

Children as passive victims or agentic subjects?

A discourse analysis of child mental health and wellbeing in
the World Health Organization (WHO) year reports

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Abstract

Child mental health has been an emerging topic in societal as well as scholar spheres. Mental health is intimately connected with wellbeing and as such their promotion by the World Health Organization (WHO) has allowed for governmental and societal structures to be aware of what is necessary to implement and change in order to achieve better child mental health and wellbeing. Through this thesis, the representations of children and how mental health and well-being are constructed are analysed using Bacchi's "What's the problem presented to be" (WPR) method. The aim of this study is to critically examine how the concepts and representations described above are discursively generated in the annual reports of 2015 and 2016 from the WHO.

When analyzing the representations of the child, mental health and wellbeing, two major themes are identified: The vulnerable/agentive child and the best place for a child. The first theme discursively represents children in three forms: Helplessness or victim, passive recipients and agentive. The second theme represents not only children but also their families, the institutions and the institutional staff. Here another three discourses emerge: Connection to the nuclear family discourse, the powerful and harming institutions discourse and the blaming the staff discourse. Regarding the concepts of wellbeing and mental health, the results comprising this thesis suggest that, in the reports, mental health is presented to be a question of who the caregiver is and how resources such as education are distributed. Wellbeing is connected to the presence of the parents with the child avoiding thus institutionalization as well as the children becoming victims of the malpractices of the negligent institutional staff and the possibility of children becoming agents in their own lives. Finally, the seemingly unproblematic aspects of such representations indicate that the arguments about the vulnerable/agentive child and the best place for a child, are not put in context and are about a generalized child that does not fit the specificity of children's worlds.

Keywords: children, mental health, wellbeing, discourse analysis, World Health Organization.

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List of Abbreviations

ADHD – Attention Deficit Hyperactivity Disorder

CRC - Convention on the Rights of the Child

NGO- Non-profit organization

PTSD – Post traumatic stress disorder

US – United States

WHO- World Health Organization

WPR – What’s the problem presented to be

1. Introduction

To define mental health is a difficult target. As Vandenhole, Desmet, Reynaert, & Lembrechts (2015) convey it can be conceptually ambiguous and although mental health problems are some of the most common issues in today's world, they are still considered to be highly stigmatized (Vandenhole, Desmet, Reynaert, & Lembrechts, 2015, p. 1). According to Paschke (2011) the WHO is "a major international health institution on a global scale" (Paschke, 2011, p. 3). Moreover Ferguson (2015) reinforces the relevance of the WHO by saying that it is "the United Nation's lead agency for directing and coordinating health" (Ferguson, 2015, p. 113). The WHO showcases positive dimensions regarding its definition of mental health (Ben-Arieh, Casas, Frønes, & Korbin, 2014, p. 2379) as "a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively, and is able to contribute to their community" (WHO, 2011). According to Ben-Arieh et al. (2014) although this definition appears more fitting for an adult regarding the productivity and potential aspect, it is also key for child mental health. Children who possess the ability to thrive into well-functioning adults are deeply influenced by "individual, familial, and collective factors and contexts that dynamically shape development over the life span" (Ben-Arieh et al., 2014, p. 2379). Children's mental health is a growing field of interest not only for healthcare institutions but also for academic research as the reality is that mental pathologies affect younger society members which are part of an increasing number of reported cases. From several mental health problems such as PTSD to anxiety or depression, health professionals must walk the path of diagnosis carefully as children are highly responsive to changes in their social worlds and environments which can in turn lead to unexpected reactions (Lester & O'Reilly, 2015, p. 3).

The concept of mental health is intimately connected with the concept of wellbeing, as it is shown by the definition of mental health proposed by the WHO. Still, according to O'Shaughnessy (2016), the definition of wellbeing is influenced by time and the persons' individual circumstances (O'Shaughnessy, 2016, p. 15). Also there are other factors which play a part in defining well-being and these are: relationships, context, personal value an individual grants to his/her own life and how this individual functions in society (O'Shaughnessy, 2016, p. 15). Child wellbeing is in the Convention of the Rights of the Child conceived as a balance between all of the following domains: physical, mental, social, spiritual, as well as moral (Kosher, Jiang, Ben-Arieh, & Huebner, 2014, p. 9).

According to Ohlsson (2018), social representations account the process in which socially shared knowledge is recreated and either constructed or reconstructed (Ohlsson, 2018, p. 299). Dias Neto, Figueiras, Campos, & Tavares (2017) convey that social representations regarding health have

been key influencers of attitudes, behaviours and of how individuals communicate such representations (Dias Neto et al., 2017, p. 736). Hacking (2003) claims that the way children, their representations and consequently the constructions of mental health as well as well-being, are products of society and of the time we live in (Hacking, 2003, p. 102). (Hall, (1997) defines representations as “the production of the meaning of the concepts in our minds through language” (Hall, 1997, p. 17). The varying representations of children and specific types of problem were based on the information which was available at the time (Hacking, 2003, p. 102). The ways in which children and mental illnesses are classified and categorized were not stable, since the classifications change meanings, since those being classified also respond to the classification in interactive processes. According to Hacking (2003) the “interactive kind” means that concepts and those being conceptualized interact with each other and this can generate modifications or replacement of such classifications (Hacking, 2003, p. 103). Hacking (2003) concludes that the way we classify children, for instance in an institutional setting, can affect the way children feel and act, which calls for reconceptualizations and new classifications (Hacking, 2003, p. 104). Moreover, according to Hacking (2003), children act back because the way they choose to behave is dependent of the classifications they are under (Hacking, 2003, p. 103)

I believe it is relevant to look for how children are represented in policy document and how they are discursively constructed in contexts where mental health and wellbeing is addressed. Andersson (2012) defines discourse as “a system of statements on an issue that produces meaning and knowledge” (Andersson, 2012, p. 8) To fulfil this goal and conduct my research I have decided to analyze two important WHO reports from 2015 and 2016, in which I looked for how children are represented in these documents as well as how are mental health and wellbeing discursively constructed. It is important to reflect on the relevance of the existence of reports such as the WHO reports which I chose to analyze. These reports are guidelines, they demonstrate current topics which are relevant to society, give insight into what has been done in the past, what is being done at the moment and what will be done in the future. At the same time, the reports produce discourses which construct concepts such as mental health and wellbeing but also different representations of children in specific ways, which I have critically analyzed in the results section.

2. Aim and Research Questions

Child Studies is a field with a broad disciplinary spectrum which focuses on important questions and matters that concern children. I believe this is an important topic for Child Studies because the way we construct the representations of children, wellbeing and mental health can influence treatment,

participation and measures that are taken in order to promote conditions which allow children to develop their full potential. According to Bacchi (2009) policy documents are key when constructing “problems” and as such, the act of analysing policy documents helps generate knowledge regarding the way different topics are discursively conveyed and what types of representations are communicated to the public (Bacchi, 2009, p. 2). In this case, it is relevant to analyze how mental health respectively and wellbeing have been contextualized and given specific meanings within the reports, including how children are represented in these reports.

