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REVIEW ARTICLE

Role of Pediatric Nurses in the Early Identification of Autism Spectrum Disorder (ASD): A Review

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ABSTRACT

Autism spectrum disorder (ASD) is a lifelong neurodevelopmental condition characterised by persistent difficulties in social communication and interaction, together with restricted, repetitive patterns of behaviour, interests or activities. Its reported prevalence has risen markedly over the past two decades; the most recent surveillance data from the United States estimate that about one in thirty-one eight-year-old children is identified with ASD, and Indian community studies report a substantial, often under-recognised burden. Although reliable diagnosis is possible by the age of two years and the core features frequently emerge in the second year of life, many children are still not identified until they are four or five years old or older, delaying access to the early intervention that most strongly predicts good outcomes. Pediatric nurses are uniquely placed to narrow this gap. They have repeated, trusted contact with infants, toddlers and their caregivers during immunisation, well-child and growth-monitoring visits, in the community and in schools, and they are therefore ideally positioned to monitor developmental milestones, to elicit and take seriously parental concerns, to administer validated screening tools such as the Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT-R/F), to recognise early behavioural red flags, to make timely referrals for diagnostic evaluation and early-intervention services, and to educate, counsel and support families while reducing stigma. This review describes the nature, epidemiology and early manifestations of ASD, the rationale for early identification, and the recommended framework of developmental surveillance and screening. It then sets out, in a structured and practical way, the role of the pediatric nurse in early identification, including a developmental red-flag guide and a discussion of the Indian context. It is intended as a practical resource for nurses, nursing students and allied child-health professionals.

KEYWORDS

• Autism Spectrum Disorder • Early Identification • Developmental Screening • Developmental Surveillance • M-Chat-R/F • Pediatric Nursing • Early Intervention

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INTRODUCTION

Autism spectrum disorder (ASD) is a lifelong neurodevelopmental condition that begins in early childhood and is defined by two core features: persistent deficits in social communication and social interaction across multiple contexts, and restricted, repetitive patterns of behaviour, interests or activities. According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition[1], these features must be present in the early developmental period and must cause clinically significant impairment in social, occupational or other important areas of functioning, although they may not become fully manifest until social demands exceed the child's capacities. The term "spectrum" reflects the wide variation in the presentation and severity of the disorder: some children have profound impairment with little or no spoken language and an associated intellectual disability, while others have fluent language and average or above-average intelligence and may not be recognised until much later.[2]

ASD is therefore not a single, uniform condition but a clinically heterogeneous group of presentations sharing a common core. What unites them, and what matters most for the child's future, is the timing of recognition and the timing of help. A large body of evidence shows that the developing brain is most amenable to intervention in the first years of life, and that children who enter structured early-intervention programmes sooner tend to make greater gains in communication, cognition and adaptive behaviour.[3,13] Yet despite the fact that the core features of ASD are often detectable in the second year of life, and that the diagnosis can be made reliably by about two years of age, a large proportion of children are not identified until they are four or five years old or older.[12] This gap between the age at which ASD can be recognised and the age at which it usually is recognised represents lost opportunity, and it is precisely the gap that pediatric nurses are well placed to close.

Pediatric nurses occupy a strategic position in the child-health system. Through immunisation clinics, well-child and growth-monitoring visits, neonatal and paediatric wards, community outreach and school health programmes, they have repeated and trusted contact with infants, toddlers and their families at exactly the ages when the earliest signs of ASD appear. They spend sustained time with caregivers, are often the first professionals to whom a worried parent voices a concern, and are skilled in observation, milestone monitoring, health education and referral. This article reviews the nature and early manifestations of ASD and then sets out, in a structured and practical way, the role of the pediatric nurse in its early identification.

