Psychology Units 3 & 4

Chapter 9 — Mental wellbeing

Aboriginal and Torres Strait Islander content has been excluded as accuracy cannot be guaranteed, and it is better to be respectful than cover the entire curriculum inaccurately.

Significant effort has been made to ensure this content is legal. Please send any areas of concern to admin@vwx.au with appropriate document/legal references so errors can be verified and changes be made.

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Chapter 9 Mental wellbeing — 9A Defining mental wellbeing: functioning, resilience and SEWB

Theory

Mental wellbeing is not a single, fixed thing that a person simply has or does not have. It can be **considered — or conceptualised — in more than one way**, and different ways of considering it draw attention to different features of a person's life. This subtopic covers **three ways of considering mental wellbeing**: **levels of functioning**, **resilience**, and **social and emotional wellbeing (SEWB)**. They are not competing "tests" that give a single score; they are different **lenses** through which the same person's wellbeing can be understood.

Levels of functioning and resilience are two ways of considering wellbeing; SEWB is a distinct, holistic framework used by and for Aboriginal and Torres Strait Islander peoples.

1. Levels of functioning. A person's **level of functioning** is **how well they carry out the day-to-day activities of life — independently and effectively**. This includes activities such as **work or study**, **maintaining relationships**, **self-care** and a daily routine, and **adapting to the everyday demands** placed on them.

- A person with **high functioning** is able to meet the demands of daily life **independently and effectively** — they manage their responsibilities, relationships and self-care without undue difficulty.
- A person with **low or impaired functioning** finds these day-to-day activities **difficult** and may struggle to manage them, or need support to do so.

Level of functioning is used as **one indicator of mental wellbeing**: high functioning is generally associated with **higher** mental wellbeing, and low or impaired functioning with **lower** mental wellbeing. The key idea to keep straight is that functioning describes a person's **current, day-to-day capability** — how well they are managing the activities of life **right now**.

2. Resilience. Resilience is the **ability to cope with and manage change and uncertainty**. Life regularly brings change a person did not choose and cannot fully predict — illness in the family, a move, a setback, a stretch of waiting to find out what happens next — and resilience is what allows a person to **meet that change, and the uncertainty that comes with it**, without their mental wellbeing being overwhelmed, and to **adapt and restore positive functioning** over time. A resilient person is **not** someone who never experiences difficulty — they still feel stress and are affected by hard events — but they are able to **cope with what has changed** and **manage the not-knowing** it brings.

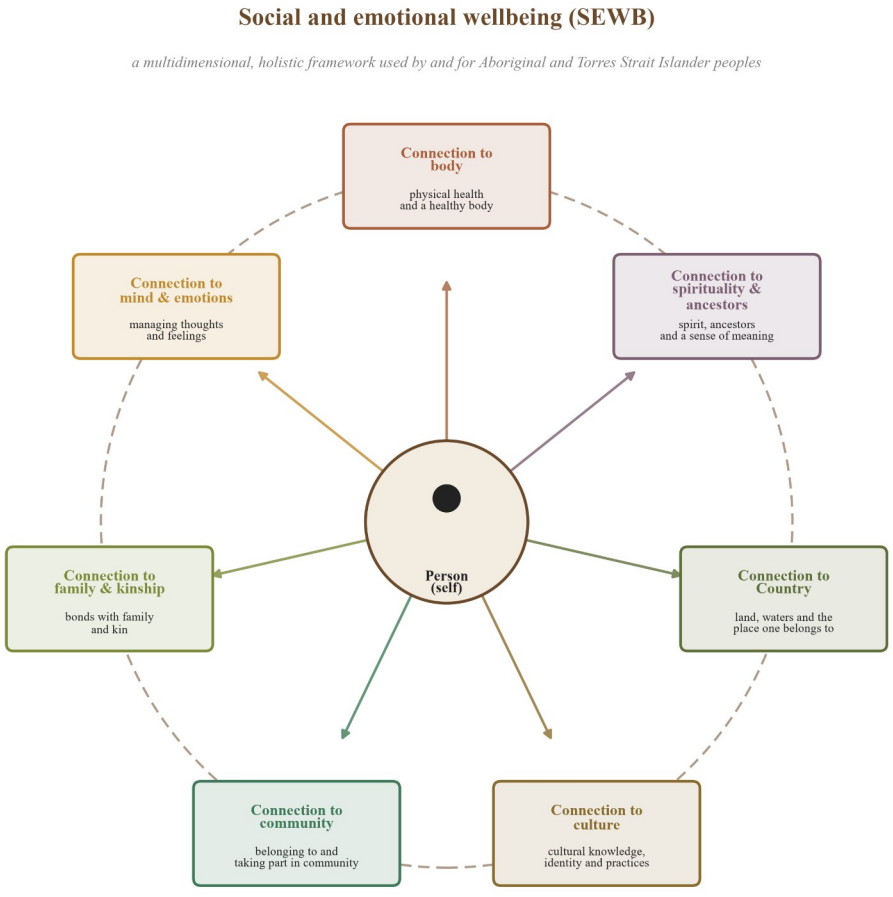
- Resilience is an **ability** — a general **capacity** a person can draw on **whenever** change and uncertainty arise. It is **not** a single coping strategy or a one-off response to one event; defining resilience as "a way of coping with a problem" is a commonly penalised error.
- Resilience is **influenced by protective factors** — for example **supportive relationships**, good **coping skills**, and access to help — which make it easier to cope with and manage change.
- Resilience **can be developed and strengthened** over time; it is **not a fixed trait** a person is simply born with or without.

The key contrast to hold onto is this: **levels of functioning** describe a person's **current capability** — how they are managing right now — whereas **resilience** describes their **ability to cope with and manage change and uncertainty** when that capability is disrupted. A person can be functioning well now, and resilience is what allows them to manage, adapt and restore that functioning if things change later.

3. Social and emotional wellbeing (SEWB). Social and emotional wellbeing is a **multidimensional and holistic framework for wellbeing used by and for Aboriginal and Torres Strait Islander peoples**. Rather than treating wellbeing as something located inside one individual's mind (as an individual "mental health" focus tends to), SEWB understands wellbeing as arising from a **web of interconnected connections**. Wellbeing is **strong when these connections are strong**, and can be harmed when a connection is disrupted. It is a **holistic and collective** view — broader than a focus on an individual's "mental health" alone.

The framework recognises **seven domains of connection**:

- **connection to body** — physical health and a healthy body;
- **connection to mind and emotions** — the ability to manage one's thoughts and feelings;
- **connection to family and kinship** — bonds with family and kin;
- **connection to community** — belonging to, and taking part in, community;
- **connection to culture** — connection to cultural knowledge, identity and practices;
- **connection to Country** — connection to the land, waters and the place a person belongs to;
- **connection to spirituality and ancestors** — connection to spirit, ancestors and a sense of meaning.



Wellbeing is strong when these connections are strong — a holistic, collective view, broader than an individual focus on 'mental health' alone.

Because SEWB draws on **many interconnected domains at once**, it is **multidimensional and holistic**; and because it centres **family, community, culture, Country and spirit** — not just the individual — it is a **collective** view of

wellbeing. Wellbeing depends on the **whole web** of connections being strong, so this framework considers wellbeing much more **broadly** than levels of functioning or resilience considered on their own.

A note on respectful, accurate language. Use **Aboriginal and Torres Strait Islander peoples** (plural "peoples", recognising many distinct nations and language groups); capitalise **Country** and **Elders**. Present SEWB as a **valid, sophisticated and holistic framework** — never as merely "a belief" or as less developed than an individual mental-health view. Keep the domains **general**: do not invent, or attribute, specific cultural practices to particular communities.

How to use each way of considering wellbeing. (1) **Levels of functioning** — ask *how well is the person carrying out day-to-day activities (work/study, relationships, self-care) independently and effectively right now?* (2) **Resilience** — ask *how well can the person cope with and manage the change and uncertainty they are facing, and what protective factors support this?* (3) **SEWB** — consider wellbeing **holistically**, across the seven connections, as a framework **used by and for Aboriginal and Torres Strait Islander peoples**.

Worked examples

Example 1 — scaffolded

Tomas, 30, usually works full-time, cooks his own meals, exercises several times a week and catches up with friends. Over the past two months his mental wellbeing has declined: he now rarely leaves the house, has stopped exercising, has missed several days of work and no longer replies to friends. (a) Identify two day-to-day activities in which Tomas's functioning has declined. (b) State whether Tomas is currently showing high or low functioning, and why. (c) Explain how level of functioning is being used here as an indicator of mental wellbeing.

Working	Comment
(a) Any two of: **work** (missing days), **self-care / exercise** (stopped exercising, rarely leaving home), **relationships** (not replying to friends).	Pick activities named in the stimulus — always link to the scenario.
(b) **Low / impaired functioning** — Tomas can no longer carry out day-to-day activities **independently and effectively**.	Judge functioning against the "independently and effectively" test.
(c) His **reduced ability to manage everyday activities** is taken as a **sign of lowered mental wellbeing**; if he were managing them well, that would indicate higher wellbeing.	State the *link*: functioning is an indicator of wellbeing, not wellbeing itself.

Example 2 — scaffolded

Explain what is meant by describing social and emotional wellbeing (SEWB) as a "multidimensional and holistic framework", and identify the seven domains of connection it recognises.

Working	Comment
State whose framework it is: SEWB is used **by and for Aboriginal and Torres Strait Islander peoples**.	Name the framework's ownership accurately and respectfully.
Define **multidimensional / holistic**: wellbeing arises from a **web of many interconnected connections** considered **together as one whole**, not from a single dimension.	"Multidimensional" = many domains; "holistic" = considered as one connected whole.
List the **seven connections**: to **body**; **mind and emotions**; **family and kinship**; **community**; **culture**; **Country**; and **spirituality and ancestors**.	Learn all seven; capitalise Country.
Add the framing: wellbeing is **strong when the connections are strong** — a **collective** view, broader than an individual "mental health" focus.	This is the mark-worthy idea that sets SEWB apart.

Example 3 — unscaffolded

Mia's workplace is being restructured. She has been told her team will change, but not whether her own role will continue, and no decision is expected for several months. Using resilience, explain what would help Mia maintain her mental wellbeing over this period.

Resilience is the **ability to cope with and manage change and uncertainty**, so it is the way of considering wellbeing that Mia's situation calls for: the restructure is a **change** she did not choose, and the months of waiting are a period of **uncertainty** she cannot resolve herself. Her resilience would show not in the restructure never affecting her — a resilient person still feels the stress — but in her being able to **manage the not-knowing** while it lasts: keeping up her work, routines and relationships as far as she can, and **adapting** as each change is announced, so that her **positive functioning is restored** rather than lost. That ability is **supported by protective factors** — **supportive relationships** with family, friends and colleagues, good **coping skills**, and access to help if she needs it — and because resilience **can be developed**, these are things Mia can build up now rather than qualities she simply has or lacks. ∴ Mia's wellbeing through the restructure depends less on the outcome itself than on her **ability to cope with and manage the change and uncertainty** it brings, which her protective factors can strengthen.

Example 4 — unscaffolded

An Aboriginal community-controlled health service, working with local Elders, runs a wellbeing program that supports young people to spend time with family and community and to strengthen their connection to culture. Using the SEWB framework, explain why this program would be expected to support wellbeing.

Under the **SEWB framework**, wellbeing is understood as arising from a **web of interconnected connections**, and wellbeing is **strong when those connections are strong**. This program strengthens several of the SEWB domains at once — **connection to family and kinship** and **connection to community** (spending time with family and community), and **connection to culture** (strengthening cultural knowledge and identity). Because SEWB is **multidimensional and holistic**, supporting several connections together supports a person's **overall** wellbeing, not just one part of it; and because the program is designed **with Elders and community**, it reflects a framework used **by and for Aboriginal and Torres Strait Islander peoples**. ∴ by strengthening the connections that SEWB identifies, the program would be expected to support the young people's social and emotional wellbeing.

Practice questions

Scaffolded

Q1. Define each of the following ways of considering mental wellbeing: (a) levels of functioning; (b) resilience; (c) social and emotional wellbeing (SEWB).

Q2. Marcus has recently started a demanding new job. He works long hours and often feels tired and under pressure, but he is meeting his deadlines, still cooks for himself most nights, trains with his football club each week, and sees his friends on the weekend. (a) State whether Marcus is currently showing high or low functioning, and give a reason. (b) Identify one change in the scenario that would lead you to judge that his functioning had become impaired. (c) Explain why feeling tired and under pressure does not, on its own, mean that Marcus's level of functioning is low.

Q3. Aisha's family home was badly damaged in a flood and the family had to move twice within a year. At first Aisha felt overwhelmed and struggled at school, but she drew on support from her family and a school counsellor, kept up her routines where she could, and after several months had settled into her new school and returned to her usual activities. (a) Identify the source of change and uncertainty Aisha faced. (b) Explain how Aisha's response shows resilience. (c) Identify one protective factor that supported her resilience.

Q4. Consider the SEWB framework. (a) State who the SEWB framework is used by and for, and give two words that describe the kind of framework it is. (b) Name the seven domains of connection recognised in SEWB. (c) Explain why SEWB is described as "holistic".

Q5. For each of the following, name which way of considering mental wellbeing (levels of functioning, resilience, or SEWB) is being used, and give a reason: (a) a support worker notes that a client is again shopping, cooking and getting to work on time; (b) a counsellor asks how well a person has been able to cope with and manage a long period

of uncertainty after a family separation; (c) an Aboriginal community-controlled wellbeing service asks a young person how strong they feel their connections to family, community, culture and Country are.

Q6. For each of the following, name the SEWB domain of connection being described: (a) a person's link to the land, waters and the place they belong to; (b) a person's bonds with family and kin; (c) a person's connection to cultural knowledge, identity and practices.

