

Development of a Trauma-Based Psychoeducation Module to Strengthen Adaptive Coping and Student Resilience in Conflict-Affected Areas of Papua: An ADDIE Approach

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Abstract

The absence of structured, evidence-based, and contextually appropriate psychoeducational materials for student survivors of armed conflict in Papua motivates the development of a psychosocial intervention module that can be delivered by non-clinical facilitators amid the scarcity of mental health professionals. This developmental study aimed to design, develop, and describe the operational feasibility of the Psychoeducation Module "Strengthening Adaptive Coping and Resilience of Students in Conflict-Affected Areas of Papua" using the ADDIE model (Analysis, Design, Development, Implementation, Evaluation; Branch, 2009). The module was grounded in an integration of Lazarus and Folkman's (1984) transactional coping theory, Carver, Scheier, and Weintraub's (1989) coping taxonomy, Masten's (2014) and Rutter's (1987) resilience theory, Bandura's (1997) self-efficacy theory, Hobfoll et al.'s (2007) five essential elements of mass trauma intervention, and trauma-informed care principles (SAMHSA, 2014), with each session explicitly mapped to Brief COPE and CD-RISC-10 dimensions to ensure content validity. The module was structured as a 5-day intensive program (4 hours/day, 20 hours total) combining psychoeducational content, structured experiential games, and reflective worksheets. Field implementation involved 30 experimental-group students at SMPN Bamusbama, Tambrau Regency, Southwest Papua. Results showed the module could be fully delivered by trained non-clinical facilitators with 100% participant retention through posttest, accompanied by statistically and practically meaningful increases in coping and resilience scores among module recipients (large effect sizes, $d = -0.910$ and $d = -1.090$). However, the development process had not yet included a formal expert-judgment content validation stage prior to implementation, and controlled comparison showed this improvement was not yet proven significantly different from the non-recipient group. The module is therefore a theoretically grounded, operationally feasible candidate product that requires formal expert validation and controlled effectiveness testing with larger samples before it can be recommended for wider replication.

Keywords: Module Development; Trauma-Based Psychoeducation; ADDIE; Stress Coping; Resilience

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Introduction

The prolonged armed conflict in parts of Papua has placed school-aged children and adolescents at high psychological risk (Paci-Green et al., 2020; Laycock et al., 2021; Yoshikawa et al., 2018). The population exposed to conflict and forced to evacuate is largely dominated by school-aged children who have also lost access to education and health services. In Bamusbama District, Tambrau Regency, the local Education Office recorded 177 elementary and junior high school-aged displaced children in 2025, with school closures that

lasted up to eight months, and the conflict continued in February 2026, once again halting learning activities for three months.

Repeated exposure to armed conflict among students has a high potential to trigger symptoms of post-traumatic stress disorder, anxiety, depression, and declining academic achievement (Betancourt & Khan, 2008), while communities in conflict-affected areas of Papua have generally not received adequate psychological support each time conflict escalation occurs, consistent with experiences of mass trauma interventions in various other conflict- and disaster-affected areas in Indonesia, which indicate that systematic psychological support still rarely reaches affected communities (Latipun, 2014).

One form of intervention relevant to conditions involving limited mental health professionals is trauma-informed psychoeducation, namely a structured psychosocial intervention that provides information about normal psychological reactions to traumatic events, accompanied by training in coping skills and strengthening protective resources, with the aim of facilitating post-trauma psychological recovery. Unlike clinical psychotherapy, psychoeducation is designed to be implemented by nonclinical facilitators who have received brief training guidance and counseling teachers, psychology students, or trained volunteers making it more feasible to implement in areas with limited access to professional psychologists or counsellors.

The theoretical foundation for developing such psychoeducational materials generally follows framework of trauma recovery stages, which identifies psychoeducation as an important component of the first stage of recovery (establishing safety and stabilization), as well as five principles of mass trauma recovery safety, calmness, self- and collective efficacy, social connectedness, and hope integrated with the principles of trauma-informed care, which emphasize safety, trust, peer support, collaboration, empowerment, and cultural sensitivity.

