

Autism and Inclusion Psychological Aspects and Family Dynamics

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Abstract

The birth of a child with autism spectrum disorders represents an inevitable alteration of the family system. For years the family of the autistic person has been the subject of accusations, in particular mothers were blamed as the cause of children's autism. The arrival of an autistic child, requires energy from the parental figures, goes to destabilize the balance of the couple, depriving themselves of the rights of autonomous happiness. The family must be seen as a resource in the construction of the intervention project, in fact it must not only be informed but actively involved so that the interventions agree and do not dissociate. The aim of this paper is to review the autism spectrum disorder within the family system. We aim to provide an analysis of the emotional response to the communication of diagnosis and family response strategies, in the face of the traumatic event. In addition, support for the family system, which aims to promote inclusion, through different forms of support, thanks to which it can take on a role of partnership within the educational-rehabilitation of the autistic person.

Keywords: Family; Children with autism; Social inclusion

Historical and Theoretical Framework of the Disorder

The word "autism" comes from the Greek "autus" which means "himself" was introduced in 1908 by well-known Swiss psychiatrist, with this term he referred to a social retreat, the cause of which was attributed to schizophrenia. Eugen Bleuer, Only in the 1940s, innovative contributions were made by Leo Kanner (1943) [1] and Hans Asperger (1944) [2], who conducted a series of studies on children, with common characteristics, the play and relationships of these children observed, They were solitary, difficult to bond, with a tendency to isolation. The language, acquired later than the evolutionary age and characterized by echolalie and sounds, also presented motor stereotypes and manifestations of behavioural crisis, in the absence of rituals. Initially schizophrenia was associated with autism, Kanner found, of the common characteristics present in the parents of children, were educated people with good social and economic success, but in the interaction with their children, showed a detached attitude and for several years, it was believed

that the basis of autism was a lack of parent-child relationship. Hans Asperger was considered the second most important pioneer, in this area, made a contribution to the independent diagnosis of autism. Asperger, like Kenner, observed a group of four children in particular examining aspects related to communication and despite the language had been acquired in the stages envisaged by the development, These children spent a lot of time talking about one topic, nonverbal language was not always consistent, facial expressions were limited, and sometimes gestures were awkward. These children had a difficult time following socially shared rules, but showed a high level of competence in activities where memory tasks were required. Asperger believed that the special characteristics of his children could not fully manifest themselves in early childhood, since social relations are only available when the possibility of interaction in social groups is greater [3].

This element differs from the thought of Kanner, who stresses that autism in young children appears from birth. Asperger never said that the symptoms he identified did not appear at birth, but Kanner needed to point it out, this fact may indicate that the latter

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subjects (those studied by Kenner 1943) had obvious characteristics at a very early stage, compared to children observed by Asperger (1944). After the work of Kanner and Asperger, interest in autism increased, for a long time parents were accused of the condition of their children and the work of psychoanalyst Bruno Bettelheim who developed the metaphor of the empty fortress, has played a very important role in this story. According to the author, the cause of autism lies in the mother's attitude: too indifferent and insensitive to the needs of the child. These "refrigerator moms" give children the idea that they cannot affect the world around them, forcing them to retreat to an empty fortress [4]. Faced with the child's attitude of withdrawal, the mother developed a further pathological response, which she defined as a vicious circle, resulting in what Bettelheim called "chronic autism", which she believes can be cured by separating the child from the parent. Bettelheim's theory has long dominated the field of science, and apparently produced a strong sense of guilt and pain among parents; has also had a negative impact on the proposed intervention hypothesis, because it focuses on the mother-child relationship rather than on the characteristics of the individual child [5]. Since the 1980s, people have gradually abandoned Bettelheim's theory of psychogenesis and produced new theories, Kolvin (1972) [6] and Rutter (1972) [7] began to study autism independently of schizophrenia. In this framework, Rutter proposed a definition of autism, the purpose of which is to refine the definition of Kanner, who had advanced many years earlier: according to Rutter [6], symptoms must present at an early stage, refer to social problems, to difficulties on communication (not due to mental retardation in both cases), and there had to be the presence of abnormal and rigid behaviours. Rutter's proposal was very relevant and strongly influenced the decision to include the category of "childhood autism" [8] in DSM-III (1980) [9], calling it a generalized developmental disorder, creating a special section in which autism can find space. The release of DSM-III is a very important watershed, because for the first time the clinical difference between schizophrenia and autism has been officially recognized, and is characterized by the absence of psychotic symptoms, delusions and hallucinations. A few years later, the publication of DSM-III-R (1987) [10] brought further conceptual changes, first represented by its definition: no longer alluded to autism with childhood autism but with autistic disorder, allowing you to include within this condition not only very young children but also older ones.