Unscaffolded

Q7. Distinguish between levels of functioning and resilience as ways of considering mental wellbeing. *(2 marks)*

Q8. Explain how levels of functioning can be used as an indicator of a person's mental wellbeing. *(2 marks)*

Q9. For the past month, Noah has been unable to keep up with his university assignments, has stopped cooking proper meals, and has cancelled plans with friends. Using levels of functioning, explain what this suggests about Noah's mental wellbeing. *(3 marks)*

Q10. After a serious injury ended Daniel's hopes of making a representative sports team, he felt very low for some weeks. With support from his coach and family he set new goals, took up coaching a junior team, and within a few months felt positive and engaged again. Explain how Daniel's response illustrates resilience. *(3 marks)*

Q11. Explain why resilience is described as something that can be **developed**, and identify how protective factors are related to resilience. *(2 marks)*

Q12. Explain why the SEWB framework is described as a **collective** view of wellbeing, and state one way this differs from considering a person's wellbeing only as their individual "mental health". *(3 marks)*

Q13. Name **four** of the seven domains of connection recognised in the SEWB framework, and briefly state what each refers to. *(4 marks)*

Q14. Using the SEWB framework, explain how a person's wellbeing may be affected when a connection is **disrupted**, and how it may be supported when connections are **strengthened**. *(4 marks)*

Q15. *Research scenario.* A researcher investigates whether a 10-week resilience-building program improves students' day-to-day functioning. Eighty Year 11 students at one school are randomly allocated either to the program (n = 40) or to a wait-list control group (n = 40). Afterwards, all students complete a validated daily-functioning scale (0–50; higher scores = better functioning). The mean scores (± standard deviation) are: program 38.4 (± 5.1); control 31.2 (± 6.0). (a) Identify the independent variable and the dependent variable. *(2 marks)* (b) The sample was drawn from a single school. Explain one limitation this places on the conclusions that can be drawn. *(2 marks)* (c) State what the results suggest about the program. *(1 mark)*

Q16. *Respectful stimulus.* An Aboriginal community-controlled organisation, working with local Elders, runs a school-holiday program in which young people spend time on Country with older community members, learn about their own family histories, and take part in daily physical activity and shared cooking. (a) Identify two SEWB domains of connection that this program is supporting, and for each, state the part of the program that supports it. *(2 marks)* (b) Explain why the SEWB framework would consider this program likely to support the young people's wellbeing. *(2 marks)*

Q17. Distinguish between the way **levels of functioning** and the way **social and emotional wellbeing (SEWB)** consider mental wellbeing. *(4 marks)*

Q18. A student writes: "Social and emotional wellbeing (SEWB) is just about how well a person manages their emotions." Identify and correct the error in this statement. *(2 marks)*

Q19. Leila cares for her younger siblings while studying at school. When her mother became unwell, Leila struggled to keep up with schoolwork and stopped seeing her friends for a while. With support from an aunt and one of her teachers, she gradually re-established her routine, and she is now managing school, caring and friendships again. (a) Using levels of functioning, describe Leila's wellbeing during the difficult period and now. *(2 marks)* (b) Explain how the scenario also illustrates resilience. *(2 marks)*

Q20. *Extended response.* Wellbeing can be considered in more than one way. Describe **levels of functioning** and **resilience** as two ways of considering mental wellbeing, and explain how **social and emotional wellbeing (SEWB)** offers a different, holistic way of considering wellbeing. In your response, refer to how each way considers wellbeing. *(6 marks)*

Answers

Q1. (a) How well a person carries out the day-to-day activities of life (work/study, relationships, self-care) independently and effectively. (b) The ability to cope with and manage change and uncertainty (adapting and restoring positive functioning over time). (c) A multidimensional, holistic framework for wellbeing used by and for Aboriginal and Torres Strait Islander peoples, in which wellbeing arises from a web of interconnected connections. **Q2.** (a) High functioning — he is still meeting his work, self-care, exercise and social commitments independently and effectively. (b) Any one of: missing deadlines/work; stopping cooking or other self-care; dropping training; withdrawing from friends. (c) Functioning is judged by how well a person is actually carrying out day-to-day activities, not by how they feel; a person can feel tired or stressed and still be managing those activities independently and effectively. **Q3.** (a) Her home being damaged by the flood and having to move repeatedly (a major source of change and uncertainty). (b) She coped with and managed the change and uncertainty and, over several months, adapted and restored positive functioning. (c) Support from family or the school counsellor (a supportive relationship); or keeping up routines (coping skills). **Q4.** (a) Used by and for Aboriginal and Torres Strait Islander peoples; it is multidimensional and holistic. (b) Body; mind and emotions; family and kinship; community; culture; Country; spirituality and ancestors. (c) Because wellbeing is understood to arise from many interconnected connections considered together as one whole, not from a single dimension. **Q5.** (a) Levels of functioning — it judges wellbeing by how well the client carries out day-to-day activities independently and effectively. (b) Resilience — it asks about the ability to cope with and manage change and uncertainty. (c) SEWB — it considers wellbeing through the strength of the framework's domains of connection. **Q6.** (a) Connection to Country. (b) Connection to family and kinship. (c) Connection to culture. **Q7.** Functioning = how well a person currently carries out day-to-day activities independently and effectively; resilience = the ability to cope with and manage change and uncertainty, adapting and restoring positive functioning. **Q8.** A person who carries out day-to-day activities (work/study, relationships, self-care) independently and effectively shows high functioning (a sign of higher wellbeing); difficulty doing so shows low/impaired functioning (a sign of lower wellbeing). **Q9.** His ability to carry out day-to-day activities (study, self-care/cooking, relationships) has declined = low/impaired functioning; because functioning is an indicator of wellbeing, this suggests his mental wellbeing is currently low. **Q10.** He faced a major, unwanted change (injury/loss of his goal) and an uncertain future, coped with and managed it (new goals, coaching) with support (coach/family = protective factors), and adapted and restored positive functioning within months — which is resilience. **Q11.** Resilience is not a fixed trait; it can be strengthened over time (e.g. by building coping skills and supportive relationships). Protective factors (supportive relationships, coping skills, access to help) increase the ability to cope with and manage change and uncertainty. **Q12.** Because SEWB locates wellbeing in connections that reach beyond the individual — family and kinship, community, culture, Country, and spirituality and ancestors — so wellbeing is shared and depends on the whole web being strong. An individual "mental health" view instead locates wellbeing inside one person, so it is narrower and does not treat family, community, culture or Country as part of wellbeing itself. **Q13.** Any four of: body (physical health); mind and emotions (managing thoughts/feelings); family and kinship (bonds with family/kin); community (belonging/participation); culture (cultural knowledge, identity, practices); Country (land, waters, place one belongs to); spirituality and ancestors (spirit, ancestors, sense of meaning). **Q14.** Because wellbeing depends on the whole web of connections, disrupting a connection (e.g. being separated from family, community, culture or Country) can reduce overall wellbeing; strengthening connections supports and can restore wellbeing. Wellbeing is considered across all the connections, not one. **Q15.** (a) IV = whether students completed the resilience program (program vs wait-list control); DV = score on the daily-functioning scale. (b) The sample is from one school, so it may not represent the wider population of Year 11 students; the results may not generalise (limited external validity). (c) The program group scored higher (38.4 vs 31.2), suggesting the program improved functioning / built resilience. **Q16.** (a) Any two of: Country (spending time on Country); family and kinship (learning about their own family histories); community (spending time with older community members in a community-controlled program); body (daily physical activity and shared cooking). (b) Because SEWB understands wellbeing as arising from a web of interconnected connections, strengthening several connections at once supports overall, holistic wellbeing — consistent with a framework used by and for Aboriginal and Torres Strait Islander peoples. **Q17.** Levels of functioning considers wellbeing by how well an individual carries out their own day-to-day activities (an individual focus on current capability); SEWB is a multidimensional, holistic and collective framework in which wellbeing arises from a web of interconnected connections considered together — broader than one individual's functioning. **Q18.** Error: managing thoughts and feelings (connection to mind and emotions) is only one of the seven domains. SEWB is multidimensional and holistic — wellbeing arises from many interconnected connections (family and kinship, community, culture, Country, spirituality and ancestors, body, and mind and emotions), not a single emotional dimension. **Q19.** (a) During the difficult period her functioning was low/impaired (struggling at school, withdrawing from friends); now her

functioning has recovered — she manages school, caring and friendships independently and effectively again. (b) She faced a major change and uncertainty at home, coped with and managed it with support (aunt, teacher), and adapted and restored positive functioning over time — resilience. **Q20.** Model response given in the solutions.

Fully-worked solutions

Q1. (a) **Levels of functioning** refers to **how well a person carries out the day-to-day activities of life — such as work or study, relationships and self-care — independently and effectively**. (b) **Resilience** is the **ability to cope with and manage change and uncertainty** — adapting to what has changed and **restoring positive functioning** over time. (c) **Social and emotional wellbeing (SEWB)** is a **multidimensional and holistic framework for wellbeing used by and for Aboriginal and Torres Strait Islander peoples**, in which wellbeing arises from a **web of interconnected connections**.

Q2. (a) Marcus is showing **high functioning**: despite the demands of the new job he is still carrying out his day-to-day activities **independently and effectively** — meeting **work** deadlines, **cooking for himself** (self-care), **training** each week, and **seeing friends** (relationships). (b) Any one change that would mean those activities were no longer being managed independently and effectively — for example, **missing deadlines or days of work**, **stopping cooking** or other self-care, **dropping his training**, or **withdrawing from his friends**. (c) Level of functioning is judged by **how well a person is actually carrying out the day-to-day activities of life**, not by how they feel while doing so. Feeling **tired and under pressure** is a normal response to a demanding job; because Marcus is still managing work, self-care, exercise and relationships **independently and effectively**, his functioning is **high**. Functioning would only be judged low once those activities themselves became difficult to manage.

Q3. (a) The source of change and uncertainty is her **home being badly damaged in the flood** and the family **having to move twice within a year**. (b) Aisha's response shows **resilience** because, although she was overwhelmed at first, she **coped with and managed** the change and uncertainty and, over several months, **adapted and restored positive functioning** — settling into her new school and returning to her usual activities. (c) One **protective factor**: the **support of her family and the school counsellor** (supportive relationships) — or **keeping up her routines** where she could (a coping strategy).

Q4. (a) SEWB is used **by and for Aboriginal and Torres Strait Islander peoples**, and it is a **multidimensional** and **holistic** framework. (b) Connection to **body**; **mind and emotions**; **family and kinship**; **community**; **culture**; **Country**; and **spirituality and ancestors**. (c) SEWB is **holistic** because wellbeing is understood to arise from **many interconnected connections considered together as one whole** — the connections are not treated as separate, unrelated parts, so wellbeing depends on the whole web of connections rather than any single dimension.

Q5. (a) **Levels of functioning**. The support worker is judging wellbeing by **how well the client is carrying out the day-to-day activities of life** — shopping, cooking and getting to work — and doing so **independently and effectively**. (b) **Resilience**. The counsellor is asking about the person's **ability to cope with and manage change and uncertainty** — here, an unsettled period following a family separation — rather than about their current day-to-day capability. (c) **SEWB**. The service is considering wellbeing through the **strength of the young person's connections** — to **family and kinship**, **community**, **culture** and **Country** — which are domains of connection in the **social and emotional wellbeing** framework, a framework used **by and for Aboriginal and Torres Strait Islander peoples**.

Q6. (a) **Connection to Country** (the land, waters and place a person belongs to). (b) **Connection to family and kinship** (bonds with family and kin). (c) **Connection to culture** (cultural knowledge, identity and practices).

Q7. Levels of functioning considers wellbeing in terms of **how well a person carries out day-to-day activities — such as work or study, relationships and self-care — independently and effectively** (their **current capability**). **Resilience** considers wellbeing in terms of a person's **ability to cope with and manage change and uncertainty**, adapting and **restoring positive functioning** over time. So the two differ in what they focus on: **current day-to-day capability** versus the **ability to cope with and manage change and uncertainty** when that capability is disrupted.

Q8. A person who can carry out their **day-to-day activities** — such as **work or study, relationships and self-care** — **independently and effectively** is showing **high functioning**, which is taken as a sign of **higher** mental wellbeing. A person who **struggles** to manage these activities is showing **low or impaired functioning**, which is taken as a sign of

lower mental wellbeing. In this way, level of functioning acts as an **observable indicator** of a person's mental wellbeing.

Q9. Noah's ability to carry out his **day-to-day activities** has clearly declined: he cannot keep up with **university study**, has stopped **cooking proper meals** (self-care), and has cancelled plans with **friends** (relationships). Because he can no longer manage these activities **independently and effectively**, he is showing **low / impaired functioning**. As level of functioning is used as an **indicator of mental wellbeing**, this decline suggests that Noah's **mental wellbeing is currently low**.

Q10. Daniel's experience illustrates **resilience** because it shows each part of the definition. He faced a major, unwanted **change** — a serious injury that ended his hopes of the representative team — and an **uncertain** future without the goal he had been working toward, and he was affected by it (he felt very low for weeks). He then **coped with and managed** that change, with the help of **protective factors** (support from his **coach and family**), by **setting new goals** and taking up **coaching**. Finally, he **adapted and restored positive functioning**, feeling positive and engaged again within a few months. Being able to cope with and manage change and uncertainty in this way, rather than being overwhelmed by it, is exactly what resilience describes.

Q11. Resilience is described as something that can be **developed** because it is **not a fixed trait** that a person simply has or lacks — it can be **built up and strengthened over time**, for example by developing **coping skills** and **supportive relationships**. **Protective factors** (such as supportive relationships, good coping strategies and access to help) are the influences that **increase resilience**: the more protective factors a person can draw on, the better able they are to **cope with and manage change and uncertainty** when it arises.

Q12. SEWB is described as a **collective** view because it does **not** locate wellbeing inside one individual. Wellbeing is understood to arise from a **web of interconnected connections** that reach well beyond the person — to **family and kinship**, **community**, **culture**, **Country**, and **spirituality and ancestors**, as well as to body and to mind and emotions — so a person's wellbeing is bound up with the wellbeing and strength of their family, community and culture, and is **strong when those connections are strong**. One way this differs from considering wellbeing only as an individual's **"mental health"** is **where wellbeing is located**: an individual mental-health focus treats wellbeing as a quality of one person's own mind, so family, community, culture and Country are at most influences on it, whereas under SEWB those connections are **part of wellbeing itself** — which makes SEWB the **broader** view.

Q13. Any **four** of the seven domains, each named with a brief description — for example: **connection to body** — physical health and a healthy body; **connection to mind and emotions** — the ability to manage one's thoughts and feelings; **connection to family and kinship** — bonds with family and kin; **connection to community** — belonging to, and taking part in, community; **connection to culture** — connection to cultural knowledge, identity and practices; **connection to Country** — connection to the land, waters and place a person belongs to; **connection to spirituality and ancestors** — connection to spirit, ancestors and a sense of meaning. Wellbeing depends on these connections being strong. *(4 marks: 1 mark for each domain correctly named and described.)*

Q14. In the **SEWB framework**, wellbeing arises from a **web of interconnected connections**, and wellbeing is **strong when those connections are strong**. Because the framework is **holistic**, the connections are not independent, so **disruption to any one connection** — for example, being separated from **family, community, culture or Country** — can **reduce a person's overall wellbeing**, not just one narrow part of it. Conversely, **strengthening connections** — for example, restoring or deepening connection to **family and kinship, community, culture or Country** — **supports and can restore** wellbeing. Wellbeing is therefore considered across the **whole web of connections**, so both harm and support are understood in terms of the strength of those connections.

Q15. (a) The **independent variable** is **whether students completed the resilience program** (the program group versus the wait-list control group); the **dependent variable** is the students' **score on the daily-functioning scale**. (b) Because the sample was drawn from a **single school**, it may **not be representative** of the wider population of Year 11 students (for example, students at other schools or in other regions). This limits the **external validity** of the study — the results **may not generalise** beyond this particular school. (c) The program group scored **higher on functioning** than the control group (**38.4 versus 31.2**), which **suggests the program improved students' day-to-day functioning** (helped build resilience).

Q16. (a) Any **two** of the following, each paired with the part of the program that supports it: **connection to Country** — the young people **spend time on Country**; **connection to family and kinship** — they **learn about their own**

family histories; **connection to community** — they spend that time **with older community members**, in a **community-controlled** program; **connection to body** — the **daily physical activity and shared cooking** support physical health. *(2 marks: 1 mark for each domain correctly named and linked to the stimulus.)* (b) Under the **SEWB framework**, wellbeing arises from a **web of interconnected connections**, and is **strong when those connections are strong**. Because this program **strengthens several of those connections at once** — Country, family and kinship, community and body — the framework would expect it to support the young people's **overall, holistic wellbeing**, not just one part of it. That the program is **community-controlled and designed with Elders** also reflects a framework used **by and for Aboriginal and Torres Strait Islander peoples**.

Q17. Levels of functioning considers wellbeing by looking at **how well an individual carries out their own day-to-day activities** — work or study, relationships and self-care — **independently and effectively**. It is an **individual** focus on a person's **current capability**, and essentially a **single dimension** (how well daily life is being managed). **SEWB**, by contrast, is a **multidimensional, holistic and collective** framework, used **by and for Aboriginal and Torres Strait Islander peoples**, in which wellbeing arises from a **web of interconnected connections** — to body, mind and emotions, family and kinship, community, culture, Country, and spirituality and ancestors — considered **together**. So the two differ both in **breadth** (a single dimension versus many interconnected domains) and in **focus** (an individual's own functioning versus a holistic, collective web of connections).

Q18. The statement is **incorrect**. Managing one's thoughts and feelings is the SEWB domain of **connection to mind and emotions**, which is **only one of the seven domains**. **SEWB is a multidimensional and holistic framework**: wellbeing arises from **many interconnected connections** — also including **connection to body, family and kinship, community, culture, Country, and spirituality and ancestors** — considered together. So SEWB cannot be reduced to "how well a person manages their emotions"; it is a much **broader, holistic** view of wellbeing used by and for Aboriginal and Torres Strait Islander peoples.

