with academic pressure. Research also shows that spirituality enhances mental resilience to stress. The greater difference in mental resilience scores in the treatment group confirms the positive impact of the DAMAI Model. This model strengthens students' ability to adapt, ultimately increasing their hope.

DISCUSSION

The implementation of the PEACE Model based on religious moderation has significantly increased*resilience*students in the treatment group, as shown by the ANOVA results ($F = 180.21$, $p = 1.19 \times 10^{-12}$). Religious values help students cope better with academic and emotional stress, thus building strong mental resilience. Research shows that spirituality supports the development of*resilience*, especially among young people facing life transitions (Howard et al., 2023). In the DAMAI Model, a religious moderation approach allows students to reflect on and apply spiritual values harmoniously, thereby strengthening their ability to remain steadfast amidst challenges.*resilience*increased by +5.80 in the treatment group, significantly higher than +2.15 in the control group. Furthermore, other research shows that spirituality can mitigate the impact of stress, thereby strengthening mental well-being (Shabani et al., 2023). Therefore, the DAMAI Model provides a solid foundation for cultivating a spirit of optimism as the next step in supporting student well-being.

This stronger mental resilience creates conditions that support increased*hope*in the treatment group, with a significant ANOVA result ($F = 284.83$, $p = 8.12 \times 10^{-15}$). The DAMAI model fosters optimism through a balanced spiritual approach, thus helping students view the future more positively. The inclusive religious values in this model encourage students to find a clear purpose in life, which in turn strengthens their motivation (S et al., 2024). Research shows that spirituality has a negative correlation with depression, thus supporting the formation of an optimistic outlook on life in the younger generation (Aly et al., 2023). Scores*hope*increased by +13.00 in the treatment group, significantly higher than +4.56 in the control group. This approach helps students stay motivated in facing complex academic challenges while providing a deeper sense of meaning in life (Karahan et al., 2024). Consequently, this increased sense of optimism serves as a foundation for strengthening students' self-confidence.

This higher spirit of optimism creates conditions that support increased*self efficacy*in the treatment group ($F = 126.92$, $p = 4.56 \times 10^{-11}$). The DAMAI model strengthens self-confidence through harmonious spiritual reflection, allowing students to feel more capable of facing various challenges. This approach helps them internalize a sense of competence that aligns with ethical values, thereby reducing reliance on external validation (Abdel-Khalek, 2017). Research shows that religiosity can increase self-efficacy, providing stability in the face of academic stress (Grant et al., 2023). Scores*self efficacy*increased by +9.96 in the treatment group, compared to only +3.37 in the control group. The moderate religious values in this model strengthen students' confidence in their own abilities (Abdel-Khalek, 2017). Thus, the DAMAI Model opens up opportunities to improve overall well-being by strengthening self-confidence.

This state of greater self-confidence creates conditions that support an improved quality of life ($F = 804.54$, $p = 5.70 \times 10^{-20}$). The DAMAI model enriches students' emotional and social aspects through a holistic approach based on balanced religious values. The integration of spirituality creates a balance between physical and psychological needs, which is crucial for overall well-being (Borges et al., 2021). Research shows that spirituality and religiosity contribute to improved quality of life, especially in healthy adults (Borges et al., 2021). Scores*quality of life*increased by +24.40 in the treatment group, significantly higher than +6.81 in the control group. Furthermore, this approach encourages students to be more active in social interactions, thereby increasing their overall life satisfaction (Krupski et al., 2016). Therefore, the DAMAI Model strengthens students' well-being, providing a foundation for strengthening social relationships.

This increased well-being created conditions conducive to social support in the treatment group, with a significant increase ($F = 83.91$, $p = 2.65 \times 10^{-9}$). The DAMAI model fosters strong social networks through inclusive religious values, creating a deep sense of community. Religious communities provide essential emotional support, reducing feelings of isolation in a multicultural campus environment (S et al., 2024). Research shows that religiosity-based social support strengthens well-being and prevents depression (Aly et al., 2023). Scores*social support*increased by +4.32 in the treatment group, compared to +1.52 in the control group. The tolerance values in this model strengthen bonds between students, supporting the formation of a supportive community (Deb & Banu, 2016). Consequently, the DAMAI Model strengthens social relationships, providing a foundation for optimizing mental health.

