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Educational guidance to families of students with autism spectrum disorder at the Huambo Special Education School

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ABSTRACT

The general objective of this dissertation is to describe a set of educational actions to guide the families of students with Autism Spectrum Disorder at the Special Education School of Huambo. For this investigation, the type of research was descriptive and theoretical methods were used, such as: historical-logical, analysis-synthesis, bibliographic research and system focus, and empirical methods such as: observation, questionnaire inquiry, consultation with specialists and mathematician-statistical. For data processing, the statistical program SPSS (Statistical Package for the Social Sciences) was used, version 20.0. Taking into account the diagnosis carried out, it was possible to assess that there is little knowledge on the part of families regarding autism; there are deficiencies regarding the diagnosis of autism from early childhood, which often hinders the educational guidance of families and the School-family relationship, as teachers do not always feel sufficiently prepared to meet the educational needs of their students. The results of this investigation revealed that the families of students with Autism Spectrum Disorder (ASD) have difficulty relating to these students, as they do not have knowledge and are not guided with methodological strategies by specialists to relate better to them. This strategy presents a set of actions aimed at educational guidance to the families of students with Autism Spectrum Disorder (ASD), as it facilitates the relationship of the same families with these students in different contexts.

Keywords: Autism Spectrum Disorder, Families and educational guidance.

INTRODUCTION

Education is a fundamental and decisive human right for the development of individuals and societies. In addition, ensuring inclusive, equitable and quality education is one of the Sustainable Development Goals (SDS). Educational practices for the care of people with Autism Spectrum Disorder (ASD) have gone through different stages in our country. However, after Angola's independence, the educational attention to students with ASD and the educational guidance to their families has been subjected to strong criticism and generate new philosophical positions expressed in the new knowledge for Special Pedagogy as a science applied to the education of this population or target group.

The education of people with Autism Spectrum Disorder (ASD) is a social process that accompanies human society throughout its history, forming a society whose universal access to basic education must always be respected and considered as a key factor in order to guarantee equality in the exercise of the right to education.

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The family is a social institution, where much of life takes place. It is a transmitter of basic nutrients, of the first emotional experiences and its proper functioning guarantees the safety and stability necessary for the normal development of children from an early age. Parents are considered the first teachers and mediators in the relationships with the social environment and with the historical and cultural legacy of humanity.

Nowadays, reflecting on the family and the community where students with autism live, their preparation to accept, live together and stimulate the development of these students, are necessary topics on the agenda of scientific debate in Angola. Therefore, Special Education professionals assume, every day, the human duty to educate and reproduce modes of action, among others, that stimulate environments that favor the socialization of students with autism.

Today we can say that the family is seen, with regard to the child's development, as one of the main pillars in his social world, because it is through it that the child experiences the first social interactions.

However, the family's task of educating always suffers external influences, the truth is that each family, and, within it, each member of the family, is affected by an autistic member in a different way; The impact of autism and the need to raise the quality of educational response, makes us rethink an approach to education from the educational orientation aspect to the families of students with autism, which represents assuming diversity in the socio-educational context.

For educational guidance to the families of students with Autism Spectrum Disorder, it has been the object of study of several researches both internationally and nationally, several authors have ventured into this theme, highlighting the studies of Kanner, Riviere, Junco, Oliveira, Valdéz, Almeida, Abreu, Maia Filho, Amanda, Nogueira, Silva & Santiago, Mapelli, Barbieri, Castro, Bonelli, Wernet & Dupas, among others.

In the national context, that is, in Angola, Filipa, Neves, Adalberta and Almeida, in general, state that there are deficiencies in relation to the approach to the exposed theme, and agree that a better educational orientation of families contributes to the success and educational care for students with autism in achieving the adjustment of the educational response for each one of them.

If there is a student with a disability in the family, education professionals must take into account the wide range of feelings, reactions, emotional adjustments and others that this causes and that distinguish the subjectivities of those who are part of these family nuclei.

It is human to accept, as legitimate and authentic, the pain that parents experience, when in the early state of the child's life, they discover that he has a disability.

Autism is one of the most recent generalized developmental disorders for special pedagogy; Although from a clinical point of view, autism is a disorder of human development that has been studied by science for almost six decades, that is, for more than 50 years, but about which there are still divergences and great questions to be answered within the scope of science, such as its origin.

Lately, not only has the number of diagnoses been increasing, but they have also been concluded at increasingly early ages, implying that, behind the beauty that a child with autism can have and the fact that autism is a problem of so many faces, its fundamental issues have been increasingly recognized more easily by a greater number of people.

In the early days, autism was known to a very small group of people, including a few doctors, a few health professionals, and a few parents who had been surprised by their children's autism diagnosis. Currently, although autism is much better known, having even been the subject of several successful films, it still surprises by the diversity of characteristics it can present and by the fact that, most of the time, a student who has autism has a totally normal appearance.

According to the Angolan Constitution, in its article 35, point 1, it affirms the family as a fundamental nucleus of the organization of society and is the special object of protection of the State. Thus, being a father or mother from the biological point of life is very easy, but being a competent father and mother, with the ability to help your children, who have ASD, to become balanced, responsible, intelligent and happy people, useful to society, is not an easy task, but it is not complicated either. Thus, they are the main responsible for the care of children and must participate in all their education. Point 5 of the aforementioned article says that children are equal before the law, and their discrimination is prohibited. Therefore, within a family if you have a student with autism you should not be discriminated against, as you have rights, namely, to their integral and harmonious education, the protection of their health, living conditions and education.

With regard to the education of students with Autism Spectrum Disorder, in order for there to be good participation, it is necessary for the family to have or acquire good information about it to act with great affection and attention so that these students lead a joyful, happy family life and that everyone enjoys this process.

It should be noted that autism distresses the families in which it imposes itself, because the person with autism generally has a harmonious appearance and at the same time an irregular development profile, with good functioning in some areas while others are quite compromised.

When a child within the family is diagnosed with autism, a set of transformations and questions arise on the part of the family: parents have several questions, doubts and fears about the future, what it will be like and whether their child will be able to have a normal life or not, questions about the culprits, they want to identify the causes and influences, in short, it is the time of deeper questions such as: Why did this happen to us? Consequently, parents may present non-acceptance, revolt and anger at the situation and only after obtaining knowledge about the disorder can they calm down.

On the other hand, according to the Family Code - Law No. 1/88, of 20 February, in Article 2, in its point 1, it says that the family must contribute to the education of all its members without exclusion in a spirit of love for work, respect for cultural values, so that all children with Autism Spectrum Disorder can be included in the family context.