Q19. (a) Using **levels of functioning**: **during the difficult period**, Leila's functioning was **low / impaired** — she struggled to keep up with schoolwork and withdrew from her friends, so she was not managing her day-to-day activities independently and effectively. **Now**, her functioning has **recovered to a higher level** — she is again managing **school, caring for her siblings and her friendships** independently and effectively. (b) The scenario also illustrates **resilience** because Leila faced a significant **change** at home and the **uncertainty** that came with it (her mother becoming unwell and the extra caring load), **coped with and managed** it with the help of **protective factors** (support from her **aunt and teacher**), and **adapted and restored positive functioning** over time — re-establishing her routine and returning to her usual activities. Being able to cope with and manage change and uncertainty in this way is resilience.

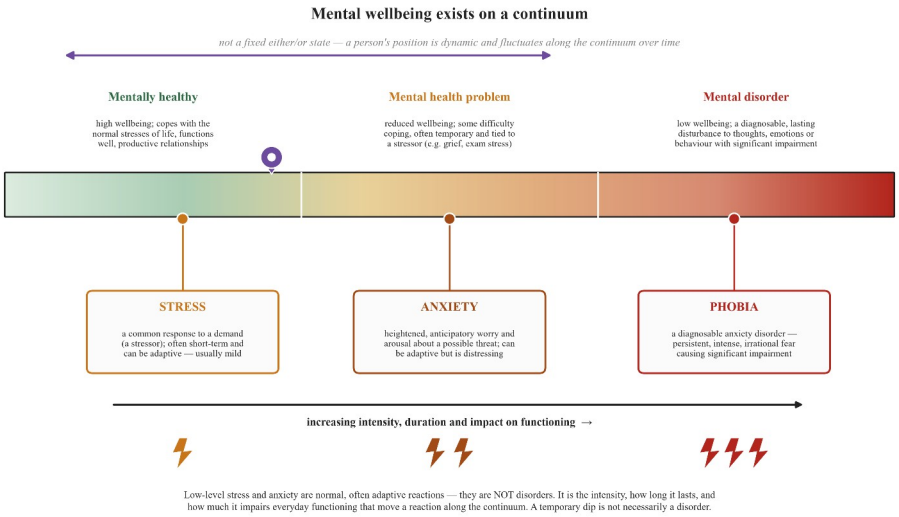
Q20. *Model response (6 marks).* Mental wellbeing can be **considered in more than one way**. **Levels of functioning** consider wellbeing in terms of **how well a person carries out the day-to-day activities of life — such as work or study, relationships and self-care — independently and effectively**. A person with **high functioning** manages these demands well (a sign of higher wellbeing), while a person with **low or impaired functioning** struggles to manage them (a sign of lower wellbeing); functioning therefore describes a person's **current, day-to-day capability**. **Resilience** considers wellbeing in terms of a person's **ability to cope with and manage change and uncertainty**, adapting to what has changed and **restoring positive functioning** over time. Rather than describing current capability, it describes the **ability to cope with and manage change** when that capability is disrupted; it is an **ability**, not a single coping response, it is **influenced by protective factors** (such as supportive relationships and coping skills), and it **can be developed** over time. **Social and emotional wellbeing (SEWB)** offers a **different, holistic** way of considering wellbeing. It is a **multidimensional and holistic framework used by and for Aboriginal and Torres Strait Islander peoples**, in which wellbeing arises not from a single individual dimension but from a **web of interconnected connections** — **connection to body; to mind and emotions; to family and kinship; to community; to culture; to Country; and to spirituality and ancestors**. Wellbeing is **strong when these connections are strong**, so SEWB considers wellbeing **collectively and holistically**, across the whole web of connections, and is **broader** than a focus on an individual's functioning or "mental health" alone. Together, these three ways of considering wellbeing highlight different features: **current capability** (levels of functioning), the **ability to cope with and manage change and uncertainty** (resilience), and a **holistic, collective web of connections** (SEWB). *(Full marks require: an accurate description of levels of functioning and of resilience, including how each considers wellbeing; and an accurate, respectful account of SEWB as a multidimensional, holistic framework used by and for Aboriginal and Torres Strait Islander peoples, arising from interconnected connections.)*

Theory

Mental wellbeing is a person's psychological state — their ability to think and process information, to regulate and express emotions, and to cope with and function in everyday life. A key idea in the study of wellbeing is that it is **not an all-or-nothing state**. A person is not simply "well" or "unwell". Instead, **mental wellbeing exists on a continuum**: a smooth scale that runs from high wellbeing at one end to low wellbeing at the other, with every degree in between.

The continuum. A common way to represent the continuum places three broad regions along a single line:

- **Mentally healthy** — a state of **high wellbeing**. The person copes with the normal demands and stresses of life, functions effectively day to day, and maintains productive relationships and activities.
- **Mental health problem** — a state of **reduced wellbeing**. The person has some difficulty coping and functioning. A mental health problem is usually **less severe and shorter-lasting** than a disorder, and is often a temporary reaction to a **stressor** (for example, the strain of an exam period or grief after a loss).
- **Mental disorder** — a state of **low wellbeing**. This is a **diagnosable** condition involving a combination of thoughts, feelings and behaviours that are **lasting** and cause **significant impairment** to the person's ability to function.



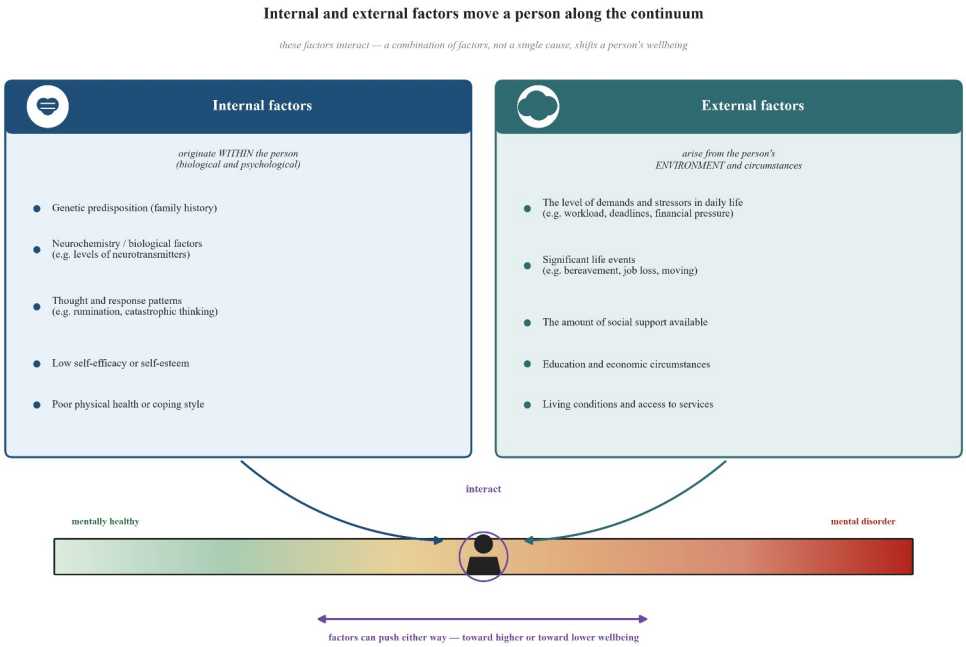
Wellbeing is dynamic and fluctuating. The most important feature of the continuum is that a person's position on it is **not fixed**. Wellbeing **changes over time**, and a person can move in **either direction** — toward higher or toward lower wellbeing. A settled, healthy period may be followed by a stressful week that shifts the person toward the middle of the continuum, and then a return to routine may shift them back. Because wellbeing naturally rises and falls, a **temporary dip is not necessarily a disorder**. A short period of feeling flat or anxious during a difficult time is an ordinary fluctuation; it becomes a concern only when the difficulty is severe, lasts a long time, and clearly impairs functioning.

What moves a person along the continuum. A person's position is shaped by many factors, which are grouped as **internal** and **external**:

- **Internal factors** originate **within the person**. They include a **genetic predisposition** (a family history of a condition), **neurochemistry and other biological factors** (such as the levels of certain neurotransmitters), a person's characteristic **thought and response patterns** (for example, a tendency to ruminate or to think catastrophically), and their **self-efficacy** (their belief in their ability to cope and succeed).
- **External factors** arise from the person's **environment and circumstances**. They include the **level of demands and stressors** in daily life (such as workload, deadlines or financial pressure), significant **life events** (such as bereavement, job loss or moving house), the amount of **social support** available, and a person's **education and economic circumstances**.

Read the first of those carefully: the **demand** is the external factor, while the **stress** it produces is the person's own response and so is internal. A question about "the pressure of the job" is asking about an external factor; a question about "how stressed the person feels" is asking about their reaction to it.

These factors **interact**. Wellbeing is rarely shifted by a single cause; more often a combination of internal and external factors moves a person along the continuum. For example, a genetic predisposition (internal) may only lead to reduced wellbeing when combined with a period of heavy demands and little social support (external). The interaction also works the other way: strong support (external) can offset an internal vulnerability and move a person toward higher wellbeing.



Illustrating the continuum: stress, anxiety and phobia. The idea of a continuum is well illustrated by three reactions that sit at **different points of increasing severity**:

- **Stress** is a state of physiological and psychological arousal produced by a **stressor** (a demand or challenge). It is a **common, everyday response**, is often **short-term**, and can be **adaptive** — a moderate level of stress can help a person focus and perform. It generally sits toward the **healthy** end of the continuum.
- **Anxiety** is a state of **heightened arousal** accompanied by feelings of **apprehension, worry or unease**, usually directed at an **anticipated or possible future threat**. Like stress, a low level of anxiety can be **adaptive** (it can motivate preparation), but it is more **intense and distressing** and can persist even without a clear cause, so it sits **further along** the continuum.
- **Phobia** is a **diagnosable anxiety disorder**: a **persistent, intense and irrational fear** of a specific object or situation that is **out of proportion** to the actual danger and leads to **significant distress and avoidance** that impairs everyday functioning. It sits at the **low-wellbeing (mental disorder)** end.

The three are best distinguished by **intensity** (mild → heightened → extreme), **duration** (short-term → can persist → persistent/chronic) and **impact on functioning** (little or even helpful → some interference → significant impairment). Crucially, **everyday stress and anxiety are normal reactions, not disorders** — of the three, it is the **phobia** that is the diagnosable disorder. Be precise here: this does **not** mean anxiety can never be diagnosable. When anxiety becomes **persistent, excessive and impairing** it can form part of a diagnosable **anxiety disorder**, and a phobia is one such disorder. What is normal, and often adaptive, is anxiety at **ordinary, everyday levels**. This is exactly what a continuum captures: the same broad kind of experience (a response to threat) can appear at very different levels of severity.

Worked examples

Example 1 — scaffolded

Priya has felt persistently low and worried for the past ten months. She no longer enjoys activities she used to love, struggles to concentrate at work, and has withdrawn from her friends. She has been diagnosed with a mental health condition. Place Priya on the mental wellbeing continuum, and justify your answer with reference to the features of her experience.

Working	Comment
Identify the three regions of the continuum: mentally healthy, mental health problem, mental disorder.	Always name the scale before placing the person on it.
Priya's difficulties are **severe** (loss of enjoyment, withdrawal), **long-lasting** (ten months) and **impair functioning** (work, relationships), and she has a **diagnosis**.	Judge the position from severity, duration and impact on functioning — the three key criteria.
These features place Priya at the **mental disorder (low-wellbeing)** end of the continuum.	Match the evidence to the region; do not just assert a label.

Example 2 — scaffolded

Classify each of the following influences on Ben's wellbeing as an **internal** or an **external** factor: (i) a family history of depression; (ii) recently losing his part-time job; (iii) a tendency to dwell on negative thoughts; (iv) strong support from his football team.

Working	Comment
(i) A family history points to a **genetic predisposition**, which originates within Ben → **internal**.	Ask: does the factor come from within the person, or from the environment?
(ii) Losing a job is an event in Ben's **environment/circumstances** → **external**.	Life events and circumstances are external.
(iii) A habitual **thought/response pattern** is a feature of Ben himself → **internal**.	Ways of thinking are psychological, internal factors.
(iv) **Social support** comes from other people in Ben's environment → **external**.	The support is a resource in the environment, so it is external.

Example 3 — unscaffolded

During the two weeks of her final exams, Mia feels tense, sleeps poorly and worries constantly. Once exams finish and she takes a holiday, she feels settled again within a few days. A friend says, "You clearly had a mental disorder during exams." Explain whether the friend is correct.

The friend is **incorrect**. Mental wellbeing is a **continuum**, and a person's position on it is **dynamic and fluctuates over time**. During exams Mia experienced **stress** — a common, short-term response to a demanding stressor — which shifted her temporarily toward the middle of the continuum (a **mental health problem** at most). A **mental disorder**, by contrast, is a **diagnosable** condition marked by **severe, lasting** disturbance that causes **significant impairment**. Mia's reaction was **brief** (a couple of weeks), was **tied to a clear stressor**, and **resolved on its own** once the stressor was removed. A **temporary dip is not necessarily a disorder**. ∴ Mia's experience is an ordinary fluctuation along the continuum, not a mental disorder.

Example 4 — unscaffolded

Distinguish between stress, anxiety and a phobia with reference to their position on the mental wellbeing continuum.

Stress is a state of arousal that is a **common response to a demand (a stressor)**; it is often **short-term** and can be **adaptive**, so it sits toward the **mentally healthy** end of the continuum. **Anxiety** is a state of **heightened arousal and apprehension about an anticipated threat**; it is **more intense** than everyday stress and can **persist** even without a clear cause, so it sits **further along**, toward the mental health problem region, while still being a **normal, non-diagnosable** reaction in its milder forms. A **phobia** is a **diagnosable anxiety disorder** — a **persistent, intense,**

irrational fear that causes **significant impairment** — so it sits at the **mental disorder (low-wellbeing)** end. The three therefore illustrate the continuum by differing in **intensity, duration and impact on functioning**, with only the phobia being a diagnosable disorder. ∴ moving from stress to anxiety to phobia is a movement along the continuum toward lower wellbeing.

Practice questions

Scaffolded

Q1. Define each of the following: (a) mental wellbeing; (b) the mental wellbeing continuum; (c) a mental disorder.

Q2. A wellbeing continuum is often drawn with three regions: mentally healthy, mental health problem, and mental disorder. (a) State which region represents the highest level of wellbeing. (b) State one feature that distinguishes a mental health problem from a mental disorder. (c) Explain what it means to say a person's position on the continuum is "dynamic".

Q3. Classify each of the following as an internal or an external factor influencing wellbeing: (a) the workload and deadlines a person is set at work; (b) an imbalance in a person's neurotransmitter levels; (c) low self-efficacy; (d) a lack of social support.

Q4. After his dog died, Jarrah felt sad and unmotivated for about three weeks, then gradually returned to his usual self. (a) Identify the type of factor (internal or external) that triggered the change in Jarrah's wellbeing. (b) Explain why this episode is best described as a fluctuation along the continuum rather than a mental disorder.

Q5. Consider stress, anxiety and a phobia. (a) State which of the three is a diagnosable mental disorder. (b) Distinguish between stress and a phobia in terms of their impact on functioning. (c) Explain why a low level of stress or anxiety is not necessarily harmful.

Q6. Dev has low self-efficacy: he doubts his ability to handle anything difficult, and puts off tasks he expects to fail at. His workplace then introduces a mentoring program, and the mentor he is paired with helps him plan his work and talks through setbacks with him. Over the following months Dev copes more confidently and feels better day to day. (a) Identify one internal and one external factor in this scenario. (b) Explain how these factors might interact to move Dev along the continuum. (c) Suggest the direction (toward higher or lower wellbeing) in which Dev has moved.