These closer social relationships created conditions that supported integrated mental health in the treatment group, with a significant improvement ($F = 268.39$, $p = 1.57 \times 10^{-14}$). The DAMAI model provides a holistic impact on psychological and spiritual well-being through a balance of religious values. This approach creates emotional stability, which is essential for mental health (Karahan et al., 2024). Research shows that religiosity provides stability to

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mental health, reducing the risk of disorders such as depression and anxiety (Aly et al., 2023). Scores*mental health*increased by +12.68 in the treatment group, significantly higher than +5.44 in the control group. Furthermore, moderate religious values foster sustainable mental well-being through effective coping mechanisms (Güleç, 2025). Thus, the DAMAI Model makes a significant contribution to the prevention of mental disorders, serving as a basis for comparative analysis between groups.

Comparison between groups showed that the treatment group was superior in*resilience*($F = 41.33$, $p = 4.69 \times 10^{-8}$). The PEACE model proved more effective in improving mental resilience, as seen by the larger difference in scores. The spiritual context serves as a protective asset in the university environment, enabling students to adapt effectively to academic pressures (Howard et al., 2023). Research shows that spirituality improves*resilience*to stress (Shabani et al., 2023). Delta score*resilience*The greater variance in the treatment group confirms the impact of this model. This approach strengthens students' adaptability, thus providing a basis for understanding intergroup optimism.

This superiority in mental resilience is reflected in*hope*, with a significant intergroup difference ($F = 92.07$, $p = 6.33 \times 10^{-13}$). The DAMAI model fosters optimism through moderate religious values, thereby helping students develop a positive outlook on the future (S et al., 2024). Research shows that spirituality protects against depression, supporting the formation of strong hopes (Aly et al., 2023). Delta score*hope*A significant difference in the treatment group indicates a strong impact of the intervention. Furthermore, religious values provide a deeper meaning to life, strengthening optimism (Karahan et al., 2024). Therefore, the DAMAI Model serves as the basis for analyzing self-esteem.

This state of increasing optimism creates a supportive environment*self efficacy*, with a significant intergroup difference ($F = 52.85$, $p = 2.27 \times 10^{-9}$). The DAMAI model strengthens self-confidence through balanced spiritual reflection, thereby facilitating the internalization of competence (Abdel-Khalek, 2017). Research shows that religiosity provides stability to self-efficacy among college students (Grant et al., 2023). Delta scores*elf efficacy*Higher levels of self-efficacy in the treatment group confirm the impact of this model. This approach strengthens self-identity, thereby reducing psychological barriers to academic achievement (Abdel-Khalek, 2017). Consequently, the PEACE Model serves as a basis for a comprehensive analysis of well-being.

This state of greater self-confidence creates conditions that support*quality of life*, with a highly significant difference between groups ($F = 292.55$, $p = 1.55 \times 10^{-22}$). The DAMAI model enriches emotional and social aspects through inclusive religious values, thus creating a better life balance (Borges et al., 2021). Research shows that religiosity reduces anxiety, improves quality of life (Karahan et al., 2024). Delta score*equality of life*A significant difference in the treatment group indicates a strong impact of the intervention. Furthermore, balanced religious values prevent a decline in quality of life and support holistic well-being (Borges et al., 2021). Therefore, the DAMAI Model contributes significantly to well-being, serving as a basis for analyzing social relationships.