In turn, Presidential Decree No. 187/2017, of August 16, on the National Policy of Special Education Oriented to School Inclusion says that it is necessary to mobilize families and parents and/or guardians of students with SEN, in particular students with autism aiming at their active involvement in the process of transformation and inclusion of children with Autism Spectrum Disorder.

Thus, the documents referenced above mention the role of the family in the teaching-learning process and inclusion of students with SEN, in particular students with Autism Spectrum Disorder, to the extent that its role is irreplaceable for success in the process of socio-educational inclusion of these students and state, from a more humanistic and participatory perspective, emphasizing that the family is the pillar in the teaching and learning process.

DEFINITION OF TERMS AND CONCEPTS

According to Morgado (2011), the term "autism" comes from the Greek word "autos" which means "own". It was this characteristic that Kanner and Asperger wanted to highlight, that is, the isolation that the individual manifests, making it difficult for him to surrender to exchange and social participation. Both authors suggest that there is a "contact disorder" of a socio-affective nature, difficulties in social adaptation, and that interests are restricted and behaviors repetitive. "**Autism** is a syndrome defined by alterations present from very early ages, typically before the age of three, and which is always characterized by qualitative deviations in communication, social interaction and the use of imagination" (Mello, 2005, p. 16).

Cunha (2014) defines that **Autism Spectrum Disorders (ASD)** results from neurodevelopmental disorders, usually manifested from the age of 3, a period in which the neurons responsible for communication and social relationships do not establish the typically established connections. It is called **a spectrum** because there is a range of conditions that range from milder levels to deeper levels of impairment in these connections, resulting in different types of autism, which can differ greatly from person to person.

In the view of Duarte & Matias (2018), **inclusion** is a process that meets the improvement of the performance, activity and participation of all students through collaborative and active learning and the recognition of diversity as a social asset.

Nascimento, Morais & Silva (2010) state that **educational guidance** is the assistance given to the student in order to provide opportunities for his full development, which is mediated in the relationship between the school, family and community environment.

For Maria and Maria (2011), **educational guidance** is the set of activities aimed at students, parents and teachers, with the aim of contributing to the development of their tasks within the specific scope of educational establishments. This educational orientation foresees planned actions that interact students, teachers, management, school curriculum and community in order to promote, in a humanized way, the physical, personal, intellectual and moral development of the student.

HISTORY OF AUTISM WORLDWIDE

Autism was first described in 1943 by Dr. Leo Kanner (an Austrian physician, living in Baltimore, USA) in his historic article originally written in English: Autistic Affective Contact Disorders (DACA). In that article, Kanner systematized the careful observation of a group of children ranging in age from 2 to 8 years, whose disorder he called 'Autistic Affective Contact Disorder'. Although the term "autism" had already been introduced in psychiatry by Plouller in 1906 as a descriptive item of the clinical sign of isolation, Kanner's careful description of such abnormalities allowed the differentiation of autism in relation to other disorders such as schizophrenia and childhood psychoses.

Kanner's work was of fundamental importance to form the foundations of Child Psychiatry in the USA (United States of America) and also worldwide. Kanner evidenced the following characteristics in the cases described: inability to develop relationships with people; delay in language acquisition; non-communicative use of language after its development; tendency to repeat the other's speech (echolalia); reverse use of pronouns; repetitive and stereotyped games; obsessive insistence on maintaining "sameness" (rigid routines and a restricted pattern of peculiar interests); lack of imagination; good mechanical memory; and normal physical appearance. According to Campos & Mendes (2014), such characteristics had not been considered until then in their "surprising singularity. As early as 1943, Kanner made it clear that this account was preliminary and needed further study, observation, and investigation.

HISTORY OF AUTISM IN ANGOLA AND IN PARTICULAR IN HUAMBO

Special education began to be implemented in Angola in the 70s of the last century, initially in the provinces of Luanda and Huíla, with the monitoring of children with hearing and visual impairments. It was only from 2002, with the advent of peace, that the system began to deserve special attention. Until 2003, there were only two special schools, but currently the school network consists of 12 units, two in Luanda, one in Benguela and an equal number in Huíla, Bengo, Moxico, Lunda Sul, Namibe, Malanje, Huambo, Cuanza-Sul, Cuando Cubango and Cunene and schools are being built in the provinces of

Cabinda, Bié, Uíge and Cuanza-Norte. In 2005, the Special Education school network was distributed as follows: 12 special schools, 13 special classrooms and 630 integrated classrooms throughout the country. In 2006, special education accompanied a total of 14,171 people throughout the country. Since its implementation, about 60,000 students have benefited from this service in the modalities for the deaf, blind and mentally disabled, within students with mental disabilities where students with ASD were included (Duarte & Matias, 2018).

AUTISM

According to Andrade & Teodoro (2012), Autism is a behavioral syndrome of multiple etiologies, which compromises the process of child development. Thus, it can be understood as a global developmental disorder that involves severe and early changes in three areas: qualitative impairment of social interaction; impaired communication and restricted, repetitive patterns of behavior, interests, and activities.

Defined simply according to Moral, Shimabukuro & Molina (2017), ASD qualifies as a neuropsychiatric disorder that presents basic signs and symptoms, such as difficulty in social interaction, *social communication deficit* (quantitative and qualitative), and inappropriate patterns of behavior.

INCIDENCE AND PREVALENCE

The incidence of autism varies according to the criterion used by each author, in the opinion of Mello (2005), considers that Bryson, in his study conducted in Canada in 1988, reached an estimate of 1:1000, that is, in every thousand children born, one has autism. According to the same source, autism is two and a half times more frequent in males than in females.

The incidence is 1:500, or 2 cases in every 1000 births. Autism affects 2 to 6 people in 1000, that is, it can affect up to 1 person in 166. Autism is 4 times more frequent in males. Autism also affects families of different races, creeds or social classes.

On the other hand, Pinto *et al.* (2016), estimate that, currently, the worldwide prevalence of ASD is around 70 cases per 10,000 inhabitants, being four times more frequent in boys. The possible reasons for the increase in the prevalence of this syndrome are related to several aspects, which include changes in diagnostic criteria, greater knowledge of parents and society about the occurrence and clinical manifestations, and the development of specialized ASD services.

According to Pinto *et al.* (2016), recent research indicates that the incidence of Autism Spectrum Disorder is one person in every 100, being more predominant in boys than in girls. ASD is more common than you might think, because of the enormous diversity of manifestations within the spectrum.

