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Beyond the Smile: Measuring Children's Psychological well-being
Au-delà du sourire : mesurer le bien-être psychologique de l'enfant

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Abstract: Measuring children's psychological well-being goes far beyond observing whether they appear happy or are smiling. It involves a holistic assessment of their inner functioning and their adaptation to the world. This concept encompasses essential dimensions such as emotional stability, self-confidence and the quality of relationships with peers and adults. It also includes the ability to engage in learning and overcome challenges, as well as the sense of having a recognized place. Unlike purely behavioral indicators, psychological well-being is a dynamic state that reflects the development of personal balance. Assessing it requires a multi-faceted approach, combining observations, interviews and validated tools, to capture the child's own voice and subjective experience. Such measurements are crucial for preventing difficulties, promoting healthy development, and tailoring educational, social and therapeutic interventions.
Keywords: Psychological well-being; Child development; Early mental health; Subjective assessment; Social-emotional skills; Self-esteem; Psychosocial adaptation; Personal fulfilment.
Résumé : La mesure du bien-être psychologique de l'enfant va bien au-delà de l'observation de son apparence heureuse ou de son sourire. Il s'agit d'évaluer de manière holistique son fonctionnement interne et son adaptation au monde. Ce concept englobe des dimensions essentielles telles que la stabilité émotionnelle, la confiance en soi et la qualité des relations avec les pairs et les adultes. Il regroupe également la capacité à s'engager dans des apprentissages et à surmonter des défis, ainsi que le sentiment d'avoir une place reconnue. Contrairement à des indicateurs purement comportementaux, le bien-être psychologique est un état dynamique qui reflète la construction d'un équilibre personnel. L'évaluer nécessite une approche multifocale, combinant observations, entretiens et outils validés, afin de capturer la voix et l'expérience subjective de l'enfant lui-même. Une telle mesure est cruciale pour prévenir les difficultés, promouvoir un développement sain et adapter les interventions éducatives, sociales et thérapeutiques.
Mots-clés : Bien-être psychologique ; Développement de l'enfant ; Santé mentale précoce ; Évaluation subjective ; Compétences socio-émotionnelles ; Estime de soi ; Adaptation psychosociale ; Épanouissement personnel.

Introduction

The laughter of a child at play, the knowing smile shared with a parent, their apparent carefreeness - these are all images that, in the collective imagination, symbolize childhood happiness. Yet behind these superficial displays may lie a far more complex psychological reality. While a crying child immediately attracts attention, one who suffers in silence while putting on a polite smile risks going unnoticed. This dissonance between outward appearance and inner experience raises a fundamental question: how can we understand what cannot be seen?

For a long time, a child's well-being was assessed primarily through material and physical indicators - height and weight, academic achievement, or living conditions. Today, the perspective is broadening. Developmental psychology and affective neuroscience reveal that psychological well-being is an essential pillar, not only for a child's current development but also for shaping the adult they will become. A psychologically well-adjusted child develops greater resilience in the face of adversity, stronger social skills, and an enhanced capacity for learning.

In a rapidly changing world, where children face unprecedented challenges – increased academic pressure, constant digital demands, and multiple societal crises – the need for reliable tools to measure their mental health has become imperative. The central issue guiding this discussion is therefore as follows: how can we objectively and accurately measure a child's subjective psychological well-being, and how can this assessment inform preventive interventions and mental health promotion from a very young age?

This issue involves several dimensions:

- The alignment between quantifiable indicators and the reality experienced by the child;
- The tension between standardizing tools and respecting the uniqueness of each child;
- Potential discrepancies between the child's account, adult observations and behavioral manifestations;
- The delicate balance between necessary assessment and the risk of early labeling;
- Taking cultural and contextual dimensions into account when assessing well-being.

Exploring these questions means recognizing that a child's smile, however precious it may be, is not enough to indicate their psychological well-being. It means being willing to equip ourselves with the tools to listen, beyond appearances, to the sometimes-silent symphony of their inner development.

A rigorous, pluralistic and ethical methodology is required to investigate children's psychological well-being in all its complexities. This approach is based on a sequential explanatory mixed-methods design, structured in several complementary phases. The first phase, which is quantitative and longitudinal, aims to establish an objective overview using a battery of validated psychometric tools, administered to a large representative sample of children, stratified by age, socio-cultural background and living context. This correlational approach will enable the identification of significant predictors of well-being. The second phase, which is qualitative and

phenomenological, will add a subjective dimension to this data by using semi-structured interviews adapted to the child's cognitive development, ethnomethodological observations in natural settings (classroom, playground, home) and projective techniques (drawings, role-play). The thematic analysis of this material will aim to understand the meaning that children themselves attribute to their well-being. Finally, an integration phase will systematically triangulate quantitative and qualitative datawhile comparing perspectives (child, parents, teachers) to identify significant points of agreement and disagreement. This methodology is underpinned by a rigorous ethical framework: informed consent and the child's assent, guaranteed anonymity, the right to withdraw at any time, and the implementation of a psychological support protocol in the event of identified distress, thereby ensuring that the measurement of well-being is not carried out at the expense of well-being itself.

The construction of the corpus is based on structured meetings with teachers and parents, thereby providing an essential dual perspective on the child's experiences. Meetings with teachers take the form of thematic focus groups organized by year group, enabling the collection of their systemic observations on social behaviors, emotional motivations, and warning signs or indicators of resilience within the school context. In parallel, semi-structured individual interviews are conducted with parents, aiming to gain a detailed understanding of the child's development within their family environment, their daily routines, their rhythms and the quality of interactions within the family unit. This dual approach enables the creation of a rich corpus that brings together perspectives on the child within their two main living environments.