UNDERSTANDING AUTISM SPECTRUM DISORDER

The DSM-5 organises the features of ASD into two domains.[1] The first is persistent deficits in social communication and social interaction, which include difficulties in social-emotional reciprocity (for example, reduced sharing of interests, emotions or affect, and failure to initiate or respond to social interaction), deficits in non-verbal communicative behaviours (such as poorly integrated eye contact, facial expression, gestures and body language), and difficulties in developing, maintaining and understanding relationships appropriate to the developmental level. The second domain is restricted, repetitive patterns of behaviour, interests or activities, which may include stereotyped or repetitive motor movements, use of objects or speech; insistence on sameness and inflexible adherence to routines; highly restricted, fixated interests of abnormal intensity or focus; and hyper or hypo-reactivity to sensory input, such as adverse responses to sounds or textures or an unusual fascination with lights or movement. The World Health Organization's ICD-11 describes an essentially similar disorder, which facilitates consistent recognition across health systems.[15]

Severity is specified according to the level of support the person requires, and the diagnosis records whether ASD is accompanied by intellectual impairment or language impairment, and whether it is associated with a known medical, genetic or environmental factor. ASD frequently co-occurs with other conditions, including intellectual disability, language disorder, attention-deficit/hyperactivity disorder, anxiety, epilepsy, sleep disturbance and gastrointestinal problems, all of which influence presentation and care.[2,3] For the purpose of early identification, however, what matters most is familiarity with the everyday behavioural signs by which these underlying features first reveal themselves in infants and toddlers, described later in this review.

EPIDEMIOLOGY AND BURDEN

The reported prevalence of ASD has risen substantially over the past two decades, driven largely by broadened diagnostic criteria, greater awareness and improved case ascertainment rather than by any single biological cause. The Autism and Developmental Disabilities Monitoring (ADDM) Network of the United States Centers for Disease Control and Prevention estimated, on the basis of data collected in 2022 and published in 2025, that approximately one in thirty-one (about 3.2%) eight-year-old children had been identified with ASD.[4] This represents an increase from the previous estimate of about one in thirty-six based on 2020 data[5], and a striking rise from roughly one in one hundred and fifty in the early 2000s. Across surveillance sites, ASD was identified more than three times as often in boys as in girls.[4]

The apparently lower rate in girls is thought to reflect, at least in part, genuine under-recognition: girls more often present with subtler social difficulties and fewer overt repetitive behaviours, and may camouflage their difficulties, so that they are identified later or missed altogether. This has direct implications for the vigilance required of front-line clinicians, including nurses.

Indian data are more limited and vary with sampling and methods, but they confirm a substantial burden. A large population-based study of neurodevelopmental disorders in children aged two to nine years across five regions of India identified ASD among the conditions contributing to disability.[6] A school-based study in Kolkata reported a prevalence of ASD of roughly one in one hundred children[7], and a systematic review and meta-analysis of Indian studies estimated the pooled prevalence to lie broadly in this range, while emphasising wide variation and probable under-ascertainment.[8] Whatever the precise figure, ASD is common enough that every pediatric nurse will encounter affected children, and the global trend of rising recognition makes competence in early identification an increasingly essential nursing skill.

WHY EARLY IDENTIFICATION MATTERS

The case for early identification rests on a simple but powerful premise: the earlier ASD is recognised, the earlier evidence-based intervention can begin, and the better the long-term outcome tends to be. The first years of life are a period of rapid brain development and heightened neural plasticity, during which targeted, intensive intervention can meaningfully alter the developmental trajectory. A landmark randomised controlled trial of the Early Start Denver Model in toddlers demonstrated significant gains in cognitive and adaptive functioning and in language when intervention began before three years of age[13], and expert consensus recommendations strongly support beginning intervention as soon as ASD is suspected, without waiting for a definitive diagnosis.[3,9]

Despite this, a persistent gap exists between when ASD can be detected and when it is. The core social-communication features are frequently observable by twelve to eighteen months, and the diagnosis is reliable by about two years; yet a systematic review and meta-analysis of studies worldwide found that the average age at diagnosis was well beyond this, commonly in the range of four to five years and later still in many settings.[12] Delays are typically greater for children with milder presentations, for girls, and for children from rural, lower-income or minority backgrounds. Every month of delay is a month of missed intervention during the most plastic period of development.

Early identification also benefits the family. A timely explanation relieves the anxiety and self-blame that parents often carry when their child's development seems different but unexplained, allows families to access support, financial assistance and respite, and replaces a cycle of misunderstanding and frustration with a constructive, informed plan of care. It is in delivering these benefits – to the child and to the family – that the pediatric nurse's contribution is most valuable.