In terms of prevalence, the DSM-V (2014) reports that in recent years, the reported frequencies of Autism Spectrum Disorder in the United States and other countries have reached 1% of the population, with similar estimates in samples of children and adults. It is not yet clear whether the higher rates reflect expansion of the DSM-IV diagnostic criteria to include subliminal cases, increased awareness, differences in study methodology, or actual increases in the frequency of the disorder.

In the view of Duarte & Matias (2018), Autism Spectrum is a disability, with no cure today, that remains throughout life. It affects about 1 child in 100 (in the United States of America the frequency rises to 1 in 50 children) and its prevalence is higher in male children than in female children in a ratio of 4 male children to 1 female child.

According to the authors, in recent years, estimates of autism prevalence have increased dramatically. In the United States of America, for example, from 1 in 150 8-year-olds in 2000 and 2002, the prevalence of ASD increased to 1 in 68 children in 2010 and 2012, reaching a prevalence of 1 in 58 in 2014, more than doubling the number of cases during that period. This increase in the prevalence of ASD is largely a result of the expansion of diagnostic criteria and the development of screening and diagnostic instruments with adequate psychometric properties.

According to the Brazilian Society of Pediatrics (2019), with the rapid increase in the prevalence of autism, many families have had difficulties in obtaining this diagnosis in time to start specialized interventions and support. Alterations in the domains of social communication and repetitive language and behaviors between 12 and 24 months have been proposed as early identification markers for autism. These clinical signs are already identified by most parents from the first year of life, however, these children will often only be diagnosed with ASD at preschool or even school age.

Causes

Regarding the etiology of autism, autism is currently part of a set of behaviors, where its etiology can have multiple factors and influences, such as: genetic, social and cultural.

For Mello (2005), the causes of autism are unknown. It is believed that the origin of autism lies in some part of the brain that has not yet been conclusively defined and probably of genetic origin. In addition, it is admitted that it can be caused by problems related to facts that occurred during pregnancy or at the time of childbirth. The hypothesis of an origin related to maternal coldness or rejection has already been discarded, relegated to the category of myth for decades. However, regarding all the evidence and the public retraction of the first defenders of this theory, there are still adherents of this current who still defend it or defend apparently different theories, but derived from it. Since the causes are not fully known, what can be recommended in terms of autism prevention is general care for all pregnant women, especially care with the intake of chemical products, such as medicine, alcohol or smoking.

Also according to the same source, there is a wide and diverse series of hypotheses. Some authors suggest that rejection or other emotional traumas in the first months of life would be the cause of this disorder. Others attribute the origin of this syndrome to deep disturbances in the child's relationship with the environment. Autism is also believed to occur in organically predisposed children, in whom emotional trauma has precipitated the disorder.

For Campos & Mendes (2014), among the environmental causes, it is admitted that agents that cause brain aggression in the areas involved with the pathogenesis of ASD can be determinants in the development of the disorder. Among them, perinatal infections, prematurity and asphyxia are the most important. Known genetic causes of ASD include:

- Chromosomal alterations detectable by usual methods (karyotype) (5%);
- Microdeletions/micro-duplications (10%);
- Monogenic diseases in which neurological findings are associated with ASD (5%).

The Brazilian Society of Pediatrics (2019) aligns with the same view when they say that ASD is caused by a combination of genetic factors and environmental factors. Studies comparing identical twins and fraternal twins show that the concordance rate of ASD is significantly higher among the former than among the latter, suggesting a strong genetic component in the etiology of autism.

In fact, there is evidence that the genetic architecture of ASD involves hundreds or thousands of genes, whose variants, inherited or de novo, and common or rare in the population, comprise multiple inheritance models. Although clearly important, genetic factors do not act alone, but their action is influenced or catalyzed by environmental risk factors, including, among others, the advanced age of the parents at the time of conception, extreme neglect of child care, exposure to certain medications during the prenatal period, premature birth, and low birth weight.

All the positions taken by the theorists consulted indicate that the subject related to the cause still lacks a vast investigative framework and, however, we can say that there is a combination of factors that contribute to the emergence of the syndromic picture of Autism Spectrum Disorder.

Features

Autism can manifest itself from the first days of life, but it is common for parents to report that the child has gone through a period of normality prior to the manifestation of symptoms.

In the view of Lopes *et al.* (2018), the child with autism, throughout his development, presents the following characteristics:

1st Stage from zero (0) to six (6) months

- He is not much of a beggar;
- He is not an affectionate child;
- It is indifferent to the absence or presence of the mother;
- He does not respond to smiles.

2nd Stage from six (6) to twelve (12) months

- Refusal to eat solid foods;
- He is not an affectionate child;
- When you lift, the muscles may be too hard or too soft.

3rd Stage from two (2) to three (3) years old

- Shows interest in stimulating specific areas (e.g., sounds);
- Observe objects in motion closely and very closely;
- He is indifferent to interpersonal contact.

4th Stage from six (6) years old to adolescent

- Relationships with people continue to be deficient and problematic;
- Language is still very limited;
- Improves responses to sensory stimuli;
- It is not effective;
- She remains oblivious and emotionally distant;
- In some cases, it communicates in a disjointed and irrelevant way;
- It can be impulsive or with little self-control (p. 19).

When analyzing the signs, we turned to the DSM-V (2014) noting that age and pattern of onset should also be observed for Autism Spectrum Disorder. Symptoms are usually recognized during the second year of life (12 to 24 months), although they can be seen before 12 months of age if developmental delays are severe, or noticed after 24 months if symptoms are more subtle.

The description of the pattern of onset may include information about early developmental delays or any losses of social or language skills. In cases where there has been a loss of skills, parents or caregivers may report a history of gradual or relatively rapid deterioration in social behaviors or language skills. This usually occurs between 12 and 24 months of age, and is distinguishable from the rare cases of developmental regression that occur after at least 2 years of normal development (previously described as childhood disintegrative disorder).

The behavioral features of Autism Spectrum Disorder initially become evident in early childhood, with some cases showing a lack of interest in social interactions in the first year of life. Some children with autism spectrum disorder have developmental plateaus or regression, with a gradual or relatively rapid deterioration in social behaviors or language use, often during the first two years of life. Such losses are rare in other disorders, and can be a useful warning sign for Autism Spectrum Disorder. Far more unusual and worthy of extensive medical investigation are losses of skills other than social communication (e.g., loss of self-care, sphincter control, motor skills) or those that occur after the second birthday.

The first symptoms of Autism Spectrum Disorder often involve delayed language development, usually accompanied by a lack of social interest or unusual social interactions (e.g., pulling people by the hand without any attempt to look at them), strange patterns of play (e.g., carrying toys but never playing with them), and unusual communication patterns (e.g., know the alphabet, but do not respond to one's own name). A diagnosis of deafness is usually considered, but is often ruled out.