The complementarity of this contextual data – between the structured school environment and the privacy of the home – provides a multidimensional understanding of the determinants of psychological well-being, while identifying any significant discrepancies between the behaviors observed in these different contexts; such discrepancies are themselves valuable indicators of the child's psychosocial adjustment.

1. Philosophical and ethical foundations

Understanding a child's psychological well-being cannot be reduced to a mere technical question of measurement. It is rooted in profound philosophical and ethical foundations that have gradually transformed the social and moral status of childhood, redefined the concept of the child's "well-being" and laid the groundwork for a collective obligation to protect and listen to them.

1.1. From object to subject: the revolution in children's rights

Historically, children were often regarded as incomplete beings, the 'property' of their families or merely the plans of adults. The decisive turning point came with the adoption of the Convention on the Rights of the Child (CRC) in 1989[1]. This text marks an ethical revolution by

[1] The Convention on the Rights of the Child (CRC) was adopted by the United Nations General Assembly on 20 November 1989. It is the first international treaty to guarantee the rights of all children, recognizing their civil, political, economic, social and cultural rights. This treaty has become the most widely ratified in the history of human rights, committing signatory states to protect the rights of every child without any discrimination.

recognizingthe child as a subject of rights, fully entitled to fundamental freedoms. Three key principles stem from this, forming the basis for any consideration of a child's well-being:

- **The best interests of the child (Article 3):** This cardinal principle requires that any decision concerning a child must, as a matter of priority, consider what is best for their development and fulfillment. It is a moral imperative that goes beyond the mere satisfaction of material needs to require consideration of the child's psychological well-being and happiness.
- **The right to participation and expression (Article 12):** A child who can form his or her own views has the right to express those views freely on any matter affecting him or her. This right provides the ethical basis for the need to seek the child's direct input when assessing their well-being. It assumes that the child is the foremost expert on their own experience and that a smile is not sufficient to indicate their inner state.
- **The rights to development, protection and non-discrimination:** These rights establish a positive framework that goes beyond the mere absence of harm, requiring the active creation of conditions conducive to the fulfillment of every child, whilst respecting their individuality.

1.2. Recognition of agency and intersubjectivity

From a philosophical perspective, this development is accompanied by a recognition of the child's agency. The child is not a passive being, shaped by their environment, but a social actor who interprets, gives meaning to their experiences and co-constructs their identity through their interactions. This perspective, influenced by the philosophy of mind and phenomenology, legitimizes an intersubjective approach to measurement: well-being cannot be fully understood without considering the child's unique viewpoint and first-person perspective.

1.3. The ethical tension between protection and autonomy

These principles give rise to fundamental ethical tension. On the one hand, the imperative of protection justifies vigilance, or even intervention, based on external observations (by parents, teachers). On the other, respect for the child's autonomy and individuality demands that their subjective account be given paramount importance, even when it contradicts the adult's perspective. Assessing psychological well-being therefore involves constantly navigating this delicate ethical terrain, avoiding both infantilization (which disregards the child's voice) and abdication (which would leave the child solely responsible for their own assessment).

2. Foundational psychological models of well-being

Understanding children's psychological well-being revolves around two major theoretical approaches which, although distinct, prove to be complementary in grasping this complex reality.

2.1. The hedonic approach: subjective well-being

Originally developed by Diener (1984)[2], this concept defines well-being as the pursuit of happiness and the avoidance of suffering. When applied to children, it is structured around three fundamental components:

- **The presence of positive emotions:** joy, enthusiasm, curiosity
- **The relative absence of negative emotions:** sadness, anxiety, persistent anger
- **Overall life satisfaction:** the child's cognitive assessment of their life in various areas (family, friends, school)

This approach has led to the development of instruments such as the "Satisfaction with Life Scale for Children" (SWLS-C)[3] which measures the child's subjective perception of their life. It has the advantage of focusing the assessment on the child's own perspective, thereby recognizing their ability to be the best judge of their own experiences.

2.2. The eudaimonic approach: psychological well-being

Inspired by the work of Ryff (1989)[4]this perspective goes beyond the purely emotional dimension to focus on optimal psychological functioning and the realization of potential. Adapted to childhood, it encompasses:

- **Emerging autonomy:** the ability to make age-appropriate choices;
- **Environmental mastery:** a sense of competence in interactions with one's environment;
- **Personal growth:** openness to new experiences and learning;
- **Positive relationships:** the ability to form warm and authentic bonds;
- **Vital engagement:** interest and involvement in one's activities;
- **Self-acceptance:** a positive view of one's abilities and limitations.

2.3. Developmental integration: the necessary synthesis

The complementary nature of these two approaches appears particularly relevant in the context of child development. While the hedonic approach captures the immediate emotional experience, which is essential for day-to-day well-being, the eudaimonic approach assesses the foundations of healthy long-term psychological development.

Theorists such as Lerner emphasize that a child's optimal well-being lies in the alignment between their individual capabilities and the opportunities offered by their environment. This dynamic view implies that any measure of well-being must necessarily incorporate:

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[2] In 1984, Ed Diener proposed a model of subjective well-being comprising three elements; it describes how people perceive the quality of their lives and encompasses both emotional reactions and cognitive judgements.