Definition and Characteristics of the Disorder

The guidelines for autism of the Italian Society of Childhood and Adolescence Neuropsychiatry (last updated February 2021) define autism as a behavioural syndrome caused by a disorder of biologically determined development, which occurs within the

first three years of life, while in more severe cases, symptoms are already evident between the 12 and the 24 months [11]. The areas mainly affected by an altered development are those related to social communication, mutual social interaction and functional and symbolic play [12]. The DSM V [13] introduces the new criteria for the diagnosis of Autism Spectrum Disorder and the levels of, listed below in the table: severity The American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5) provides standardized criteria to help diagnose ASD.

Diagnostic Criteria for Autism Spectrum Disorder

To meet diagnostic criteria for ASD according to DSM-5, a child must have persistent deficits in each of three areas of social communication and interaction (see A.1. through A.3. below) plus at least two of four types of restricted, repetitive behaviours (see B.1. through B.4. below).

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviour to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour. For either criterion, severity is described in 3 levels: Level 3 – requires very substantial support, Level 2 – Requires substantial support, and Level 1 – requires support.

B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity

Severity is based on social communication impairments and restricted, repetitive patterns of behaviour. For either criterion, severity is described in 3 levels: Level 3 – requires very substantial support, Level 2 – Requires substantial support, and Level 1 – requires support.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment with or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor

(Coding note: Use additional code to identify the associated medical or genetic condition.)

Associated with another neurodevelopmental, mental, or behavioural disorder

(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioural disorder[s].

With catatonia (refer to the criteria for catatonia associated with another mental disorder)

(Coding note: Use additional code 293.89 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

It is important to consider that some people may be below level 1, indicating a need for mild support, which means that some of them may retain good function, without support while maintaining the cognitive characteristics typical of the syndrome. The individuals to whom reference is being made are those who have had the greatest ability to adapt the peculiarities of their characteristics to the environment. Despite this ability to adapt, these people may be so uncomfortable that they need help because of their condition, which should not be considered pathological (Table 1).

Table 1: Support levels of autism spectrum disorder.

Support level	Social communication	Restricted, repetitive behaviors
Level 3 «Very substantial support is needed»	'Serious shortcomings in social, verbal and non-verbal communication skills can lead to serious impairment of functions; very limited initiative in social interaction and minimal responses to the initiative of others. »	Behavioural inflexibility, extreme difficulty in facing change. Stress when rituals or routines are interjected; difficulty in diverting the subject from his focus of interest, and when this happens, his attention quickly returns to it. »
Level 2 «Significant support is needed»	'Deficits focused on verbal and non-verbal social communication skills; the social difficulties appear evident even with support; limited initiative of social interactions and response to the initiative of others reduced or	«Behavioural inflexibility, difficulties in coping with changes; Restricted/repetitive behaviors are sufficiently frequent to be apparent to a random observer and if interrupted they cause stress or frustration.



	abnormal. »	»
Level 1 «Support is needed»	In the absence of support, deficits in social communication cause considerable impediments that can be noticed. Difficulty in initiating social interactions, and shows clear examples of atypical responses or failure to others' initiatives. The individual may show little interest in social interactions. »	Behavioural inflexibility causes significant interference in one or more contexts. Difficulty in moving from one activity to another. Problems in organization and planning hinder independence. »