During the second year, strange and repetitive behaviors and absence of typical games become more evident. According to DSM-V (2014), since many young children with normal development have strong preferences and enjoy repetition (e.g., eating the same foods, watching the same movie or soap opera many times), in preschoolers it can be difficult to distinguish restricted and repetitive patterns of behaviors diagnostic of Autism Spectrum Disorder. The clinical distinction is based on the type, frequency, and intensity of the behavior (e.g., a child who aligns objects daily for hours and suffers greatly when one of them is moved).

Usually, what catches the attention of parents initially is that the child is excessively calm and sleepy or that he cries without consolation for prolonged periods of time. A frequent complaint from parents is that the baby does not like the lap or rejects the snuggle. Later parents will notice that the baby does not imitate, does not point in the direction of sharing feelings or sensations and does not learn to communicate with gestures commonly observed in most babies, such as waving hands to greet or say goodbye. Generally, these children do not seek eye contact or maintain it for a very short period of time.

For Mello (2005), the appearance of stereotypies is common, which can be repetitive movements with the hands or body, the fixation of the gaze on the hands for long periods and habits such as biting oneself, biting one's clothes or pulling one's hair. Feeding problems are frequent, and can manifest themselves by refusal to eat or taste restricted to few foods. Sleep problems are also common.

The recognition of the symptoms manifested by the child with autism is essential to obtain an early diagnosis. According to Pinto et al. (2016), clinical manifestations are commonly identified by parents, caregivers and family members who experience behavioral patterns characteristic of autism, in view of the unique needs of these children. The signs have variable expressiveness and usually begin before the age of three. Children with ASD have a unique triad, which is characterized by difficulty and qualitative impairments in verbal and non-verbal communication, in social interactivity and in the restriction of their cycle of activities and interests. In this type of disorder, stereotyped movements and mannerisms may also be part of the symptomatology, as well as a variable intelligence pattern and extremely labile temperament.

Duarte *&* Matias (2018), also describe some signs that people with ASD may present such as: Low tolerance for others, difficulty waiting for their turn or sharing, not liking to lose or participate in social games, social behavior inappropriate to different contexts and/or activities, lack of or little empathy towards others.

CRITERIA FOR DIAGNOSIS

"The diagnosis of Autism Spectrum Disorder (ASD) must follow internationally defined criteria, with complete evaluation and use of validated scales. Complexity faces the etiological and phenotypic heterogeneity of cases" (Brazilian Society of Pediatrics, 2019).

Regarding the criteria for diagnosis, the DSM-V (2014) presents the following criteria:

Persistent deficits in media and social interaction in multiple contexts, as manifested by the following, either currently or by previous history (examples are illustrative only and not exhaustive.

Deficits in socio-emotional reciprocity, ranging, for example, from abnormal social approach and difficulty establishing normal conversation to reduced sharing of interests, emotions, or affection, difficulty initiating or responding to social interactions.

Deficits in nonverbal communicative behaviors used for social interaction, ranging for example from poorly integrated verbal and nonverbal communication to abnormality in eye contact and body language or deficits in gesture comprehension and use, total absence of facial expressions, and nonverbal communication.

Deficits in developing, maintaining, and understanding relationships, ranging for example from difficulty adjusting behavior to suit diverse social contexts to difficulty sharing imaginative play or making friends, to lack of peer interest.

Restricted and repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following criteria:

Motor movements, use of stereotyped or repetitive objects or speech (e.g., simple motor fixation, aligning toys.

Insistence on the same things, inflexible adherence to routines or ritualized patterns of verbal or nonverbal behaviors (e.g., extreme distress over small changes, difficulties with transitions, rigid thought patterns, greeting rituals, the need to take the same route or eat the same foods daily).

Fixed and highly restricted interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, overly circumscribed or persevering interests).

Hyper or hyporeactivity to sensory stimuli or unusual interest in sensory aspects of the environment (indifference to pain, temperature, contrary reaction to specific sounds or textures, smelling or touching objects excessively, visual fascination with lights or movement).

According to the DSM-V (2014), symptoms must be present early in the developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by strategies learned later in life).

Symptoms cause clinically significant impairment in social, occupational, or other important areas of the individual's life.

These disorders are no longer better explained by intellectual disability (intellectual developmental disorder) or by global developmental delay. Intellectual disability or autism disorder are often comorbid.

For Duarte & Matias (2018), early diagnosis, usually carried out by paediatricians or child psychiatrists in cooperation with other technicians (according to medical criteria defined in international publications such as DSM V and ICF 107), enables a timely intervention that allows the child to develop, from a very early age, the necessary skills to learn to adapt their individual behaviour and interact appropriately, controlled and structured in all contexts of life.

According to the Brazilian Society of Pediatrics (2019), late diagnosis and consequent delayed intervention in children with ASD cause damage to their overall development. This late aspect of diagnosis has been directly associated with low family income, ethnicity, little stimulus, little observation of children's development by parents, health professionals, educators and caregivers, and less severe clinical forms of symptom presentation. The belief of family members and health professionals that "we will wait for the child's time", even when he or she has evident delays, is one of the factors that directly interfere with early detention. The popular saying of "let's wait for the child's time" must respect the pre-defined limits of the maximum age of acquisition of each milestone, according to the validity scales for the monitoring of neuropsychomotor development.

For Duarte & Matias (2018), late diagnosis leads, in most cases, to feelings of isolation, loneliness, confusion, depression, and self- or heteroaggression that can worsen over the years. Hypersensitivity to sensory stimuli, variations in light intensity, color, intensity or type of sound, tastes and smells can lead to feelings of disorientation, behavioral decompensation or fixation on objects and/or movements.

According to Morgado (2011), the diagnosis of the syndrome consists of two phases. The first phase consists of parents and teachers filling out a questionnaire consisting of a checklist. The purpose of the questionnaire is to detect the signs of the syndrome. The second phase consists of the diagnostic evaluation, carried out by clinicians and is based on established criteria. The diagnostic assessment lasts at least one hour and consists of an examination of the children's social, linguistic, cognitive and motor skills, and interests.

In the end, the information obtained is applied to the formal criteria. It is only possible to recognize the syndrome through the observation of behaviors, it is not a specific behavior, but deduced through the analysis of a behavioral pattern. The researchers have partnered in order to develop coherent criteria for this diagnosis.