[3]The Satisfaction with Life Scale for Children (SWLS-C) is a 5-point self-report measure used to assess the overall life satisfaction of children and adolescents. Adapted from the original adult scale, it uses simplified language and a 5-point response format to ensure it is understandable to those aged 9 and over. Validated across numerous languages and cultures, it is a reliable tool for mental health professionals and researchers.

[4] Carol Ryff's work (1989) defined the concept of 'psychological well-being' through six key dimensions: self-acceptance, positive relationships with others, autonomy, environmental mastery, having a purpose in life, and personal development. This model is based on Aristotle's philosophy, which views well-being as a virtuous life rather than simply feeling happy.

- **Emotions experienced** (hedonic dimension)
- **The development of psychosocial skills** (eudaimonic dimension)
- **The quality of interactions with the environment** (contextual dimension)

This theoretical integration underpins the need to use a variety of measurement tools capable of capturing the richness and complexity of children's experiences of well-being, beyond a mere outward smile.

3. Theories of Development and Resilience

Theories of development and resilience provide an essential framework for understanding the complex dynamics of a child's psychological well-being, viewing it as an evolving and interactive process rather than a static state.

3.1. Key Contributions of Developmental Theories

John Bowlby's attachment theory[5](1969), supplemented by the work of Mary Ainsworth, constitutes a fundamental pillar. It posits that the quality of early bonds between the child and their attachment figures determines the development of a secure internal working model. A secure child, having experienced a sensitive and consistent response to their needs, develops a secure base that enables them to explore the world with confidence, regulate their emotions and build positive social relationships. Conversely, insecure attachment is a vulnerability factor that can hinder the development of well-being. The measurement of well-being must therefore incorporate indicators of the quality of attachment bonds.

Psychosocial development models, such as Erik Erikson's (1950)[6], conceptualize development as a succession of normative crises that the child must resolve to flourish. Psychological well-being thus depends on the successful resolution of these key stages: the acquisition of basic trust (vs. mistrust) in early infancy, autonomy (vs. shame and doubt), and initiative (vs. guilt) in young children. This approach emphasizes that well-being is a progressive construct, where each stage builds on the achievements of the previous one.

Bronfenbrenner's bioecological approach (1979)[7]although socio-ecological, is profoundly developmental. It emphasizes the importance of chronosystemic interactions – the impact of life

[5] The British psychiatrist and psychoanalyst John Bowlby (1907–1990) founded attachment theory in 1958 after studying the effects of premature and prolonged separations between children and their parents following the Second World War. More than a simple need for closeness, attachment forms an essential foundation for security, exploration, self-construction and future interpersonal relationships.

[6] Psychosocial development models, such as Erikson's (1950), describe human development as a series of eight stages, or 'crises', which occur from birth to death. At each stage, the individual faces a psychosocial conflict that must be resolved to develop a healthy competence and avoid feelings of inadequacy that might resurface later. The successful resolution of each conflict leads to virtue (such as hope, willpower, fidelity, etc.) and a stronger personality.

[7] Bronfenbrenner's bioecological approach (1979) is a theory of human development which posits that development is influenced by the interaction between the individual and their environment, divided into five nested systems: the microsystem (immediate environment), the mesosystem (interactions between microsystems), the exosystem (indirect environments), the macrosystem (culture, values, laws) and the chronosystem (temporal dimension). The

events and transitions (moving house, starting school, divorce) on a child's development across different contexts. Well-being is therefore inseparable from the child's adaptation to these normative and non-normative transitions.

4. The resilience paradigm: understanding the ability to bounce back

Theories of development and resilience provide a vital framework for understanding the evolving dynamics of a child's psychological well-being, moving beyond a static view to grasp the processes of adaptation and growth.

4.1. Contributions from historical developmental theories

Jean Piaget's[8] seminal work on the stages of cognitive development highlights that a child's ability to assess and express their well-being is intrinsically linked to their cognitive abilities. A preschooler, whose thinking is egocentric and magical, does not perceive their well-being in the same way as a pre-adolescent capable of hypothetical-deductive reasoning. Similarly, Lev Vygotsky's sociocultural theory emphasizes the social mediation of development: well-being is constructed through interaction with peers and adults via the internalization of discourse and frames of reference. The zone of proximal development[9]thus becomes a conceptual space for thinking about well-being not as a state, but as a potential to be realized through social support.

4.2. Attachment theory: the cornerstone of emotional security

John Bowlby's contribution (1969), supplemented by Mary Ainsworth's work on the "strange situation"[10], is fundamental. She establishes that the quality of attachment to parental figures constitutes the child's "emotional cradle". A secure attachment provides a secure base from which the child explores the world, regulates their emotions and builds future relationships. Conversely, insecure attachment (ambivalent, avoidant or disorganized) is a vulnerability factor that can hinder the development of well-being. Measurement of well-being must therefore incorporate

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approach emphasizes the dynamic and interconnected nature of these systems, highlighting that development is the product of mutual accommodation between the individual and their multiple life environments over time.

[8] Jean Piaget's seminal work on the stages of cognitive development reminds us that a child's ability to assess and express their well-being evolves as they progress through the stages of development. Between the ages of 2 and 7 (preoperational stage), children are egocentric and struggle to understand other people's perspectives, which limits their ability to verbalize and assess their well-being in a complex manner. It is only as they progress to the concrete operational stage (from 7 to 11 years) that children begin to develop more logical and less self-centered thinking, enabling them to better understand and express their well-being.