The focus of this study will concern the WHO reports regarding child health. The WHO reports I have chosen focus on topics such as mental health, wellbeing, institutionalization, children’s rights, health, agency, education, support, integration, economy, poverty, medical care, gender and child participation. I chose these reports as they were the most recent by the WHO regarding the topics I am interested in, which are children, wellbeing and mental health. As I have previously mentioned, the reports were published in 2015 and 2016.

The aim of the study is to analyze the discourses in order to understand the representations of children as well as how mental health and wellbeing are constructed in the chosen reports. To fulfil the proposed aim, these are the research questions I will be answering:

- How are children represented in the chosen reports?
- How is mental health discursively constructed in the chosen reports?
- How is wellbeing discursively constructed in the chosen reports?

3. Epistemological Perspective

This study is of qualitative nature as my objectives require mostly words rather than numbers, contextual understanding, meaning of action and elaboration of concepts and theories from collected data (Bryman, 2012, p. 408).

My epistemological position has as its base interpretivism as this is a position that allows me to develop knowledge through deep investigation which ultimately leads me to understand the phenomenon which I intend to study (Mc Manus, Mulhall, Ragab, & Arisha, 2017, p. 4). Interpretivism does not allow for the generalization of results but rather to conclusions which reflect the circumstances of a specific context (Mc Manus et al., 2017, p. 4). According to Mc Manus, Mulhall; Ragab, & Arisha (2017), when choosing interpretivism one must acknowledge that this means the research showcases a subjective view of the world as well as reality being a socially constructed concept (Mc Manus et al., 2017, p. 4). Such an approach reflects my wish to use my point

of view and knowledge acquired during previous research to interpret the discourses displayed in the reports of the WHO (Bryman, 2012, p. 380)

4. Literature Review

A significant amount of literature can be found regarding mental health and wellbeing, yet there is a lack of publications regarding children and how their representations are discursively constructed in mental health and well-being. In its majority, the literature review for this research was conducted using Google, Google Books and Linköping University Library search engine. The search words which were valuable to my research regarding the theoretical section were: “Child mental health discourses”, “Child mental health policy discourses”, “Wellbeing and mental health discourses”, “Representations of wellbeing” and “Representations of mental health”. The chosen time period to limit the search results was 2010-2018, in order to keep the information as current as possible. To complement my research with clear examples of what had been written regarding these topics I used the library search engine of other Scandinavian universities such as the Norwegian University of Science and Technology (NTNU), the University of Oslo (UiO) and Stockholm University (SU). All the documents used in the process of the writing of this thesis are public domain.

The next sections will allow for a brief background on the concepts which are valuable to my research, these being mental health and wellbeing. This will be followed by a presentation of prior research concerning discursive constructions of child mental health and wellbeing in media and research articles. Finally, there will be a section referring to a brief background of the WHO, the organization which published the reports I used for this thesis.

4.1 Definitions of concepts – mental health and wellbeing

According to Keyes & Simoes (2012), mental health in a historical perspective has been perceived as the absence of a mental disorder, yet today it is known that mental health is much more complex than just the previous definition (Keyes & Simoes, 2012, p. 2164). Estee-Wale (2013) claims that mental health is a double-sided concept as it combines both medical and social influences that take part in the “maintenance of a healthy lifestyle and the resources and application needed to address ill health” (Estee-Wale, 2013, p. 5). Edens (2013) conveys that mental health can be defined by the interaction one has with the people which surround him/her, the way one balances the stress of daily life (school, work, family life) and how the individual copes with difficult situations while trying to live life in an appropriate manner (Edens, 2013). (Dias Neto et al., 2017) convey that in mental health, social

representations take many forms: from positive elements which are connected with the promotion of wellbeing as well as shading light on the conceptions of mental health, to negative elements which are commonly linked to the perpetuation of stigma (Dias Neto et al., 2017, p. 736). Such representations of mental health in social discourse influence individual belief as well as opinions of professionals on how experiences are understood (Dias Neto et al., 2017, p. 737). According to Dias Neto et al. (2017), the research regarding mental health suggests that the most impactful situation linked to social representations of mental health is stigma (Dias Neto et al., 2017, p. 737). Dias Neto et al. (2017) conclude that the stigma which arises from representations of mental health can promote difficult health access, lack of integration as well as it impacts personally on the self-esteem of those you may be searching for support (Dias Neto et al., 2017, p. 737). Finally, the authors conclude that, regarding societal structures, representations can affect both policy and mental health services (Dias Neto et al., 2017, p. 737).

Wellbeing is a concept which is socially constructed and defined by objective and subjective indicators (Kosher et al., 2014, p. 9). Savahl et al. (2015) agree with Kosher et al. (2014) regarding the idea that the concept of wellbeing is highly subjective and as such objective indicators can only partially demonstrate what is quality of life (Savahl et al., 2015, p. 749). Yet, individual discourses, influenced by personal experiences can present how individuals feel about as well as evaluate different aspects of their life (Savahl et al., 2015, p. 749). The authors report that the contemporary research shows that child well-being is dependent on the following dimensions: “Economic and material wellbeing, health, safety, productive activity, place in community, intimacy and emotional well-being” (Savahl et al., 2015, p. 749). Nonetheless, Savahl et al. (2015) argue that it is through qualitative research and the consideration of children as key informants as well as agents in their participation that one can get an insight into the child’s perspective and a more comprehensive knowledge regarding child wellbeing (Savahl et al., 2015, p. 750). In sum, the concept of child wellbeing has many shapes, it is fluid and it changes across time. It must be thought of as a concept which has objective measures but that is also highly subjective. Moreover, the construction of the concept of wellbeing should take into consideration the particular reality of each individual should be taken into consideration as well as how this context affects the way the individual feels and responds with his set of skills to everyday life.

4.2 Key studies

Several studies have been conducted regarding the representations of children in relation to mental health. The studies I present in this section relate to various ways of carrying out discourse analysis

of child mental health in different kinds of documents and settings. According to Wahl (2009), the media is a means of communication that has an impact on how individuals construct mental health and mental illness but also how children are represented in relation to these contexts (Wahl, 2009, p. 249). Clarke, Mosleh, & Janketic (2016) claim that historically children have had little to no control over their representations and have ended up being constructed as objects instead of being portrayed as subjects (Clarke et al., 2016, p. 391). According to Clarke et al. (2016), “social constructions of acceptable and unacceptable children’s behaviours and emotional expression are fundamental to our lives” (Clarke et al., 2016, p. 391). The conceptions of healthy and disordered childhood are a reflection of several complex and powerful interests that affect different parts of our daily life ranging from the political sphere, to social structures to cultural values (Clarke et al., 2016, p. 391). The 20th century has been considered the century of the child yet this became problematic as parenting developed into an active interaction and not merely a social relationship (Clarke et al., 2016, pp. 391–392).

