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Collaboration Between Parents and Teachers in Addressing School Refusal in Preschool Students with Rectal Atresia (A Case Study of a Home–School Collaboration-Based Educational Psychology Intervention)

Eliza Sutri Utami[1], Tri Yuningsih[2], Yoni Elviandri[3], Lusi Tania Agustin[4], Mutiara Subhiyah[5]
[1] Universitas Teknologi Nusantara
[2,5] Universitas Islam Indonesia
[3] Lentera Muda Kerinci Foundation
[4] IAI Sumbar Pariaman

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ABSTRACT

School refusal in kindergarten-aged children can develop through an interplay of anxiety, unpleasant social experiences, dependency on caregivers, and environmental responses that inadvertently reinforce school avoidance. This article analyzes the collaborative process between parents and a teacher in addressing school refusal in a kindergarten student with a history of anal atresia and difficulties with elimination control. Data were gathered through observation, interviews, cognitive testing, school refusal assessment, functional analysis, intervention implementation, and outcome evaluation. The child exhibited refusal to go to school, crying and fear at the school gate, refusal to enter the classroom without his mother, limited attendance duration, and social withdrawal from peers. Case history revealed that experiences of being teased regarding odor and diaper use/elimination management were social factors that likely reinforced feelings of shame and avoidance. A prolonged absence from school reinforced the pattern of non-attendance, while the mother's presence at school provided a sense of security but also potentially perpetuated dependency. Interventions included parental counseling and psychoeducation, teacher psychoeducation, gradual exposure to the school environment, the gradual reduction of maternal accompaniment, positive reinforcement, and structured play to enhance peer interaction. Results showed increased attendance duration, an improvement in the ability to attend without the mother (from 0% at baseline to 100% in the recorded post-intervention phase), and an increase in peer interaction (from 0% to 100% on observed indicators). A review of recent literature underscores the importance of early intervention, parental involvement, teacher support, positive teacher-child relationships, and school environment adjustments for children with medical conditions affecting continence. This case demonstrates that managing school refusal in a child with anal atresia requires integrating behavioral interventions with an approach sensitive to stigma, toileting/elimination needs, privacy, and psychosocial support.

Corresponding Author:

Name: Eliza Sutri Utami
Institution: Universitas Teknologi Nusantara
Email: elizasutriutami27@gmail.com

1. INTRODUCTION

School refusal is a school attendance problem characterized by a child's difficulty attending or remaining in school, related to emotional distress, anxiety, fear, or other reinforcing factors. Recent literature positions school refusal as a multidimensional phenomenon involving individual, family, school, and social context factors. A systematic review by [1] shows that risk and protective factors for school refusal lie not only in the child but also in the family and school environment. Positive teacher-student relationships, teacher support, good family functioning, and effective family-school relations are among the important protective factors [1].

In the context of early childhood, the responses of parents and teachers are crucial because children do not yet have fully developed emotional regulation capacities and mature coping strategies. A systematic review of parental factors found that family functioning, parental psychopathology, and some forms of overprotection were associated with school refusal, although the strength of the evidence for each factor varied. These findings support the need for interventions that address not only the child but also the parenting system and parental responses [1].

The case in this article is unique because the child has a history of anal atresia. Anorectal malformation (ARM) can be accompanied by problems with continence, soiling, constipation, and the need for bowel management that persist into school age. Studies of the experiences of parents of children with ARM indicate that toilet access, school readiness, and teacher understanding are real issues; approximately 45% of parents in the study reported negative experiences with the school or its toilet facilities [2]. A 2024 study also confirmed that fecal incontinence in children with ARM has implications for school readiness and quality of life [3].

More recent findings have expanded the focus from physical functioning to mental health. A 2025 study of adolescents with ARM found that approximately one-third of participants met criteria for a mental health disorder, with emotional/internalizing problems being the most prominent pattern. These findings do not prove that ARM causes school refusal, but they do strengthen the case for including psychosocial monitoring in the long-term management of children with ARM [4].

Based on this context, this article focuses on the question: how can collaboration between parents and teachers explain and reduce school refusal in kindergarten children with atresia ani? The aims of the article are (1) to describe the dynamics of the case, (2) to analyze the contributions of child, family, peer, and school factors, (3) to evaluate changes after collaborative intervention, and (4) to interpret the case findings using the latest literature.