To begin to outline intervention strategies, it is first necessary to resort to diagnosis or, through evaluation, identify what we should teach a child with autism, which is a complicated and delicate task, adapting the teaching method to students with autism. According to Morgado (2011), all forms of evaluation will give us sufficient information to define the objectives, if they are chosen according to the following criteria: adequacy to the child's evolution; presentation of normal evolution; functionality, as far as possible and adaptation of the child with autism to natural environments. These criteria should be considered when selecting the activities that are intended to work towards achieving the objectives in the priority areas in the education of students with autism. In short, the specific blocks in the education of children with ASD are those in which they really present the greatest difficulties: communication – interaction; language; cognitive development.

For Campos & Mendes (2014), the objective of the evaluation is not only to establish the diagnosis itself, but to identify the potential of the person and his family. This can be achieved by extracting from teams what expertise they have in their respective fields of activity, while each area interacts with the other. Considering: (a) that the diagnosis of ASD involves the identification of "qualitative deviations" in development (especially in the field of social interaction and language); (b) the need for differential diagnosis; and (c) the identification of potentialities as well as impairments, it is important to be able to count on a team of at least a psychiatrist and/or neurologist and/or pediatrician, psychologist and speech therapist.

Medical evaluation, regardless of specialty, includes anamnesis and physical examination and, if necessary, laboratory and imaging tests. When there are, for example, very important emotional and behavioral changes, changes in sleep, appetite, consciousness, gait, excess aggressiveness and psychomotor agitation that require more precise assessment and drug interventions, the action of specialists in the areas of neurology and/or psychiatry is generally recommended. The indication is made on a case-by-case basis. Psychiatric evaluation classically includes two types of interview: 1) subjective (direct evaluation of the patient); and 2) the objective (evaluation of the individual's behavior through the report of family members, caregivers or other people in the individual's life).

In order for there to be an accurate medical diagnosis of ASD, according to Morgado (2011), the child must be very well examined, both physically and psycho-neurologically. The evaluation should include interviews with parents and other interested family members, observation and psychomental examination, and sometimes complementary examinations for genetic and/or hereditary diseases. Nowadays, some biochemical, genetic and chromosomal studies, electroencephalographic, anatomical and functional brain imaging and others that are necessary to clarify the clinical picture can be carried out. Nevertheless, the diagnosis of Autism remains predominantly clinical and, therefore, cannot be made purely on the basis of tests and/or some assessment scales.

In the evaluation of school-age or developmental individuals, in addition to direct observation of behavior, it is necessary to report from teachers and other professionals who work in the community, as it is common to have significant differences in behavior according to the environment. The objective neurological evaluation is to evaluate the functional aspects of the central nervous system that can be analyzed by clinical-neurological examination. The speech therapist is qualified to evaluate linguistic aspects that differentiate ASD from other conditions, especially language disorders in the presence of hearing impairment or primary language conditions. To this end, attention should be paid to the following aspects:

- Anamnesis to families focused on the survey of the general history;
- The data provided by complementary interviews (with the school and other professionals);
- The examination of the patient should aim at the description of verbal and/or non-verbal behaviors and the identification of symbolic processes, as well as the identification of interactional availability with different interlocutors and the description of communicative resources;
- The examination of the patient should aim at the detection of dietary difficulties and/or idiosyncrasies and the identification of organic and/or symbolic conditions;
- The examination of the patient should clarify the vocal conditions and qualities and identify the organic and/or symbolic conditions underlying them (Campos & Mendes, 2014).

SOCIO-EMOTIONAL IMPACT OF THE FAMILY IN THE FACE OF THE INITIAL DIAGNOSIS OF STUDENTS WITH AUTISM SPECTRUM DISORDER

The family is the first relational context of an individual. For this reason, it has an important influence on the determination of human behavior and the formation of personality. In it, the participation of each member, with its particularities, affects all the others, as well as is affected by them, in a relationship of interdependence. Thus, every change exerts an influence on each individual member and on the system as a whole. Some situations of change in the family system can be accompanied by stress, and its main sources are:

- Contact of a member with extra-family strengths;
- Contact of the whole family with extra-family strengths;
- Transition points in the family;
- Idiosyncratic problems.

The stressful contact of a member with forces outside the family constitutes a situation that imposes on its members the need to adjust to the new circumstances faced by one of its members, such as the loss of a job. In turn, Andrade & Teodoro (2012) state that the difficulty in family transition points is characterized by changes inherent to the family development cycle, for example, when a new child is born.

According to Monte & Pinto (2015), when waiting for the birth of a child, the family is surrounded by expectations: of what the child will be like, whether it will be a man or a woman, its physical form and even about its personality, whether its genetics will be more similar to that of its mother or father. The feelings of love, fear and affection are also part of this. When the family verifies that it has a child affected by Autism Spectrum Disorder, these expectations of what the child will be like, its genetics, personality, future, love, fear and affection, become more intense and confusing. They can cause impairment and changes in relation to the affective-emotional aspects of the parents and, as a consequence, there are losses in the family psychodynamics.

In Yoshijinna's (2000) view, the beginning of living with an autistic child places the family in front of a reality that is still unknown to them, and that will only cease to be so when they are able to get in touch with themselves; which means the acceptance of the situations then established. It is at this moment that the family is faced with its own prejudices, which may lead to the rejection or acceptance of autism. To be able to accept to observe reality, this being the starting point that will enable the creation of instruments capable of interfering and, thus, even modifying reality. Otherwise, contact with autism will always be postponed, as it is too painful. The concept of family often imprisons the behavior of the family in the face of its difficulties. Being able to create your own concept of family life should be the role of each family, according to the demands of each member.

For Monte & Pinto (2015), the presence of a child with autism in the family can present different reactions in family members, causing stress generated by the change in routine with therapies, doctors, and medication expenses. Solidarity and ruptures can also be present in some families. Each family will react differently, there is no exact definition or pattern of family behavior, it depends on their proximity to the child and according to the expectations they have created around the child diagnosed with autism.

From the perspective of Andrade & Teodoro (2012), stress around idiosyncratic problems refers to specific difficulties that arise as a function of time. For example, a family that is adapted at a certain time to the demands of a chronic disease in one of its members may present difficulties in subsequent phases, due to new demands of human development. The emergence of a chronic disease in the family is a change that implies the intertwining of three evolutionary threads: the disease, the life cycles of the individual and the family.

According to Monte & Pinto (2015), stress can alter the psychodynamics of the family and especially that of the maternal figure, who is considered the primordial figure in the recovery of their children. As the studies explained, the mother is also the main bearer of stressful aspects that take into account her time of dedication and involvement in the child's therapeutic activities. Some mothers have to give up their professional career to dedicate themselves fully to the therapeutic processes of their child, they consider that the routines of the therapies are intense in which the mothers are the ones who are present, available and participants.