Clarke & Mosleh (2015) claim that, in the US there has been an increasing number of representations of children’s mental health pathologies in the mainstream media. The authors convey that these representations are usually connected to biological features which must be monitored continuously by “mothers whose chief task is to raise happy, nice and successful children” (Clarke & Mosleh, 2015, p. 1). In the study conducted by Clarke et al. (2016) regarding the discourses about children’s mental health and developmental disorders in North American women’s magazines 1990–2012, children who were considered healthy were always implicitly or explicitly represented as “nice”, “successful” and “well-liked” (Clarke et al., 2016, p. 393). Children were represented as dependent on social interaction such as “having friends” in order to achieve happiness or on medication which could provide them with a “more normal life” (Clarke et al., 2016, p. 394). The authors argue that the children who do not fit the pattern described above but are rather “not nice”, “unsuccessful” and “disliked” are the ones who are represented as in need of being medicalized and controlled (Clarke et al., 2016, p. 394). In this study, children end up being portrayed as victims of strong power-relations between themselves, the parents and the doctors who control them through diagnosis as well as treatment (Clarke et al., 2016, p. 394). In the study conducted by Clarke & Mosleh (2015) shows that the representations of children’s mental health, behavioural and emotional problems were heavily linked to family environments (Clarke & Mosleh, 2015, pp. 8–9).

Still regarding mental health representations now in children’s media, according to Wahl (2009) the public inaccurately perceives individuals with mental illnesses as “dangerous, unpredictable, unattractive, unworthy, and unlikely ever to be productive members of their communities” (Wahl, 2009, p. 249). These perceptions have consequences such as self-reports marked by feelings of stigmatization and challenges in life and recovery (Wahl, 2009, p. 249). Wahl

(2009) argues that these inaccurate perspectives have its roots in childhood. After revising several studies since the 1980s Wahl (2009) concluded that although children did not have concrete knowledge of what mental illnesses are or what symptoms they can display, they had already showcased attitudes which “recognized mental illnesses as somehow less desirable than other kinds of health conditions” (Wahl, 2009, p. 250). While children acquire such perspectives through socialization processes with family, educators, friends among others, the media also plays a relevant role in contributing to the construction of the concepts of mental health and mental illness (Wahl, 2009, p. 250). According to Wahl (2009) a study conducted by Gebner regarding children’s television programmes concluded that mentally ill characters are represented as being more likely to fail to complete their goals rather than succeeding. Moreover, mentally ill characters are, as elderly women, more likely to experience injury, exploitation or even death. (Wahl, 2009). Wahl (2009) also refers to another study conducted on children’s films which contained at least one character labelled as having mental illness. The results of this study suggest that although these characters had positive attributes such as being trustworthy and even helpful, they were represented to be frightening as well as threatening to other characters (Wahl, 2009, p. 252).

A very detailed study on representations of mental illness in children’s television was carried out in New Zealand by Wilson et al. (2000). The researchers examined 58 hours of the children’s shows and aimed to look into what were the attributes of the characters represented as having mental illness and what was the language used to refer to them. Wilson et al. (2000) concluded that most of the programs with references to mental illness were cartoons rather than shows with human actors (Wahl, 2009, p. 253). The terms that were most commonly used to refer to mental illness were “crazy” “mad” and “losing your mind”. (Wahl, 2009, p. 253). The six characters which had a mental illness, three were represented as comic and three as evil villains. Mentally ill comic characters behaved in an irrational way which other characters found amusing while mentally ill villains were “were ‘determined and obsessive’ and engaged in criminal acts such as kidnapping and attempted murder” (Wahl, 2009, p. 253). The authors also concluded that there was no understanding of the suffering mental illnesses entail (Wahl, 2009, p. 253).

Other key studies have been conducted in regards to how children are discursively constructed in the context of mental health and mental illness. Bringewatt (2013) wrote a study on children’s mental health diagnoses and their respective contributions to the discourse. The author is heavily influenced by the new sociology of childhood and understands children as active participants both in their social world but also in their personal experiences (Bringewatt, 2013, p. 1220). Events that took place in children’s lives are worth studying as they provide us with an insight into their own perspectives and how, as Corsaro (2011) reports, they are active agents in society, yet also constrained by social structure (Bringewatt, 2013, p. 1220; Corsaro, 2011, p. 29). Estee-Wale (2013) has

identified discourses which represent children as “powerless” and as such argues that although children may only be allowed to be active agents to some extent in health, that there should be an effort to strive for a change in the discourse of children as “powerless and incapable of independent agency” (Estee-Wale, 2013, p. 51). Children are perceived as having little to no knowledge of their pathologies and as such are constructed as recipients of the decisions of their doctors and caregivers (Estee-Wale, 2013, p. 51).

Bergnehr & Zetterqvist Nelson (2015) conducted a study on the discursive exploration of the positioning of children in research on mental–health-promoting interventions. This study was based on 10 articles from eight journals, which derive from the following countries: Denmark, Finland, Sweden and Norway (Bergnehr & Zetterqvist Nelson, 2015, p. 187). These articles were aimed at young people in compulsory education (Bergnehr & Zetterqvist Nelson, 2015, p. 187). According to Bergnehr & Zetterqvist Nelson (2015), most of the articles they analyzed regarding topics such as bullying, general health promotion, social skills, self-esteem, coping and stress do not describe a need of knowing the experiences and opinions of children (Bergnehr & Zetterqvist Nelson, 2015, p. 192). The authors argue that in their chosen articles, health is generally perceived as individual and decontextualized, which leads to a representation of children as the child formed by adults (Bergnehr & Zetterqvist Nelson, 2015, p. 192). Bergnehr & Zetterqvist Nelson (2015) also report that in the articles used for their study, WHO’s suggestions of carrying out “health promotion by and with people, rather than on or to people” were in most cases not actively brought up or discussed (Bergnehr & Zetterqvist Nelson, 2015, p. 192). Yet, the authors point out in a few of the analyzed articles children as well as young people are represented as active agents and health is considered to be “discursively constructed as culturally and socially related” (Bergnehr & Zetterqvist Nelson, 2015, p. 192).

I believe that my research can contribute to this field of study by shedding light upon the types of child representations which are discursively generated in the chosen WHO-reports. Another contribution is the creation of knowledge on how the WHO, in their reports, defines and uses the concepts of mental health and wellbeing.