EARLY SIGNS AND RED FLAGS OF ASD

Recognising ASD early depends on knowing what the earliest signs look like in real infants and toddlers. The signs cluster in the two diagnostic domains, but in the youngest children they appear mainly as differences in social engagement and communication, and as the absence of expected milestones rather than the presence of dramatic abnormality.[14] The nurse should hold a low threshold for concern when these features are present.

Social and communication signs

- Limited, fleeting or absent eye contact and reduced social smiling.
- Reduced response to name being called by 9–12 months, despite normal hearing.
- Reduced sharing of interest or enjoyment – little pointing to "show" things, limited following of another's point or gaze (joint attention).
- Few or no gestures such as waving, reaching up to be picked up, or shaking the head by 12 months.
- Delayed babbling and delayed first words; little back-and-forth "conversational" vocalising.
- Preference for being alone, limited interest in other children, and difficulty with simple social games such as peek-a-boo.

Restricted and repetitive behaviours

- Repetitive movements such as hand-flapping, body-rocking, spinning or toe-walking.
- Repetitive use of objects, such as lining up toys or spinning wheels rather than playing imaginatively.
- Strong insistence on routines and marked distress at small changes.
- Unusual, intense or narrow interests, and unusual sensory responses – distress at certain sounds or textures, or fascination with lights, fans or spinning objects.

Developmental red flags by age and regression

Certain milestones, if absent, should always prompt action. The American Academy of Pediatrics highlights, among others, no big smiles or warm joyful expressions by 6 months; little or no babbling, pointing or meaningful gestures by 12 months; no single words by 16 months; and no meaningful two-word phrases (not including imitating or repeating) by 24 months.[3] A loss of previously acquired speech, babbling or social skills at any age – developmental regression – is a particularly important red flag and warrants prompt evaluation. The summary in Table 1 links common red flags to the action a nurse should take.

Table 1: Developmental red flags and the pediatric nurse's response

Age	Red flag/ missing milestone	Suggested nurse response
By 6 months	No big smiles or warm, joyful expressions; limited eye contact	Document; reassure but heighten surveillance; review at next visit
By 9–12 months	No response to name; no babbling; no gestures (pointing, waving); poor joint attention	Confirm normal hearing; administer/plan structured screening; discuss concerns with parents
By 16 months	No single meaningful words	Apply ASD-specific screen; refer for developmental evaluation if indicated
By 18–24 months	No meaningful two-word phrases; limited pretend play; repetitive behaviours	Administer M-CHAT-R/F at 18 and 24 months; refer on positive screen
Any age	Loss of previously acquired speech or social skills (regression)	Refer promptly for diagnostic evaluation; do not adopt "wait and see"

DEVELOPMENTAL SURVEILLANCE AND SCREENING

Best practice for early identification combines two complementary activities: continuous developmental surveillance and periodic standardised screening.[3,10] Surveillance is the ongoing, flexible process of monitoring a child's development at every contact – eliciting and attending to parental concerns, taking a developmental history, observing the child, tracking milestones, and identifying risk factors. Screening is the use of a validated, standardised instrument at defined ages to detect children who need further evaluation, regardless of whether a specific concern has been raised.

The American Academy of Pediatrics recommends developmental surveillance at every well-child visit, general developmental screening at the 9, 18 and 30-month visits, and autism-specific screening of all children at the 18 and 24-month visits, with referral for evaluation and intervention whenever a screen is positive or a parent or clinician is concerned.[3,10] Screening at 18 months is important because the features of ASD

frequently emerge by this age; screening again at 24 months captures children who regress, plateau or were missed earlier. It is worth noting that the United States Preventive Services Task Force concluded that there was insufficient evidence to recommend universal screening of children in whom no concern had been raised;[17] nevertheless, the prevailing paediatric guidance supports universal screening because of the benefits of earlier intervention and because most children who screen positive prove to have developmental needs worthy of attention even if ASD is not ultimately confirmed.[3]

The most widely used screening tool is the Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT-R/F), a two-stage, parent-completed instrument validated for children aged 16 to 30 months; the structured follow-up interview that forms its second stage substantially improves its predictive value.[11] Other tools used in surveillance and screening include general instruments such as the Ages and Stages Questionnaires and the Parents' Evaluation of Developmental Status. Crucially, a screening tool does not diagnose ASD; a positive result identifies a child who should be referred for a comprehensive diagnostic evaluation and, in the meantime, for early-intervention services. Table 2 summarises commonly used screening tools.