Unscaffolded

Q7. Distinguish between viewing mental wellbeing as a continuum and viewing it as two separate categories (well vs unwell). *(2 marks)*

Q8. Classify each of the following as an internal or an external factor: (i) limited access to affordable mental health services in a person's area; (ii) a long-term physical illness that leaves a person constantly fatigued; (iii) the breakdown of a close friendship; (iv) a habit of blaming oneself for events outside one's control. *(2 marks)*

Q9. Sam has felt severely depressed for the past eight months, cannot get out of bed most days, has stopped attending university, and has received a diagnosis from a psychologist. Place Sam on the mental wellbeing continuum and justify your placement with reference to two features of his experience. *(3 marks)*

Q10. Rafi has felt anxious and flat for the past four months. He still gets to work and still sees his friends, but says he no longer enjoys either and that each day takes real effort. He has not sought a diagnosis. Explain why Rafi's position on the continuum is difficult to classify, and state where he is best placed. *(3 marks)*

Q11. Distinguish between stress and anxiety. *(2 marks)*

Q12. Distinguish between anxiety and a phobia, making clear which one is a diagnosable mental disorder. *(3 marks)*

Q13. Explain how an internal factor could move a person toward the lower-wellbeing end of the continuum. Use a specific example. *(3 marks)*

Q14. Explain how a change in a person's external circumstances could move them toward the higher-wellbeing end of the continuum. Use a specific example. *(3 marks)*

Q15. *Research scenario.* A psychologist tracked the wellbeing of 200 first-year university students, measuring each student's wellbeing on a 0–100 scale (higher = greater wellbeing) at three time points: the first week of semester, the middle of the exam period, and two weeks into the mid-year break. The mean wellbeing scores are shown below.

Time point	Mean wellbeing (0–100)
First week of semester	74
Middle of exam period	52
Two weeks into the break	71

(a) Identify the independent variable and the dependent variable in this investigation.

(b) Explain how these results illustrate that mental wellbeing is dynamic and fluctuates over time.

(c) A student argues the exam-period result shows that most of the group had developed a mental disorder. Explain why this conclusion is not justified. *(5 marks)*

Q16. *Research scenario.* To investigate whether social support influences wellbeing, researchers recruited 60 adults who reported feeling isolated. Half were randomly allocated to a six-week structured peer-support program; the other half received no program. Wellbeing was measured (0–100) before and after the six weeks. The results are shown below.

Group	Mean wellbeing before (SD)	Mean wellbeing after (SD)
Peer-support program	48 (6)	63 (7)
No program (control)	47 (5)	49 (6)

(a) Identify the independent variable and the dependent variable.

(b) State whether social support is an internal or an external factor, and justify your answer.

(c) Write a directional hypothesis for this investigation that includes both levels of the independent variable.

(d) Identify one ethical consideration the researchers should address in relation to the control group. *(6 marks)*

Q17. A student writes: "A phobia is just a very strong version of everyday stress." Identify and correct the error in this statement. *(2 marks)*

Q18. For each of the following, state whether the reaction is best described as **stress**, **anxiety** or a **phobia**, and justify your choice by referring to its intensity, duration and impact on functioning. (i) Kiri's heart races and she cannot settle in the week before a job interview; once the interview is over she feels like herself again within a day. (ii) Tomas has felt on edge and unable to relax for the past several months, often worrying that something will go wrong although he cannot point to any particular cause. He still manages his work and study, but finds both harder than he used to. (iii) At the sight of a dog anywhere near her, Nadia is overwhelmed by terror. She will not walk down a street where a dog might be and has stopped visiting the friends who own one. *(6 marks)*

Q19. Noah has a family history of anxiety and tends to interpret ambiguous situations as threatening. After moving to a new city where he has no friends yet and taking on a demanding job with long hours, he begins to feel constantly worried and on edge, though he is still able to work and has not been diagnosed with any condition. (a) Identify the internal and external factors influencing Noah's wellbeing. (b) Explain how these factors have interacted to move Noah along the continuum. (c) State, with justification, whether Noah currently has a mental disorder. *(5 marks)*

Q20. *Extended response.* "Mental wellbeing is best understood as a continuum shaped by internal and external factors, not as a fixed state." Using the continuum, the roles of internal and external factors, and the example of stress, anxiety and phobia, discuss this statement. *(6 marks)*

Answers

Q1. (a) A person's psychological state — their ability to think, regulate emotions and function in daily life. (b) The idea that wellbeing lies on a scale from high to low wellbeing, not in fixed categories. (c) A diagnosable condition of lasting disturbance to thoughts, emotions or behaviour causing significant impairment. **Q2.** (a) Mentally healthy. (b) A mental health problem is less severe and usually shorter-lasting or temporary; a disorder is diagnosable, lasting and significantly impairing. (c) The person's position changes over time and can move in either direction. **Q3.** (a) External. (b) Internal. (c) Internal. (d) External. **Q4.** (a) External (a life event — the death of his dog). (b) It was short-lived, tied to a clear stressor and resolved on its own, so it is a normal fluctuation, not a lasting, impairing disorder. **Q5.** (a) A phobia. (b) Stress has little (or even positive) impact on functioning; a phobia causes significant impairment/avoidance. (c) Low levels can be adaptive — helping focus, motivation and preparation. **Q6.** (a) Internal = Dev's low self-efficacy; external = the workplace mentoring program/his mentor's support. (b) The external support builds his belief that he can cope, offsetting the internal vulnerability, so he copes better with the same demands. (c) Toward higher wellbeing. **Q7.** A continuum treats wellbeing as a graded scale with many positions and gradual movement; the two-category view treats it as a fixed either/or (well or unwell) with no in-between. **Q8.** (i) External; (ii) internal; (iii) external; (iv) internal. **Q9.** Mental disorder (low-wellbeing) end — the disturbance is severe and long-lasting (eight months), impairs functioning (cannot attend university), and is diagnosed. **Q10.** The criteria pull in opposite directions — the duration is long (four months, not a brief dip) but the impairment is only partial (still working and socialising) and he is undiagnosed. Because the continuum is a graded scale with no sharp cut-off between regions, Rafi sits toward the lower end of the mental health problem region rather than clearly in one region or the other. **Q11.** Stress is arousal in response to a present demand/stressor and is often short-term; anxiety is more intense, is directed at an anticipated/possible future threat, and can persist without a clear cause. **Q12.** Anxiety is heightened worry and arousal about an anticipated threat; at everyday levels it is a normal reaction and is not in itself a disorder. A phobia is a diagnosable anxiety disorder — a persistent, intense, irrational fear causing significant impairment. Of the two, the phobia is the diagnosable disorder. **Q13.** Any valid example, e.g. a neurotransmitter imbalance (internal) reduces mood regulation, shifting the person toward lower wellbeing. **Q14.** Any valid example, e.g. gaining strong social support (external) improves coping and shifts the person toward higher wellbeing. **Q15.** (a) IV = time point/phase of semester; DV = wellbeing score. (b) Scores fell during exams and recovered afterwards, showing wellbeing changes over time and can move both ways. (c) The dip was temporary and stressor-linked (exams) and the group recovered; a disorder requires severe, lasting, impairing disturbance, which group means cannot establish. **Q16.** (a) IV = whether the peer-support program is received (program vs no program); DV = wellbeing score. (b) External — social support comes from the person's environment. (c) e.g. "Isolated adults who complete a six-week peer-support program will show a greater increase in wellbeing scores than those who receive no program." (d) e.g. justice — the control group carry the burden of taking part but receive none of the benefit, so the researchers should offer them the program after the study (a wait-list control). Also creditworthy if tied to the control group: beneficence (a potentially beneficial program is withheld); informed consent that discloses before agreement that half the participants will receive no program. **Q17.** Error: a phobia is not merely strong stress; it is a diagnosable anxiety disorder marked by persistent, irrational fear and significant impairment, differing in kind (diagnosable) as well as degree. **Q18.** (i) Stress — mild-to-moderate arousal, short-term, tied to a present demand, no lasting impairment. (ii) Anxiety — heightened, persists for months without a clear cause, some interference but he still functions. (iii) Phobia — extreme and out of proportion, persistent, and the avoidance significantly impairs everyday life (a diagnosable disorder). **Q19.** (a) Internal = family history + threat-biased thinking; external = new city with no friends + demanding job with long hours. (b) The internal vulnerabilities combine with the high-demand, low-support environment to reduce his wellbeing. (c) No — he is worried but still functioning and undiagnosed, so he is in the mental health problem region, not the disorder end. **Q20.** Discussion given in the solutions.

Fully-worked solutions

Q1. (a) **Mental wellbeing** is a person's psychological state — including their ability to think and process information, to regulate and express emotions, and to cope with and function in everyday life. (b) The **mental wellbeing continuum** is the idea that wellbeing lies along a graded scale, from high wellbeing (mentally healthy) at one end to low wellbeing (mental disorder) at the other, rather than in a small number of fixed categories. (c) A **mental disorder** is a diagnosable condition involving a combination of thoughts, feelings and behaviours that represent a lasting disturbance and cause significant impairment to a person's functioning.

Q2. (a) The **mentally healthy** region represents the highest level of wellbeing. (b) A **mental health problem** is generally **less severe** and **shorter-lasting** (often a temporary response to a stressor), whereas a **mental disorder** is **diagnosable**, **lasting**, and causes **significant impairment**. (c) Saying the position is **dynamic** means it is **not fixed**: a person's wellbeing **changes over time** and can move in **either direction** along the continuum as their circumstances and internal state change.

Q3. (a) The **workload and deadlines** are demands set by the person's workplace, so they come from the environment → **external**. (Take care: the *stress* the person feels in response is their own reaction and so is internal; the external factor is the **demand** that produces it.) (b) A neurotransmitter imbalance is biological and within the person → **internal**. (c) Self-efficacy is a psychological characteristic of the person → **internal**. (d) Social support (or its absence) is a feature of the environment → **external**.

Q4. (a) The trigger was an **external** factor — a significant **life event** (the death of his dog). (b) The episode is a **fluctuation along the continuum** rather than a disorder because it was **short-lived** (about three weeks), **clearly tied to a stressor**, and **resolved on its own** without significant lasting impairment. A **temporary dip is not necessarily a disorder**; a disorder involves severe, lasting disturbance and significant impairment, which Jarrah did not show.

Q5. (a) A **phobia** is the diagnosable mental disorder. (b) **Stress** typically has **little impact** on functioning and can even be **adaptive** (aiding focus and performance), whereas a **phobia** causes **significant impairment**, including avoidance of the feared object or situation that disrupts everyday life. (c) A **low level** of stress or anxiety is **not necessarily harmful** because it can be **adaptive** — moderate arousal can improve focus, motivation and preparation for a challenge (for example, mild pre-exam nerves that prompt study).

Q6. (a) The **internal** factor is Dev's **low self-efficacy** — his belief that he cannot handle difficult tasks, which is a psychological characteristic of Dev himself. The **external** factor is the **workplace mentoring program** and the **support of his mentor**, which comes from his environment. (b) The factors **interact**: on its own, low self-efficacy keeps Dev avoiding difficult tasks and confirms his belief that he cannot cope. The **external support** breaks that cycle — planning the work and talking through setbacks gives him repeated experiences of managing, which **raises his self-efficacy**, so the same demands now feel manageable. Neither factor explains the change alone; it is the combination that moves him. (c) Dev has moved **toward higher wellbeing** on the continuum — a reminder that the interaction of internal and external factors can push a person in **either** direction.

Q7. Viewing wellbeing as a **continuum** treats it as a **graded scale** on which a person can occupy **any position** and move **gradually** in either direction over time. Viewing it as **two separate categories** treats a person as either "well" or "unwell", a **fixed either/or** with no in-between and no gradual movement. The continuum better reflects the reality that wellbeing varies by degree and changes over time.

Q8. (i) **Access to services** is a feature of where the person lives, not of the person → **external**. (ii) A **long-term physical illness** is a biological state within the person → **internal**. (iii) The **breakdown of a friendship** is a life event that reduces the social support available in the person's environment → **external**. (iv) A habit of **blaming oneself** for events outside one's control is a characteristic thought/response pattern → **internal**.

Q9. Sam is at the **mental disorder (low-wellbeing) end** of the continuum. This is justified by: (1) the disturbance is **severe and long-lasting** — he has felt severely depressed for **eight months** and cannot get out of bed most days; and (2) it causes **significant impairment** — he has **stopped attending university** — and has been **formally diagnosed**. Severe, enduring, impairing and diagnosed features place him at the disorder end.

Q10. Position on the continuum is judged from **severity**, **duration** and **impact on functioning**, together with whether the condition has been **diagnosed** — and in Rafi's case these criteria **point in different directions**. On **duration**, four months is well beyond the brief, stressor-linked dip that would be an ordinary fluctuation. On **impact**, however, he is still **working and still seeing friends**, so his functioning is reduced (nothing is enjoyable, everything is an effort) rather than significantly impaired, and he is **undiagnosed**. Because mental wellbeing is a **continuum** and not a set of boxes, the regions **shade into one another** and there is **no sharp cut-off**: a person can sit between them. Rafi is therefore best placed toward the **lower end of the mental health problem region**, moving in the direction of the disorder end without meeting the criteria for one. ∴ the honest answer is a **position on a scale**, not a category — and only a qualified professional, assessing him properly, could determine whether a diagnosable disorder is present.

Q11. Stress is a state of physiological and psychological arousal that occurs in response to a **present demand or stressor**, and it is often **short-term** (it eases when the stressor passes). **Anxiety** is a state of **heightened arousal and apprehension** that is directed at an **anticipated or possible future threat**; it is **more intense** than everyday stress and can **persist even without a clear or present cause**. Both differ in their trigger (present demand vs anticipated threat) and in their intensity and persistence.

Q12. Anxiety is a state of **heightened worry and arousal** about an **anticipated threat**. At **everyday levels** it is a **normal reaction** and is **not in itself a disorder** — in mild forms it can even be adaptive, motivating preparation. (Anxiety that becomes persistent, excessive and impairing may form part of a diagnosable **anxiety disorder**; ordinary, everyday anxiety does not.) A **phobia** is a **diagnosable anxiety disorder** — a **persistent, intense and irrational fear** of a specific object or situation, **out of proportion to the actual danger**, that leads to **significant distress, avoidance and impairment**. The key difference is that the **phobia is a diagnosable disorder** causing significant impairment, whereas everyday anxiety is a normal response that leaves functioning largely intact.

Q13. An **internal factor** can move a person toward **lower wellbeing** by changing their biology or psychology in a way that reduces coping. For example, an **imbalance in neurotransmitter levels** (a biological, internal factor) can disrupt mood regulation, making a person more prone to persistent low mood and shifting them along the continuum toward the lower-wellbeing end. (Other valid examples: a genetic predisposition, or a habit of catastrophic thinking that magnifies threats.)

Q14. A change in **external circumstances** can move a person toward **higher wellbeing** by improving the resources and support available to them. For example, **gaining a strong network of supportive friends** after moving to a new area (an external factor) improves the person's ability to cope with stress, shifting them toward the mentally healthy end of the continuum. (Other valid examples: securing stable employment, or a reduction in daily demands.)

Q15. (a) The **independent variable** is the **time point / phase of semester** (first week, exam period, break); the **dependent variable** is the students' **wellbeing score** (0–100). (b) The mean wellbeing **fell** from 74 to **52 during exams** and then **recovered to 71** in the break. This rise and fall shows that wellbeing is **dynamic** — it **changes over time** and can move in **both directions** along the continuum in response to changing circumstances. (c) The conclusion is **not justified**. The exam-period dip was **temporary** and **linked to a clear stressor** (exams), and the group **recovered** afterwards. A **mental disorder** requires a **severe, lasting, impairing** disturbance that is diagnosed on an **individual** basis; a lower **group mean** at one time point cannot establish that individuals had a disorder, and a short-lived, stressor-linked dip is an ordinary fluctuation, not a disorder.