[9]The zone of proximal development (ZPD) is a concept developed by Lev Vygotsky that describes the gap between what an individual can do on their own and what they can achieve with the help of a more experienced person. It represents an effective learning space where a child, guided by an adult or a more advanced peer, can successfully complete tasks that are currently beyond their reach when working independently. The role of the teacher or mentor is to provide appropriate support to help the learner progress within this zone.

[10] John Bowlby's attachment theory (1969) posits that babies have an innate need for closeness to their attachment figure to ensure their security and development. Mary Ainsworth complemented this work by developing a strange situation' to assess the quality of this attachment, identifying three main styles: secure attachment, avoidant insecure attachment and resistant insecure attachment.

indicators of the quality of attachment bonds, which underpin the ability to trust, manage stress and feel empathy.

4.3. The bioecological model: the child within their contexts

Bronfenbrenner's model (1979) broadens the perspective by situating child development within a system of nested influences. Well-being is not merely the product of intrapsychic processes, but emerges from the dynamic interactions between:

- **The microsystem** (the quality of family, school and peer relationships).
- **The mesosystem** (educational consistency between home and school).
- **The exosystem** (parents' work-related stress, local government policies).
- **The macrosystem** (cultural values and social representations of childhood).

This model highlights the imperative need for a multi-level assessment of well-being, which examines both the child and their ecosystems.

4.4. The theory of resilience: from risk to growth

Popularized in France by Boris Cyrulnik, resilience is the "process that enables one to rise above one's suffering". It brings about a crucial paradigm shift: rather than merely listing risk factors (trauma, deprivation), it identifies the protective factors that enable these to be overcome. These factors are:

- **Internal:** an "easy-going" temperament, social skills, self-esteem, a sense of personal efficacy (Albert Bandura's concept of self-efficacy).
- **External:** the presence of a resilience mentor (a reliable and caring adult), a strong social network, a supportive school environment, and structured frameworks.

Resilience is not a personality trait, but an interactive and evolving process. Measuring the well-being of a child who has experienced adversity is therefore less about assessing their scars and more about mapping their resources and their capacity for positive reorganization.

5. Practical Framework: The Four Pillars of a Child's Psychological Well-Being

For a holistic assessment, we propose structuring the measurement around six fundamental pillars. Each pillar can be observed and assessed using mixed methods (observations, interviews, standardized tools).

5.1. The Emotional Pillar

- **What is measured:** The ability to identify, express and regulate one's emotions. The predominance of positive emotions (joy, curiosity) over negative emotions (sadness, fear, anger).
- **How to measure it:**
  - **Observation:** Richness of emotional vocabulary, reactions appropriate to situations, ability to calm down after a setback.
  - **Tools:** Emotion scales with faces (for young children), semi-structured interviews (What makes you happy/sad/angry?).

5.2.The Social and Relational Pillar

- **What is measured:** The quality of relationships with peers (friends) and significant adults (parents, teachers). The ability to form bonds, cooperate, resolve conflicts and feel empathy.
- **How to measure it:**
  - **Observation:** Group interactions, cooperative games, reactions to a classmate in distress.
  - **Interviews:** Questions about friendships (Do you have a good friend? What do you do with him/her?), perception of family support.

5.3.The Pillar of Physical and Somatic Well-Being

- **What is measured:** Sleep quality, appetite, the presence of somatic complaints (stomach aches, headaches) with no clear medical cause. Relationship with the body.
- **How to measure it:**

  - Interview with parents and the child: Sleep patterns, eating habits, frequency of physical complaints.

5.4. The pillar of meaning and cognition

- **What we measure:** The ability to envisage the future, to have goals and dreams. Flexible and creative thinking. The ability to make sense of one's experiences.
- **How to measure it:**
  - **Observation:** Ability to plan a game, to find alternative solutions to a problem.
  - **Interviews:**"What would you like to do when you grow up?", "What is your fondest memory?"

6. Case study of ten children

Case 1. Anis, aged 8

Profile: Anis is an 8-year-old boy in Year 2. His teacher is concerned because he is 'too well-behaved, is being quietly bullied by two classmates, and has recently seen his academic performance drop. At home, his parents describe him as "an easy-going child who doesn't cause any trouble."Anis's smile in public masks a more complex reality.

Domain	Assessment	Clinical observations
Emotional	Low	Low Anis uses few words to describe his emotions. He often says,"I'm fine". During a role-play, he struggles to express anger. He admits to feeling "a bit sad for no reason" sometimes in the evening. Difficulties with emotional regulation; internalized negative emotions.
Social	Very low	At break time, Anis is often on the fringes of the group. He consistently gives up his turn to others. He says he doesn't really have a "best friend" and that "the other children are

		stronger than him. "
Physical	Low	Anis sometimes wake up at night. He often complains of stomach aches on Sunday evenings and Monday mornings.
Cognitive	Weak	He struggles to envisage the future ("I don't know what I'll do later on"). His speech focuses on avoidance ("I'd like others to forget about me"). Lack of perspective and sense of agency.

Table 1. Measuring Anis's well-being across the four pillars

Analysis and well-being assessment: Anis'sassessment is alarming. His "smile" and "wisdom" are in fact coping strategies designed to avoid conflict and go unnoticed. His psychological well-being is generally poor, with significant deficits in the social, identity and emotional domains. He is at risk of developing generalized anxiety or childhood depression.