4.3 World Health Organization (WHO) – A brief background

The WHO was founded on the 7th of April 1948 and headquartered in Geneva, Switzerland as a result of the immediate aftermath of the Second World War with values that later sparked the creation of the United Nations (Clift, 2014, VIII). WHO’s main responsibilities are “providing leadership on global health matters, shaping health research agendas, norms, standards, evidence-based policies,

technical support and monitoring and assessing of health trends for countries” (WHO, 2015 cited by Ferguson, 2015, p. 113). According to Clift (2013), the WHO had the mission to provide “the attainment by all peoples of the highest possible level of health” (Clift, 2013, p. 6) and as such to improve the international public health status while fighting to contain and eradicate infectious diseases worldwide (Paschke, 2011, p. 7). Paschke (2011) argues that through their constitution the WHO invested in reducing health inequity (Paschke, 2011, p. 7). In accordance with Clift (2013), the WHO’s first two decades were heavily focused on “for the application of technical and medical expertise to infectious disease control – such as its eradication programmes for malaria and smallpox” (Clift, 2013, p. 7) The malaria program turned out to be one of their greatest failures (Paschke, 2011, p. 8) while the smallpox program was one of their greatest achievements as the WHO proclaimed that this disease was eradicated worldwide in May 1980 (Clift, 2013, p. 7).

The WHO has and will continue to be relevant because “it is the lead UN agency on health policy” (Ferguson, 2015, p. 113). The WHO contributes and influences the creation as well as the development of global health policies (Ferguson, 2015, p. 113). Moreover, The WHO has been a constant supporter and promoter of mental health for individuals and society at large. Their work compiles “the promotion of mental wellbeing, the prevention of mental disorders, the protection of human rights and the care of people affected by mental disorders” (World Health Organization). The WHO has published several mental health plans as well as written extensively about neurological disorders such as dementia, epilepsy, among others, created initiatives such as “Mental Health and Psychosocial Support in Emergencies” and “Preventing Suicide”, created reports regarding maternal and child mental health, women’s, adolescents’ and children’s mental health, published several fact sheets regarding mental disorders such as depression, psychosis and bipolar disorders, schizophrenia as well as child and adolescents mental disorders (World Health Organization).

Today, the WHO has over 7000 employees from over 150 countries who work in 150 country offices which are placed in six regional offices at their Swiss headquarters in Geneva (World Health Organization).

5. Method

In this section I will describe the use of WPR by Bacchi (2009) for this qualitative research. Data collection section presents the reasons for my choice of reports, what I expected to achieve, how the research was conducted, justification of the chosen method and aims of the analysis.

5.1 Data Collection

For this thesis I have made the decision to work with reports not only because it is what I find most appropriate but also because the access to the data is immediate (Silverman, 2015, p. 58). As I intend to work with the most recent data my documents of choice are the reports on child health from 2015 and 2016 written by the WHO. I intend to understand how children, wellbeing and mental health are discursively constructed. I have chosen these two reports for their similarities regarding its aim population which is children, although the report of 2016 also is directed to adolescents and women, as well as for the similarities of the discussed topics. I conducted my research mostly online using Google as the search engine and going through the chosen reports of the WHO. The search words that were valuable to my research in the WHO reports were: child, children, mental health and wellbeing. Finally, in my research I tried to understand how these reports used the words I mentioned previously and in what type of discourses they fit in.

5.2 Data Analysis

The chosen method for data analysis is WPR (What is the problem represented to be) by Bacchi (2009). I intended to investigate “a particular way of talking about and understanding the world (or an aspect of the world)” (Jorgensen & Phillips, 2002, p. 1) and, according to Bacchi, WPR or What is the problem represented to be, “is a resource, or tool, intended to facilitate critical interrogation of public policies. It starts from the premise that what one proposes to do about something reveals what one thinks is problematic (needs to change)” (Bletsas & Beasley, 2012, p. 21). I have chosen this method to analyze the way mental health, well-being and representations of children are portrayed in the discourses of the WHO reports because, as I have pointed out previously during the literature review, the way we construct mental health as well as wellbeing can impact the way children are represented but also how children perceive themselves. I have also looked for meanings behind the texts and how these concepts are constructed as social problems through the use of specific language (Bacchi, 2009). The data will be analyzed using Bacchi’s WPR (2009) method which is composed of six key questions to be used when analyzing government reports:

1. What is the problem represented to be in a specific policy?
2. What presumptions or assumptions underlie this representation of the problem?
3. How has this representation of the problem come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the problem be thought about differently?
5. What effects are produced by this representation of the problem?

6. How/where has this representation of the problem been produced disseminated and defended?
How could it be questioned, disrupted and replaced? (Bacchi, 2009, p. 2)

Although I will be following this method I will only be using three out of the six questions suggested by Bacchi (2009): What is the problem represented to be in a specific policy?, What presumptions or assumptions underlie this representation of the problem? and What is left unproblematic in this problem representation?. I have chosen these questions as they focus more directly on the analysis of the text itself which reflects my interest on how children, wellbeing and mental health are discursively constructed.

Firstly, I read through the full length of the reports, but during further readings I scanned through the text while looking for the following words: “children”, “mental health” and “wellbeing”, which I then proceeded to highlight. Secondly, I started using the WPR questions I had selected to divide the different types of information that belonged to each question. Regarding my personal use of the questions I used the first question, to identify what problem(s) the reports are addressing in 2015 and then in 2016. I used the second question to look for the underlying meanings of the problem(s) and scrutinize if there are representations of children which are not evident at first. As a result of questions one and two I created themes, which according to Braun & Clarke (2013) are “coherent and meaningful patterns in the data relevant to the research question” (Braun & Clarke, 2013, p. 123). These themes which repeated itself throughout the reports and I divided the information which I felt corresponded to different each of them. Finally, the fourth question allowed me to explore what was left unsaid regarding not only the problem(s) but also the representations which I have found.

6. Reports

The reports used for the analysis were written in English by the WHO in the years of 2015 and 2016. The chosen documents fit the theme in the sense that they represent children in the context of mental health and well-being. All the material used to understand the representations of children as well as the concepts I have previously mentioned are available in the WHO homepage as they keep a public record of the reports they issue. Prior to disclosing the contents of each report, a table will be presented as it allows for an overview of the two reports used as data for the purpose of this research.

	Report Title	Publisher	Publishing Date
Report I	Promoting rights and community living for children with psychosocial disabilities	World Health Organization	2015
Report II	The global strategy for women's, children's and adolescent's health (2016-2030)	Every Woman Every Child	2016

Figure 1. Overview of reports.

6.1 Report I – A brief summary

	Report I
Report Title	"Promoting rights and community living for children with psychosocial disabilities
Publisher	World Health Organization
Publishing Date	2015
Report Length	83 pages
Topic	Initiatives regarding children with psychosocial disabilities

Figure 2. Overview of report I

This first report is part of a series of other reports which were coproduced by the WHO and the Calouste Gulbenkian Foundation's Global Mental Health Platform. The problem presented by the report is that children with psychosocial disabilities are more likely to end up in institutional care and due to the fact that this is detrimental to their development as well as mental health, the report suggests that children should stay with their parents. Moreover, the report suggests that services which aid caregivers to fulfil the needs of the children should be put into place.