Incidence and Prevalence

Autistic behaviours are found in all populations of the world, so there would be no clear ethnic or geographical prevalence. However, data on the incidence of autism has undergone some very important changes. In the mid-1980s, it was estimated that there were differences in the ratio of 4/6 autistic patients to 10,000 people, partly because of the geographical area in which the study was conducted, and partly because of the method of observation. In the mid-1990s, this number rose to 14/15 out of 10,000, recording an increase in autism cases, but if we think that the study provided an estimate of 60% in the early 2000s, this did not stop autism. It is estimated that worldwide about 1 in 100 children has autism [14]. This estimate represents an average figure, and reported prevalence varies substantially across studies. Some well-controlled studies have, however, reported figures that are substantially higher. The prevalence of autism in many low- and middle-income countries is unknown. Of course we want to know the cause and whether the main reason for the increase in cases is attributable to the new definition of diagnostic criteria, a greater attention to autism and its behaviour. There are no clear answers to these questions, but autism as it is classified today is very different from the definitions of the past, where the main focus was social isolation. Today we are more attentive to a set of characteristics of behaviour and this has allowed to diagnose a greater number of cases affecting the prevalence.

Etiopathogenesis

The cause of autism is still under study. It is believed that a single cause cannot be identified for all different forms of autism. There are evidence and studies done that autism can be caused by a variety of physical factors that affect brain development. Autism is the final common pathway of pathological situations of various nature and probably with different etiology. From the review of the literature, a high rate of heredity and a significant relationship between monozygotic twins is evident: the risk of birth of another autistic child is 20 times higher. Despite these tests, the

etiological path that leads to the development of autism images remains unknown. The data generated by this research show a strong heterogeneity and complexity of genetic etiology, and it is possible to identify cellular or molecular pathways. However, only hypotheses about the origin of the disease can be proposed, and deterministic factors about the cause, are still unknown [15,16].

Family

The first approach to the study of families of children with disabilities can be considered "pathological". It can be summarized as follows: the disability of the child represents the disability of the family. According to this view, the disabled child is a stressor that has a negative and inevitable impact on the family. The family is the pre-eminent social nucleus that allocates the material and emotional resources that an individual needs to grow in a healthy and balanced way. It takes care of vulnerable people, such as minors, the elderly, the disabled, etc, for this it plays a fundamentally active role in the care of needs.

Parents faced with disability: from diagnosis to acceptance.

The impression of a person is that there is no way out in the labyrinth, no sober ability to face the situation that occurs at a specific moment, all love and patience seem to be reduced to nothing. The birth of an autistic child is a particularly delicate moment that involves the redefinition of the family structure; it is an event characterized by the activation of a series of processes, both individual and husband/wife systems that will allow adaptation to this new condition [17]. You want to receive as much information as possible at the time of your child's diagnosis, even if they are unable to fully understand or find such information unpleasant. Therefore, in this regard, a useful reflection concerns the way in which the diagnosis must be communicated: clarity and graduality seem to be the basic elements of attention to parents, who naturally cannot avoid pain, but can accompany them on the path of hope [18]. Even before

his birth, future parents will establish together or separately an idealized image of their child, based on the meaning of the event and their needs and expectations [19]. Regardless of their preferences, for the physical or other characteristics of their child, the important thing that they want is that their child is born with good health. Once we know about the diagnosis, regardless of how it was communicated, the emotional impact that follows is naturally very strong. There may be different initial reactions from parents, for this reason, in most cases, it takes quite a long time to deal with the situation in its different aspects.