2. METHODS

2.1 Design

This article is a single-case study of a client in a psychological setting. Data were analyzed based on a series of assessments and interventions. The child's identity has been disguised and is not used in the manuscript.

2.2 Data Sources and Assessment

The assessment was conducted through a series of participant and non-participant observations of the child's behavior at school and at home, semi-structured interviews with mothers, teachers, and other relevant parties, observations of interactions with friends and siblings, cognitive ability assessments using the Progressive Matrices Test for Children (CPM),

and school refusal assessments. The assessments were conducted to understand the child's physical, cognitive, affective, social, and behavioral conditions. Cases were also analyzed using functional antecedent–response–consequence/strength (RACS) to map the maintenance of refusal behavior.

2.3 Intervention

The intervention involved three main components. First, parent counseling and psychoeducation to improve understanding of school refusal, the impact of avoidance, support strategies, and parental stress management skills. Second, teacher psychoeducation regarding the child's condition, triggers, strategies for dealing with refusal, and the importance of peer support. Third, child intervention included scheduling departure times, gradual exposure to school, gradually reducing maternal attendance, teacher support, positive reinforcement, and structured play to increase social interaction. This design is consistent with existing approaches and aligns with current evidence that places exposure, behavioral strategies, parental involvement, and school support as essential components of managing school refusal [1], [5].

3. RESULTS AND DISCUSSION

3.1 Case Description

The child, a Kindergarten A student, was approximately five years old at the time of the assessment. Prior to the onset of the problem, the child was able to participate in school activities without his mother's presence. Refusal developed when the child began experiencing unpleasant social experiences related to smells and diaper use. The child then increasingly withdrew, crying at the school gate, making excuses for illness, and ultimately missing approximately 50 days of school. After a home visit from the teacher, the child returned to school but required his mother's presence.

Cognitively, the CPM results indicate Grade II ability, with a standard score of 90, so academic difficulties are not the primary explanation for school refusal. At home and in the Koran study environment, children can play, communicate, and display positive affect. The behavioral differences between the home/Quran study environment and school support the hypothesis that the school context, particularly social experiences and separation anxiety, play a significant role.

The assessment also found that the child was more attached to his mother at school, ensuring her presence, refusing to enter class without her, and exhibiting physiological signs of anxiety such as cold hands, sweating, a pale face, and a stiff body when asked to enter the classroom. At the same time, the child tended to interact less with friends at school, although he was able to play with neighborhood children at home.

3.2 Baseline and Functional Analysis

The 12-day baseline showed that children were only in school for about 18 hours, or an average of 1.5 hours per day, compared to a typical school day of about five hours. All 12 days of the baseline showed children present with their mothers, resulting in 0% unaccompanied attendance.

The school refusal scale completed by parents showed the highest scores in the avoidance of school situations that cause negative feelings/anxiety model. The average score for this model was 7, higher than avoidance of social situations/school performance (6), seeking attention from significant others (6), and seeking enjoyable activities outside of school (4.5).

Functionally, the initial pattern can be formulated as follows: antecedent demands to go to and enter school; response demands to cry, refuse to go to school, ask mother to stay, play outside the classroom, and ask to go home; consequence demands to postpone school and increase closeness with mother. In this context, permission to miss school and long leave of absence can provide negative reinforcement for avoidance behavior because the child is temporarily free from the situation that causes distress.

3.3 Collaborative Interventions

For parents, the intervention included three sessions: understanding the condition and parental role, understanding treatment methods, and improving parental well-being. Results showed changes in mothers' understanding of triggers, the impact of school refusal, coping strategies, and acceptance of their child's condition.

For teachers, two psychoeducational sessions discussed assessment results, characteristics of school refusal, intervention procedures, and the roles of teachers, peers, and school personnel. Teachers then welcomed the child, established closeness, soothed crying children, offered praise and rewards upon entering the classroom, and avoided excessive coercion.