The systematic development process of psychosocial intervention modules or programs commonly refers to instructional design models, one of which is the ADDIE model (Analysis, Design, Development, Implementation, Evaluation), which enables modules to be developed sequentially, from needs analysis to evaluation of implementation outcomes. A community-based psychoeducation module development approach using such a systematic framework has been applied in various contexts in Indonesia, for example, psychological preparedness and community resilience modules for tsunami-prone coastal communities (Rahmawan et al., 2026) and post-disaster trauma healing interventions combining art therapy and relaxation. Nevertheless, trauma-informed psychoeducation modules that are explicitly mapped onto standardized psychological instrument constructs (Brief COPE and CD-RISC-10) while also being designed to be culturally sensitive to the Papuan context for student populations in areas of active armed conflict remain relatively scarce in the literature.

Based on this gap, this article aims to describe the process and results of developing the Psychoeducation Module "Strengthening Adaptive Coping and Student Resilience in Conflict-Affected Areas of Papua" through the stages of the ADDIE model, including the theoretical foundation for the development of the materials, the structure and content of the final product, and the results of the operational feasibility evaluation in an initial field trial. This article focuses on the development process and description of the module product as a candidate psychosocial intervention and is not intended to establish claims of the module's causal effectiveness under controlled conditions the discussion of controlled effectiveness testing is reported separately and in greater detail in an accompanying study on the effectiveness of psychoeducation on students' stress coping and resilience (see Kurniawati, Latipun, & Anwar, in a separate publication process).

Methods

Research Design

This study is a research and development study that adapts the ADDIE model (Analysis, Design, Development, Implementation, Evaluation) to develop a trauma-informed psychoeducation module. The ADDIE stages in this study were carried out through the Implementation and Evaluation stages in the form of a field trial with the target group, but had not yet undergone formal content validation through expert judgment prior to implementation this limitation is further explained in the Discussion section.

Trial Subjects

The field trial was conducted with 30 students in the experimental group at SMPN Bamusbama, Bamusbama District, Tambrau Regency, Southwest Papua Province part of a total of 60 students in Grades VII-IX (12-16 years old) who participated in the broader study on this psychoeducation program, with the other 30 students serving as a control/waitlist group that received the identical module after data collection was completed. The subjects were selected based on the following inclusion criteria: being active students in Grades VII-IX; being indigenous residents or residing in conflict-affected areas; obtaining written consent from parents/guardians; and being willing to participate in the entire program series.

Development Procedures and Data Collection Techniques

Data at the Analysis and Design stages were collected through document review (data from the local Education Office and reports from humanitarian organizations) and a theoretical-empirical literature review on stress coping, resilience, and trauma-informed psychoeducation. At the Development stage, the materials were prepared based on explicit mapping of the Brief COPE dimensions and the CD-RISC-10 aspects and were organized into session scripts, student worksheets, and facilitator guidelines. At the Implementation stage, the module was tested with the experimental group in an intensive program conducted over 5 consecutive days, with operational feasibility data collected through observations of session implementation by facilitators, daily facilitator evaluation sheets, and program feedback forms from students. At the Evaluation stage, product feasibility was assessed formatively through observations of the implementation process and summatively through comparisons of pretest-posttest scores on the Brief COPE and CD-RISC-10 among the group receiving the module, as one of the initial indicators of the product's potential benefits not as sole causal evidence, given that the study design was not intended to isolate the effect of the module from other factors outside the recipient group.

Data Analysis

The development process data (Analysis, Design, and Development stages) were analyzed descriptively and qualitatively to describe the module product generated at each stage. Field trial data (Implementation-Evaluation stages) were analyzed descriptively (participant retention and session implementation) and inferentially using a Paired Samples t-Test and Cohen's d effect size (Cohen, 2013) for the pretest-posttest scores of the group receiving the module, as initial indicators of product feasibility and potential benefits.