6.2 Report II – A brief summary

	Report II
Report Title	The global strategy for women’s, children’s and adolescent’s health (2016-2030)
Publisher	Every Woman Every Child
Publishing Date	2016
Report Length	108 pages
Topic	Initiatives regarding women’s, children’s and adolescent’s health

Figure 3. Overview of report II

This second report is part of a series of other reports which were produced by the WHO during the years of 2010, 2013 and 2016. The first problem presented by the report is that women, children and adolescents are still the most affected when they wish to access resources such as potable water, sanitation, nutrition, health and education. The second problem presented in the report is that women, children and adolescents suffer violence as well as discrimination which makes it challenging not only to actively take part in society but also to use their human rights.

7. Results

This chapter will be organized taking into consideration the three questions of the WPR by Bacchi (2009) which I believe are the most suitable for the aims of my study. The questions I decided to answer are the following: What is the problem represented to be in a specific report? (The problem represented), what presupposition or assumptions underlie the representation of the problem? (Representations of the problem) and what is left unproblematic in this problem representation? (Seemingly unproblematic aspects).

Regarding the representations of the problem, the choice of themes I present in this section took place after reading both reports. I concluded that several of the discussions in the documents focused on the status of the children, their vulnerability as well as their agentic roles. Within the reports’ discussions there was yet another focus and this one being about the best place for a child, either with their parents or in an institution. As such, I realized I had found my two themes: “The vulnerable/agentic child” and “The best place for a child”. Besides these being the most discussed themes throughout the reports, the “The vulnerable/agentic child” has also been a relevant theme to

Child Studies. I believe this perspective regarding health reports can be of interest to the theoretical field as it provides insight to the way children are discursively constructed. “The best place for a child”, in my opinion, is also relevant as this theme can encourage not only the academic world but also society to think about the current concepts of where it is best to care for a child. Regarding other themes I found, there was one I identified which referred to the needs of the child. “The child in need” theme, although interesting was not discussed enough in both reports to be considered for analysis.

Regarding the discourses, I have tried to identify them and respective argumentation within these two themes. The discourse choice was based on which topics appeared more often in connection to the themes “The vulnerable/agentive child” and “The best place for a child”. In the theme “The vulnerable/agentive child” I found the following discourses: Helplessness or victim discourse, passive recipients discourse and agentive discourse. The theme “The best place for a child” is divided into another three discourses: Connection to the nuclear family discourse, the powerful and harming institutions discourse as well as the blaming the staff discourse.

The separation of the two themes and then the division into several discourses that have been found has the aim to clarify the content that creates the different representations of children in the chosen WHO reports.

7.1 The problem represented

This first section is based on the question what is the problem represented to be in a specific policy? and aims to generate an understanding about how the problems of the reports are represented and how the concepts of well-being as well as mental health are discursively constructed.

7.1.1 Disability, Institutionalization and Mental Health

Report I represents children with psychosocial disabilities as being at risk of institutionalization. The report suggests, as a solution to this issue, the creation of services in the child’s community so that the child can remain with the parents. This solution conveys the idea that if the parents do not have these services they cannot provide the necessary care for the child and this will result in institutionalization.

In report I, another topic that is approached is mental health. This report provides the following definition of lack of mental health:

“A health condition characterized by alterations in thinking, mood or behaviour associated with distress or interference with personal functions” (“Promoting rights and community living for children with psychosocial disabilities,” 2015, p. 13).

In the discourse of the report it is possible to understand that the lack of mental health is constructed in association with institutionalization. Ideal mental health is implicitly described as only being attainable if the child spends the first six months of life in a family-based environment.

“One of the leading factors that contribute to the mental health of children is the quality of the relationship with the caregiver, which is characterized by confidence, support, continuity and warmth” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 40).

Moreover, this quote and the report construe mental health as dependent upon the type of relationship the child has with the caregivers. In conclusion, report I represents institutionalization and separation from the parents as major contributors to the lack of child mental health. Finally, the report conveys that institutionalized children and children who are separated from their parents are represented to be more likely to develop attachment problems.

7.1.2 Gender and Wellbeing

Report II focuses on the health and well-being of children, women and adolescents. This report represents children as being at higher risk of death, disease and marginalization. This report conveys that the solution to the problems mentioned above is the creation of services which allow children to attain access to health, education, etc which ultimately contribute to their wellbeing. The construction of well-being in report II has a connection to the topic of gender equality. Report II conveys the idea that girls are represented as being more likely to suffer with lack of access and participation because of their gender, which in turn can affect their wellbeing.

The report represents women as being mostly affected by the lack of access to services, yet women are, in most parts of the world, thought to be the primary caregivers of the children and as such their lack of access to health due to discrimination based on gender implicitly may also impact the wellbeing of their children.

“Despite progress, societies are still failing women, most acutely in poor countries and among the poorest women in all settings. Gender-based discrimination leads to

economic, social and health disadvantages for women, affecting their own and their families' well-being in complex ways throughout the life course and into the next generation” (World Health Organization, 2016, p. 25).

In report II well-being is constructed through being able to create the best possible conditions for children to exercise their rights to access health and therefore promote their own wellbeing. This discourse also implies that there is a lack of equality for women, adolescents and children to be able to access health and that societies perpetuate these differences.

“By helping to create an enabling environment for health, the Global Strategy aims to transform societies so that women, children and adolescents everywhere can realize their rights to the highest attainable standards of health and well-being” (World Health Organization, 2016, p. 5).

To conclude wellbeing is constructed as being dependent of the availability of services that children may need and of gender equality.

7.2 Representations of the problem

This second section is based on the question What presupposition or assumptions underlie the representation of the problem?. It aims to uncover what knowledge is taken for granted regarding the chosen reports. This question focuses on the dichotomy of the vulnerable/agentive child and on the theme the best place for a child. The theme the vulnerable/agentive child produces the discourses that will follow: Helplessness or victim discourse, passive recipients discourse and agentive discourse. These discourses convey different representations of children in the reports and how they are connected to the concepts of mental health and wellbeing. The theme the best place for a child produces the discourses the following discourses: Connection to the nuclear family discourse, the powerful and harming institutions discourse as well as blaming the staff discourse. These discourses present different arrangements which are considered to be the best for the child as well as how the contexts contribute to the constructions of wellbeing and mental health.

7.2.1 Helplessness or victim discourse

The helplessness or victim discourse portrays children as having a lack of decision making power. This discourse conveys the idea that institutions, parents and governmental structures should decide what is best for the children in areas which concern them such as health. The helplessness or victim discourse represents children as not being capable to use their own abilities to change the situations they are facing, for example lack of medical care or negligence.

Children are perceived as the victims of the lack of interventions which promote their quality of life. This is intertwined with the way mental health and well-being are construed, as these concepts are presumed to be connected to the fulfilment of the children's needs.

Although children are not associated with the term "victim", implicitly that is what children are considered to be throughout the reports. Children are perceived as helpless and without the possibility of self-defense. Moreover, children are portrayed as victims of others when it comes to sexual abuse or physical violence. In report I, the WHO enforces the idea previously stated in the following example:

"The risk of physical violence is real, and children with psychosocial disabilities are especially at risk of sexual violence and emotional abuse" (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 16).