Table 2: Commonly used developmental and autism-specific screening tools

Tool	Age range	Purpose / notes
M-CHAT-R/F	16–30 months	Autism-specific, parent-completed, two-stage screen with follow-up interview; recommended at 18 and 24 months
Ages and Stages Questionnaires (ASQ)	1–66 months	General developmental screen across multiple domains; parent-completed
Parents' Evaluation of Developmental Status (PEDS)	0–8 years	Elicits and categorises parental concerns; used in surveillance
Developmental milestone checklists	All ages	Support ongoing surveillance at every visit

THE ROLE OF THE PEDIATRIC NURSE IN EARLY IDENTIFICATION

Because the early identification of ASD depends on repeated contact, careful observation, trusted relationships with families and timely referral, it is work to which pediatric nursing is exceptionally well suited.[18] The nurse's contribution can be understood as a set of overlapping functions, described below.

1. Developmental surveillance and milestone monitoring

At every immunisation, well-child and growth-monitoring contact, the pediatric nurse is in a position to monitor the child's development against expected milestones in communication, social, motor and adaptive domains. By incorporating a few targeted questions and observations into routine visits – Does the child respond to his or her name? Point to show interest? Make eye contact? Play pretend games? – the nurse maintains the continuous surveillance that the guidelines describe as the foundation of early identification.[3,10] Maintaining and reviewing milestone records over successive visits allows the nurse to detect not only static delay but also plateau and regression.

2. Administering and interpreting standardised screening

Nurses frequently administer, score and help interpret standardised screening instruments, and in many settings they are the professionals who ensure that the recommended autism-specific screen is ctually carried out at 18 and 24 months.[3,11] The nurse explains the purpose of the questionnaire to caregivers, helps them complete it accurately, conducts the structured follow-up interview where the M-CHAT-R/F requires it, and ensures that a positive result triggers the agreed referral pathway rather than being filed and forgotten. Embedding screening into routine practice is one of the most concrete ways in which nursing advances early identification.

3. Eliciting and validating parental concerns

Parents are usually the first to notice that something is different about their child's development, but their concerns are too often dismissed with reassurance to "wait and see." The nurse, who is frequently the most approachable member of the team, should actively elicit caregiver concerns, listen to them carefully, and treat them as valuable clinical information rather than over-anxiety.[10] A parent's report that a toddler does not respond

to his or her name, has lost words, or does not point should never be brushed aside; it should be documented and acted upon. Equally, the nurse can sensitively raise concerns that parents have not voiced, framing them in a supportive, non-alarming way.

4. Structured observation of the child

Beyond formal screening, the skilled nurse observes the child throughout the encounter – during history-taking, examination and play – noting eye contact, response to name, gestures, joint attention, language, play behaviour and repetitive movements. Brief office contacts can miss subtle features, so the nurse's observations across repeated visits, combined with information from parents and, where relevant, from other carers or teachers, build a fuller and more reliable picture than any single assessment.[14]

5. Timely referral and care coordination

Identifying a concern is only useful if it leads to action. A central nursing responsibility is to ensure that a child with a positive screen or significant concern is referred promptly and simultaneously for both a comprehensive diagnostic evaluation and early-intervention services – the guidelines are explicit that intervention should not wait for a confirmed diagnosis.[3,9] The nurse helps families navigate what can be a confusing system, explains what the referral involves, helps secure appointments, follows up to ensure the child is actually seen, and coordinates communication between the family, the paediatrician or developmental specialist, therapists and, later, the school. This care-coordination role is one in which nurses add particular value, especially for disadvantaged families who might otherwise be lost to follow-up.

6. Health education and raising awareness

Education is woven through every other function. The nurse explains, in language the family can understand, the typical course of early development, the signs that warrant attention, the difference between screening and diagnosis, and the importance and availability of early intervention. Beyond the individual family, nurses working in the community and in schools can raise awareness among parents, anganwadi and childcare workers, and teachers, helping them recognise early signs and know where to seek help.[16] Well-informed caregivers and community workers become an extended network of early identification.