Q16. (a) The **independent variable** is **whether the peer-support program is received** (program vs no program/control); the **dependent variable** is the **wellbeing score** (0–100). (b) Social support is an **external** factor because it comes from the person's **environment** (other people), not from within the person. (c) A suitable **directional hypothesis**: *"It is hypothesised that isolated adults who complete a six-week peer-support program will show a greater increase in wellbeing scores than isolated adults who receive no program."* (This names both levels of the IV and a directional DV.) (d) The consideration that belongs specifically to the **control group** is **justice** — the ethical concept requiring the **benefits and burdens** of research to be distributed fairly, with **no unfair burden on a particular group** and **fair access to the benefits**. The control group carry the burden of the research (they are recruited, tested twice, and remain isolated for six weeks) while the benefit — a program that raised the other group's mean wellbeing by 15 points against their own 2 — goes to everyone but them. The researchers should therefore run a **wait-list control**: offer the peer-support program to the control group once the study is complete. (Also creditworthy, provided it is tied to the control group: **beneficence**, since a potentially beneficial program is deliberately withheld from people who report feeling isolated; or the guideline of **informed consent**, which requires the control group to be told **before** they agree that allocation is random and that half the participants will receive no program. A generic mention of consent, **withdrawal rights** or confidentiality that applies equally to both groups does not answer the stem, which asks for a consideration **in relation to the control group**.)

Q17. The statement is **incorrect**. A **phobia** is **not merely a strong form of everyday stress**. It is a **diagnosable anxiety disorder** characterised by a **persistent, intense and irrational fear** that is **out of proportion to the actual danger** and causes **significant impairment** through distress and avoidance. It therefore differs from stress **in kind** (it is a diagnosable disorder at the low-wellbeing end of the continuum), not merely in **degree**.

Q18. (i) Kiri is experiencing **stress**. Her arousal (racing heart, unable to settle) is **mild to moderate** in **intensity**, it is **short-term** — it lasts the week before the interview and eases within a day once the demand has passed — and its

impact on functioning is minimal, and may even be **adaptive** in prompting her to prepare. This places her toward the **mentally healthy** end of the continuum. (ii) Tomas is experiencing **anxiety**. His **intensity** is **heightened** rather than mild — he is on edge and cannot relax — its **duration** is **months**, and it **persists without a clear cause**, being directed at what "might" go wrong rather than at a present demand. Its **impact** is **some interference**: work and study are harder, but he still manages both. This places him in the **mental health problem** region, further along the continuum than Kiri. (iii) Nadia has a **phobia**. Her **intensity** is **extreme** (terror) and **out of proportion** to the actual danger a dog presents; its **duration** is **persistent** — it is triggered every time, not tied to one passing event — and its **impact** is **significant impairment**, because the **avoidance** has reshaped her life (the streets she walks, the friends she sees). This is a **diagnosable anxiety disorder**, at the **mental disorder** end of the continuum. ∴ the three sit at increasing points along the continuum precisely because they increase in intensity, duration and impact on functioning — only the third is a diagnosable disorder.

Q19. (a) **Internal** factors: Noah's **family history of anxiety** (genetic predisposition) and his tendency to **interpret ambiguous situations as threatening** (a thought/response pattern). **External** factors: **moving to a new city with no friends yet** (low social support) and taking on a **demanding job with long hours** (high demands). (b) These factors have **interacted**: Noah's internal **vulnerabilities** have been expressed under the **high-demand, low-support environment**, combining to reduce his wellbeing and move him along the continuum toward lower wellbeing. (c) **No**, Noah does **not currently have a mental disorder**. Although he feels constantly worried, he is **still able to work** and has **not been diagnosed**; his experience lacks the **severe, lasting, significantly impairing** features of a disorder. He is best placed in the **mental health problem** region, not at the disorder end.

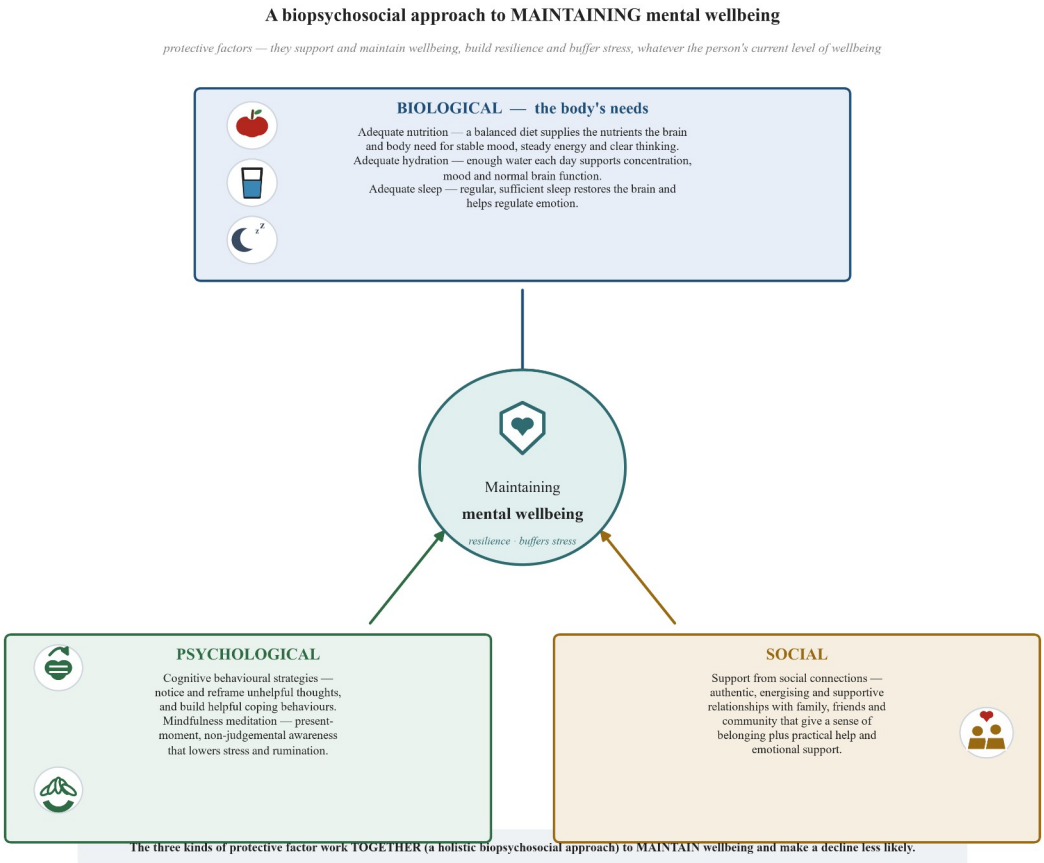
Q20. *Model response (6 marks).* Mental wellbeing is best understood as a **continuum** rather than a fixed state. A continuum represents wellbeing as a **graded scale** running from **high wellbeing (mentally healthy)** through a **mental health problem** to **low wellbeing (a mental disorder)**, with every degree in between. Crucially, a person's position is **dynamic and fluctuates over time** and can move in **either direction**, so a **temporary dip is not necessarily a disorder**. A person's position is shaped by **internal factors** that originate within them — such as a **genetic predisposition**, **neurochemistry**, characteristic **thought patterns** and **self-efficacy** — and by **external factors** from their environment — such as the **level of demands and stressors**, **life events**, **social support**, and **economic circumstances**. These factors **interact**: a vulnerability such as a genetic predisposition may only reduce wellbeing when combined with heavy demands and low support, and equally, strong support can offset a vulnerability and move a person the other way. The example of **stress, anxiety and phobia** illustrates the continuum well. **Stress** is a common, often short-term and adaptive response to a demand and sits near the healthy end; **anxiety** is a more intense, anticipatory worry that sits further along but at **everyday levels** is still a normal reaction; and a **phobia** is a **diagnosable anxiety disorder** — a persistent, intense, irrational fear causing significant impairment — at the low-wellbeing end. The three differ in **intensity, duration and impact on functioning**, showing how the same broad kind of experience can appear at very different points on the scale. ∴ wellbeing is a continuum shaped by interacting internal and external factors, not a fixed state. *(Full marks require: the continuum with its three regions and its dynamic/fluctuating nature; internal and external factors with examples and the idea that they interact; and the stress –anxiety–phobia illustration distinguished by intensity/duration/impact, with the phobia identified as the diagnosable disorder.)*

Theory

Maintaining mental wellbeing means supporting a person to stay in a good state of mental health over time, and making a decline in their wellbeing less likely. The factors studied here are **protective factors**: resources, habits and relationships that support and maintain wellbeing, **build resilience** (the ability to **cope with and manage change and uncertainty**) and **buffer** (soften) the impact of stressors.

Because mental wellbeing lies on a **continuum** (9B) and moves up and down over time, protective factors matter **wherever a person currently sits on it**. They help a mentally healthy person stay well; they help a person whose wellbeing has dipped under a stressor to hold on to, and rebuild, their usual functioning; and for a person who has experienced a mental disorder they help guard against its **re-occurrence**. What makes a factor *protective* is its **purpose** — supporting and maintaining wellbeing — not the person's diagnosis.

The biopsychosocial approach. The **biopsychosocial approach** is a **holistic** framework that explains and supports wellbeing using three interacting kinds of factor at once — **biological**, **psychological** and **social**. Applied to *maintaining* wellbeing, it identifies protective factors in each of these three domains, and recognises that they work **together**: wellbeing is best supported when a person's body's needs, their thinking and coping, and their relationships are all looked after.



Biological protective factors — the body's needs. These meet the physical needs of the brain and body so that they have a healthy foundation for wellbeing.

- **Adequate nutrition** — a **balanced diet** supplies the nutrients (such as glucose for energy, and the vitamins, minerals and proteins the brain uses to make neurotransmitters) that the brain and body need to function well. Adequate nutrition supports **stable mood, steady energy and clear thinking**; a consistently poor diet can undermine mood and energy.
- **Adequate hydration** — drinking **enough water** each day supports **normal brain function, concentration and mood**. Even mild dehydration can make it harder to concentrate and can lower mood, so keeping hydrated helps a person feel and think at their best.

- **Adequate sleep** — getting **regular, sufficient sleep** allows the brain and body to restore themselves, and helps a person **regulate their emotions** and think clearly the next day. Meeting the ongoing need for sleep helps keep mood and functioning stable over time.

Psychological protective factors — how we think and cope. These are mental strategies a person develops and uses to manage everyday demands and keep themselves well.

- **Cognitive behavioural strategies** — practical strategies based on the link between a person's **thoughts, feelings and behaviour**. They involve **recognising unhelpful or unrealistic thoughts and reframing them** into more balanced, helpful ones, and **developing helpful behaviours and coping** (for example, breaking a big task into steps, scheduling enjoyable activity, or problem-solving rather than avoiding). Used **proactively** — before difficulties build up — these strategies help a person manage stress and maintain their wellbeing.
- **Mindfulness meditation** — intentionally paying attention to the **present moment**, in a **non-judgemental** way — noticing thoughts, feelings and bodily sensations as they are, without getting caught up in them or labelling them as good or bad. Regular practice **reduces stress and rumination** (repetitively dwelling on negative thoughts) and supports emotion regulation, which helps maintain wellbeing.

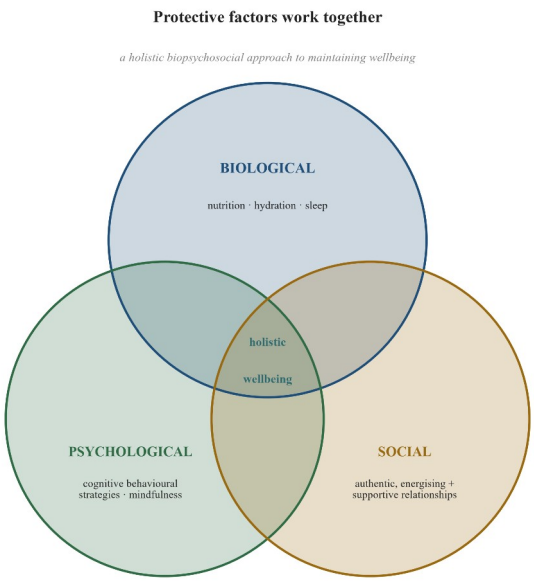
Note that a complete account of mindfulness meditation needs **both** of its components: the **attention** component (deliberately attending to the **present moment**) *and* the **acceptance** component (allowing thoughts and feelings to be experienced **without judging them**). Describing only the attention half — "focusing on your breathing" — is a common way marks are lost. Practising mindfulness usually feels calming, but a person can also be mindful of an *unpleasant* feeling by observing it without reacting.

Social protective factors — our connections with others. Wellbeing is supported by **support from family, friends and community** — but it is the **quality** of those connections, not merely how many people a person knows, that matters. The study design describes this support as being **authentic and energising**:

- **authentic** — genuine and honest, where a person can be themselves;
- **energising** — uplifting, leaving a person feeling replenished and positive rather than drained.

Support like this provides **practical help** (advice, assistance) and **emotional support** (comfort, being listened to, a sense of belonging). Authentic, energising support from **family, friends and community** gives a person a **sense of belonging**, helps them cope with stress, and maintains their wellbeing. A large number of shallow or draining relationships does not provide this protection — **quality matters more than quantity**.

They work together (holistic). Because the biopsychosocial approach is **holistic**, the three kinds of protective factor are strongest **in combination**: eating and sleeping well gives the body a healthy base, cognitive behavioural strategies and mindfulness support helpful thinking and coping, and authentic relationships provide belonging and support. Together they **maintain wellbeing and build resilience**.



How to classify a protective factor. Ask what the factor is *about*: something about the **body's physical needs** (food, water, sleep) is **biological**; something about a person's **thoughts or mental strategies** (reframing thoughts, mindfulness) is **psychological**; something about **relationships and connection with others** is **social**.

Keep the key distinction straight. A **protective factor** works to **support and maintain** wellbeing and to make a decline **less likely** — it protects. A **treatment** (Chapter 10) is an intervention delivered **for a diagnosed disorder**, aimed at **relieving its symptoms and restoring** the person's functioning. The same activity (for example, a cognitive behavioural approach) can appear in both, so it is the **purpose** — protecting and maintaining wellbeing versus treating a diagnosed disorder — that decides which it is. The two are **not alternatives**: a person being treated for a disorder can also draw on protective factors, which help maintain their wellbeing and guard against **re-occurrence**.

Worked examples

Example 1 — scaffolded

Mira keeps herself well with a daily routine: she drinks about two litres of water, gets eight to nine hours of sleep, spends ten minutes on mindful breathing, keeps a thought diary in which she challenges unhelpful thoughts, and has an honest weekly catch-up with a close friend. Classify each part of Mira's routine as a **biological**, **psychological** or **social** protective factor.

Working	Comment
Drinking about two litres of water = **adequate hydration → biological** (a body need).	Water, food and sleep meet the body's physical needs → biological.
Eight to nine hours of sleep = **adequate sleep → biological**.	Sleep restores the brain and regulates emotion — a biological need.
Ten minutes of mindful breathing = **mindfulness meditation → psychological**.	Present-moment, non-judgemental awareness is a mental strategy → psychological.
A thought diary that challenges unhelpful thoughts = **cognitive behavioural strategy → psychological**.	Recognising and reframing thoughts is a psychological (thinking) strategy.
An honest weekly catch-up with a close friend = **support from an authentic social connection → social**.	A relationship providing connection and support → social.

Example 2 — scaffolded

Marcus has been getting only five hours of sleep and feels flat and short-tempered. He decides to go to bed earlier so he gets eight hours a night. Explain how adequate sleep, as a **biological protective factor**, helps Marcus **maintain** his mental wellbeing. Set out your answer as a chain.

Working	Comment
Identify the factor and its domain: adequate sleep is a **biological** protective factor (it meets a body need).	Name the factor *and* its domain to show you have classified it.
State the mechanism: regular, sufficient sleep lets Marcus's **brain restore itself and regulate his emotions**, so his mood and concentration stay stable.	Give *how* it works — the middle link in the chain, tied to the body.
State the maintenance outcome: with stable mood and energy Marcus is better able to cope with daily demands, so his wellbeing is **maintained** (kept from declining).	Finish on *maintenance / keeping well*, not "treating" a disorder, and refer to Marcus.