For children, interventions were implemented in stages. The departure time was moved up from around 10:30 to 7:45. The mother's presence was gradually reduced, while the teacher provided support when the mother left the child. In the next phase, structured play with peers was used to foster interaction.

3.4 Intervention Results

The results showed an increase in attendance hours from baseline to the intervention and follow-up phases. Adjustments to departure times still took into account the child's elimination needs; mothers delayed departure when the child had not yet defecated so that the child could leave more prepared. Meanwhile, independence from maternal assistance also increased. At baseline, 0% of observation days showed attendance without the mother. In the intervention phase, the figure was 61%, while in the posttest phase, the figure was 100%. Interaction with friends also increased. At baseline, the total observed interaction indicators were recorded at 0%; in the intervention phase, 37%; and in the posttest, 100%. Children began to respond to greetings, respond to invitations to play, join in learning activities, participate in center activities, play during breaks, laugh with friends, talk, and show physical contact during social activities. Overall, the post-intervention functional analysis showed that children were able to come to school, enter class, be left by their mothers without crying, participate in activities from morning until the end, and begin to respond to friends.

3.5 Discussion

3.5.1 School Refusal as an Ecological Problem

This case demonstrates that school refusal is not appropriately understood as simply "not wanting to go to school." The child possesses adequate cognitive abilities and can function socially in other contexts, but exhibits distress primarily when in the school setting. This pattern aligns with the ecological perspective of school refusal, which places anxiety and individual factors alongside family, school, peer, and environmental factors as part of a problem system. A systematic review by Leduc et al. emphasized the centrality of anxiety symptoms and the importance of social and contextual factors in differentiating children with school refusal from those without [6].

In this case, the experience of teasing related to smell and diapers became a relevant social event. It's important to be cautious: the case data do not prove that this single incident was the sole cause of school refusal. However, temporally and functionally, the experience was followed by increased school withdrawal, fear, and avoidance. This condition can be understood as an aversive social experience that increases negative expectations about school.

3.5.2 Vulnerability

Anal atresia/ARM is not positioned as a direct cause of school refusal in this case. Its role is better understood as a medical condition that can create elimination management needs, risk of soiling or odor, need for privacy, and dependence on adults. Studies in children with ARM indicate that continence issues can impact school readiness and quality of life [3], [7].

Findings from a study of parents' experiences also indicate that schools are not always prepared to provide appropriate toileting arrangements and support for

children with ARM. This is important because insensitive school responses can exacerbate children's feelings of shame and anxiety. In the cases analyzed, odor and diaper use were sources of peer comment; therefore, school support should be directed not only at attendance behavior but also at preventing stigma and managing private elimination needs [2].

A 2025 study of the mental health of adolescents with ARM found a significant proportion of emotional problems. Although that sample was older than this case and cannot be directly generalized to kindergarteners, the findings reinforce the importance of monitoring mental health throughout development, particularly when negative social experiences or continence issues are present [4].

3.5.3 The Role of Parents: From Accommodation to Structured Support

In the initial phase, mothers accommodate their children by allowing them to miss school and making the decision to grant them leave. This response can be understood as an attempt to protect the child from distress, but behaviorally, it can reinforce avoidance because the child receives immediate relief from the anxiety-provoking situation. Recent literature on school refusal emphasizes the importance of parental involvement and interventions that target family responses. Ulaş and Seçer's systematic review included parent counseling as one intervention approach, while research on the development of ISAAC (School Avoidance Program) indicates the need for easily implemented parent-focused interventions for emotional-based school avoidance [1], [8].

A key change in the case is the shift in the mother's role: from a figure primarily providing security through physical presence to a facilitator of the child's independence. Supervision is gradually reduced, rather than abruptly stopped. This strategy helps the child learn that separation is tolerable and that teachers are alternative safe figures at school.

3.5.4 The Role of Teachers and The Quality of Teacher-Child Relationships

Teachers serve as a bridge between home and school. In this case, teachers welcome children, provide special attention, comfort them when they cry, offer praise/rewards, and avoid unnecessary coercion. This intervention changes the consequences of avoidance behavior: children no longer have an "out" of going home or staying out of class, but receive support to persist in the school situation until their anxiety subsides.

