India-centric implementation of naturalistic developmental behavioral interventions (NDBIs) for autism spectrum disorder : A review and roadmap

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Abstract

Naturalistic Developmental Behavioral Interventions (NDBIs) represent a class of evidence-based approaches that integrate principles from applied behavior analysis (ABA) and developmental psychology. Globally recognized for their efficacy in early autism intervention, NDBIs are increasingly being adapted to diverse cultural contexts. In India, where autism prevalence is rising and access to standardized care remains uneven, the integration of NDBIs into public health and clinical frameworks offers a promising pathway. This review synthesizes global evidence on NDBIs, evaluates their cultural adaptability, and explores their implementation within the Indian context, highlighting challenges, innovations, and future directions. Drawing from recent meta-analyses, Indian field studies, and global trials, we highlight the promise of parent-mediated NDBIs and community-based delivery models in bridging gaps in accessibility, efficacy, and cultural fit.

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- Community-Based Intervention

Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition characterized by deficits in social communication and restricted, repetitive behaviors. Globally, early intervention is recognized as critical for improving developmental outcomes. Autism Spectrum Disorder (ASD) affects approximately 1 in 100 children in India, though true prevalence may be underreported due to diagnostic disparities. [1] If there is one disorder which can be called as complex, bewildering, impenetrable, recondite and demanding then it must be ASD. Indian Academy of Pediatrics conducted a Pan-India mega workshop 'Cradle to Crayon' to train Pediatricians which succeeded in its mission to update their knowledge about the commonly occurring NDD and in particular ASD. However, on the down side, it looks like we have left these practicing Pediatrician in a state of "limbo", with enough knowledge to pick a case of ASD and no knowledge about its management. The result is that parents of children with ASD are in a "shelter-skelter" state knocking on one door after the other in the pursuit of a remedy. Today we neither have a standardized intervention module nor a program to address this ailment in our country. Even in the west, the highly structured "Applied behavioral analysis"

(ABA) for intervention has failed to evoke the desired response and acceptance from all quarters for various reasons.

The Rashtriya Bal Swasthya Karyakram (RBSK) is India's flagship child health screening and early intervention program under the National Health Mission (NHM). Initiated in 2013, RBSK's vision is to improve the quality of life for children by systematically identifying and treating four categories of health challenges—the "4Ds": Defects at Birth, Diseases, Deficiencies, and Developmental Delays including Disabilities. [2] Importantly, autism spectrum disorder (ASD) falls squarely within the list of "developmental delays including disabilities" tracked and managed under RBSK, underlining policy-level compatibility with interventions for autism. India's health system faces shortages of psychologists, speech therapists, and behavior analysts, especially in rural and remote areas. MHTs and ASHAs are overburdened, facing dual workloads (screening, data entry), limited mobility support, and, sometimes, inadequate remuneration and recognition. [3]

The Indian context of Autism Interventions:

In the Indian context, numerous limitations in interventions persist. Most interventions are concentrated in urban centers, leaving rural populations under served as is evident from a systematic review which shows that many of the studies in Indian context are of small sample size limiting generalizability of findings [4] A narrative review highlighted low public awareness, stigma, and misconceptions as major barriers to early diagnosis and intervention with parents often facing negative experiences in both family and community due to lack of understanding and support.[5] Current challenges in the diagnosis is also glaring with a systematic review highlighting limited use of validated tools like ADOS-3 or CARS-2, shifting from centre to centre by the families due to lack of standardized care, cultural mismatches imported without sufficient cultural tailoring by many centres which does not align with Indian parenting style.[6] Language barriers and lack of localized tools hinder accurate diagnosis and treatment delivery. In the context of clinic based therapy services becoming unaffordable for extended duration coupled with deficiencies of various accepted models like ABA and DTT, Indian children need a more affordable accessible, culturally adaptable parent/ child implemented service as a sustainable model for our masses. A systematic analysis pointed to the need to evaluate the effectiveness of evidence based interventions in routine healthcare settings in India. [7] The shortage of therapists trained in evidence-based models like ESDM, ABA, or NDBIs and infrastructural gaps making services inaccessible to families is noted in studies done by institutions like NIMHANS. [8] The inherent disadvantages of models further complicate the issue like for the ABA & Discrete trial training being a) difficulty to "generalize" the new skill across multiple contexts, b) emergence of escape/avoidance motivated challenging behaviors, c) deficiency in spontaneity of response, and d) prompt dependency. With increasing awareness and demand for early intervention, India faces a critical need for scalable, culturally sensitive, and evidence-based models. The Indian autism intervention landscape is fragmented, with a predominance of eclectic models and limited use of standardized, evidence-based approaches. Naturalistic Developmental Behavioral Interventions (NDBIs) offer a promising alternative, combining the rigor of applied behavior analysis (ABA) with the sensitivity of developmental science. NDBIs, which emphasize child-led learning in natural environments, offer a compelling alternative to traditional clinic-based ABA models. Though global evidences are plenty on usefulness of NDBI with a meta-analysis showing large effect size for parent mediated NDBI's, [9] Indian data shows a different picture with domination of Sensory integration and eclectic models, but lack empirical validation. [7]