At this moment they are catapulted into a reality, in which a late adaptation is required with respect to birth, precisely because, unlike other disabilities, it does not show up early, and that is why it is even more difficult. At this stage some are hopeful and extremely motivated to help the child acquire skills and this contributes to improving the climate in the family system. For others, the acceptance of the diagnosis of autism of their child is a process that develops gradually, passing through different stages, from the initial ones in which shocks and guilt prevail, to the final ones of adaptation. The sense of powerlessness they feel can lead them to use a number of defense mechanisms, such as denial, to protect themselves from pain and to detach themselves emotionally from the situation in which they found themselves. Such a refusal in the face of diagnosis can also manifest resentment towards all those people who express comments on the problems and abnormalities of behaviour of their child, such as stereotypes and self-harming or aggressive attitudes that. Due to the absence of an outward appearance of disability, they can arouse in people more attention, provoking criticism towards parents, considered responsible for that strong behaviour.

The reaction of parents at this point is usually to condemn themselves forced to self-isolation, because any contact with the social environment will seriously jeopardize their self-esteem and sense of adequacy. These difficulties lead some parents to assume an attitude of unconditional freedom to the child, fearing that an imposition may be a cause of further detachment towards them. The education of the autistic child, the management of his behaviours, can be the cause of relational dysfunction within the parental couple, especially when these, have diametrically opposite positions [20]. The parents of an autistic child may adopt a tolerant or authoritarian attitude, according to the belief that an authoritarian method is more appropriate for education. At the stage of bargaining, the parent to deal with the disability of the child, accepting the limitations due to the pathology, seeks reassurance in health professionals, with whom he comes into contact, asks for information on the evolution of the disease. If the bargaining has a positive side, will follow the acceptance [17].

The Main Factors of Stress

The birth of an autistic child causes parents anxieties, worries and especially stress, which are not normally found when the child is neurotypical. Research shows that the quality of life of these parents is significantly lower than that of able-bodied children. Mario Farne (1999) [21] in his book "stress", argues that it can be represented as a two-sided coin, given the difference between eustress and distress.

Neustress defines a beneficial response by the body, which even improves cognitive performance. Distress: it is a cause of excessive physical and psychological activation, which will be followed by a phase of adaptation and if this is not activated, it will go to the phase of exhaustion, resulting in anxiety, psychic and muscular tension, functional and subjective disorders. In families with an autistic child, parents face many stressful events, it is difficult to understand the problems of the child, due to the complexity of the syndrome [17].

The child, uses a different relational mode than that expected by the parents, shows difficulty in eye contact, and the behaviour is of closure and indifference to human interactions that can be perceived, at an early stage, as a personal rejection of them, rather than a real inability of the child to relate. Communication difficulties can become an important cause of stress for parents, especially for a lack of understanding of what the child asks. Research (Konstantareas and Homatidis, 1989) [22] found a difference between the two spouses, pointing out that for fathers the most stressful symptom of the child is related to his difficulty of verbal communication, for mothers are self-harming behaviours, hyperactivity and inappropriate use of the body to produce more stress. Milgram and Atzil (1988) believe that maternal stress is the result of failure in parental competence [23].

The ideology of other children

Becoming a parent is a difficult task: an adventure that is generally considered a "privilege" by the outside world, but the real commitment and responsibility required to do so is never mentioned. Educating your child to cope with the various stages of his growth requires parents a constant "rebirth", in this process parents must constantly change to appeal to different skills, emotions and dynamics of relationship [24]. Where in the family nucleus there are, in addition to an autistic child, also other children, we often witness an attempt of idealization of the latter by the parents. Therefore, implicitly asking the "non-autistic children" to compensate, more or less consciously, the wound inflicted by the birth of the child with syndrome. Therefore, in response to the increasingly visible difficulty of the child with a disability, which is certainly accentuated in the growth from year to year, there is a need for parents to obtain satisfactory and positive results from other children [17].

The idealization that occurs is expressed in several ways, such as:

- emphasize the qualities of healthy children, invest a lot of money on these qualities and express them to the maximum;
- not paying enough attention to the vulnerability of non-autistic children, considering him as the one who has less need of his brother;
- Not pay attention to the true talent of their neurotypical children and cleverly certain inheritances and qualities are attributed to them to compensate for those that the other child cannot express.