Results and Discussion

Analysis Stage (Needs Analysis)

The needs analysis confirmed the dual gaps underlying the development of this module. First, the continuing escalation of conflict in Papua, including Bamusbama District, requires systematic psychological services for students, yet many areas still do not provide structured psychological support services Bamusbama District itself recorded 177 displaced elementary

and junior high school children in 2025, with a history of school closures lasting up to eight months. Second, students are the most vulnerable group while also being the most critical to the continuity of education and psychosocial recovery in post-conflict areas, meaning that interventions need to be focused and deepened for this group, while generally available psychoeducation materials have not been specifically mapped onto measurable coping and resilience constructs or made sensitive to the Papuan cultural context. The results of this analysis became the basis for formulating the objectives and content of the module at the Design stage.

Design Stage (Design)

The Design stage produced the formulation of program objectives, participant targets, and a framework for mapping the materials onto theoretical constructs. The general objective of the module is to increase the stress-coping capacity and resilience of student survivors of armed conflict through structured, tiered, interactive, and culturally sensitive psychoeducation, implemented through an intensive 5-day program. Eight specific objectives were formulated, including: (a) students' understanding of normal psychological reactions following abnormal events; (b) scientific understanding of stress coping and resilience; (c) the ability to independently practice at least two self-calming techniques; (d) the ability to use problem-focused coping strategies (active coping, planning); (e) the ability to use adaptive emotion- and socially focused coping strategies (reframing, social support, healthy humor, spirituality) while recognizing maladaptive patterns within themselves; (f) strengthening hardiness, stress tolerance, and self-efficacy; (g) strengthening cognitive adaptability, social connectedness, and hope for the future, accompanied by a plan for the sustainability of peer support; and (h) knowledge of basic preparedness steps before, during, and after armed conflict occurs. The target participants were students in Grades VII-IX (12-16 years old), conducted in groups of a maximum of 20-30 students so that interaction and support could remain optimal.

The psychoeducation materials were designed based on two main theoretical frameworks, which were then explicitly mapped onto the dimensions of the research instruments (Table 1). The stress-coping materials referred to the taxonomy of Carver et al. (1989), which is multidimensional and operational, allowing each dimension to be directly translated into concrete skills-training activities. The resilience materials referred to the perspective of Masten (2014), which views resilience as the result of the functioning of basic human adaptive systems (ordinary magic) that can be developed through structured interventions, including factors of self-efficacy (Locke, 1997), hardiness and cognitive flexibility (Rutter, 1987), as well as support from supportive figures and communities (Werner & Smith, 1992).

Table 1. Mapping of Psychoeducation Materials to Stress Coping and Resilience Constructs (Summary)

Construct	Theoretical Basis	Aspect/Dimension	Example of Material
Stress Coping	Carver et al. (1989)	Active coping & Planning (problem-focused)	Graduated problem-solving skills training; simulation of everyday conflict cases
Stress Coping	Carver et al. (1989)	Positive reframing & Acceptance (cognitive)	Cognitive restructuring; exercises to examine automatic thoughts following conflict
Stress Coping	Carver et al. (1989)	Emotional & instrumental support (social)	Social support network mapping; assertive

			communication role-play for asking for help
Stress Coping	Carver et al. (1989)	Religion & Humor (contextual-cultural)	Strengthening meaning-based coping through local spirituality and adaptive humor
Stress Coping	Carver (1997); Compas et al. (2001)	Denial, disengagement, self-blame (maladaptive)	Psychoeducation for self-awareness (self-monitoring) of maladaptive coping patterns
Resilience	Masten (2014); Rutter (1987)	Hardiness & stress tolerance (hardiness)	Hardiness training through structured group challenges
Resilience	Locke (1997)	Self-efficacy & self-control	Strengthening self-efficacy through mastery experience, peer modeling, and verbal persuasion
Resilience	Masten (2014); Rutter (1987)	Adaptability & cognitive flexibility	Reframing difficult situations; hope-building; peer sustainability plans

Note: Summarized from the complete mapping matrix used as the basis for developing the session scripts (Development stage).

The above material design was then integrated into a five-day program structure following the five principles of mass trauma recovery proposed by Hobfoll et al. (2007) safety, calmness, self-efficacy, social connectedness, and hope so that each implementation day had an explicit relationship with the aspects/dimensions of stress coping and/or resilience constructs targeted for achievement, as summarized in Table 2.