Overview of NDBIs

NDBIs are a class of interventions that integrate behavioral and developmental principles to support learning in natural environments. [10,11] The core features of NDBI are: a) Child-led interactions: Emphasis on following the child's lead to promote engagement. B) Embedded learning: Skills are taught within daily routines and play. C) Developmental appropriateness: Targets are aligned with typical developmental trajectories. D) Use of natural reinforcers: Rewards are intrinsic to the activity (e.g., access to toys, social praise). [12,13] Some of the prominent NDBIs are given in Table 1.

Table 1 Prominent NDBI Models: [10,11]

Model	Key Features	Evidence Base
Early Start Denver Model (ESDM)[10]	Combines ABA with developmental strategies	Strong RCT support
JASPER	Focuses on joint attention and symbolic play	Effective in low-resource settings
PRT (Pivotal Response Treatment)	Targets motivation and self-initiation	Widely used in parent training

In the complex labyrinthine maze of interventional modalities, NDBI appears as the one which would benefit most Indian children with ASD, especially if implemented by developmental paediatricians. Training developmental Paediatricians to equip parents with NDBI strategies could enhance accessibility and continuity of care. By promoting parent-led interventions and culturally relevant implementation, NDBI offers a promising framework for ASD management in India. This is evident from many studies done so far. Naturalistic Developmental Behavioral Interventions (NDBIs) actively promote parents—especially mothers—as primary interventionists in place of or alongside therapists. This approach is grounded in the idea that embedding learning opportunities within everyday routines enhances developmental outcomes and increases intervention fidelity. [10] Parent-mediated NDBIs have shown robust improvements in parental fidelity, children's social skills, language, and adaptive functioning abroad and even in India. [13,14] Research has demonstrated that NDBIs can be especially beneficial for young children (ages 2–6), with impacts reported across communication, social interaction, adaptive behaviour, and even parent wellbeing. [11,13,14] Because these interventions rely heavily on family engagement and real-world delivery, they are considered adaptable for diverse and low-resource contexts—a feature crucial for India's vast, varied, and resource-constrained child health landscape. RBSK's comprehensive reach and existing infrastructure offer a promising foundation for NDBI delivery, while NDBI's adaptable and family-centered approach matches RBSK's emphasis on community and continuity of care.

Cultural compatibility: With optimal cultural adaptations this method can easily be adapted in India. Cultural adaptation is a planned, organized, iterative, and collaborative process that includes participation from the targeted population. [12] The key considerations while considering the cultural adaptations of NDBI in India are- Joint family systems: Interventions must engage extended caregivers; Language diversity: Materials and training must be multilingual; Parenting norms: Emphasis on obedience may conflict with child-led approaches. A recent analysis gives evidence on issues creeping up due to cultural adaptation problems while implementing NDBI's. [15] Accordingly, language and Communication Adaptation can be done by using Multilingual Training Materials: Develop caregiver coaching manuals and video modules in regional languages (e.g., Kannada, Tamil, Hindi, Bengali) and use of culturally familiar gestures and expressions to enhance child engagement and caregiver fidelity. Contextualizing Play and Learning Materials can be done by replacing Western toys with locally available, culturally relevant items (e.g., kitchen utensils, traditional dolls, musical instruments) and by embedding learning in daily routines such as prayer, mealtime, and storytelling. Family Structure Integration can be done by involving extended family members (e.g., grandparents) in coaching sessions to reflect joint family dynamics as well as using family rituals as scaffolds for social communication goals. India's deep mobile penetration can be used in Technology-Enabled Delivery by leveraging WhatsApp, voice notes, and mobile apps for remote coaching, especially in rural or underserved areas. Use of asynchronous video feedback to support caregiver fidelity without requiring live sessions. Manualized NDBIs may need flexibility along with fidelity to increase fit with marginalized families while maintaining effectiveness by cultural contextualization. This Balancing Fidelity and Flexibility can be done by adapting manualized NDBIs with flexible delivery formats while maintaining core principles (e.g.,