Monte & Pinto (2015) state that parents need to be monitored by professionals, as they start to experience such feelings with intense loads of emotions, which can generate a state of mental confusion. Each family member will react in a unique way to this information, and it is through follow-up, therapeutic interventions that information can be obtained, which results in the alteration of self-esteem, dissolution of stigmas and distorted information. The professional needs to listen more to the family and seek, together with them, a solution for each case. Parents can sometimes come across professionals who know little about their needs, their conflicts, their expectations and their dreams.

According to Campos & Mendes (2014), the presentation of the diagnosis should be complemented by the suggestion of treatment, including all the activities suggested in the singular therapeutic project. The referral to the professionals who will be involved in the care of the case must be done objectively and immediately, respecting, of course, the time necessary for each family to elaborate the new situation. It is important to clarify that autism is a "syndrome", which means "a set of clinical signs", a set that defines a certain condition of life different from that experienced by the family until then. In addition, such a condition imposes differentiated care and routines. It is equally important to clarify that care will be shared between the professional team responsible for the treatment and the family. In other words, it is important to make them note that they (the family) will not be alone in this process and that their autonomy in decision-making will be respected.

For Monte & Pinto (2015), when parents receive the diagnosis that their child is affected by Autism Spectrum Disorder, they present an organization, which is characterized as follows: the new schedule of schedules, appointments, consultations, food. This organization can generate an initial stress load.

Pinto *et al.* (2016), point out that it is a situation that triggers changes in family life due to the child's needs to monitor their development. The diagnosis of a chronic disease in the family environment, especially in the case of children, is an impact situation, which can have repercussions on the change in the daily routine, the readaptation of roles and causing various effects in the occupational, financial and family relationships.

Faced with the moment of revelation of the chronic syndrome, such as ASD, the family commonly goes through a sequence of stages, namely: impact, denial, mourning, external focus and closure, which are associated with difficult and conflicting feelings. Thus, it is understood that the diagnostic disclosure of autism becomes a complex, delicate and challenging moment for the family, as well as for the health professionals responsible for this mission.

The physical environment associated with the other circumstances related to the news may interfere positively or not in minimizing family suffering. Lack of time, inability to communicate and emotional support of health professionals are still important barriers to this activity that is legally the responsibility of the physician. However, the importance of the presence of the multiprofessional team in this process should be considered in order to share the questions, anxieties and needs of the family members that are established at the time of diagnosis.

However, it is necessary to plan the way in which this diagnosis will be revealed to the family, maintaining the comprehensive dialogical relationship to facilitate the flow of information provided, as well as to enable a better acceptance by the family, so that it establishes the strategies to cope with the problem of the autistic student.

Educational guidelines for families of students with ASD

Before addressing educational guidance for families of students with ASD, it is first important to highlight that guidance is a process that aims to advise families with various strategies that enable them to have a healthy relationship with their children-students. Thus, Nascimento, Morais *&* Silva (2010) state that the assistance given to the student in order to provide opportunities for his full development is mediated in the relationship between the school, family and community environment. This educational orientation provides for planned strategies that interact students, teachers, management, school curriculum and community in order to promote, in a humanized way, the physical, personal, intellectual and moral development of the student.

For Maria *&* Maria (2011), educational guidance is the set of activities aimed at students, parents and teachers, with the aim of contributing to the development of their tasks within the specific scope of educational establishments.

Based on the assumptions presented by the aforementioned authors, we can agree that educational guidance is a system of actions directed to the various actors of the Teaching-Learning Process, specifically to students and families, with a view to integral development, thus promoting the socio-educational inclusion of the student.

Faced with the diagnosis of autism, many parents see their expectations and desires frustrated since the symptoms of autism can, among others, involve hyperactivity, crying, aggressiveness, difficulty in establishing eye contact, repetition of words and actions, impulsivity, screaming and social interaction different from the standard. For Yoshijinna (2000), it is important that the family seeks specialists who will provide knowledge, explanations and treatment, in addition to differentiating various characteristics and details of the disorder, through monitoring linked to the student's family, seeking to know the family histories, cultural and socioeconomic aspects, among others, in order for parents to broaden their view of certain situations and make an overview of their origin so that they know how to behave and help when crises arise Arise. It is necessary and vital to involve and understand the thoughts and attitudes of all family members so that, together, they can take care of difficult moments and experience them in the most natural way possible. It takes courage and perseverance to change from what we know to what we dream of.

The student with special educational needs the attention, care and affection of the family, and all the monitoring and encouragement for his progress, because he may even have excellent professionals who stimulate him, but the dedication and patience of the parents is essential in the life of this student with disorder, because the parents are the basis of him, and their involvement is extremely important for the development of this autistic student, as confirmed by Cunha (2014), the student with autism can only develop if he is truly integrated into the family environment. Parents have a greater impact on their children's development than any other professional they know. If parents spend at least two hours interacting with their children daily, they will influence their child's progress two or three times more than any teacher or therapist.

Families then constitute the first universe of sociable relationships where students develop, as Dessen (2001) emphasizes, especially in the case of students with ASD, who require specific attention and care from families. Therefore, families will be fundamental in the whole process.

Importance of the family in the context of school inclusion of students with ASD

It is perceived that many professionals in the area of education who, when they are faced with students with special educational needs, particularly with ASD, do not have the necessary knowledge or information on how to act with them, which makes the process of inserting these special students in regular school difficult, because, in order to include these students, teachers are first needed to receive and provide specialized care. According to Cunha (2014), many parents and other professionals are also not prepared and trained to deal with this situation and, in this way, give the necessary follow-up and attention, because autism is a topic little discussed and very difficult to explain and diagnose in childhood, because one of the characteristics of the child, autistic students, is the difficulty of communication. These students have difficulties expressing themselves orally, which makes it difficult for adults, parents, educators, to understand what they feel, so it becomes difficult to accurately diagnose if they have the disorder, since children in the age group of one to three years are still in the process of mastering language.

The family, in turn, is often not prepared to accept and help the child, due to lack of information and knowledge on the subject. In most cases, treatment is sought by the family when the child is already in the age group of three to four years, usually when school life begins. It is worth mentioning that, in the first years of life, the signs indicating the risk of autism are not so noticeable for those who do not have a minimum of information and knowledge on the subject. Often the signs are not valued by parents, family members and doctors because, in view of the signs and signs, it is erroneously concluded that it is a normal process for the child's age. One of them is usually the delay in speech, which begins to appear and intensify around the age of three, however a lot of time has already been lost in the sense of early intervention and the search for possibilities for a change in the condition that has been constituted, because, the faster the diagnosis, Sooner the right treatment and interventions begin, which will result in children progressing.