Case 2. Sérine, aged 6 – Masked separation anxiety

Profile:Sérine is a lively, chatty 6-year-old girl at home. Since she started nursery, she has been having tantrums and crying fits in the mornings at drop-off that are impossible to calm. The teacher reports that once the outburst has passed (after 10–15 minutes), Sérine takes part in activities but keeps to herself, following another child around like a shadow.

Domain	**Assessment**	**Clinical observations**
Emotional	Significant dysregulation	Inability to cope with separation anxiety (fear, sadness), followed by an emotional "freeze" once the crisis has passed.
Social	Dependent	Mirroring rather than interactive relationships. She does not take the initiative to play with peers.
Physical	Normal	She performs activities appropriately for her age, but her anxiety hinders her ability to demonstrate her skills.
Cognitive	Impaired	School holds no positive meaning for her; it is a place of danger and abandonment.

Table 2. Measuring Serine's well-being across the four pillars

Analysisand well-being assessment: Low, with a central anxiety disorder. Well-being is hampered by separation anxiety, which affects all other areas.

Areas for intervention: Introduction of a transitional object (photo, scarf), reassuring rituals to mark separation, extensive positive reinforcement of moments when the child is calm, working with parents on consistency and trust.

Case 3. Adem, aged 8 – The 'invisible' child with high intellectual potential (HPI)

Profile: Adem is in Year 3 of primary school (3rd AP). He is calm, polite and follows instructions. His results are average. He never causes any trouble. In class, he often daydreams. At home, he spends his free time building complex worlds in Minecraft. No one is worried about him, but his parents find him "absent" and lacking close friends.

Domain	Assessment	Clinical observations
Emotional	Seemingly unemotional on the surface, but deeply sensitive inside	He appears reserved, but during the interview he describes a keen sensitivity to injustice and a fear of rejection.
Social	Self-imposed isolation	He feels out of step with other children his age, whom he finds "immature". He avoids interactions in anticipation of failure.
Physical	Normal	No notable symptoms.
Cognitive	Strong but unshared	He has a rich inner world and elaborate plans (to create a video game), but does not share them with anyone, which makes him vulnerable.

Table 3. Measuring Adem's well-being across the four pillars

Analysis andwell-being assessment: Fragile and unbalanced. Their well-being is maintained within their "bubble" but is very low when interacting with the outside world. There is a risk of academic and social disengagement during adolescence.

Areas for intervention: Identifying her high intellectual potential (HPI) to help her understand how she functions. Inclusion in a group of children with similar interests. Academic enrichment boosts her motivation. Parental guidance to help her connect her inner world with the outside world.

Case 4. Lina, aged 9 – Performance at any cost

Profile: Lina is a brilliant pupil in Year 4, top of her class and a high-level athlete. She is well-liked by her teachers. Her parents are proud of her. For the past few months, she has been suffering from insomnia and episodes of tetany before tests and has started pulling out her eyelashes (trichotillomania).

Domain	Assessment	Clinical observations
Emotional	Anxious and controlled	Intense fear of failure. Unable to relax. Trichotillomania is an outlet for unbearable internal tension.
Social	Superficial	Her relationships are often competitive. She hides her vulnerability, which prevents her from forming genuine friendships.
Physical	Exhausted	Insomnia, muscle tension, symptoms of anxiety (tetany); trichotillomania.
Cognitive	External and urgent	The meaning of her life is to perform. There is no room for exploration or error.

Table 4. Measuring Lina's well-being across the four pillars

Analysis and well-being assessment: impaired, showing signs of juvenile burnout. Well-being is being sacrificed in the name of performance. The situation is cause for concern and requires prompt intervention.

Areas for intervention: psychotherapy to work on unconditional self-esteem, fear of failure and anxiety management. Reassessment of family and academic expectations. Learning relaxation techniques (meditation, cardiac coherence). The aim is to help her redefine her identity beyond her academic results.

Case 5. Iyad, aged 7 – Restlessness as a form of communication

Profile: Iyad is described as "unmanageable": he cannot sit still, talks incessantly, interrupts, and can have impulsive reactions (such as accidentally bumping into people). He is often punished. Yet he is very creative and has a great sense of humor. He says he feels "stupid" and that "nobody loves him."

Domain	Assessment	Clinical observations
Emotional	Unregulated and intense	Excessive emotional reactions (frustration, joy) that he cannot control.
Social	Conflictual	His peers reject him because of his impulsiveness. He is seen as annoying or "mean".
Physical	Restless	A constant need to move; difficulty settling down.
Cognitive	Disorganized	Ideas come thick and fast, but he cannot organize them into a coherent plan.

Table 5. Measuring Iyad's well-being across the four pillars

Analysis and well-being assessment: severely impaired. His outward behavior (restlessness) masks significant inner distress (rejection, low self-esteem). An assessment for ADHD (attention deficit hyperactivity disorder) is required.

Recommendations: neuropsychological assessment. Implementation of strategies to channel his energy (active roles in class, movement breaks). Systematic positive reinforcement of his appropriate behaviors. Therapy to help him understand how he functions and rebuild his self-esteem. Guidance for parents on appropriate educational methods.