It also often happens that parents believe that the goals achieved by the autistic child are positive, while those achieved by the able-bodied child, as something taken for granted and that it is due, creating in the latter a strong sense of frustration. At other times we witness, in terms of children, a full idealization of self that parents have proposed in the educational and family model. In fact, often, many siblings of autistic children or boys demonstrate a high level of self-confidence, a high level of responsibility and a sense of duty, a subtle propensity to take care of others and to understand what is preferable or better for him than [17]. In this sense, the role that siblings play in the family can be influenced, because they can be involved in the care of the disabled brother or, which happens especially with older daughters, who have to assume some responsibilities in the household, for example, which in normality would be the duties of the mother. The disability of the child is an issue that affects the whole family, and the modes of reaction of the same are multiple and will in turn affect the development of the child. It seems, therefore, that, after the arrival of the autistic child, a delicate but obvious "distribution of parts" occurs, attributing to children who are not disabled, often, a role halfway between the parental/adult and the autonomous child, that does not need special attention [17].

Fear of the future

The thing that most worries parents with an autistic child is the "after us", that is, the moment when, after the death of the parents, the child in question can be left without the support of people who can provide safe and meaningful references. The expression reflects precisely the feelings of concern and anguish for the future of their disabled children on the part of families. The concept of responsibility for the future according to the studies, contains in itself also that of reciprocity in the sense that caring for the other cannot become an effort in solitude, but an evolution that brings together other people who share this commitment, in fact at the legal level we can say that to help this real concern of parents comes to the aid of Law No 112/2016, which gave rise to a new way of understanding the "after us", stressing the importance of the disabled person. It is in line with the provisions of the 2006 UN Convention on the Rights of Persons with

Disabilities: "In fact, the United Nations Convention requires that the disabled person be considered no longer because of his or her limitations (ICDH health model) or because of the relationship between these limitations and the surrounding environment (ICF bio-psycho-social model), but for his being a person and, therefore, like everyone, he has intrinsic rights, his own path of life, to be developed, in conditions of equal opportunity with all others, through the right supports and supports (model of human rights). Law n. 112/2016 is essentially divided into two parts of intervention, but with a common objective: to promote the welfare, social inclusion and autonomy of people with disabilities after the death of their parents [25]. A first part of the law provides for a special National Fund, divided by the Regions according to their regional programming, that allow the activation of measures that are in the first place in full consistency with what is established in the individual project drawn up by the social services of the municipality of residence, in collaboration with the disabled person and his family (Art. 14 of Law No. 328/2000).

These measures may be:

- groups-apartment;
- interventions for temporary stay in an extra-family dwelling to deal with any emergency situations;

The second part, on the other hand, provides for fiscal measures; such as

- discounts on insurance policies;
- Property provided by parents, relatives or benefactors.

On the other hand, it would be desirable and preferable for parents themselves, with the help of services, to prepare the "after us" in the period of "during us", to avoid emergency solutions that do not meet the expectations of family members. Imagining having an adult autistic child who is self-aware and capable of leading a "normal" and independent life is an achievable goal that many parents consider unrealistic, if not utopian. Yes, it is undeniably difficult to consider the future of one's child; it is something that causes anxiety in addition to doubts and uncertainties about the ability of the family and society to provide adequate assistance to such people [26]. Increasingly, in recent years, however, families are able to look further ahead, within a project life, and not see themselves as the only place and resource of future life for their children [26]. In this new point of view, families must face the challenge of preparing and facilitating the great disarray between them and the child, and they do so in order to implement life experiences that help the child to take small steps towards autonomy, and his family to gradually elaborate its independence [27].