The children this report refers to are seen to be victims of stigmatization and often marginalized by what capacities they lack instead of appreciated for the capacities they have. This discourse is ultimately linked to a representation of children as victims of circumstances such as "family poverty, stigma, discrimination, social exclusion, and a lack of community services and resources for children and families" (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 15).

To conclude, the helplessness or victim discourse reinforces the idea that children lack agency as they are unable to make decisions. Decisions regarding, for instance, health are thought to belong to the parents, institutions or other authority figures. Children are represented as victims of institutionalization and of lack of resources in their communities which would allow them to remain with their parents while receiving treatment.

7.2.2 Passive recipients discourse

This discourse focuses on children being represented in the reports as passive recipients of support and in a position of lack of control regarding their own lives. Authorities such as health professionals,

governmental staff or parents are represented as being the ones who take the decisions for the children because they are also portrayed as knowing what children need. An example of the lack of control over their lives is when children are represented as if they cannot choose to stay with their parents. Children are portrayed as having to agree to be separated from their nuclear family if the parents or other health professionals decide it is in their best interest to be institutionalized with the argument that it is the best way for the child to receive medical support.

The decision to put them there is often taken by members of the health services and government authorities rather than parents” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 8).

The quote above is a clear representation of the child as a passive recipient of the decisions of others, in this case members of the health services and government authorities. Report I conveys that the parents should be the ones to take decisions for the child rather than the institutional authorities. This means that the parents are thought to know what the child needs, although this is not always the case. When the report conveys that the decision-making power should belong to the parents instead of the child, this perpetuates a lack of child participation and reinforces the representation of children as passive recipients. In the reports this seem to be an acceptable attitude which has been taken for granted because the goal of parents, health professionals, among others is to provide the child with support. Report I implies that children want and need every type of support that is available to them.

In conclusion, both reports intend to position children as central parts of the matters which concern them, yet the discourse displays a lack of child participation in these same areas. Children are represented as passive recipients of support by different structures (NGO’S, governmental parties, etc) which take care of their well-being but also as passive recipients of the situations they face (institutionalization, lack of access to medical care etc) without the possibility to report to authorities the malpractices they suffer or they themselves being able to take action against them.

7.2.3 Agentic discourse

This discourse presents children as powerful agents with potential to improve their own lives. Moreover, this discourse has a focus on gender as girls are represented as having more difficulties in becoming agents because of gender discrimination.

In report II, children are represented as possibly being active actors in their lives although when the report suggests community participation regarding decisions there is actually no child participation included.

“Women, children and adolescents are potentially the most powerful agents for improving their own health and achieving prosperous and sustainable societies”
(World Health Organization, 2016, p. 58).

Although the agentic discourse focuses on the possibility of the child having an active part in issues such as health, only governmental and non-governmental structures are represented as having an active role in the decision making of areas which affect children’s lives. The discourse in report I presents a view on children in which they may not know they are entitled to participate in issues that concern them because they live in extreme poverty situations or they do not have access to school where they can attain such knowledge and more. Both reports share a focus regarding the education of the child. What I found interesting in the quote below, is that report II represents the homogenous school as the natural choice, in spite of discussions on differentiation also being a way to go.

Inclusive education refers to the provision of meaningful learning opportunities for all school-age children. It allows children both with and without disabilities to attend the same school, with individually tailored support provided to the children who need it, as opposed to segregating children with disabilities in separate schools or providing no opportunities for education at all” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 26)

Yet in report II there is a focus on gender, as girls are represented to be the most affected by the inequality of access to school but also by how they are perceived by boys.

“School curricula should include elements to strengthen the self-esteem of girls and increase respect for girls among boys” (World Health Organization, 2016, p. 21).

As such, the report represents girls as having even more hardships when becoming active agents through personal decision making due to their gender. Girls are represented as having less access to health and education and as such, they are less likely to be agentic. Report II represents girls as being believed to have lower self-esteem than boys and that boys display a lack of respect for girls. I believe this represents girls as vulnerable and as in need of protection. Boys are represented as being in need

to be educated on how to be respectful towards girls, as if there is a gender difference when giving an individual respect. Moreover, I believe that this displays that girls do not have a choice regarding their self-esteem, but boys are represented as having some agency regarding the choice of respecting girls or not.

7.2.4 Connection to the nuclear family discourse

This discourse portrays that the best place for the child is with his/her parents. This discourse also suggests that the parents can provide the best care for the child as well as everything the child needs.

Report I presents several community services and support which are available to parents as well as caregivers, in order to facilitate the provision of care to the child. This implicitly suggests that the individuals responsible for children with psychosocial disabilities need help and support in order to provide the necessary care to the children and avoid their institutionalization. It also implies that these individuals are the best at caring for the child and that they ensure an environment that allows the child to develop. It reinforces the idea that institutionalization is negative and that it can impact the wellbeing and mental health of the children.

Although report I portrays children as having several rights such as the right to remain close to their parents while receiving treatment, they appear to have difficulties exercising those same rights.

“Other children’s rights include freedom from torture or degrading treatment or punishment, the rights to live in the community and to access health-care services, the right to education and, for children with disabilities, the right to receive assistance so that they may access and receive that education” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 1).

Yet I believe the report takes for granted that all children have nurturing nuclear family environments. The reports generalize the idea that the nuclear family is the best place for a child, as if that is always the case for all children.

Report I represent the institutionalization of children in need of care as a negative dimension to the construct of well-being. It conveys the idea that in order to promote child wellbeing, institutionalization must be avoided as much as possible by providing the family with the help which is necessary for them to care for the child. Also, this care should be provided in the child’s house in order to minimize the risk of separation from the parents.

“(...) numerous benefits of early family placement and enhanced caregiving for institutionalized children, including: improved attachment patterns; reduced signs of emotional withdrawal; improved measures of positive affect; and reduced prevalence of psychiatric disorders” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 39).

To avoid the child’s separation from his/her parents, the report also focuses an example of short-break services for children with disabilities in Russia. This service provides the caregivers with the support they need in their own home when caring for their child, thus avoiding institutionalization.

“An evaluation of the programme has shown that it has successfully prevented admission to institutional care” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 69).

This is another example of how report I provides alternatives to avoid the separation of the child from the parents, as this is perceived to be detrimental to the child, yet there is no mention of what situations could propel this separation or what conditions the parents must provide the child with in order to insure the child remains with them.

In conclusion, child well-being in the WHO reports is associated with the provision of constant presence of his/her parents to the child battling an illness and with the provision of care in their own homes as well as the assurance of their caregiver’s health which in turn works in favour of the child’s wellbeing. The connection to the nuclear family discourse, can lead to the placement of children with their family just because it is conceived that this is the best place for them. It is important to generate awareness about such preconceptions which may hide harmful situations to children such as dysfunctional families which can impact the child’s mental health and well-being.