Case 6. Camillia, aged 9 – The "perfect" child who can no longer sleep

Profile: Camillia is a model pupil: her work is neat, she is quiet in class, and she spontaneously helps classmates who are struggling. The teachers adore her. At home, she tidies her room without being asked, packs her schoolbag herself and never questions her parents' decisions. Her mother has sought advice because Camillia"can't sleep anymore": she wakes up several times a night, has nightmares, and gets up exhausted. At school, nobody has noticed anything out of the ordinary.

Domain	Assessment	Clinical observations
Emotional	Severely impaired	Camillia never expresses anger or frustration. In an interview, she says, "Children who cry are annoying." She has rigid emotional control.
Social	Superficially well-adjusted	She helps others but never asks for help herself. She has no best friend; she is the 'helper' of the class.
Physical	Severely impaired	Severe insomnia, nightmares, chronic fatigue, daily headaches.
Cognitive	Deficient	She doesn't know what she really likes. Her dreams are those her parents have for her (doctor, lawyer).

Table 6. Measuring Camillia's well-being across the four pillars

Analysisand well-being assessment: Camillia exhibits pathological perfectionism, possibly accompanied by performance anxiety and an internalized disorder. Her emotional hyper-control is a risk factor for future anxiety or depressive disorders.

Case 7. Yanis, aged 6 - Hidden domestic violence

Profile: Yanis was referred to by his teacher due to "problematic" behavior: he suddenly flies into a rage for no apparent reason, has hit two classmates, and was caught hiding food in his locker. At home, his mother says he is "difficult"... but gives no further details. Yanis avoids eye contact and curls up into a ball when an adult raises their voice.

Domain	Assessment	Clinical observations
Emotional	Severe dysregulation	Hypervigilance. Explosive anger followed by a breakdown. Difficulty naming emotions (traumatic alexithymia).
Social	Defiant and fearful	Alternates between aggression and "little soldier"behavior (unquestioning obedience). No friends.
Physical	Warning signs	Dark circles under the eyes, bedwetting (secondary enuresis), suspicious marks (hand-shaped bruises), hides food.
Cognitive	Absent	No plans. When asked "What do you want to do when you grow up?", he replies,"Not get hit".

Table7. Measuring Yanis's well-being across the four pillars

Analysisand well-being assessment: Yanis is very likely a victim of physical and/or psychological abuse within the family. There are numerous warning signs: hypervigilant behavior, alternating between aggression and submission, hoarding food, bedwetting, and bruises. It is essential to report this to the Child Protection Unit (CRIP).

Case 8. Laila, aged 9 - autism spectrum disorder without intellectual disability (ASD-WID)

Profile: Laila has always been "shy. "At secondary school, the situation has deteriorated: she eats alone, does not participate in class, and has developed " tantrums " at home (screaming, self-harm). Her parents describe her as "demanding" and "stubborn." She has an exceptional memory

for her interests (planets, horses) but seems completely disoriented at break time. Her perceived well-being is non-existent.

Domain	Assessment	Clinical observations
Emotional	Dysregulation due to sensory overload	Meltdowns occur after a day of "pretending to be normal. " High sensitivity to noise and light.
Social	Significantly impaired	She does not understand the unspoken rules of social interaction. She takes things literally when they are meant figuratively. The other girls find her "weird."
Physical	Sensory overload	Headaches at break time (noise). Extreme tiredness in the evening. Sleep disturbances.
Cognitive	Isolation from areas of interest	Her sense of purpose lies in her passions, but she cannot share them. School holds no social meaning for her.

Table 8. Measuring Laila's well-being across the four pillars

Analysis and well-being assessment: Laila has an autism spectrum disorder without intellectual disability, which has probably not been diagnosed previously (underdiagnosis is common among girls). Her "breakdown" in Year 7 was due to the increasing complexity of the social demands of secondary school. Autistic burnout is a real phenomenon.

Case 9. Sofiane, aged 10 – After a traumatic bereavement

Profile: Six months ago, Sofiane suddenly lost his father in a road accident. Sofiane was "brave": he didn't cry at the funeral, went back to school quickly, and told his mother, "We must be strong." But for the past month, he has been zoning out in class, his schoolwork has deteriorated, and he has been caught 'stealing' small items from the supermarket.

Domain	Assessment	Clinical observations
Emotional	Massive avoidance	Refuses to talk about his father. Says, "I don't feel anything."Sudden, uncontrollable crying during trivial moments (a song on the radio).
Social	Withdrawal	Has distanced himself from his friends. Finds them"too frivolous. "He prefers to be alone or with adults.
Physical	Disturbed	Sleep disturbances (insomnia, nightmares about the accident). Loss of appetite. Physical complaints (fatigue, generalized aches and pains).
Cognitive	Devastated	His father's death has shattered his understanding of the world. He seeks meaning through risky behavior (theft, possible future runaways).

Table 9. Measuring Sofiane's well-being across the four pillars

Analysis and well-being assessment: Sofiane suffers from complex traumatic bereavement with a risk of post-traumatic stress disorder (PTSD). His apparent "courage" is pathological emotional avoidance. Flight behaviors are attempts to regain control of a world that has lost its meaning.

Case 10. Dania, 10 years old - The little mother

Profile: Dania's 42-year-old mother was diagnosed with progressive multiple sclerosis three years ago. Since then, Dania has "taken responsibility": she wakes up her mother in the morning, prepares breakfast for her and her 7-year-old brother, checks that medication is taken, and accompanies her mother to medical consultations. At school, Dania is a serious student, discreet, and always ready to help. But her grades have dropped; she doesn't go on field trips anymore ("I have to come home early"), and her best friend reports that she "never talks about her problems. " The school nurse is worried: Dania has recurring abdominal pain and unexplained absences.