Table 2. Structure of the 5-Day Intensive Program

Day	Main Focus	Main Content
1	Opening, Safety, and Understanding Coping-Resilience	Pretest; psychoeducation on normal post-trauma reactions; basic materials on stress coping and resilience; armed-conflict preparedness
2	Calmness and Active Coping	Stabilization/relaxation techniques (abdominal breathing, 5-4-3-2-1 grounding); active coping and planning (Brief COPE)
3	Social Connectedness, Advanced Adaptive Coping, and Self-Awareness	Reframing; social support mapping; assertive communication for asking for help; awareness of maladaptive coping patterns
4	Hardiness and Self-Efficacy	Hardiness training; Locke's (1997) four sources of self-efficacy: mastery experience, peer modeling, verbal persuasion, emotion regulation
5	Cognitive Flexibility, Hope, Consolidation, Posttest, and Closing	Adaptability and hope-building (Hope Tree, Hope Compass); integrated simulation; sustainability plan; posttest; evaluation and closing

Note: Total program duration was 20 hours (4 hours/day × 5 days). The control group did not receive the program during the research period but received the identical program after all data collection had been completed (waitlist).

Development Stage (Product Development)

The final module product was organized into five chapters. Chapter 1 contains the introduction to the module: background, general and specific objectives, target participants, and program structure. Chapter 2 contains general facilitator guidelines, including facilitator qualifications and numbers (1 main facilitator with a bachelor's/master's degree in psychology, a guidance and counseling teacher, or personnel trained in trauma-informed psychoeducation, assisted by 2 co-facilitators/local assistants per group of 20-30 students), nine basic implementation principles (six trauma-informed care principles from SAMHSA safety, trust, peer support, collaboration, empowerment, and cultural sensitivity complemented by three additional operational principles, namely voluntariness, confidentiality, and daily energy management), room arrangement and equipment, the general format for each day, referral protocols for students showing signs of severe distress, and ethical considerations for the control group, which remained entitled to receive the identical program after data collection was completed.

Chapter 3 contains basic knowledge materials on stress coping, resilience, and armed-conflict preparedness simplified using language and contextual examples appropriate for students in Grades VII-IX, supplemented with scientific references to ensure academic accountability. Chapter 4 contains detailed minute-by-minute implementation of the five-day program, daily learning objectives, main activities, and supporting structured games (e.g., the "Anchored Ship" grounding technique, the "Resilience Tower" game to train hardiness, the "I Have Succeeded Before" activity for mastery experience, the "Hope Tree" and "Hope Compass" for hope-building), accompanied by daily summative questions with answer keys for facilitators to check students' understanding. Chapter 5 contains daily facilitator evaluation sheets for formative monitoring of program implementation. The appendices contain the research blueprint and scales (Brief COPE, CD-RISC-10), student worksheets (Small Steps Map, My Support Map, I Have Succeeded Before Card, My Hope Commitment), as well as activity documentation.

The distinctive features of the developed module include experiential learning through structured games in every session, so that conceptual psychoeducation materials are practiced concretely and enjoyably by school-aged adolescents; cultural sensitivity, through the involvement of local assistants who understand the local language and culture and the integration of elements of Papuan spirituality and local customs into reframing and meaning-making sessions (meaning-based coping); voluntariness and confidentiality, in which students are never forced to describe traumatic experiences in detail; and daily energy management through energizers/ice breakers at every transition between activities, considering that a duration of 4 hours per day is relatively long for adolescents.

Implementation Stage (Field Trial)

The module was tested with 30 students in the experimental group at SMPN Bamusbama for five consecutive days, 4 hours per day (20 hours in total), and was implemented by facilitators according to the qualifications established in Chapter 2 of the module. All 30 students in the experimental group (and 30 students in the control group who only participated in the pretest-posttest measurements) maintained their participation through the posttest, resulting in a 100% retention rate a logistical and ethical achievement that is not insignificant given that the implementation took place in an area that had experienced total cessation of teaching and learning activities due to armed conflict eight and three months previously. The sequence of sessions, games, and worksheets in Chapter 4 of the module was implemented according to the planned schedule. In accordance with research ethics, the control group received the identical psychoeducation program after the entire data collection process (pretest and posttest) had been completed (waitlist control principle).