Example 3 — unscaffolded

Distinguish between **cognitive behavioural strategies** and **mindfulness meditation**, and explain why both are classified as psychological protective factors.

Cognitive behavioural strategies work by **changing** unhelpful thinking and behaviour: a person **recognises an unhelpful or unrealistic thought, tests it and reframes it** into a more balanced one, and **builds helpful behaviours** such as breaking a task into steps or scheduling enjoyable activity. **Mindfulness meditation** works instead by **observing** experience as it is: deliberately attending to the **present moment** (the attention component) and allowing thoughts, feelings and sensations to be experienced **without judging them** (the acceptance component), rather than disputing or changing them. So the two differ in what the person does with a thought — **challenge and change it** versus **notice it and let it pass**. Both are **psychological** protective factors because both are **mental strategies for thinking and coping** that the person applies to their own thoughts and feelings, and both, practised regularly, **reduce stress and support emotion regulation**, helping to maintain wellbeing. ∴ cognitive behavioural strategies restructure unhelpful thinking while mindfulness meditation builds non-judgemental awareness of it, and both maintain wellbeing as psychological protective factors.

Example 4 — unscaffolded

A student says, "Using mindfulness and eating well to keep myself well is really the same thing as getting treatment for a mental disorder." Explain why this statement is incorrect.

The statement confuses a **protective factor** with a **treatment**. Mindfulness meditation and adequate nutrition are **protective factors**: their purpose is to **support and maintain** wellbeing, build resilience and buffer stress, so that a decline in wellbeing is **less likely**. **Treatment** (Chapter 10) is different: it is an intervention delivered **for a diagnosed disorder**, such as a specific phobia, and its purpose is to **relieve the symptoms of that disorder and restore** the person's functioning. The two therefore differ in **purpose**, not in the activity itself — a cognitive behavioural approach, for example, can appear in both. They are also **not alternatives**: someone receiving treatment can still use protective factors to help maintain their wellbeing and guard against **re-occurrence**. ∴ protective factors and treatment serve different purposes, so looking after your own wellbeing is not the same thing as being treated for a disorder.

Practice questions

Scaffolded

Q1. Define each of the following: (a) a protective factor, in the context of maintaining mental wellbeing; (b) the biopsychosocial approach; (c) mindfulness meditation.

Q2. Classify each of the following protective factors as **biological**, **psychological** or **social**: (a) adequate hydration; (b) using cognitive behavioural strategies to reframe unhelpful thoughts; (c) an authentic and energising friendship.

Q3. The study design lists three biological protective factors. (a) Name the three biological protective factors. (b) For adequate nutrition, state one way it supports wellbeing. (c) For adequate sleep, state one way it supports wellbeing.

Q4. Supportive social connections are described as authentic and energising. (a) Explain what it means for a relationship to be **authentic**. (b) Explain what it means for a relationship to be **energising**. (c) Explain why the **quality** of social connections matters more than the number of them.

Q5. Consider the two psychological protective factors named in the study design. (a) Outline what **cognitive behavioural strategies** involve. (b) State one difference between cognitive behavioural strategies and mindfulness meditation. (c) Explain why **both** are classified as **psychological** protective factors.

Q6. (a) Explain the difference between a **protective factor** and a **treatment**. (b) Explain what it means to say the biopsychosocial approach is **holistic**. (c) Give one biological, one psychological and one social protective factor.

Unscaffolded

Q7. Distinguish between a biological protective factor and a psychological protective factor, using one example of each. *(2 marks)*

Q8. Sort each of the following into the correct domain (biological, psychological or social): drinking enough water; a weekly game of cards with genuine friends; scheduling enjoyable activities to lift mood; getting eight hours of sleep; practising ten minutes of mindful awareness. *(3 marks)*

Q9. Explain how **adequate nutrition** acts as a biological protective factor that helps a person maintain their mental wellbeing. *(2 marks)*

Q10. Léa often forgets to drink water on busy days and notices she feels foggy and irritable by the afternoon. Explain how **adequate hydration** could help Léa maintain her wellbeing. *(3 marks)*

Q11. Explain how **mindfulness meditation** helps a person maintain wellbeing, referring to its effect on **rumination**. *(3 marks)*

Q12. Before an exam period, Declan notices himself thinking "I'll fail everything," and he starts avoiding study. His teacher suggests he write the thought down, ask whether it is realistic, replace it with a more balanced thought, and break his study into small scheduled sessions. Identify the psychological protective factor Declan is using and explain how it helps him maintain his wellbeing. *(3 marks)*

Q13. Anika has two hundred online followers she rarely speaks to, and one close friend, Josie, who she can be honest with, who leaves her feeling positive, and who helps her when she is stuck. Using the idea of **authentic and energising** connections, explain which of these better protects Anika's wellbeing, and why. *(3 marks)*

Q14. Rohan has finished treatment for a specific phobia and is now well again. His psychologist meets with Rohan's family to explain how they can support him. Explain how **support from family that is authentic and energising** helps Rohan maintain his mental wellbeing now that his treatment has ended. *(3 marks)*

Q15. Outline **two** ways in which **adequate sleep** protects a person's mental wellbeing. *(2 marks)*

Q16. *Research scenario.* A psychologist records the average nightly sleep and a daily mood rating (out of 10) of 60 adults over two weeks. Adults who averaged seven to nine hours of sleep reported higher mood ratings than those who averaged under six hours. No variable was manipulated. (a) Identify the two variables the psychologist measured. (b) Identify whether this investigation allows the psychologist to conclude that better sleep *caused* the higher mood, and justify your answer. (c) State one conclusion the psychologist can reasonably draw from these results. *(4 marks)*

Q17. *Research scenario.* A psychologist runs an eight-week course teaching adults cognitive behavioural strategies for everyday stress. Twenty-five adults complete a wellbeing questionnaire (scored out of 45; a higher score means greater wellbeing) in the week before the course begins and again in the week after it finishes. The results are shown below.

Time of measurement	Mean wellbeing score	Standard deviation
Before the course	26.8	6.2

Time of measurement	Mean wellbeing score	Standard deviation
After the course	33.5	5.4

(a) Name the experimental design used in this investigation.

(b) Identify which domain of protective factors the course targets.

(c) The psychologist concludes that the course caused the increase in wellbeing. Explain one reason this conclusion is not justified. *(4 marks)*

Q18. Dev eats well, sleeps well and uses cognitive behavioural strategies, but he has recently withdrawn from all his friends and family. Using the biopsychosocial approach, identify which domain of protective factors Dev is neglecting, suggest one specific protective factor he could add, and explain how it would help him maintain his wellbeing. *(3 marks)*

Q19. Explain why the biopsychosocial approach to maintaining wellbeing is described as **holistic**, and justify your answer with reference to an example that includes all three domains. *(3 marks)*

Q20. *Extended response.* Harper is a healthy Year 12 student who wants to stay mentally well through a demanding year. Design a **biopsychosocial wellbeing-maintenance plan** for Harper that includes **one biological, one psychological and one social protective factor**. For each factor, explain how it helps Harper **maintain** (rather than treat) her wellbeing. *(6 marks)*

Answers

Q1. (a) A resource, habit or relationship that supports and maintains wellbeing, builds resilience and buffers stress, making a decline less likely. (b) A holistic framework that considers biological, psychological and social factors together. (c) Deliberate present-moment, non-judgemental awareness of thoughts, feelings and sensations. **Q2.** (a) biological; (b) psychological; (c) social. **Q3.** (a) Adequate nutrition, adequate hydration, adequate sleep. (b) Supplies nutrients for stable mood/energy and clear thinking. (c) Restores the brain and helps regulate emotion. **Q4.** (a) Genuine and honest — a person can be themselves. (b) Uplifting — leaves a person feeling replenished and positive, not drained. (c) Because authentic and energising relationships provide belonging and support; many shallow or draining ones do not. **Q5.** (a) Recognising and reframing unhelpful thoughts and developing helpful coping behaviours. (b) Cognitive behavioural strategies change unhelpful thoughts and behaviour; mindfulness observes thoughts and feelings without judging or changing them. (c) Both are mental strategies for thinking and coping that a person applies to their own thoughts and feelings. **Q6.** (a) A protective factor supports and maintains wellbeing, making a decline less likely; a treatment is an intervention for a diagnosed disorder, aimed at relieving symptoms and restoring functioning. (b) It considers biological, psychological and social factors together, not in isolation. (c) e.g. adequate sleep (biological); mindfulness (psychological); supportive friendship (social). **Q7.** A biological protective factor meets a body need (e.g. adequate sleep); a psychological protective factor is a mental strategy (e.g. mindfulness). **Q8.** Biological: drinking enough water; eight hours of sleep. Psychological: scheduling enjoyable activities; mindful awareness. Social: weekly cards with genuine friends. **Q9.** A balanced diet supplies nutrients for stable mood, energy and clear thinking, giving the brain a healthy base and helping keep wellbeing stable. **Q10.** Adequate water supports concentration and mood, so Léa is less foggy and irritable and better able to cope, maintaining her wellbeing. **Q11.** Mindfulness fosters present-moment, non-judgemental awareness, which reduces rumination and stress, helping maintain wellbeing. **Q12.** Cognitive behavioural strategies — reframing the unhelpful thought and scheduling behaviour help Declan manage stress and stay well. **Q13.** Josie better protects Anika: the friendship is authentic and energising, whereas the followers are not; quality matters more than quantity. **Q14.** Genuine, honest support that leaves Rohan replenished gives him belonging, practical help and emotional support, buffering stress and building resilience — so his wellbeing is maintained and a decline, including a re-occurrence of the phobia, is less likely. **Q15.** Any two of: it lets the brain and body restore themselves, keeping mood and energy stable; it helps a person regulate their emotions; it supports clear thinking and concentration the next day, so daily demands are easier to cope with. **Q16.** (a) Average nightly sleep and daily mood rating. (b) No — no variable was manipulated (observational), so cause cannot be concluded. (c) There is a relationship/association between more sleep and higher mood. **Q17.** (a) A within-subjects (repeated-measures) design. (b) Psychological. (c) There was no control group, so an extraneous variable acting over the eight weeks could explain the rise instead. **Q18.** Social — Dev is neglecting social protective factors; he could reconnect with an authentic, supportive friend or family member, which would give him belonging and support that buffers stress and maintains his wellbeing. **Q19.** Holistic = it treats biological, psychological and social factors together; e.g. sleeping well + mindfulness + a supportive friend jointly maintain wellbeing. **Q20.** Model response given in the solutions.

Fully-worked solutions

Q1. (a) A **protective factor** is a resource, habit or relationship that **supports and maintains** a person's wellbeing, **builds resilience** and **buffers** the impact of stressors, so that a **decline in wellbeing is less likely**. (b) The **biopsychosocial approach** is a **holistic** framework that explains and supports wellbeing by considering **biological, psychological and social factors together** rather than in isolation. (c) **Mindfulness meditation** is deliberately paying attention to the **present moment** in a **non-judgemental** way — noticing thoughts, feelings and sensations as they are, without getting caught up in them.

Q2. (a) Adequate hydration is a **biological** protective factor (it meets a body need). (b) Using cognitive behavioural strategies is a **psychological** protective factor (a mental/thinking strategy). (c) An authentic and energising friendship is a **social** protective factor (a relationship/connection).

Q3. (a) The three biological protective factors are **adequate nutrition**, **adequate hydration** and **adequate sleep**. (b) **Adequate nutrition** supplies the nutrients the brain and body need, supporting **stable mood, steady energy and clear thinking**. (c) **Adequate sleep** allows the brain and body to **restore themselves** and helps a person **regulate their emotions**, keeping mood and functioning stable.

Q4. (a) An **authentic** relationship is **genuine and honest** — one in which a person can be their true self rather than putting on a front. (b) An **energising** relationship is one that **uplifts** a person, leaving them feeling **replenished and positive** rather than drained. (c) **Quality** matters more than **quantity** because it is **authentic and energising** connections that provide belonging, practical help and emotional support; a large number of shallow or draining relationships does not give this protection, so *how* a person is connected matters more than *how many* people they know.

Q5. (a) **Cognitive behavioural strategies** involve **recognising unhelpful or unrealistic thoughts and reframing them** into more balanced ones, and **developing helpful behaviours and coping** (such as problem-solving, breaking tasks into steps or scheduling enjoyable activity). (b) One difference is **what the person does with a thought**: cognitive behavioural strategies **challenge and change** an unhelpful thought, whereas **mindfulness meditation observes** the thought in the present moment and lets it pass **without judging or changing it**. (c) Both are **psychological** protective factors because both are **mental strategies for thinking and coping** that a person applies to their own **thoughts and feelings** — they act on the mind rather than on the body's physical needs or on the person's relationships.

Q6. (a) A **protective factor** works to **support and maintain** wellbeing and make a decline **less likely** — its purpose is protection. A **treatment** (Chapter 10) is an intervention delivered **for a diagnosed disorder**, aimed at **relieving its symptoms and restoring** functioning. The same activity can appear in both, so it is the **purpose** that separates them. (b) The approach is **holistic** because it considers **biological, psychological and social** factors **together** as interacting influences, rather than looking at any one in isolation. (c) For example: **adequate sleep** (biological), **mindfulness meditation** (psychological) and an **authentic, supportive friendship** (social).

Q7. A **biological** protective factor meets one of the **body's physical needs** — for example, **adequate sleep**, which restores the brain and regulates emotion. A **psychological** protective factor is a **mental strategy** for thinking and coping — for example, **mindfulness meditation**, which builds present-moment, non-judgemental awareness. The two differ in *what they act on*: the body versus the mind.

Q8. Biological: drinking enough water (hydration) and getting eight hours of sleep (both meet body needs). **Psychological:** scheduling enjoyable activities (a cognitive behavioural strategy) and practising mindful awareness (mindfulness) — both are mental/coping strategies. **Social:** the weekly game of cards with genuine friends (an authentic, supportive connection).

Q9. Adequate nutrition means eating a **balanced diet** that supplies the nutrients the brain and body need to function. This supports **stable mood, steady energy and clear thinking**, giving a person a healthy biological base so that their wellbeing is **maintained** and less likely to decline.

Q10. Adequate hydration means Léa drinking **enough water** across the day. Because water supports **normal brain function, concentration and mood**, staying hydrated should reduce the afternoon **fogginess and irritability** she notices when she forgets to drink. Feeling clearer and steadier, Léa is better able to cope with her busy days, which helps **maintain** her wellbeing.

Q11. Mindfulness meditation builds **present-moment, non-judgemental awareness** of thoughts and feelings. Practised regularly, it **reduces rumination** — the habit of repetitively dwelling on negative thoughts — because a person learns to notice such thoughts and let them pass rather than getting caught up in them. Lower rumination and stress support emotion regulation, which helps **maintain** wellbeing.

Q12. Declan is using **cognitive behavioural strategies**. He **recognises an unhelpful thought** ("I'll fail everything"), checks whether it is realistic and **reframes it** into a more balanced thought, and he **develops helpful behaviour** by breaking study into small scheduled sessions instead of avoiding it. By changing both his thinking and his behaviour, Declan can manage his exam stress and **maintain** his wellbeing rather than letting it decline.

Q13. Josie better protects Anika's wellbeing. The friendship with Josie is **authentic** (Anika can be honest) and **energising** (it leaves her feeling positive), and it genuinely **supports** her (Josie helps her when she is stuck) — providing belonging, practical help and emotional support. The two hundred followers she rarely speaks to are **not** authentic or energising, and offer no supportive connections. This shows that the **quality** of social connections protects wellbeing more than their **quantity**.