7.2.5 The powerful and harming institutions discourse

The powerful institutions discourse represents institutions as being detrimental to children and children as being at risk of lack of treatment or lack of living conditions.

Report I conveys the idea that when children are institutionalized, they become at risk of receiving wrongful treatment, lack of stimuli and attention, impersonal relationships with staff, lack of hygienic conditions, overcrowded rooms and wards which provide children with abusive rather than caring treatment. Children are portrayed as being institutionalized due to parental lack of knowledge and services but most importantly due to the high pressures generated by authority figures

from these institutions. Children are represented to be highly at risk as I have mentioned before, without being able to report any kind of abuse as it is difficult to do so and even more to make authorities take action. Still, the report assumes that institutionalization induces major harm not only to mental health but also to physical health for the children who endure it.

“The decision to put them there is often taken by members of the health services and government authorities rather than parents” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 8).

As I have referred in the beginning of this section and that can be supported by the previous quote, the institutions are represented to be very powerful. Report I also conveys the idea that the institutions can convince the parents to put their children into institutional care, which implies that parents do not have enough knowledge or power to take their own decisions.

7.2.6 Blaming the staff discourse

The blaming the staff discourse represents institutional staff as being likely to offer wrongful treatment and commit malpractices which children cannot denounce.

In report I, the staff are represented as negligent, likely to commit malpractice and being capable of escaping their mistakes. The staff whom are supposedly taking care of the children are said to be blamed for their malpractices yet, at the same time, they are perceived as being able to excuse themselves due to lack of training and personnel.

“Low numbers of staff, lack of training, poor quality of care, harmful treatment practices and overall neglect preclude any positive outcomes for these children” (World Health Organization & Fundação Calouste Gulbenkian, 2015, p. 19).

The previous quote is an example of how the blaming the staff discourse is presented in report I. The report portrays the staff as overworked, displaying lack of knowledge, neglecting the children they care for and often administering wrongful treatment. The report represents staff as being one of the contributing factors for the lack of well-being and mental health of the children under their supervision. This report even conveys that the staff can deny the children their rights to receive medical treatment such as immunization which makes them more likely to perish.

This representation of the institutional staff conveys the idea that they can be blamed of their shortcomings due to the following reasons: lack of knowledge, lack of training, lack of staff numbers and overall impunity. This discourse also promotes the following misconceptions for the ones who read it: It is almost seen as expected that staff make mistakes due to the factors I have mentioned before and that although they are blamed for their actions they tend to escape their mistakes because they do not have adequate working conditions in order to provide the care the children need.

7.3 Seemingly unproblematic aspects

In this section I will address what I believe has been left unsaid in the reports I have chosen. The seemingly unproblematic aspects which are present in the representations I found will be addressed in the following part.

The reports represent children as being helpless or victims yet, I believe that there are other arguments to this type of discourse. By representing children as victims, children are assumed to be unable to use their own capabilities to change their situations. The helplessness or victim discourse also influences the way institutions and society perceive children. This can stimulate the provision of adequate help and promotion child participation in issues which concern them in order to inspire change not only in the way children are represented but also how the reports address them. Yet, the helpless or victim discourse can also have other risks: institutions and society by perceiving children as incapable of action may neglect their care even further, promote unethical behaviours since children are not capable of reporting them or even perpetuate the perspective of the victim children for their own personal gain, as their malpractices and shortcomings go unpunished. The passive recipients discourse present in the reports does not take into account that children might have a say in the decisions about their care. This is not included in the report, as the idea that is conveyed is that children just submit to the decisions of the adults who surround them. Although report II has a heavy focus on issues which concern children, women and adolescents, are generally portrayed with lack of power to intervene in matters such as health, nutrition, education, etc. This representation of children as incapable of participation silences the importance of personal experiences and of having a voice to make proactive changes to policies as well as to their representations.

The reports have a strong connection to the nuclear family discourse and they do not mention other options such as the child not wanting to stay with the caregivers, the caregivers not desiring to look after the child, the context that needs to be created for the well-being and mental health of the child or what are the determining factors which contributes to the child being taken away of the

family. Finally, this discourse fails to acknowledge that some children can only survive and live because institutionalization saved them from harmful situations.

8. Discussion

I cannot claim to know all the types of the representations of children as well as how the concepts of mental health and wellbeing are construed by the WHO due to the fact that I have only looked into the mentioned reports, which is by all means not representative of the amount of reports produced by this organization yearly.

The problem represented section indicates that report I conveys the idea that children with psychosocial disabilities are the ones who are most likely be institutionalized. In this report wellbeing is associated with the children remaining with the parents and having access to all services they need in order for them to stay in their communities when they receive treatment. This implies that the quality of child mental health is influenced by the type of relationship the child has with the caregivers and if they are present attending to their needs. Report II represents that gender has an influence on well-being as girls are thought to have more difficulties accessing services and health. The report suggests that there should be more interventions focused on the promotion of gender equality, which in turn suggests that girls are still perceived as struggling to have agency and participation in matters which concern them.

The representations of the problem originated two major themes: The vulnerable/agenic child and the best place for a child. In the theme “The vulnerable/agenic child” I found the following discourses: Helplessness or victim discourse, passive recipients discourse and agenic discourse. The theme “The best place for a child” is divided into three other discourses: Connection to the nuclear family discourse, the powerful and harming institutions discourse as well as blaming the staff discourse.

In the helplessness or victim discourse, children are represented to be lacking agency and needing the institutions or the parents to take their decisions for them. This discourse portrays children as not being capable to use their own abilities to change their situations. The helpless or victim discourse influence how children are classified, and because they are aware of the way they are classified, such categorization may lead to the children experiencing themselves as helpless or victims or more actively start challenging the classification. Most importantly, these classifications interact with both the children’s perceptions and acts and with the adults surrounding the children.

Regarding the second discourse of the theme the vulnerable/agenic child, it represents children as passive recipients of the decisions of others, such as health and government authorities. Such

portrayal of children as passive can be connected to the study conducted by Clarke et al., (2016), where children end up being represented as victims of strong power-relations between themselves, the parents and the doctors (Clarke et al., 2016, p. 394). This discourse continues this type of representation as the child's decisions should be taken by their parents. The passive recipients discourse implies that the parents know what is best for the child and not that the child should have some participation in the matters such as their mental health or wellbeing. Again, such a discourse represents that it is granted that the parents know what is best for their children. Moreover, regardless if the parents know best for their child, the discourse on passive recipients does not include child participation. This discourse portrays such attitudes in the behalf of the parents, health professionals, among others as acceptable because they are providing support to the children. In conclusion, the passive recipients discourse does not represent the child as having a say, portraying children are as recipients of support by governmental and non-governmental structures which look after their well-being but also as passive recipients of any situations they may face (institutionalization, lack of access to medical care etc) without any representation of them having possibilities to report to authorities the malpractices they suffer or they themselves being able to take action against it.