These findings are consistent with a systematic review of school refusal that identified positive teacher-student relationships and perceived teacher support as protective factors [1]. A 2025 study on a school-partnered approach to emotionally based school avoidance also identified school involvement and collaborative implementation as crucial elements, particularly to ensure consistent school responses and avoid blaming families [9].

3.5.5 Gradual exposure and positive reinforcement

The intervention in this case used the principle of graded exposure: attendance was moved up, school time was increased, maternal supervision was reduced, and interaction with peers was gradually increased. This approach aligns with systematic evidence that places exposure, systematic desensitization, modeling, shaping, and cognitive-behavioral strategies as widely used techniques for school refusal [1].

Case results show that behavioral changes occurred simultaneously across several indicators: attendance time, independence from mother, and social interaction. This suggests that intervention targets should not stop at "school attendance," but should also encompass the quality of children's engagement after they attend. Systematizing these indicators is crucial to prevent false successes, such as children attending but continuing to avoid class or experiencing severe distress throughout the day.

3.5.6 Home-School Collaboration as a Mechanism for Change

The most important finding from this case is that change occurs when messages and responses between home and school become consistent. Parents understand that long-term avoidance of school can perpetuate the problem; teachers understand that refusal is not simply defiant behavior; and the child gains new experiences that school is predictable, teachers are trustworthy, and separation from mother does not result in threats.

This collaborative model can be summarized into four components: (1) joint case formulation, (2) measurable behavioral targets, (3) role sharing between parents and teachers, and (4) regular communication about progress. The literature on parents' experiences with emotional barriers to school attendance also suggests that inconsistencies between home and school can hinder collaboration and leave parents feeling blamed. Therefore, collaboration needs to be built as a partnership, not a transfer of responsibility [10].

3.6 Practical Implications

First, schools need to conduct a simple functional assessment when a child refuses school: when the refusal began, what the child said, who was with the child, what happened after the refusal, and whether there were any social or academic triggers. Second, for children with ARM, schools need to have an elimination support plan that maintains privacy, restroom access, flexible schedules, and limited communication to adults who need to know about the condition. Third, teachers need to discourage comments or teasing related to odor, diapers, physical condition, or medical needs. Peer education should be conducted in a developmentally appropriate manner without disclosing the child's diagnosis to the entire class. Fourth, parents and teachers need to use the same indicators, such as arrival time, duration of class, need for support, frequency of crying during separation, and interactions with friends. Fifth, if school refusal persists or is accompanied by symptoms of severe anxiety, depression, sleep disturbances, significant somatic complaints, or extensive functional decline, further professional evaluation is necessary. For children with ARM, coordination with the medical team is also important to ensure that continence or pain issues are not dismissed as solely psychological.

3.7 Limitations

This article has limitations as a single case study. The data come from a case of a psychology client and therefore cannot reflect the prevalence or effectiveness of interventions for the general population of children with ARM. There was no control group, randomization, or long-term follow-up measurements available. Furthermore, some medical and social factors could not be reconfirmed through contemporary examination. Therefore, the results should be understood as individual clinical evidence suggesting the potential benefit of a collaborative approach, not as evidence of causality or universal effectiveness. Therefore, the claim that anal atresia causes school refusal cannot be made based on this case; what can be concluded is that the ARM condition and elimination difficulties constitute a context of vulnerability that interacts with social experiences and environmental responses.

4. CONCLUSION

*School refusal*In this case, the condition of a kindergarten child with anal atresia developed through an interaction between school anxiety, embarrassing social experiences, elimination difficulties, maternal dependence, and environmental responses that maintained avoidance. An intervention combining parent counseling and psychoeducation, teacher psychoeducation, gradual exposure, reduced maternal supervision, positive reinforcement, and social play resulted in changes in attendance, independence from maternal supervision, and peer interactions.

Recent literature analysis indicates that case findings align with an ecological and

collaborative approach to school refusal. For children with ARM, psychological interventions need to be expanded with school support that is sensitive to the needs for elimination, privacy, stigma, and mental health. Therefore, treatment success is measured not only by the child's willingness to come to school, but also by the child's ability to attend consistently, feel safe, participate in learning, and build social relationships without experiencing humiliating treatment.

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