child-led engagement, natural reinforcement). Also, use iterative field testing across states to validate adaptations. Participatory Adaptation Process can be ensured by engaging local caregivers and practitioners in co-designing intervention materials and using bottom-up feedback loops to refine cultural fit and implementation strategies. These strategies adapted from studies done by Lee et.,al 2023 may be used to improve the cultural adaptations while implementing NDBI by the developmental Pediatricians. [15,16] A checklist for cultural adaptation may be handy in determining the appropriateness of the adaptation to improve the quality. [16]

Road map for India centric NDBI:

India centric NDBI focuses on child-led learning within natural environments, emphasizing parental involvement, in particularly mothers as key interventionists. Core components include selecting developmentally appropriate teaching targets, embedding learning opportunities in daily routines, and using evidence-based instructional strategies like modelling, shaping, and reinforcement. A crucial aspect of NDBI is its emphasis on motivation, environmental arrangement, and child-initiated teaching episodes to improve engagement and social communication (Box3). Adoption of NDBI in India, where structured intervention programs for ASD are lacking requires training developmental Paediatricians/ pediatricians to equip parents with NDBI strategies to enhance accessibility and continuity of care. By promoting parent-led interventions and culturally relevant implementation, NDBI offers a promising framework for ASD management in India.

Reasons for advocating NDBI: It follows the natural developmental curve of the child. It lets the child dictate what he/she wishes to learn. It is flexible yet has a strict framework. It is instituted by the parent (especially Mother). It combines all the good qualities of the other interventions such as -Early start Denver model (ESDM), Enhanced milieu training (EMT), Incidental teaching (IT), Joint attention, symbolic play, engagement and regulation (JASPER), Pivotal response treatment (PRT), Project impact, and ABA & DTT, which most consider as the "Gold Standard" in the management of ASD [12,13,16,17,18,19].

Core Elements of NDBI: The three core elements of NDBI are: The nature of teaching targets; Context in which intervention was delivered; and Instructional strategies. *The nature of the targets* chosen were from a broad range of developing domains which include language, communication, play, social interaction, cognition and motor skills. These skills have a cascading effect and foundational role in the later development especially in the core "social deficit" of ASD. Many other skills were also included like reciprocal engagement, joint attention, functional communication via the use of gestures, facial expressions and words. *Context of treatment delivery*: When the intervention is delivered during an enjoyable and familiar play routines and using a variety of material, created more chances of a success. Examples of the learning opportunities are imitating facial expression and actions, identifying body parts during bathing and building shared engagement and social initiation during "Peak-a-boo" etc. *Instructional strategies* like modelling, shaping, chaining, prompting and differential reinforcement are also used in intervention. Most mothers do things "automatically in an attempt to help their children", which is wrong, for example: if a child wants to go out to play and is standing in front of the door, she automatically opens the door, which is wrong! If she were to wait for a while it would force the child to initiate an activity wherein the child has to indicate to the mother to open the door which is a desired activity.

NDBI promotes the use of mothers for intervention instead of the qualified interventionists who can certainly help if there is specific issue which is hampering the progress. To achieve this goal, we need to train the mother to do intervention. [20] And for this there must be a module which specifies: What, when, how to do, and how to measure progress made. Often when a child is referred to a centre for intervention, most often Developmental Paediatricians lose touch with the patient as they hardly return. NDBI is an intervention that Developmental Paediatrician can easily get trained to teach intervention to the parents, the problem of monitoring the child's progress and continuous contact with the child can both be solved. Suggestions for possible interventions are included in the annexures 1,2,3 and 4. Parent-mediated interventions are pivotal.