Evaluation Stage (Product Evaluation)

Summative evaluation was conducted through comparisons of Brief COPE and CD-RISC-10 pretest-posttest scores among students who received the module (experimental group). The paired samples t-test results showed a significant increase from pretest to posttest in stress coping ($t = -4.985$; $df = 29$; $p < 0.001$; Cohen's $d = -0.910$, large effect) and resilience ($t = -5.970$; $df = 29$; $p < 0.001$; Cohen's $d = -1.090$, large effect), as summarized in Table 3. These findings indicate that students who received the module experienced substantial changes in stress coping and resilience scores during the program and provide one initial indicator that the module product has the potential to benefit participants.

Table 3. Summative Evaluation Results: Pretest-Posttest Scores of the Module Recipient Group ($n = 30$)

Variable	M Pretest	M Posttest	t	p	Cohen's d	Interpretation
Stress Coping	57.27	82.73	-4.985	<0.001	-0.910	Large effect
Resilience	10.27	23.13	-5.970	<0.001	-1.090	Large effect

Note: $df = 29$. The data refer to the same broader study; the figures are identical to those of the experimental group in the controlled effectiveness study (see note in the Discussion section).

As an important note for interpreting the product evaluation results, a direct comparison with students who did not receive the module (the control group in the same broader study) showed that the control group also experienced significant increases in stress coping and resilience scores during the same period, and the magnitude of the increase (gain score) between the two groups had not been shown to differ significantly statistically (stress coping: $p = 0.740$; resilience: $p = 0.063$). Therefore, the increase in pretest-posttest scores in Table 3 should be interpreted as an indicator of operational feasibility and the potential benefits of the module for its recipients, rather than as confirmed causal evidence that the module was specifically superior to no intervention; establishing causal effectiveness requires a controlled comparative design, which is reported separately and in greater detail.

Formative evaluation through the daily facilitator evaluation sheets and student feedback forms at the end of the program (Chapter 5 and Day 5 of the module) indicated that the sequence of sessions, games, and worksheets could be implemented according to the planned schedule by trained nonclinical facilitators, without requiring major revisions to the structure or sequence of sessions during the trial period. The module was also equipped with a referral protocol for students showing signs of severe distress (e.g., uncontrollable crying, dissociation, expressions of self-harm) to professional personnel prepared before the program began, as part of the trauma-informed care principles applied operationally.

Discussion

The development process of this module demonstrates several strengths that are consistent with best practices in trauma-informed psychoeducation design. First, in terms of content validity, each session and activity in the module was explicitly mapped onto the dimensions of the Brief COPE (Carver, 1997) and aspects of the CD-RISC-10 (Campbell-Sills & Stein, 2007), rather than being mechanically constructed according to the items of the instruments, but instead derived from the theoretical frameworks underlying the two constructs (Carver et al., 1989; Masten, 2014; Rutter, 1987; Locke, 1997). This explicit mapping approach strengthens the alignment between what is trained and what is measured, an aspect that is often overlooked in the development of psychoeducation modules constructed more loosely. Second, in terms of cultural sensitivity, the module involved local assistants who understand the local language and

culture and integrated elements of Papuan spirituality and customs into reframing and meaning-making sessions — consistent with the emphasis of Latipun (2014) and the Faculty of Psychology UMM that mass trauma interventions that consider sociocultural contexts and involve local facilitators tend to be more meaningful and sustainable, as well as relevant to the strong customary and religious ties within Papuan communities.

Third, in terms of program structure, the integration of the five principles of mass trauma recovery proposed by Hobfoll et al. (2007) into the five-day implementation framework safety on the first day, calmness on the second day, social connectedness on the third day, self-efficacy on the fourth day, and hope on the fifth day provides a logical sequence consistent with the principles of trauma-informed care, in which participants need to feel safe and understand their reactions before they are ready to effectively practice coping skills. Such a tiered structure is comparable to community psychoeducation module approaches for psychological preparedness in other disaster contexts in Indonesia (Rahmawan et al., 2026) and post-disaster trauma healing interventions, which also emphasize the importance of a gradual sequence from stabilization toward strengthening adaptive skills.