TREATMENT AND PSYCHOPEDAGOGICAL INTERVENTION OF STUDENTS WITH ASD

It is good to emphasize the distinction we can make between intervention and treatment. History on autism shows that some symptoms are persistent and that most of them are lifelong with different levels of severity. The term treatment usually refers to drug therapy or not, while intervention can be understood as the search for a better development of the individual's abilities with a view to overcoming their difficulties. Treatment and intervention should be conducted in conjunction with a team of professionals with different backgrounds.

According to Cunha (2014), for many specialists, the cure, according to traditional medical criteria, would be to get patients with autism to behave, in all senses, as typical individuals. In reality, the expected results are to reduce abnormal behaviors and minimize the losses present. Therefore, treatment and psychopedagogical intervention must be conducted together, with specific and combined education guidelines. Drug therapy should not be isolated but accompanied by other forms of help.

According to the Brazilian Society of Pediatrics (2019), the gold standard treatment for ASD is early intervention, which should be started as soon as there is suspicion or immediately after diagnosis by an interdisciplinary team that will consist of a set of therapeutic modalities that aim to increase the potential of the student's social and communication development, protect their intellectual functioning by reducing damage, improve quality of life and direct skills towards autonomy, in addition to reducing the anguish of the family and the expenses with therapies without scientific evidence bases.

Each child with ASD has individualized needs, which are in accordance with their functionality, family dynamics and the amount of resources that the community offers and, therefore, needs a personalized therapeutic evaluation that allows the establishment of an individualized intervention plan (*Ibid*).

Among the therapeutic modalities are:

Cognitive Behavioral Stimulation based on (ABA): a widely used and recognized behavioral program that aims to develop social and communicative skills, along with the reduction of non-adaptive behaviors, based on reinforcement strategies. While Mello (2005) goes further when he says that the analytical behavioral treatment of autism aims to teach the student skills that he does not have, through the introduction of these skills in stages. Each skill is taught, in general, in an individual scheme, initially presenting it associated with an indication or instruction. When necessary, some support is offered (such as physical support), which should be withdrawn as soon as possible, so as not to make the student dependent on it. The student's adequate response results in the occurrence of something pleasant for him, which in practice is a reward. When the reward is used consistently, the student tends to repeat the same answer.

Parental Coaching: family guidance and parental training, aiming at managing the behavior of caregivers, adapting routines and co-responsibility for stimulation.

Supplementary and alternative communication: from the use of signs, gestures, symbols, and pictures (such as the PECS - Picture Exchange Communication System) in nonverbal autistics; it was developed to help children and adults with autism and other developmental disorders acquire communication skills. According to Morgado (2011), the system is primarily used with individuals who do not communicate or who have communication, but use it with low efficiency. PECS aims to help students realize that through communication they can achieve the things they want much faster, thus stimulating them to communicate. It does not require complex or expensive materials and was developed with a view to its use by educators, family members, in a multiplicity of environments and places that the student frequents. The system can be used with students who do not communicate or who have low effectiveness communication. The interlocutors use cards to establish communication, making it possible to satisfy the needs of individuals in their daily contexts.

According to Mello (2005), the TEACCH method is based on the organization of the physical environment through routines organized in boards, panels or agendas and work systems, in order to adapt the environment to make it easier for the student to understand it, as well as to understand what is expected of him. Through the organization of the student's environment and tasks, the TEACCH method aims to develop the student's independence so that he needs the teacher for learning, but can also spend a large part of his time occupying himself independently.

In the TEACCH method, visual stimuli (photos, pictures, cards, etc.), body stimuli (pointing, gestures, body movements, etc.) and auditory stimuli (sounds, words, etc.) are used. The practice of the method is structured in the use of an agenda with individual routines that work on the notion of beginning, development and end. Vision is used a lot in activities with objects, pictures and words, depending on the phase of the method in which the student is.

It is important that the family is aware of the functioning of the intervention methods, whether behavioral or environmental, because the work carried out in schools or specialized institutions must have continuity in the family environment. Because "progress in the development of family and social life of autistic people depends on the effectiveness of the role of the family in the search for a quality of life for this autistic student and this search must be reinforced at all times and aiming at good results" (Lopes, 2018, p.59).

For Mello (2005), one should first seek to develop autonomy and independence, among other skills (non-verbal communication; social rules). At the same time, it is important to: work on reducing behavior problems; use pharmacological treatment if necessary; that the family receives guidance and information; that teachers receive necessary advice and support.

According to the author, the greatest criticisms of TEACCH have been related to its use with high-functioning students. Our experience has shown that TEACCH, properly used, can help these students a lot. Results above expectations have been achieved, not in a sudden and miraculous way, but as a result of a long work and always focused on the individual characteristics of each student.

Interdisciplinary team

According to the Brazilian Society of Pediatrics (2019), the main pillars are the family, the education and health team for the proper management of children with ASD with the aim of learning to have behavioral modifications worked on by interdisciplinary teams (psychologists, speech therapists, occupational therapists, psychopedagogues, social workers, physiotherapists, physical educators and others). Parents should also be trained by these professionals to work with the student at home. Recent research confirms that families who received ABA-based behavioral training had significantly better results in the most varied contexts.

Family intervention

According to Andrade & Teodoro (2012), in the presence of a member with autism in the family, parents gradually develop different *coping* strategies to deal with difficulties: active denial, focus on the problem, positive thinking and religiosity. Faced with the difficulties related to the child's behavior, they predominantly use the strategies of direct action and acceptance. To deal with emotions, they preferentially resort to distraction, seeking social/religious support, inaction and avoidance. Families that use a variety of active coping strategies not only experience decreased stress levels, but also have increased family cohesion as a consequence. Parents who use active coping strategies also see their experience as more rewarding and satisfying.

According to Yoshijinna (2000), the family has the fundamental role of being able to choose the paths they need, as they live with these difficulties all the time. The results of the treatments are not directly linked to an excessive number of therapies to which the autistic student is subjected, nor to an unlimited commitment of the household budget. It is necessary to seek a balance, verifying the cost/benefit ratio of each treatment. The family should not give up its leisure, its well-being and its limits, the autistic student needs to be treated as a member of the family and not as a sovereign, to whom everything is allowed. No one is to blame for having an autistic person in the family. No one, therefore, needs to be penalized. Of course, there are the stresses that living with an autistic person itself causes, but that can be mitigated, as the family is able to channel their expectations.