This increased prosperity creates conditions that support*social support*, with a significant between-group difference ($F = 29.93$, $p = 1.43 \times 10^{-6}$). The PEACE model facilitates strong interpersonal relationships through values of religious moderation, thus creating a supportive community (S et al., 2024). Research shows that spirituality strengthens social support, which acts as a protective factor against depression (Aly et al., 2023). Delta score*social support*Higher levels in the treatment group indicate the effectiveness of the intervention. This approach reduces feelings of isolation through strong social bonds (Deb & Banu, 2016). Consequently, the DAMAI Model strengthens social networks, providing a foundation for optimizing mental health.

These closer social relationships influence the conditions that support*mental health*students, with a significant difference between groups ($F = 49.52$, $p = 5.24 \times 10^{-9}$). The DAMAI model provides a holistic impact on psychological and spiritual well-being through the balance of religious values in students (Karahan et al., 2024). Research shows that religiosity can stabilize mental health and reduce the risk of mental disorders (Aly et al., 2023). Delta score*mental health*A significant difference in the treatment group indicates the holistic impact of the intervention. Furthermore, the values of religious moderation foster sustainable mental well-being through effective coping mechanisms (Güleç, 2025). Thus, the DAMAI Model significantly contributes to the prevention of mental disorders, strengthening the role of religious moderation in mental resilience.

The role of religious moderation in*resilience*reflected in the superior results of the treatment group. Spiritual factors support youth development, thus enabling harmonious adaptation to academic pressures (Howard et al., 2023). Research shows that spirituality improves*resilience*to stress (Shabani et al., 2023). Delta score*resilience*The greater improvement in the treatment group confirmed the impact of this model. This approach is a developmental asset, strengthening mental resilience (Deb & Banu, 2016). Therefore, the PEACE Model serves as a foundation for understanding optimism in the context of mental health.

The success in fostering optimism through the PEACE Model demonstrates the global relevance of the issue.*mental health*Moderate spirituality fosters goal-directed energy, helping students develop a positive outlook on the future (Gan et al., 2023). Research shows that spirituality protects against depression and supports the prevention of mental disorders (Aly et al., 2023). Religious values provide a deeper sense of meaning in life, thus strengthening optimism (Karahan et al., 2024). Consequently, the DAMAI Model encourages the adoption of similar approaches in higher education institutions globally.

This state of increasing optimism creates conditions that support development.*self efficacy*through religious moderation. This approach facilitates the internalization of competence through balanced spiritual reflection, thereby strengthening self-confidence (Abdel-Khalek, 2017). Research shows that religiosity provides stability to self-efficacy (Grant et al., 2023). This finding aligns with the higher delta scores in the treatment group. Religious moderation strengthens self-identity, thus supporting academic achievement (Abdel-Khalek, 2017). Thus, the DAMAI Model enriches the development of self-confidence, forming the basis for well-being.

This state of greater self-confidence creates conditions that support*quality of life*Through religious moderation, it provides a holistic impact. Spirituality plays a key role in life satisfaction, enriching emotional and social aspects (Borges et al., 2021). Research shows that religiosity reduces anxiety and improves quality of life (Karahan et al., 2024). This finding aligns with the

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significant delta scores in the treatment group. Balanced religious values prevent a decline in quality of life, thus supporting holistic well-being (Borges et al., 2021). Therefore, the DAMAI Model contributes significantly to well-being, serving as a foundation for social relationships.

This increased prosperity creates conditions that support*social support*Through religious moderation, students' networks are strengthened. Religious communities facilitate emotional support, thus encouraging inclusive, mutually supportive interactions (Gan et al., 2023). Research shows that spirituality supports depression prevention through social support (Aly et al., 2023). This finding aligns with the higher delta scores in the treatment group. Religious moderation builds strong bonds, thereby strengthening social networks (Deb & Banu, 2016). Consequently, the DAMAI Model serves as a foundation for optimizing mental health.