The field trial results indicate that the module is operationally feasible: the 20-hour program could be fully implemented by trained nonclinical facilitators in an area with limited infrastructure and that had only recently recovered from a total cessation of school activities due to conflict, with perfect participant retention (100%) through the posttest. This achievement is important to note given that the implementation of structured psychosocial programs in active conflict areas often faces significant logistical and security challenges. The significant and large increases in stress coping and resilience scores ($d = -0.910$ and $d = -1.090$) among students receiving the module also provide an initial indicator supporting the product's potential benefits.

Nevertheless, several important limitations need to be emphasized so that the status of this module is not misunderstood. First and most importantly, the development process followed the ADDIE stages through the field trial (Implementation-Evaluation), but had not undergone formal content validation through expert judgment prior to implementation. The module and instruments used therefore constitute candidates that have been operationally tested in the context of this study, but their content validity among junior high school students in the Papuan cultural context has not been independently verified beyond readability testing among several students. Second, as emphasized in the summative evaluation results, the increase in pretest-posttest scores in the module recipient group cannot directly be interpreted as evidence of the module's causal effectiveness, because the controlled comparison in the same broader study showed that the group that did not receive the module also experienced significant increases, and the magnitude of the increase between groups had not been shown to differ statistically. The error that needs to be avoided by readers and prospective module users is equating "operational feasibility and score changes among recipients" with "demonstrated causal effectiveness" two methodologically different concepts. Third, the field trial was conducted at only one location (SMPN Bamusbama) with a single implementation cycle without iterative revision based on expert evaluation, meaning that generalization of the product to other conflict-affected areas of Papua, which may have different cultural and conflict characteristics, needs to be approached cautiously.

Its practical implication is that this module is most appropriately positioned as a candidate product grounded in strong theory and demonstrated to be operationally feasible, but it cannot yet be recommended as a demonstrably effective psychoeducation module for broad replication without further validation. Schools and Education/Health Offices interested in implementing

this module are advised to treat it as a pilot program accompanied by continuous evaluation using a stronger research design.

Conclusion

The Psychoeducation Module "Strengthening Adaptive Coping and Student Resilience in Conflict-Affected Areas of Papua" was successfully developed through the stages of the ADDIE model Analysis, Design, Development, Implementation, and Evaluation with a strong theoretical foundation and explicit content mapping to the Brief COPE and CD-RISC-10 constructs. The final product consists of a five-chapter module containing facilitator guidelines, basic knowledge materials, detailed implementation of the five-day intensive program, evaluation sheets, and student worksheet appendices, designed to be implemented by trained nonclinical facilitators and to be sensitive to the Papuan cultural context. The field trial involving 30 students in the experimental group at SMPN Bamusbama showed that the module could be fully implemented with 100% participant retention, accompanied by significant and practically meaningful increases in stress coping and resilience scores among module recipients. Nevertheless, the development process did not include formal expert content validation prior to implementation, and the increase in scores among module recipients had not been shown to differ significantly from the group that did not receive the module in the controlled comparison. The module therefore remains a candidate product that is operationally feasible, rather than an intervention whose effectiveness has been scientifically demonstrated.

Suggestion

Further research and development are recommended to: (1) complete the ADDIE process with formal content validation through expert judgment, involving clinical/trauma psychology experts and Papuan cultural experts, before the module is replicated more broadly; (2) independently test the validity and reliability of the Brief COPE and CD-RISC-10 instruments in junior high school student populations within the Papuan cultural context; (3) conduct iterative revisions of the module based on expert evaluation results and field feedback from several implementation cycles, consistent with the nature of the ADDIE model that allows continuous refinement; (4) test the effectiveness of the module through a controlled design with a larger sample, as reported in the accompanying study on program effectiveness; (5) expand trials to several other conflict-affected areas of Papua to assess the generalizability and cultural adaptability of the product; and (6) systematically document the use of referral protocols in future implementations as part of program safety monitoring. Practically, this module can continue to be examined and further tested as one candidate model of psychosocial intervention for students in conflict-affected areas of Papua, while ensuring the availability of trained facilitators, consistency with trauma-informed care principles, and referral protocols for students requiring further support.

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