Domain	Assessment	Clinical observations
Emotional	Massive suppression	Dana says, "I don't have time to be sad". In a one-on-one interview, she breaks down in tears when asked what she would like to do for herself. She confides: "If I break, everything collapses."
Social	Impoverished	She has gradually abandoned her friends, whom she finds "immature" with their schoolgirl concerns. She feels misunderstood and out of touch.
Physical	Severely	Impaired abdominal pain (somatization of anxiety), insomnia, and chronic fatigue. Discreet but significant weight loss.
Cognitive	Entirely dedicated to each other	"The meaning of my life is taking care of mom."No personal projection. To the question "What do you want to do later?" she replies: "I haven't thought about it. If mom is doing well."

Table 10. Measuring Dania's well-being across the four pillars

Analysis and well-being assessment: Dania is in a situation of severe parentification, a process in which the child assumes adult roles and responsibilities (instrumental and/or emotional) chronically and unsuitably for her age. This is silent developmental violence. The major risks are exhaustion, generalized anxiety, depression, and later, difficulties in establishing horizontal relationships (couple, friendship) and taking care of herself.

7. General summary of the 10 cases

7.1. Overview: Profiles and Ages

Case	First Name	Age	Central Issue	Emergency Level
1	Anis	8 years	Passive harassment, internalization	High

2	Serine	6 years	Separation anxiety	Moderated
3	Adem	8 years	HPI, social isolation	Moderate
4	Lina	9 years	Performance anxiety, burn-out	High
5	Iyad	7 years	Probable ADHD, social rejection	High
6	Camellia	9 years	Pathological perfectionism	High
7	Yanis	6 years	Domestic violence	Extreme
8	Laila	9 years	ASD without disability, autistic burnout	High
9	Sofiane	10 years	Traumatic grief	High
10	Dania	10 years	Parentification, family responsibilities	High to extreme

Table 11. Profiles and Ages of the 10 cases

1.1. Cross-sectional analysis by pillar

Level of Achievement	**Cases concerned**	**Typical events**
Severe dysregulation	Yanis, Iyad, Laila	Explosive anger, collapse, hypervigilance.
Controlled anxiety	Lina, Camellia, Sérine	Intense fear, rigid control, somatization.
Internalization/Avoidance	Anis, Sofiane, Dania, Adem	Tendency to keep emotions quiet, "it's okay" as a façade.

Table 12. Most often reached (10/10 cases)

Key Findings:

- No child in this series has an intact emotional pillar.
- Two major profiles emerge: **hyper-control** (Lina, Camellia, Adem) and **external dysregulation (Yanis, Iyad, Laila).**
- The "wise" children (Anis, Camellia, Dania) are those whose suffering is most**invisible.**

Social Pillar:

Pattern social	**Cases concerned**	**Description**
Isolation suffered	Anis, Yanis, Laila	Peer rejection, harassment, exclusion.
Isolation chosen by protection	Adem, Sofiane, Dania	Avoidance of relationships is deemed "immature" or risky.
Superficial/competitive relationships	Lina, Camellia	No real friendships, one-way help.
Dependency	Sérine	Follows another child as a "shadow."

Table 13. Second most vulnerable pillar (9/10 cases)

Only case with an unaltered social pillar: None. Even Iyad, who is agitated, suffers rejection.

Key Findings:

- School bullying (visible or subtle) is underlying in Anis, Laila and Yanis.
- The absence of "best friend" is a **red marker** common in almost all cases.

Physical Pillar:

Physical symptom	**Cases concerned**	**Clinical Meaning**
Anticipatory abdominal pain	Anis, Sérine, Dana	Separation or school anxiety.
Insomnia, nightmares	Lina, Camellia, Sofiane, Yanis, Dania	Hypervigilance, post-traumatic stress disorder, anxiety.
Eating disorders/enuresis	Yanis (food cache, enuresis)	Sign of deficiency or violence.
Sleep disorders + fatigue	Laila, Sofiane	Sensory or traumatic overload
Trichotillomania	Lina	Outlet for an unbearable internal tension.

Table 14. The often-overlooked indicator (8/10 cases)

Key Findings:

- **The body speaks**: even before the child verbalizes his suffering, physical signs appear.
- Sunday night stomach aches **are** a classic of school anxiety (Anis, Serine, maybe Dania).
- Yanis presents the most serious somatic table (hidden dietary deficiency, enuresis, hematomas).

Pillar of Meaning/Cognition:

Situation	**Cases concerned**	**Involvement**
Meaning destroyed/broken	Sofiane, Yanis	Severe trauma, loss of trust in the world.
External direction (performance)	Lina, Camillia	Success Dependent Identity.
Meaning rich but not shared	Adem, Laila	Vulnerability related to the isolation of passions.
Faulty sense (empty)	Anis, Sérine, Dania	Lack of projection, exhaustion of the "for what purpose?"

Table 15. The most variable, but revealing (7/10 cases)

Key Findings:

- The question **"What makes you get up in the morning?"** is an excellent clinical indicator.
- Adem and Laila have a rich but solitary **sense**: their vulnerability is not emptiness, but the impossibility of sharing it.
- Sofiane and Yanis have lost their meaning following a **traumatic event** (sudden death, repeated violence).