The Importance of Support in Families with Autistic Children

Over time, however, families of children with permanent conditions such as autism may run out of family resources. It is therefore important that families are supported by an adequate social support network. It is important that these parents develop interests and friendships, as it is a way to protect their health and that of their children. In fact, a stressed, anxious and depressed parent cannot effectively play his role as a caregiver. The closest network with family members are relatives and friends, but also parishes, schools, societies, etc. which can play an important social support function. Social networks are an element in the process of developing essential resilience. According to Heiman, the factors that most help families facing crises and intense stress, such as the birth of a child with autism, are:

- cooperation, consultation and dialogue with friends, relatives and professionals;
- Create a support network among families facing the same issues [28]
- use of services for diagnosis and specific care, but also for advice and personal support
- Families with autistic children tend to retreat for fear of judgment and misunderstanding by others. For example, parents fear that the hyperactive or aggressive and self-defeating behaviour of the child may appear to others as a lack of education. This results in the inability of parents of children with autism to integrate and develop the social networks of which they are part. However, it is necessary for them to understand that it is wrong to isolate oneself from one's life: cultivating interests and friendships, or focusing on one's hobbies, is not a selfish act towards an afflicted child, but a type of attitude to avoid situations of severe stress. It is therefore important that these families have access to effective, broad and explicit social support. Scholars believe that social support is an interpersonal interaction involving one or more of the following expressions: affection (expressing connection, love, admiration, and respect), reassurance (express agreement or appreciation for the proper management of a situation or point of view) and assistance (operations that provide assistance, may include things, money, information, advice [29].

Social support cannot be defined as an intervention, much less as a treatment provided by a professional operator, it is more a feeling/attitude and an expression of interest and sharing. It is unknowingly invested by family, friends and neighbours for the care of the other; it can also be considered an essential resource because its use and effectiveness are not necessarily influenced by stressful conditions or situations. Of course, social support becomes more effective and important in situations of stress or crisis. Vaux believes that the quantity and quality of social

support meets people's needs and pressures and activates their core resources. The search for social support is seen by scholars as a positive action strategy to solve problems and difficulties. The tutor therefore has a dual function: a resource and source of energy for those with difficult tests and tasks, and a goal for those who need to add more arrows to the bow. Face [29]. The existence of a child with autism requires considerable effort and a lot of time and energy from the family. Autistic children need a lot of care and families are forced to maintain constant contact with doctors, specialists and health workers. Social support structures can support and understand these families in the daily lives of these children. Social support inside and outside the home available to families with autistic children has direct and indirect effects on family well-being. Social support can not only have a general anti-stress effect, but under certain conditions it can be effective in improving the quality of life of children with chronic disabilities housing [29].

Home interventions and residential and semi-residential centres

For many parents, managing the daily life of an autistic child can be difficult. It is for this reason that a series of family interventions may be useful, which can partially relieve parents of the burden of responsibility that comes from the management of non-neurotypical children. In addition to giving partial relief to parents, family interventions are part of a true global care that takes into account all the different areas of life of people with autism. Communication with others is important and home education interventions can be very useful. The fundamental aim of this intervention for people with autism is to acquire personal, social and relational autonomy. The Home Education Assistance Service, is represented by an educator who regularly visits the house (usually several afternoons a week) and/or accompanies the minor or one or more family members in activities outside the home [30].

In addition to listening, educators offer a variety of activities to help their world, they help them:

- to develop their primary skills, in particular,
- personal autonomy, attention to personal hygiene;
- to live in social environments such as playgrounds, supermarkets, parishes, etc. ;
- improving formal learning by supporting the implementation of school tasks;
- To optimize leisure time, like practicing some sports.
- For an effective family educational intervention, the A.S. must bring benefits not only to the primary recipients of the intervention, the autistic person, but also within the family. The interventions can be requested directly from the family or recommended by a social worker or other worker related to the family unit (e.g. teacher or child psychiatrist). In the case of coercive measures, the interventions of home