Training modules may be developed should start with: start with everyday activities and simple play routines; progress to modelling, shared control, and natural reinforcement; emphasize self-paced learning, video-based self-reflection, and peer support networks; Incorporate stress-reduction strategies for caregivers to maintain engagement and wellbeing. [11,13]

Autism falls in the developmental delays and disabilities domain of RBSK. Scalable NDBI training for all frontline paediatricians and home level monitoring of parents by health workers; deployment of technology (apps, telemedicine); deep engagement with NGOs; policy and budget allocation for autism-specific interventions; community awareness and stigma reduction, prioritizing monitoring, evaluation, and adaptive learning from pilot sites for national scale-up will help a long way. Studies have demonstrated feasibility of wide scale implementation. [21]

The areas of priorities for which Future Directions are important are mainly in research in NDBI. The priority areas and topic may be Validation of NDBI models in in diverse Indian settings and evaluate outcomes across linguistic, socioeconomic, and regional subgroups; Development of culturally adapted fidelity checklists [22]; Study how cultural norms (e.g., joint family systems, parenting styles) influence caregiver-mediated NDBI delivery. Investigate the effectiveness of mobile-based coaching (e.g., WhatsApp, video feedback) for parent training and assess scalability and engagement in rural and low-resource settings. Study the impact of caregiver training on child outcomes, parental stress, and intervention fidelity as well as compare synchronous vs. asynchronous coaching models. Evaluate models for embedding NDBIs into government programs (e.g., Rashtriya Bal Swasthya Karyakram).

Policy Recommendations:

This include Inclusion of NDBIs in national autism guidelines; Funding for community-based pilot programs, and training of health care workers in NDBI principles. Integrating NDBI into RBSK in India is not only conceptually compatible and operationally promising, but, with robust commitment, stands to transform autism care and outcomes in one of the world's largest and most diverse child health systems.

Conclusion

India stands at a pivotal moment in autism care. By embracing Naturalistic Developmental Behavioral Interventions and adapting them to its rich cultural tapestry, the country can move toward more inclusive, effective, and scalable solutions. NDBIs not only align with developmental science but also offer a humane, family-centered approach that resonates with Indian values of nurturing and community. Developmental Pediatricians can be trained to teach intervention to the parents, the problem of monitoring the child's progress and continuous contact with the child can both be solved.

Conflict of Interest None

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Annexures:

Box 1: Components, procedures and strategies for NDBI

Core components

- All the core components are taken from the well-established principles of ABA
- Individualize the goals for each child using development based interventional strategies and sequences.

Common procedural elements

- Procedures should be clearly specified in the intervention manual.
- Since there may be considerable variations in implementations procedures for assessing treatment fidelity are included.
- During interventions, Involve ongoing measurement of progress.

Common instructional strategies

- Specify how environment should be arranged to ensure that the child must initiate or interact with an adult in order to gain access to desired material, favoured activity or familiar routines
- Utilise natural reinforcement and other motivation enhancing procedures
- Use prompting and prompt fading during acquisition of a new skill
- Use balanced turns within teaching routines

Using modelling

Utilise adult imitation of child language, play, or body movements

Work to broaden the attentional focus of the child

Involve some form of child initiated teaching episodes

Box 2: Strategies for making environmental arrangements

- **Place preferred items in transparent containers** that are visible but inaccessible, prompting the child to request or signal for them.
- **Maintain control of desired materials** until the child initiates a request through gesture, vocalization, or other communicative behavior.
- **Introduce playful interruptions** during ongoing activities to create opportunities for the child to signal continuation or express intent.
- **Use materials that require adult assistance**, thereby naturally encouraging the child to seek help or engage socially.
- **Engage in expectant waiting**, where the adult pauses intentionally to allow the child time to initiate or respond.
- **Alter familiar routines deliberately**, prompting the child to notice and correct the deviation, thereby fostering communication and cognitive flexibility.

Box 3: Alternatives to keep motivated: Guiding Strategies

Preferred Activity	Underlying Appeal	Suggested Alternatives
Bubbles	Visually stimulating	Balloons, car ramp toys, spinning tops, liquid-filled sensory toys
Swinging	Kinaesthetic movement	Spinning in a chair, tickling games, blanket rides
Pressing buttons on cause-and-effect toys	Auditory feedback	Musical instruments, freeze dance, rhyming or singing books, pretend sneezing games
Pressing and rolling clay or putty	Tactile sensory exploration	Dry rice or beans, shaving cream, finger painting, kinetic sand

Box 4: Engagement Challenge (difficult behaviour) and Responsive Strategies- example

Challenge	Suggested Strategies	Illustrative Examples
Child appears disengaged and wanders aimlessly	Present clear choices or initiate an inviting activity to spark interest	"Would you like to play with the star stackers or look at a book?"
	Use visually engaging materials and non-verbal cues to draw attention	Set up a ball ramp, release the balls, and gesture or comment with enthusiasm
	Initiate a sensory-rich social routine to capture attention, then gradually introduce demands and guide toward other tasks	Begin with a tickling or bouncing game; once the child responds, transition to structured play