7. Counselling and supporting families

The period around suspicion and diagnosis is stressful and emotionally charged for families. The nurse provides a calm, supportive presence: acknowledging parents' feelings, dispelling myths and guilt, correcting misinformation, and offering hope grounded in the genuine benefits of early intervention.[3] By supporting the family's coping and connecting them with parent support groups and counselling, the nurse strengthens the very relationships on which the child's progress will depend.

8. Advocacy and reducing stigma

In many communities, developmental difference is misunderstood and stigmatised, and families may fear blame or social exclusion. The nurse advocates for the child's right to timely assessment and services, challenges stigma and mislabelling, and promotes inclusive attitudes in clinics, schools and the wider community.[16] Advocacy also means working to ensure that screening and referral pathways actually exist and function in the nurse's own setting.

9. Accurate documentation

Finally, careful documentation underpins continuity and accountability. Recording milestones, parental concerns, screening results and referrals at each visit allows trends to be detected over time, ensures that information is not lost between providers, and provides the evidence base for follow-up. Good records are themselves a tool of early identification, because they make plateau and regression visible across successive contacts.[10]

CHALLENGES IN THE INDIAN CONTEXT

Several factors shape early identification of ASD in India and have direct implications for nursing. Awareness of ASD among parents, teachers and the general public remains limited, so early signs are frequently misread as shyness, stubbornness, hearing trouble or simple delay, and children are identified late.[8] Stigma surrounding developmental and mental disorders discourages families from seeking help, and the "wait and see" advice that children will "grow out of it" remains common. Specialist developmental

and child-psychiatry services are unevenly distributed and concentrated in cities, so rural and underserved families face long distances and waiting times. The shortage of trained personnel and validated screening tools in local languages further hampers systematic screening.

There are, however, real opportunities. India's Rashtriya Bal Swasthya Karyakram (RBSK) provides for the screening, early identification and management of developmental delays and disabilities, including ASD, in children from birth to eighteen years, delivered substantially through mobile health teams and nurses in community and school settings.[20] Nurses – especially those working in primary health centres, community health, anganwadi-linked services and school health programmes – are ideally positioned to advance early identification, family education, de-stigmatisation and referral within these programmes. Strengthening nurses' training and equipping them with validated, locally adapted screening tools could substantially improve early detection across the country.

IMPLICATIONS FOR NURSING PRACTICE

This review highlights several priorities for practice. First, pediatric nurses should be equipped, through pre-service and in-service education, to recognise the early behavioural signs of ASD, to monitor developmental milestones confidently, and to administer and interpret validated screening tools such as the M-CHAT-R/F.[3,11] Second, autism-specific screening should be embedded into routine well-child and immunisation contacts at the recommended ages, with clear referral pathways that nurses can activate. Third, nurses should adopt a family-centred, non-judgemental approach that elicits and respects parental concerns, supports caregivers emotionally, and reduces stigma. Fourth, nurses should act as care coordinators, ensuring that children with positive screens are referred promptly for both diagnostic evaluation and early intervention and are not lost to follow-up. Finally, given the limited Indian evidence base, nurses are encouraged to participate in and lead research evaluating nurse-led screening, structured teaching programmes and awareness interventions, so that practice in this setting becomes increasingly evidence-based.

CONCLUSION

Autism spectrum disorder is a common, lifelong neurodevelopmental condition whose outcome depends heavily on the timing of recognition and intervention. Although its core features often emerge in the second year of life and the diagnosis can be made reliably by about two years of age, many children are still identified far too late, losing precious time during the most plastic period of brain development. Pediatric nurses are uniquely placed to close this gap. Through their repeated, trusted contact with infants, toddlers and families, they can monitor developmental milestones, elicit and validate parental concerns, administer standardised screening, recognise early red flags, refer promptly for diagnosis and early intervention, and educate, counsel and advocate for children and their families while reducing stigma. With adequate training, embedded screening, functioning referral pathways and a compassionate, family-centred approach, nurses can ensure that more children with ASD are identified early – and that early identification is translated into the timely help that gives every child the best possible start. Strengthening nurses' knowledge and skills in this area, and building the Indian evidence base, should be a continuing priority.

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