education can be requested and ordered by the court for minors through the custody of social services. To initiate an intervention, social services must activate a contact person for educational services, which may be a service run by the municipality or a service run by an external body in the third sector. Together with the request to activate the intervention, the social services usually send a report form to the educational service together with the documentation necessary to understand the individual and family situation of the autistic person. Following a request to start Social Services, the contact person of the Educational Services evaluates the probability of accepting the request, then presents a case and an educator/minor family match in a meeting with the educators. After combining educational service relationships, meetings are organized with social workers and operators involved in educational interventions. In this meeting a group evaluation was conducted and a project was developed that identified: objectives of the educational intervention, modalities of activation and implementation, timing and inspection. The social worker then organizes a visit to the family, which will also be attended by the educator of reference for the intervention: "The purpose of the visit is to present the educator to the minor and the parents, and to suggest their objectives, timing and methods of intervention [30].

Finally, the family, minors, social services and educational services, each undertakes to respect their own responsibilities. The administrative authority responsible for family education is the authority responsible for social intervention, or the place of residence of the child who takes on the financial commitment or the competent management body. In some cases, at the discretion of the municipality or the governing body, families can share the cost of the intervention. This cost sharing can greatly influence the way parents see educators. Usually, when the family shares the expenses, the educator is voluntarily paid because he is paid and obliged to be hired by the family and to do whatever it asks of him. In reality this is not the case, as the role of educator is inserted in specific projects aimed at achieving certain objectives. In these situations, social workers play a very important role. The latter, in fact, must clarify the role of educators to families at the beginning of the journey and beyond to generate positive trends in educational interventions. In addition to supporting people with autism, home education services must support families by helping them read, understand and support the growth and development dynamics of their child. Especially in out-of-home activities, educators can bring autistic people to day care centers for the disabled or to the socio-educational centers that constitute semi-residential services.

A Day Centre for Disabled People is a territorial service of educational, rehabilitation and welfare interventions, a non-residential structure, open at least 8 hours a day, 6 days a week, with rehabilitative therapeutic functions aimed at preventing or/and stopping relational isolation processes and containing

hospitalization. The day care center for the disabled has a variety of professionals who can meet the needs of people with disabilities in all respects. The professionals who make up the multidisciplinary team of day care centers are the head-coordinator, the professional educator, the psychologist, the social worker, the pedagogist and the health care personnel. Work with families, here too, is important so that they can understand the paths of growth and development of their loved ones. Another semi-residential service is the Autonomous Education Service (SFA), which is aimed primarily at young people with moderate disabilities, as those with autism level 1. The main purpose of the service is to stimulate and enhance the abilities of each individual through the implementation of individualized projects, valuing personal autonomy and possible employment opportunities [30].

Often laboratory activities are carried out as well as activities in outdoor environments, such as libraries or youth aggregation centers, where the tasks are carried out by autistic subjects established to be carried out independently. Access to these services involves a multidimensional assessment, which leads to a separate project, the contribution of which is also provided by social workers.

Another intervention that families with children with autism can take advantage of in their homes is home care that allows people to stay at home and receive the necessary care and assistance in their home environment without the need for shelter or residential facilities [30]

Home Care Services (SAD) are designed to help people with autism carry out daily activities to alleviate the burden of care for their families, albeit in part. They are carried out by social workers

Health is mainly about helping people:

- personal care and hygiene,
- completion of bureaucratic procedures;
- do the shopping;
- preparing and eating meals at home;
- take care of the environment of daily life;
- When travelling for medical reasons.

This type of intervention can provide very important support to families, especially when both parents are working, there are other children at home, and there are no informal support networks available to help parents manage children with autism. Start Social Services now. After accepting a request for family assistance, assess the situation after a first verification of the request for visit. The most common tools used by social workers for assessment are home visits and interviews. The assessments of social workers must take into account:

- the needs of the person with autism and his or her family/carers,
- Social and economic conditions

- of available informal resources.