Regarding the agentic discourse the children are represented as powerful agents with potential to improve their own lives. This discourse has also a focus on gender, as girls are represented as having more difficulties in becoming active agents because of the lack of equality they face. Girls are represented as struggling the most when it comes to accessing health and education. Also, this discourse portrays girls as having low self-esteem and boys as being disrespectful towards girls. Girls can be perceived also as passive recipients or as victims of the boys' disrespect and as such less agentic. Such representations of girls are a continuation of the "girls with low self-esteem" and the "disrespectful boys" representations. In this discourse, boys are represented to be more agentic as they can choose or not to respect girls while girls remain passive actors who cannot change their low self-esteem.. Taukobong et al. (2016) argues that evidence has shown that "gender norms and inequalities are highly contextual, multifaceted and vary based on intersections with other social stratifies, such as age, race, ethnicity, (dis)ability, income and education" (Taukobong et al., 2016, p. 1493). This suggestion of Taukobong et al. (2016) supports my claim that girls will find themselves expected to be passive actors, if we do not contextualize our representations of them.

The first discourse of the theme "The best place for a child" is the connection nuclear family discourse. Here I was able to conclude that, as conveyed by the discourse, the best place for the child is to be with his/her parents. This discourse also suggests that the parents are the best at providing care for the child all well as what is necessary for the child to develop. Here it is also possible to make a connection with the passive recipients' discourse as similar arguments can be found. The passive recipients discourse represents the parents as the ones taking the decisions for the child as they know

what is best for him/her. In the connection nuclear family discourse, the same idea is implied: parents are seen to be the ones who know best for the child and the child seems to be best placed with the parents. This discourse implies that all nuclear families have a nurturing environment and it does not mention that some families may be dysfunctional for instance, which may not allow them to fulfill the child's needs.

The powerful institutions discourse represents institutionalized children as being at risk not only of wrongful treatment but also of difficult relationships with the staff. This discourse is linked to the connection of the nuclear family because children are represented as only being institutionalized due to pressures generated by authority figures from these institutions. The powerful institutions discourse conveys the idea that if the parents would not be pressured by institutional authorities that their children would remain in parental care. Also, the institutions are represented as being negative towards children but also to their parents. In this discourse the parents appear to be unable to go against the institutions due to their power and as such they are portrayed as struggling to keep their children and ultimately succumbing to the pressures of the powerful institutions.

Finally, the blaming the staff discourse represents institutional staff as negligent as well as likely to commit malpractices. The staff are portrayed as having lack of knowledge and being overworked which leads to the poor mental health and well-being of the children under their care.

There is a dichotomy regarding the construction of wellbeing and mental health in the chosen WHO reports. In the discourses mental health and wellbeing can be attained when parents take decisions for the children in order to provide them with adequate care yet, on the other hand, a child can have mental health and well-being when she/he is agentic as well as an active actor in all matters which concern him/her. These representations of children in well-being and mental health discourses can be connected to the study conducted by Clarke et al. (2016) regarding the discourses about children's mental health and developmental disorders in North American women's magazines 1990–2012. In their study, children who were considered healthy were always implicitly or explicitly represented as “nice”, “successful” and “well-liked” (Clarke et al., 2016, p. 393). I believe that the passive recipients discourse along with the connection to the nuclear family discourse are the ones that influence the construction of the concepts of wellbeing and mental health in the reports. Thus, in the reports, children who can be mentally healthy and have wellbeing are represented either as agents or as passive recipients of support when they are with their parents which is represented as the best place for them. The blaming the staff discourse and the powerful institutions discourse only affirm that the connection to the nuclear family discourse has the strongest link to the concepts of wellbeing and mental health since the nuclear family is considered to be able to protect children from institutionalization, which has already been considered as a contributing factor to the lack of well-being and mental health. The nuclear family is perceived as having the opportunity to defend their

children from the negligent staff, which are thought to provide wrongful treatment to those in their care, if they choose to keep the children in their own homes. The powerful institutions discourse constructs the concepts of wellbeing and mental health as being harmed when the children are institutionalized because children are represented as more likely to have developmental issues as well as attachment problems.

In the seemingly unproblematic aspects I concluded that the way the reports represent children can have several risks which are not addressed, for instance the representation of children as helpless or victims may contribute to their perception as unable to use their own capabilities to change their situations. Also, this categorization can cause children to perceive themselves this way and be detrimental to their well-being as well as their mental health. The helplessness or victim discourse and its representation of children goes in line with the argument of Estee-Wale (2013) which identifies that children are generally portrayed discursively as “powerless” when it comes to their health for instance (Estee-Wale, 2013, p. 51). This discourse is also associated with the child representations institutions and societal structures have. As Bergnehr & Zetterqvist Nelson (2015) have concluded, in their study regarding the discursive exploration of the positioning of children in research on mental-health-promoting interventions, that a lack of an active participation on the child’s behalf regarding the “intervention processes and outcomes” can lead to the children being represented as decontextualized. (Bergnehr & Zetterqvist Nelson, 2015, pp. 188–189). The same can happen when children are represented as helpless victims since it presupposes that children are not able to participate in matters which concern them. Moreover, this representation of children as incapable of action can promote unethical behaviours on behalf institutions and societal structures and perpetuate the perspective of the victim children which can create environments in which the children are not being listen to.

The passive recipients discourse present in the reports does not take into account that children might have a say in the decisions about their care. This can perpetuate the idea that children just submit to the decisions of the adults who surround them.

The strong connection to the nuclear family discourse does not address which context needs to be created for the well-being and mental health of the child or what are the determining factors which contributes to the child being taken away of the family. It also does not account for the fact that some nuclear families may be dysfunctional which could jeopardize the wellbeing and mental health of the child. Moreover, there is a generalization that all institutions are detrimental to children, yet the discourse does not convey the idea that some children can only survive and live because institutionalization saved them from harmful situations.

Finally, the representations of children influence not only the way they are perceived by organizational structures, institutional staff, parents but also themselves. When children are perceived

as agents and informants, their experiences are acknowledged, and they contribute to a better understanding of what factors as well as services contribute to their wellbeing and mental health.

9. Methodological Discussion

What I found challenging about this method was how difficult it can be, as the researcher, to set aside preconceived notions and look in between the lines and as such be aware of the implicit meanings behind the discourse. I believe the biggest challenge of working with such reports is to draw a line between what the reports conclude about a phenomenon and how they represent for example children and health. Another difficulty is to scrutinize the implicit meanings of the reports' texts. It is challenging to realize such implicit values because one becomes blinded to them while immersed in the analysis.

10. Suggestions for Further Research

After conducting my research, I believe there is a literature gap concerning the representations of wellbeing. There are several resources available regarding representations of mental health, but this is not the case when it comes to well-being. Moreover, what could be interesting to explore would be the representations of mental health without necessarily connecting this concept to psychological illness. Both constructs are worth exploring from the child's perspective. To conclude, I believe it is of interest to continue exploring the positioning of children in health reports and how they are discursively represented.

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