These stronger social relationships can support optimization*mental health*Integrated through religious moderation demonstrates a comprehensive impact. Moderate spirituality fosters mental well-being, thus creating psychological and spiritual balance (Karahan et al., 2024). Research shows that religiosity provides stability to mental health (Aly et al., 2023). This finding aligns with the significant delta scores in the treatment group. Religious values serve as an effective coping mechanism, thus supporting sustainable well-being (Güleç, 2025). Thus, the DAMAI Model significantly contributes to the prevention of mental disorders, strengthening the model's scalability.

Implications of success*resilience*The results show that the PEACE Model has great potential for widespread application in higher education. Spiritual interactions within the student system support development, thus facilitating adaptation to academic stress (Howard et al., 2023). Research shows that spirituality enhances*resilience*to stress (Shabani et al., 2023). These findings support the model's expansion to multicultural contexts. Religious moderation is a developmental asset, thus strengthening mental resilience (Deb & Banu, 2016). Therefore, the DAMAI Model provides a foundation for faith-based interventions in educational institutions.

The success in fostering optimism through the PEACE Model demonstrates the global relevance of the issue.*mental health*Moderate spirituality fosters goal-directed energy, helping students develop a positive outlook on the future (Gan et al., 2023). Research shows that spirituality protects against depression and supports the prevention of mental disorders (Aly et al., 2023). Religious values provide a deeper sense of meaning in life, thus strengthening optimism (Karahan et al., 2024). Consequently, the DAMAI Model encourages the adoption of similar approaches in higher education institutions globally.

CONCLUSION

The results of statistical analysis using One-Way ANOVA show that the implementation of the DAMAI Model based on religious moderation is significantly effective in improving students' integrated mental health. This is proven through a comparison of changes in scores (delta = post-test 2 - pre-test) between the treatment group and the control group, with a p-value <0.05 in all dependent variables, namely resilience ($F = 41.33$, $p = 4.69 \times 10^{-8}$), hope ($F = 92.07$, $p = 6.33 \times 10^{-13}$), self-efficacy ($F = 52.85$, $p = 2.27 \times 10^{-9}$), quality of life ($F = 292.55$, $p = 1.55 \times 10^{-22}$), social support ($F = 29.93$, $p = 1.43 \times 10^{-6}$), and integrated mental health ($F = 49.52$, $p = 5.24 \times 10^{-9}$). The average change in scores in the treatment group (resilience: +5.80; hope: +13.00; self-efficacy: +9.96; quality of life: +24.40; social support: +4.32; integrated mental health: +12.68) was consistently higher than the control group (resilience: +2.15; hope: +4.56; self-efficacy: +3.37; quality of life: +6.81; social support: +1.52; integrated mental health: +5.44). This finding confirms that the DAMAI Model, which integrates the values of religious moderation through the components of Dialogue, Attitude, Moderation, Action, and Inclusive, is able to provide a significant positive impact on optimizing students' integrated mental health. This means that hypothesis 1 is proven: Implementation of the DAMAI Model based on religious moderation is effective in optimizing students' integrated mental health.

ANOVA analysis on the treatment group showed a significant difference between pre-test and post-test 2 scores on all dependent variables, with a p-value < 0.05. These results were seen in resilience ($F = 180.21$, $p = 1.19 \times 10^{-12}$), hope ($F = 284.83$, $p = 8.12 \times 10^{-15}$), self-efficacy ($F = 126.92$, $p = 4.56 \times 10^{-11}$), quality of life ($F = 804.54$, $p = 5.70 \times 10^{-20}$), social support ($F = 83.91$, $p = 2.65 \times 10^{-9}$), and integrated mental health ($F = 268.39$, $p = 1.57 \times 10^{-14}$). There was a finding of a positive increase in the average score in the treatment group after receiving the DAMAI Model intervention, indicating that the treatment resulted in statistically significant changes in all aspects of mental health measured. The religious moderation-based approach in the DAMAI Model was proven to be able to strengthen students' resilience, hope, self-efficacy, quality of life, social support, and integrated mental health. This means that hypothesis 2: There are significant differences in integrated mental health variables, including resilience, hope, self-efficacy, quality of life, and social support of students before and after treatment.

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