On the basis of the assessment made, verify that the person who needs home intervention has the necessary conditions to access the following services. After this verification, if the result is positive, determine the cost share to be borne by the user and prepare the Individual Assistance Project (PAI): The drafting is carried out with the contribution of all interested operators (doctors, nurses, OSS, physiotherapists, social workers, educators, psychologists, speech therapists). The PAI has been developed to customize interventions and clearly define:

- objectives and results to be achieved;
- benefit schemes and levels of intensity and duration;
- the actions, types of services and professional figures involved;
- family contact person or companion, responsible or responsible for the case;
- Timing and tools for project evaluation and validation.

The PAI must be communicated and shared with the person receiving the intervention and his family. As a result of the above, the implementation of aid projects, if the services are not outsourced, can be managed directly by the local authority, or by social cooperatives or social enterprises affiliated with the local authority. Home care services can also be realized by offering job vouchers (vouchers) or service vouchers. When people with autism are temporarily or permanently deprived of the help and support of family members, hospitalization services are used. They present different organizational models (Health Care Residences, Housing Communities, Apartment Groups...) with different operating parameters according to the autonomy of the guests and the relative needs of educational assistance. Residential services are open 24 hours a day all year round. Generally, residential facilities for the disabled are managed by an accredited third sector body or a public service company. Expenditure commitments for the inclusion of people with disabilities in residential facilities are shared by ASL, municipalities and users and/or their families. The Nursing Homes for Disabled (RSA) accommodate from 20 to 40/60 people, mainly adults and severely handicapped. Especially in nursing homes, the following benefits are provided: medical assistance, nursing and rehabilitation, assistance in daily activities, social and recreational activities, catering services, laundry and cleaning. Housing communities are smaller structures than the RSA, which can accommodate from 6 to 10 people. These communities tend to have the characteristics of ordinary apartments and try to recreate an environmental atmosphere similar to the domestic and social environment of hospitalized patients. It is a socio-sanitary-residential structure dedicated to elderly people who are not self-sufficient, but also to disabled adults, who need medical assistance, nursing and full-time

rehabilitation. The services that operate there are functional services that meet individual needs, maintain the skills and levels of autonomy acquired, paths of personal growth and social integration [30]. However, this type of residential service is usually aimed at people in the mental health sector.

A fundamental requirement for inclusion in these residential structures is the absence of households or the impossibility of staying at home, or the lack of autonomy for people with disabilities who cannot live alone, although there are several forms of support and assistance that can be activated at home. Access to the residential structure begins with the request of the person concerned or his family members to the local social services agency. Upon receipt of the request, the social worker initiates a multidimensional evaluation process carried out by the evaluation office. On the basis of the assessment made, determine the type of structure to which the person concerned will go. A specific structure is then identified, taking into account individual and family preferences and compatibility between individual needs and the type of structure. If possible, it is recommended to choose a building not far from where the disabled person lives and where his family lives, so that his family and social relationships can be well maintained. At this stage it is necessary to conduct interviews with individuals and/or family members to explain the results of the evaluation and develop hypotheses for a feasible reception. After identifying the most suitable structure, a presentation session was organised. This meeting is usually attended by social workers, managers and operators of the structure, who together review the evaluation of the UVM and agree on how the integration will take place. Upon entry, the person is welcomed on a predefined date. After insertion a period of knowledge and observation is provided, culminating in a personalized educational project in collaboration with individuals and family members. This step defines the official management of the structure in favour of the disabled. Even after users have entered, it is good that the social services agency continues to monitor the situation through regular meetings with individuals and their families, as well as with the structure team. In most cases, the admissions within the residential structures occurred after the disappearance of the reference family figures for people with disabilities. This makes the hospitalization itself even more tiring and traumatic for the latter, who see themselves completely disconnected and abandoned from their living environment, both physically and socially. Just to make up for the trauma of these events was approved on 16 June 2016 Law n. 112 Provisions for assistance to the seriously disabled without family support. It is important to sensitize families with autistic children, or with disabled children, generally speaking, to think about a "after us, a between us"; realizing therefore, the adult life independently managed of the person with disabilities while the family is still

able to accompany this process, and in turn be accompanied in processing it [30].

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