Q14. Support from family that is **authentic** (genuine and honest, so Rohan can be himself about how he is going) and **energising** (leaving him replenished rather than drained) is the **social protective factor** named in the study design. It maintains Rohan's wellbeing by giving him **belonging**, **practical help** (people who will go with him or help him plan) and **emotional support** (people he can talk to and be encouraged by), which **buffers** the stress he meets and **builds his resilience**, so he is better able to cope with change and uncertainty. Because its purpose is to **protect and maintain** his wellbeing rather than to treat a disorder, it keeps working now that his **treatment has ended**: it makes a decline in his wellbeing — including a **re-occurrence** of the phobia — **less likely**.

Q15. Any **two** of the following. (1) **Restoration:** during **regular, sufficient sleep** the brain and body **restore themselves**, so the person's **mood and energy stay stable** from day to day. (2) **Emotion regulation:** adequate sleep helps a person **regulate their emotions**, so they are less likely to become irritable or overwhelmed by ordinary demands. (3) **Clear thinking:** adequate sleep supports **concentration and clear thinking** the next day, so study, work and relationships are easier to manage. Each of these keeps functioning steady, which is how sleep **protects** wellbeing as a biological factor.

Q16. (a) The two variables measured are **average nightly sleep** (hours) and **daily mood rating** (out of 10). (b) **No** — the psychologist **did not manipulate any variable**; sleep was simply *measured* as it naturally occurred (an observational/correlational investigation). Without a manipulated independent variable and control of other factors, a **cause-and-effect** conclusion cannot be drawn (other factors, such as stress or exercise, could explain both). (c) A reasonable conclusion is that there is an **association** in this sample between **more sleep and higher mood** — adults who slept seven to nine hours tended to report higher mood than those who slept under six hours.

Q17. (a) The design is **within-subjects (repeated measures)** — the **same** twenty-five adults are measured in **both** conditions (before the course and after it). (b) Cognitive behavioural strategies are **mental strategies for thinking and coping**, so the course targets the **psychological** domain of protective factors. (c) The investigation had **no control group**: every participant did the course, so there is nothing to compare the change against. The mean rise from **26.8 to 33.5** could therefore be caused by an **extraneous variable** acting over the eight weeks — for example seasonal change, other events in the participants' lives, or the participants expecting to feel better because they knew they were on a wellbeing course — rather than by the course itself. Without a comparison group, a **cause-and-effect** conclusion is not justified.

Q18. Dev is neglecting the **social** domain of protective factors — he eats and sleeps well (biological) and uses cognitive behavioural strategies (psychological), but he has **withdrawn from his relationships**. A suitable **social protective factor** would be to **reconnect with an authentic, supportive friend or family member** — for example, arranging a regular catch-up with someone he can be honest with. This would give Dev **belonging**, **practical help** and **emotional support**, which **buffers** the stress he is under, so his wellbeing is **maintained** and all three domains of the biopsychosocial approach are supported.

Q19. The biopsychosocial approach is **holistic** because it treats **biological, psychological and social** factors as **interacting influences that must be considered together**, not in isolation. For example, a student who **sleeps and eats well** (biological), **uses mindfulness** (psychological) *and* **stays connected to a supportive friend** (social) is protected on all three fronts at once; the factors reinforce one another, so together they **maintain wellbeing** more effectively than any one alone. This joint, whole-person view is what makes the approach holistic.

Q20. *Model response (6 marks).* A biopsychosocial wellbeing-maintenance plan for Harper includes one protective factor from each domain. **Biological — adequate sleep.** Harper sets a regular bedtime so she gets eight to nine hours of sleep each night. Sufficient sleep lets her **brain restore itself and regulate her emotions**, so her mood and concentration stay stable through a demanding year — helping to **maintain** her wellbeing. **Psychological — cognitive behavioural strategies.** When Harper notices an unhelpful thought such as "I can't cope," she **reframes it** into a more balanced thought and **breaks her workload into small scheduled tasks**. Managing her thinking and behaviour this way helps her handle study stress and **keeps** her wellbeing from declining. **Social — support from an authentic, supportive connection.** Harper keeps a regular catch-up with a close friend she can be honest with and who leaves her feeling positive. This **authentic and energising** relationship gives her belonging and both practical and emotional support, buffering stress. Because these three factors act **together** (a **holistic** biopsychosocial approach), they build Harper's resilience and **maintain** her wellbeing across the year. Importantly, each of these is a **protective factor**: its purpose is to **support and maintain** Harper's wellbeing and make a decline **less likely**, not to **treat** a diagnosed disorder. *(Full marks require: one correctly classified protective factor from each of the three domains; an*

explanation of how each maintains wellbeing; and the point that they work together and are about maintenance, not treatment.)

Theory

For **Aboriginal and Torres Strait Islander peoples**, wellbeing is understood **holistically** — as **social and emotional wellbeing (SEWB)**, a whole-of-life view in which a person's wellbeing is bound up with **seven domains of connection**: to **body**; to **mind and emotions**; to **family and kinship**; to **community**; to **culture**; to **Country**; and to **spirituality and ancestors** (the SEWB framework is covered in **9A**). Within this holistic view, **connection to, and strength of, culture is a foundation of wellbeing**. This subtopic looks at the **cultural determinants** of wellbeing, and in particular at two of them named in the study design: **cultural continuity** and **self-determination**.

Cultural determinants are **aspects of culture that protect and promote wellbeing** — the **strengths that come from belonging to, practising and maintaining one's culture**. They are a **strengths-based** idea: they describe what culture *gives* a person and a community, not what is missing or what has gone wrong. For Aboriginal and Torres Strait Islander peoples, **connection to and strength of culture is a foundation of social and emotional wellbeing**: culture is not a problem to be managed but a **living source of identity, belonging and strength** that protects and promotes wellbeing. Because they work by *building strength*, cultural determinants are best understood as **protective**, and as **integral to the maintenance of wellbeing** — not as risk factors.

Cultural continuity. Cultural continuity is the **passing on and maintenance of culture across the generations** — the ongoing strength and transmission of **culture, knowledge, language, identity, practices and connection** (to **Country**, kinship and community) from one generation to the next. Everyday illustrations, kept general, include **Elders** and older community members **passing language and knowledge to younger generations**, and communities keeping cultural practices and connection to Country **strong and continuous over time**. Cultural continuity is **protective**: where culture is strong, continuous and able to be passed on, people have a secure, unbroken sense of **identity and belonging**, and **higher cultural continuity is associated with better wellbeing**. Note that cultural continuity is about **living, present-day culture** — culture being kept strong *now* and handed on into the future — not about preserving something that belongs only to the past. In short, cultural continuity answers the question *"is culture being kept strong and handed on across generations?"*

Self-determination. Self-determination is the **right of Aboriginal and Torres Strait Islander peoples to make the decisions that shape their own lives, communities and futures** — to set their own priorities and directions rather than have them set for them. In everyday terms, it means having **genuine control, choice and decision-making power over one's own life, community and affairs** — being the ones who **lead and make the decisions** that affect them, rather than having decisions made for them. A general illustration, kept respectful and non-specific, is

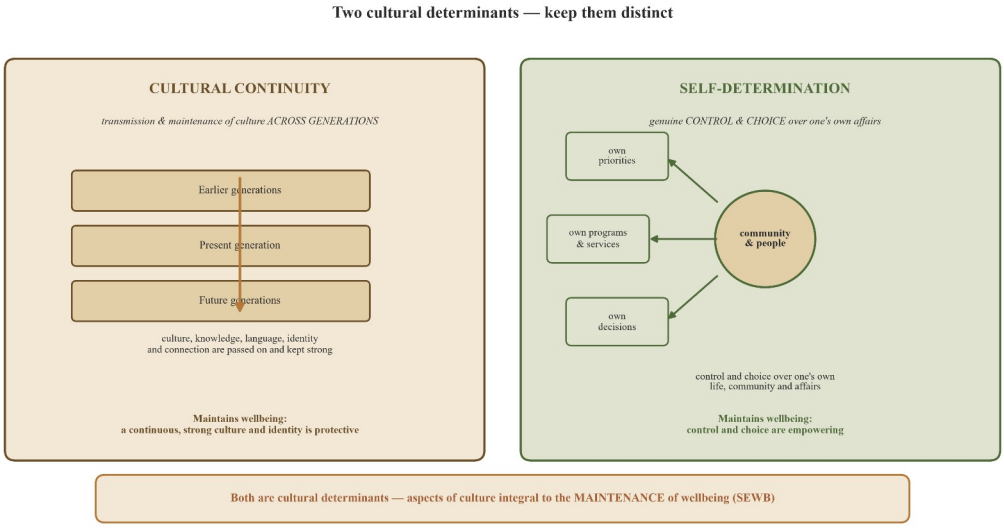
communities leading and controlling their own health, education or community programs, so that services are designed and run **by and for** the community. Self-determination **supports wellbeing**: having real **control and choice** over one's own life and community is **empowering**, and this sense of agency and self-governance **protects and strengthens** wellbeing. In short, self-determination answers the question *"who holds the control, choice and decision-making power?"*

How the cultural determinants maintain wellbeing. Both determinants are described as **integral to the maintenance of wellbeing** for Aboriginal and Torres Strait Islander peoples, and both connect back to the **holistic SEWB framework (9A)**:

- they are **protective** — a strong, continuous culture and a secure cultural identity guard wellbeing and build resilience;
- they are **empowering** — genuine control and choice over one's own life and community give people agency and self-governance;
- they are **strengthening** — keeping culture strong and connection to it alive, and holding control and choice over one's own affairs, continually **build up the cultural foundation** on which wellbeing rests, so that wellbeing is kept strong over time rather than left to decline.

Note the word **maintenance**. Like the protective factors in **9C**, cultural determinants work **while wellbeing is strong, to keep it strong**: they build strength and **buffer** stressors, so that a decline in wellbeing is less likely in the first place. Because SEWB is **holistic**, strengthening the *cultural* connections at its foundation supports wellbeing across the whole framework — which is why these cultural determinants are described as **integral** to maintaining, and not merely as adding to, wellbeing.

Keeping the two determinants distinct. In the exam it is important not to blur the two. **Cultural continuity** is about the **transmission and maintenance of culture *across generations*** (culture being kept strong and handed on over time). **Self-determination** is about **control, choice and decision-making power over one's *own affairs*** (who is leading and deciding). They are related — self-determination can help communities keep culture strong, and strong culture supports communities to lead — but they are **different ideas**, and a question that asks you to *distinguish* between them wants the **transmission / across-generations** idea on one side and the **control / choice** idea on the other.



A note on respectful, accurate language. Use **Aboriginal and Torres Strait Islander peoples** (plural "peoples", recognising many distinct nations and language groups) or **First Nations peoples**; capitalise **Country** and **Elders**. Present cultural determinants as **valid, living, empowering and central** to wellbeing — never as historical, and never as "just a belief". Keep examples **general and respectful** (for example, "communities leading their own health programs", or "passing language and knowledge to younger generations"); do **not** invent, or attribute, specific practices, ceremonies or claims to any particular community.

Worked examples

Example 1 — scaffolded

Explain what is meant by "cultural determinants" of wellbeing, and why connection to culture is described as a foundation of wellbeing for Aboriginal and Torres Strait Islander peoples.

Working	Comment
Define the term: **cultural determinants** are **aspects of culture that protect and promote wellbeing**.	Answer the "what" first, using the study-design meaning.
Make the framing explicit: cultural determinants are **strengths-based** — they describe the **strengths that come from culture itself**, what culture *gives* a person and a community.	Naming the strengths-based framing shows you understand the term precisely.
Explain the foundation idea: for Aboriginal and Torres Strait Islander peoples, **connection to and strength of culture is a foundation of social and emotional wellbeing (SEWB, 9A)** — culture gives identity, belonging and strength.	Link to the holistic SEWB framework — this is the "why".
Emphasise they are **protective and integral to maintaining wellbeing**, not risk factors.	Pre-empt the trap of treating culture as a problem rather than a strength.

Example 2 — scaffolded

Distinguish between cultural continuity and self-determination as cultural determinants of wellbeing, and state what the two have in common.

Working	Comment
State the core of **cultural continuity**: the **passing on and maintenance of culture** — knowledge, language, identity, practices and connection — **across the generations**.	"Distinguish between" needs both sides; give the *across-generations / transmission* idea first.
State the core of **self-determination**: **genuine control, choice and decision-making power over one's own life, community and affairs**.	Now the other side — the *control / choice* idea.
Make the contrast explicit: continuity is about **culture being kept strong and handed on over time**; self-determination is about **who holds the control and makes the decisions**.	A distinguish answer must name the point of difference, congruently.
Note the shared point: both are **cultural determinants** that are **protective / empowering** and **integral to maintaining wellbeing (SEWB)**.	Shows they are two members of the same, strengths-based family.

Example 3 — unscaffolded

A community-controlled organisation plans, staffs and delivers its own family support and housing services, and the community itself decides which services are offered and how they are run. Identify the cultural determinant this best illustrates, and explain how it helps to maintain wellbeing.

This best illustrates **self-determination** — the community has **genuine control, choice and decision-making power over its own affairs**, in this case its own family support and housing services, rather than having those decisions made for it. Self-determination helps to **maintain wellbeing** because having real control and choice over one's own life and community is **empowering**: services that are designed and run **by and for** the community are more likely to fit its needs and to strengthen a sense of agency, ownership and self-governance, all of which **protect and strengthen** social and emotional wellbeing (SEWB). ∴ a community leading and controlling its own services is an example of self-determination, which maintains wellbeing by giving the community empowering control and choice over its own affairs.

Example 4 — unscaffolded

A student writes: "Cultural determinants are just another name for the risk factors that damage the health of Aboriginal and Torres Strait Islander peoples." Identify what is inaccurate about this statement, and rewrite it accurately.

The statement is **inaccurate** in two ways. First, it wrongly frames culture as a **risk factor that "damages" health**, when cultural determinants are **protective strengths** — for Aboriginal and Torres Strait Islander peoples, connection to and strength of culture is a **foundation of wellbeing**. Second, it treats cultural determinants as **harmful conditions acting on people**, when in fact they describe the **strengths that come from culture itself** — from belonging to, practising and maintaining one's culture — and are **integral to the maintenance of wellbeing**. A more accurate statement is: "Cultural determinants, such as cultural continuity and self-determination, are aspects of culture that protect and promote the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples." ∴ cultural determinants are strengths-based and protective, not risk factors.

Practice questions

Scaffolded

Q1. Define each of the following: (a) cultural determinants; (b) cultural continuity; (c) self-determination.

Q2. Cultural determinants describe the strengths that come from culture itself. (a) State what cultural determinants are. (b) State one strength that comes from belonging to, practising and maintaining one's culture. (c) Explain why, for Aboriginal and Torres Strait Islander peoples, connection to culture is described as a foundation of wellbeing.

Q3. Consider cultural continuity. (a) State what is passed on and maintained across the generations. (b) Explain why higher cultural continuity is described as protective for wellbeing. (c) Give one general, respectful example of cultural continuity.

Q4. Consider self-determination. (a) State what self-determination means in terms of control and choice. (b) Explain how self-determination helps to maintain wellbeing. (c) Give one general, respectful example of self-determination.

Q5. Cultural determinants link to the holistic SEWB framework (9A). (a) State what "SEWB" stands for. (b) Explain what it means to say cultural determinants are "integral to the maintenance of wellbeing". (c) Explain why strengthening culture supports wellbeing across the whole SEWB framework.

Q6. Compare cultural continuity and self-determination. (a) State the key idea of cultural continuity in a few words. (b) State the key idea of self-determination in a few words. (c) State one clear difference between the two.