For Andrade & Teodoro (2012), during this whole process, parents build explanatory beliefs about the causality of their children's Autism Spectrum Disorder. They often attribute the disorder to single causes and/or inability of doctors. They also make causal attributions related to heredity and environment. In general, attributions to one's own fault and to the environment are related to a worse adjustment of parents to the condition of their children. In this case, a reformulation of beliefs becomes necessary. In addition, the formulation of a belief system of acceptance, adaptation, and optimism enables feelings of hope and control and allows us to extract meaning from adversity.

In this sense, according to Yoshijinna (2000), it is evident that the role of parents is very difficult, because the child they once thought they would have, did not develop like the children of friends, neighbors and others, and rewrite the life project from a reality of which nothing was known. But it is by groping here and there that a better life can be made possible by going through many successes and many mistakes. And it takes courage and perseverance to change from what we know to what we dream of.

Social support refers to the help of family members, spouses and friends in participating in the care of students with Autism Spectrum Disorder. For Andrade & Teodoro (2012), spouses who establish partnership relationships provide the best source of informal support, providing time for rest to the partner, sharing the responsibilities of managing the home and sharing the role of disciplinarian. The use of support services allows parents to engage in social and recreational activities, since, in general, they report experiencing difficulty accessing recreation and leisure services due to issues related to having a child with autism. Enabling this time of rest can reduce stress and give them time for personal development, making them better able to deal with the child compared to those who do not use this help.

EDUCATIONAL INCLUSION OF STUDENTS WITH AUTISM SPECTRUM DISORDER

The schooling of students with Autism Spectrum Disorder is a field under construction marked by the different ways of understanding these students, their development and the educational possibilities of each approach. In the view of Pletsch & Lima (2014), historically, the schooling of these students has been under the responsibility of specialized special education institutions. The care provided to students with Autism Spectrum Disorder in these institutions was based on the clinical medical model in which the educational work was centered on the student's disability, aiming to correct or mitigate the *deficit*, crystallizing the image of the student with Autism Spectrum Disorder at his diagnosis and determining an inability to learn and develop.

Teodoro *et al.* (2016), for inclusion to actually occur, it is necessary to have awareness, accept differences and learn to live with diversity, this coexistence is beneficial both for the teacher and for the other students and all other individuals in the school community. The teacher must also be well prepared to serve students with disabilities, especially the autistic student and his peculiarities, seeking to obtain continuing education, courses in the area of special education and reflect on the subject. The teacher must make the necessary curricular adaptations, so that the student with Autism Spectrum Disorder learns like other students.

Thinking about inclusion is more than simply inserting a student into the regular classroom and it is necessary to prepare to include these students with SEN, in particular, with Autism Spectrum Disorder. Training, continuous training of teachers and improvement is one of the main ways for the inclusion of students with ASD to be a fact. The state, the family, the school community and society in general must ensure that anyone with SEN, in this case specifically students with Autism Spectrum Disorder (ASD) have a quality education from Early Childhood Education to Higher Education.

For Battisti *&* Heck (2015), based on the assumption that it is necessary to know what each student needs to learn, it is also important to constantly analyze and evaluate the curriculum proposed during the Teaching-Learning Process. From this, the educator will be able to evaluate the student in his advances and obstacles.

However, the same authors, Battisti *&* Heck (2015), say that in order for the educator to be able to make this relationship about what and how to teach the student with autism, adequate training is necessary, otherwise the methodology used in the classroom will not serve to achieve the desired objective, which is learning. This is a major problem found in schools, as teachers are not prepared to deal with these students, due to lack of training. The inclusion of students with Autism Spectrum Disorder in regular schools needs attention from all those involved as mentioned above, in this way:

According to Teodoro *et al.* (2016), in the context of inclusive education, this contribution of the family and the school makes students feel more confident with the participation and interaction of the family. Including disabled students in regular education is also the duty of the family, which needs to be aware of the laws that defend and support its children and, however, they also need to support the school, encourage and be active in the school life of the students.

Inclusion does not happen quickly, to include it is necessary to work as a team, think about the well-being of all, have a relationship between school and family where one supports the other, the relationship between student and teacher, preparation of the school and students and also of society, thus making a team that includes students with disabilities and not just inserts them without thinking about learning. Therefore, the importance of the family/school union in the teaching and learning process of students with Autism Spectrum Disorder (ASD) is underlined. Thus, Teodoro *et al.* (2016), with the arrival of new students Target Audience of Special Education, the school must be fully prepared, and for a successful inclusion it is necessary to restructure the educational system at all levels, political-administrative, school and in the classroom itself.

For Duarte *&* Matias (2018), a good articulation between the school, the family and the community is an essential condition for a quality education that is intended for all. The absence of a relationship between school and family will create problems for students that will become evident in the school environment and affect their development. The importance of good articulation among all can contribute to greater support for students with SEN, in this case, Autism Spectrum Disorder, so that they learn to know how to be equal in difference. The active participation and co-responsibility of all stakeholders, each assuming a differentiated but complementary responsibility, in supporting the student with Autism Spectrum Disorder, can create conditions for an inclusive education that is intended for all.

According to Cunha (2014), although at home every situation should be pedagogical, from time to time, parents feel insecure to correct their child, look for ways to attract them to the less rigorous family world, leaving a more demanding behavioral intervention to the school.

In this line of thought, the family cannot leave this responsibility only to the school, but both institutions constitute the two main environments of human development in contemporary societies. Therefore, it is known that the relationship between family and school are fundamental in the development of any child, especially for students with ASD. Thus, Marturano (1999) cited by Henrique (2021), points out that the school and the family are systems in which the child is inserted and where they must play different roles, so they must participate in the education process of students with ASD, but often the family is not in a position to play this role, as they do not have the scientific knowledge to be able to relate in a healthy way with autistic students.

In the perspective of Cunha (2014), a great help for all individuals with autism, regardless of the degree of severity, comes from family relationships, due to the focus on community, social interaction and affection. The school and the family need to be in agreement in learning actions and interventions, mainly because there is great support in behavioral education. This means that the way the autistic person eats, dresses, bathes, brushes his teeth, handles objects and the various stimuli he receives for his personal contact need to be analyzed consonants in both environments.

Therefore, it is corroborated with the authors cited, because in the process of inclusion of students with Autism Spectrum Disorder, it is necessary to involve and exchange between the family and the school so that this desideratum is achieved with the active participation of both institutions. The school, by an institution equipped with specialists, should guide families with scientific knowledge that enables them to have an adequate relationship with autistic students in their homes. And the family must see the school as a worthy partner in the search for a solution to the concerns defined in their students, and for this they must place trust and be more open with the school and the autistic child, following the guidelines issued by the school institution.

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