1.2. Implications for clinical practice: what these 10 cases teach

- **Do not rely on a smile:** a child can smile and suffer enormously. Sometimes a smile is an armor, not an indicator.
- **The body is a witness**: abdominal pain, insomnia, secondary enuresis, weight loss, psychomotor agitation—these are objective warning signs.
- **The absence of complaints is not the absence of a problem**: "good" or "perfect" children who do not make waves are often at the highest risk of masked depression.
- **School bullying is a major risk factor:** Anis, Laila, Yanis (who becomes an aggressor after being a victim?) ... Bullying is often invisible to adults.
- **Undiagnosed neurodivergent children pay a heavy price:** the exhaustion of "masking" (pretending to be normal) leads to burnout.
- **Parentification is not empowerment:** Dania is not "mature for her age" — she is suffering.
- **Reporting is not a betrayal**: for Yanis, protecting the child takes precedence over loyalty to the family.

Conclusion

Our study aimed to demonstrate that a child's psychological well-being cannot be reduced to the appearance of a smile, wisdom, or good academic performance. Through the detailed analysis of ten clinical cases of children aged 6 to 12 years, with various profiles, we applied an evaluation framework structured around four fundamental pillars: emotional, social, physical, and sense/cognition.

The results speak for themselves. In eight of the ten cases studied, the child was perceived by those around him as "easy, " "wise", "perfect," or "discreet"-qualifiers that paradoxically delayed the identification of their suffering. Anis, Camellia, and Dania perfectly illustrate this observation: the more discreet the child becomes, the more likely their distress goes unnoticed. Conversely, children whose behavior is externalized, such as Iyad and Yanis, are quickly identified as "problematic," but their inner suffering-rejection, low self-esteem, lived violence-often remains unrecognized. Agitation is therefore no more a sign of well-being than wisdom.

The body speaks. Seven out of ten children had recurring physical symptoms: abdominal pain in Anis, Serine, and Dania; insomnia in Lina, Camellia, Sofiane, Dania, and Yanis; secondary enuresis and hiding food in Yannis's house; trichotillomania in Lina; weight loss in Dania. In all these cases, physical symptoms preceded the explicit psychological complaint. The lesson to be

learned is clear: any recurring and unexplained physical symptom in a child, especially when it occurs on Sunday evening or before school, must lead to the search for possible psychological suffering. The pediatrician and the general practitioner play a key role here in early identification.
On the social front, the results are equally alarming. Nine out of ten children had a major alteration of this pillar: isolation, absence of a best friend, peer rejection, superficial or competitive relationships. The absence of a close friend is thus an almost universal red marker in this series. School bullying, whether visible or subtle, is underlying in Anis, Laila, and probably Yanis. Yet, in none of these cases did the teacher or parents identify harassment before the assessment. This finding confirms that bullying in schools remains massively under detected.
Three children, Adem (HPI), Laila (ASD), and Iyad (likely ADHD), also illustrate the exhausting cost of "masking," that is, the constant effort to appear "normal" to avoid rejection. Their collapse often occurs during a change of school cycle, such as entering middle school for Laila, or when social demands exceed their ability to adapt. The practical lesson is this: extreme shyness, restricted and intense centers of interest, a feeling of permanent disconnect, and the absence of genuine friendships must evoke autism spectrum disorder or high intellectual potential, even in a "discreet" girl. Underdiagnosis, especially among girls, remains unfortunately common.
Two cases stand out for their severity and urgency. Yanis, a victim of domestic violence, hides food, has hand-shaped bruises, secondary enuresis, and replies, "do not make me hit," when asked about his future. For him, reporting concerning information to the collection unit is a legal and ethical obligation, not an option. Dania, for her part, embodies severe parentification: at only ten years old, she has "taken responsibility" in the face of her mother's illness and has "no time to be sad. "This silent developmental violence exposes her to burnout, anxiety, depression, and future relational difficulties.
Finally, the pillar of meaning deserves special attention. Children who have lost the meaning of their actions-Sofiane, Yanis, Anis, Sérine-are most at risk of dropping out or exhibiting paradoxical behaviors such as theft, running away from home, or self-aggression. The question "What's the use?" is not just a teenage provocation: it sometimes expresses deep philosophical distress. Conversely, Adem and Laila have a rich but unshared sense. Their vulnerability lies not in a vacuum but in the impossibility of connecting their inner world to the outer one.
The child's psychological well-being is a dynamic, fragile, and multidimensional state. It can be read neither on the face, nor on the school report card, nor in obedience. It is measured by the child's ability to feel and name his emotions, to enter relationships with others without getting lost, to inhabit his body without symptoms of alert, and to give meaning to what he experiences, even when this sense is threatened. The ten children in this study: Anis, Sérine, Adem, Lina, Iyad, Camellia, Yanis, Laila, Sofiane, and Dania are no exceptions. They are the reflection of a daily clinical reality: children who suffer, often in silence, often masked by a smile or misleading wisdom.
Our responsibility, as clinicians, teachers, parents, or citizens, is to learn to look where the child does not show up-in their stomachaches, insomnia, silences, unexplained tantrums, absences,

avoidance behaviors, or, on the contrary, in their hyperactivity control and its apparent perfection. Measuring a child's psychological well-being is not like administering a test. It's taking the time to sit next to him, to listen to what he doesn't say, and to see what he shows unintentionally.

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