Unscaffolded

Q7. Describe what is meant by "cultural determinants" of wellbeing. *(2 marks)*

Q8. Distinguish between cultural continuity and self-determination. *(2 marks)*

Q9. Explain how cultural continuity helps to maintain the wellbeing of Aboriginal and Torres Strait Islander peoples. *(3 marks)*

Q10. Explain how self-determination helps to maintain the wellbeing of Aboriginal and Torres Strait Islander peoples. *(3 marks)*

Q11. Cultural continuity and self-determination are distinct, but they are related. Explain one way in which each can support the other. *(2 marks)*

Q12. Explain the link between cultural determinants and social and emotional wellbeing (SEWB). *(3 marks)*

Q13. A student writes: "Cultural determinants matter because they preserve traditions from the past." Identify and correct the error in this statement. *(2 marks)*

Q14. *Respectful stimulus.* Two regional towns each run a youth and family program. In the first town, the program is planned and run by an outside agency, which sets the priorities and decides how the program will operate. In the

second town, the local Aboriginal community establishes its own organisation, which plans, leads and runs the program and sets its own priorities. (a) Identify which town's arrangement illustrates self-determination. *(1 mark)* (b) Explain how this difference is likely to affect the maintenance of that community's wellbeing. *(3 marks)*

Q15. *Respectful stimulus.* Over many years, Elders and older members of a community work with younger people to pass on language, knowledge and cultural practices, so that these are kept strong and continuous across the generations. (a) Identify the cultural determinant this scenario best illustrates. *(1 mark)* (b) Explain how this cultural determinant helps to maintain the community's wellbeing. *(3 marks)*

Q16. Explain why cultural determinants are described as **protective** factors for the wellbeing of Aboriginal and Torres Strait Islander peoples. *(2 marks)*

Q17. "Self-determination supports the wellbeing of Aboriginal and Torres Strait Islander peoples." Justify this statement with reference to control and choice. *(3 marks)*

Q18. *Respectful stimulus.* A community both decides for itself how its own local health service is run *and* supports its Elders to pass language and knowledge to younger generations. (a) Identify which cultural determinant each part of the scenario illustrates. *(2 marks)* (b) Explain how, together, these cultural determinants help to maintain the community's wellbeing. *(3 marks)*

Q19. Cultural determinants are described as integral to the **maintenance** of wellbeing. Explain why they matter for Aboriginal and Torres Strait Islander communities that are already well, and not only for those whose wellbeing has declined. *(3 marks)*

Q20. *Extended response.* Explain what is meant by cultural determinants of wellbeing, describe cultural continuity and self-determination, and explain how they are integral to the maintenance of wellbeing for Aboriginal and Torres Strait Islander peoples. In your response, link the cultural determinants to social and emotional wellbeing (SEWB). *(6 marks)*

Answers

Q1. (a) Aspects of culture that protect and promote wellbeing. (b) The passing on and maintenance of culture (knowledge, language, identity, practices, connection) across the generations. (c) The right of Aboriginal and Torres Strait Islander peoples to make the decisions that shape their own lives, communities and futures — genuine control, choice and decision-making power over their own affairs. **Q2.** (a) Aspects of culture that protect and promote wellbeing. (b) e.g. a secure sense of identity, or belonging, or strength and resilience. (c) Because connection to and strength of culture gives identity, belonging and strength, and is a foundation of social and emotional wellbeing. **Q3.** (a) Culture, knowledge, language, identity, practices and connection (to Country, kinship and community). (b) Because a strong, continuous, unbroken culture gives a secure sense of identity and belonging, which protects wellbeing. (c) e.g. Elders passing language and knowledge to younger generations. **Q4.** (a) Genuine control, choice and decision-making power over one's own life, community and affairs. (b) Because real control and choice are empowering, giving agency and self-governance that protect and strengthen wellbeing. (c) e.g. a community leading and controlling its own health programs. **Q5.** (a) Social and emotional wellbeing. (b) That they are central to protecting and maintaining wellbeing — a core part of how wellbeing is kept strong — not an optional add-on. (c) Because SEWB is holistic, so strengthening the cultural connections at its foundation supports wellbeing across the whole framework. **Q6.** (a) Passing on / maintaining culture across generations. (b) Genuine control and choice over one's own affairs. (c) Continuity is about transmission of culture across generations; self-determination is about who holds control and makes decisions. **Q7.** Aspects of culture that protect and promote wellbeing — the strengths that come from belonging to, practising and maintaining one's culture (a strengths-based, protective idea). **Q8.** Cultural continuity = passing on and maintaining culture across generations; self-determination = genuine control, choice and decision-making power over one's own affairs. **Q9.** By keeping culture strong and handing it on across generations, giving a secure, continuous identity and belonging (higher continuity is protective), which maintains SEWB. **Q10.** By giving genuine control and choice over one's own life and community, which is empowering and protects and strengthens SEWB. **Q11.** Self-determination supports cultural continuity: a community that holds control and choice can lead its own language and culture programs, so culture is kept strong and handed on. Cultural continuity supports self-determination: a strong, continuous culture and secure identity give a community the knowledge, confidence and leadership to make its own decisions. **Q12.** Connection to and strength of culture is a foundation of holistic SEWB; cultural determinants protect, maintain and strengthen that foundation, so they are integral to SEWB. **Q13.** Error: cultural determinants are not only about the past. Culture is living and present — cultural continuity is culture being kept strong and handed on now and into the future, and self-determination is about who holds decision-making power today; both maintain wellbeing in the present. **Q14.** (a) The second town (the community-controlled organisation). (b) That community holds genuine control and choice over its own program, which is empowering and gives agency and self-governance, and a program led by and for the community better fits its needs — so wellbeing is maintained; in the first town those decisions are made for the community, so this cultural strength is absent. **Q15.** (a) Cultural continuity. (b) Language, knowledge and practices are kept strong and passed across generations, giving a secure, continuous identity and belonging that protects wellbeing. **Q16.** Because they are strengths that guard and promote wellbeing: a strong, continuous culture and genuine control give identity, belonging and empowerment, which build resilience and buffer stressors, so wellbeing is kept strong. **Q17.** Control and choice over one's own life and community are empowering, give agency and self-governance, and produce decisions and services that fit the community — all of which support wellbeing. **Q18.** (a) Deciding how the health service is run = self-determination; Elders passing on language/knowledge = cultural continuity. (b) Together, control over their own affairs (empowering) and a strong, continuous culture (protective) maintain and strengthen holistic SEWB. **Q19.** Because they work by building and keeping strength: a strong, continuous culture and genuine control maintain identity, belonging and empowerment while a community is well, buffering stressors and building resilience, so wellbeing is kept strong rather than allowed to decline — which is what "integral to the maintenance of wellbeing" means. **Q20.** Model response given in the solutions.

Fully-worked solutions

Q1. (a) **Cultural determinants** are **aspects of culture that protect and promote wellbeing** — a strengths-based idea. (b) **Cultural continuity** is the **passing on and maintenance of culture across the generations** — the ongoing strength and transmission of culture, knowledge, language, identity, practices and connection (to Country, kinship and community). (c) **Self-determination** is the **right of Aboriginal and Torres Strait Islander peoples to make the**

decisions that shape their own lives, communities and futures — in practice, having **genuine control, choice and decision-making power over their own affairs**.

Q2. (a) **Cultural determinants** are **aspects of culture that protect and promote wellbeing** — the strengths that come from belonging to, practising and maintaining one's culture. (b) Any one strength that culture provides, for example a **secure sense of identity**, a sense of **belonging**, or **strength and resilience**. (c) For Aboriginal and Torres Strait Islander peoples, **connection to and strength of culture** gives **identity, belonging and strength**, and is described as a **foundation of social and emotional wellbeing** — so culture is a source of wellbeing, not a problem to be managed.

Q3. (a) What is passed on and maintained is **culture, knowledge, language, identity, practices and connection** (to Country, kinship and community). (b) **Higher cultural continuity is protective** because a **strong, continuous, unbroken culture** gives people a **secure sense of identity and belonging**, and this protects and strengthens wellbeing. (c) A general, respectful example: **Elders and older community members passing language and knowledge on to younger generations**, so that culture is kept strong across time. (No specific practice is attributed to any particular community.)

Q4. (a) **Self-determination** means having **genuine control, choice and decision-making power over one's own life, community and affairs** — being the one who leads and decides, rather than having decisions made for you. (b) It helps to **maintain wellbeing** because real **control and choice are empowering**: they give a sense of **agency and self-governance**, and lead to decisions and services that fit the community — which **protects and strengthens** wellbeing. (c) A general, respectful example: **a community leading and controlling its own health, education or community programs**.

Q5. (a) **SEWB** stands for **social and emotional wellbeing** — the holistic, whole-of-life view of wellbeing used with Aboriginal and Torres Strait Islander peoples (9A). (b) Saying cultural determinants are **"integral to the maintenance of wellbeing"** means they are **central to protecting and maintaining** wellbeing — a core part of how wellbeing is kept strong, not an optional add-on. (c) Because SEWB is **holistic** (its parts are interconnected), **strengthening the cultural connections at its foundation** flows through and **supports wellbeing across the whole framework**.

Q6. (a) Cultural continuity: **passing on and maintaining culture across generations**. (b) Self-determination: **genuine control and choice over one's own affairs**. (c) A clear difference: cultural continuity is about the **transmission of culture across generations** (keeping culture strong over time), whereas self-determination is about **who holds the control, choice and decision-making power**.

Q7. Cultural determinants are **aspects of culture that protect and promote wellbeing**. They are a **strengths-based, protective** idea — the strengths that come from **belonging to, practising and maintaining one's culture** — describing what culture *gives* a person and a community, rather than what is missing or what has gone wrong.

Q8. Cultural continuity is the **passing on and maintenance of culture across the generations** — the transmission of culture, knowledge, language, identity, practices and connection over time. **Self- determination** is having **genuine control, choice and decision-making power over one's own life, community and affairs**. So continuity is about **culture being kept strong and handed on**, whereas self-determination is about **who holds the control and makes the decisions**.

Q9. Cultural continuity maintains wellbeing by keeping **culture strong and handing it on across generations**. When culture, knowledge, language, identity and connection are **passed on and kept continuous**, people have a **secure, unbroken sense of identity and belonging**. Because **higher cultural continuity is associated with better wellbeing**, this continuity acts as a **protective** cultural determinant that maintains social and emotional wellbeing (SEWB).

Q10. Self-determination maintains wellbeing by giving Aboriginal and Torres Strait Islander peoples **genuine control, choice and decision-making power over their own lives, communities and affairs**. Having real control and choice is **empowering**: it provides a sense of **agency and self-governance**, and means that decisions and services are led **by and for** the community, so they better fit its needs. This empowerment **protects and strengthens** social and emotional wellbeing (SEWB).

Q11. The two determinants **reinforce each other**. **Self-determination supports cultural continuity**: when a community holds genuine control, choice and decision-making power, it can lead its own language, education and

culture programs, so culture is kept strong and handed on across the generations in the way the community itself decides. **Cultural continuity supports self-determination**: a strong, continuous culture and a secure cultural identity give a community the knowledge, confidence and leadership — carried by Elders and shared across generations — to make and hold its own decisions.

Q12. Cultural determinants are closely linked to **social and emotional wellbeing (SEWB)**. SEWB is a **holistic** view of wellbeing, and **connection to and strength of culture is a foundation of it**. Cultural determinants such as cultural continuity and self-determination **protect, maintain and strengthen** that cultural foundation, so strengthening them supports wellbeing across the whole holistic framework. This is why they are described as **integral to the maintenance of wellbeing**.

Q13. The statement is **incorrect** — cultural determinants are **not only about the past**. Culture is **living and present**: **cultural continuity** is culture, knowledge, language and identity being kept strong and **handed on now and into the future**, and **self-determination** is about **who holds the control, choice and decision-making power today**. A more accurate statement is that cultural determinants matter because living, continuing culture and genuine control **protect and maintain wellbeing in the present**, not because they preserve something historical.

Q14. (a) The **second town**, where the local Aboriginal community runs the program through its own organisation. (b) In the second town the community holds **genuine control, choice and decision-making power over its own affairs** — it plans, leads, runs and sets the priorities for its own program — whereas in the first town those decisions are made **for** the community by an outside agency. That difference matters because **control and choice are empowering**: they give the second community **agency and self-governance**, and a program led **by and for** the community is more likely to fit its needs. So in the second town self-determination is acting as a cultural determinant that **protects and maintains** social and emotional wellbeing, while in the first town that cultural strength is absent.

Q15. (a) This best illustrates **cultural continuity**. (b) Language, knowledge and cultural practices are being **passed on and kept strong across the generations**, from Elders and older members to younger people. This maintains wellbeing because a **strong, continuous culture** gives a **secure sense of identity and belonging**; since **higher cultural continuity is protective**, keeping culture continuous in this way protects the community's social and emotional wellbeing.

Q16. Cultural determinants are **protective** because they are **strengths that guard and promote wellbeing**, rather than risks that damage it: a **strong, continuous culture** and **genuine control and choice** give people a secure sense of **identity, belonging and empowerment**. Those strengths **build resilience and buffer stressors**, so that wellbeing is **kept strong** — which, within the holistic **SEWB framework**, is what it means to call them protective cultural determinants.

Q17. The statement is **justified**. **Self-determination** gives Aboriginal and Torres Strait Islander peoples **genuine control and choice over their own lives, communities and affairs**. Having real **control** means the community — not an outside body — decides its own priorities and how things are run; having real **choice** means those decisions can reflect what the community actually needs. This is **empowering** and provides **agency and self-governance**, which protect and strengthen wellbeing. Therefore, because control and choice are empowering, self-determination supports the wellbeing of Aboriginal and Torres Strait Islander peoples.

Q18. (a) The community **deciding for itself how its own health service is run** illustrates **self-determination** (the community has control and choice over its own affairs); **Elders passing language and knowledge to younger generations** illustrates **cultural continuity** (culture is maintained and handed on across generations). (b) Together, these cultural determinants maintain wellbeing on **two fronts**: self-determination gives the community **empowering control and choice** over its own services, while cultural continuity keeps its **culture and identity strong and continuous**. Both are **protective** cultural strengths that, within the holistic **SEWB** framework, **protect, maintain and strengthen** social and emotional wellbeing.

Q19. Cultural determinants work by **building and keeping strength**, so they matter while a community is **already well**. Within the **holistic SEWB framework**, **connection to and strength of culture is a foundation of wellbeing** for Aboriginal and Torres Strait Islander peoples, so a **strong, continuous culture** and **genuine control and choice** keep identity, belonging and empowerment secure day to day. Because those strengths **build resilience and buffer stressors**, they make a decline in wellbeing **less likely in the first place**. That is why the study design describes them

as integral to the **maintenance** of wellbeing — they keep wellbeing strong, rather than being called on only once it has declined.

Q20. *Model response (6 marks).* **Cultural determinants** are **aspects of culture that protect and promote wellbeing** — the **strengths that come from belonging to, practising and maintaining one's culture**, rather than anything that is missing or has gone wrong; for **Aboriginal and Torres Strait Islander peoples**, **connection to and strength of culture is a foundation of social and emotional wellbeing (SEWB, 9A)**. Two key cultural determinants are cultural continuity and self-determination. **Cultural continuity** is the **passing on and maintenance of culture across the generations** — the ongoing strength and transmission of culture, knowledge, language, identity, practices and connection (to Country, kinship and community); where cultural continuity is high, people have a secure, continuous sense of **identity and belonging**, which is **protective**. **Self-determination** is the **right of Aboriginal and Torres Strait Islander peoples to make the decisions that shape their own lives, communities and futures**, and in practice means having **genuine control, choice and decision-making power over their own affairs** — for example, communities leading and controlling their own programs; this control and choice are **empowering**. These determinants are **integral to the maintenance of wellbeing** because they **protect** (a strong, continuous culture and identity), **empower** (control and choice), and **strengthen** the cultural foundation on which wellbeing rests. Because **SEWB is holistic**, strengthening these cultural connections at its foundation supports wellbeing across the whole framework — which is why cultural continuity and self-determination are described as **integral to maintaining** the wellbeing of Aboriginal and Torres Strait Islander peoples. *(Full marks require: an accurate definition of cultural determinants; accurate descriptions of both cultural continuity and self-determination, kept distinct; an explanation that they maintain wellbeing (protective / empowering / strengthening); and a clear link to holistic SEWB.)*