Eye care and autism: What professionals know, do and need

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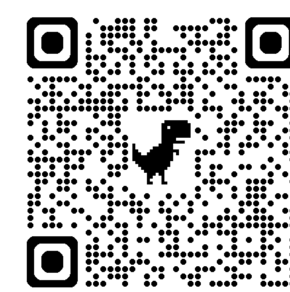

Introduction

Autistic people experience significant barriers to healthcare, contributing to persistent health inequities. When accessing eye care, Autistic people and their families report:

- Sensory overload in clinical environments.
- Unclear communication and unpredictable procedures by professionals.
- Rigid appointment structures and limited time.

Autistic people are also at elevated risk of vision conditions (e.g., refractive error, strabismus, amblyopia) that require timely care.

However, little is known about how eye care professionals understand and respond to the needs of Autistic patients.

Understanding clinicians' knowledge, confidence, and support needs is critical to designing autism-inclusive eye care.

This study forms part of a larger program examining eye care from the perspectives of Autistic adults, families, and providers.

Research questions

RQ1: What are levels of autism knowledge, self-efficacy, and disability attitudes among eye care professionals?

RQ2: Do professional role, country, experience, personal connection to autism, and frequency of contact predict these outcomes?

RQ3: How are autism knowledge, self-efficacy, and disability attitudes related?

RQ4: What challenges, strategies, and support needs do clinicians report when caring for Autistic patients?

Method

- Mixed-methods, cross-sectional online survey.
- 198 eye care professionals
  - » 54% optometrists, 26% ophthalmologists, 20% other roles.
  - » 42% Australia, 40% USA, 10% UK, 8% other countries.
- Measures included: Autism Knowledge Scale (Unigwe et al., 2017), AASPIRE Self-Efficacy Scale (Nicolaidis et al., 2021), and Attitudes and Perspectives toward Persons with Disabilities scale (Myong et al., 2021)
- Predictors tested in regression models: professional role, country, age, years of experience, personal connection to autism, and frequency of seeing Autistic patients.
- Pearson correlations examined relationships between autism knowledge, self-efficacy, and disability attitudes.
- Open-ended responses analysed using conventional qualitative content analysis (NVivo)

Results

RQ1

- Autism knowledge: High ($M = 13.03/14$, $SD = 1.32$; range 6–14).
- Self-efficacy: Moderately high ($M = 23.05/30$, $SD = 4.35$; range 13–30).
- Disability attitudes: Generally positive ($M = 1.91$, $SD = 0.45$; range 1.00–3.36; lower = more positive).
- Training gap: Only 14% reported formal autism-specific training.

RQ2

- The model predicting self-efficacy was significant ($R^2 = 0.24$, $p < .001$), indicating that clinician characteristics explained 24% of variance in confidence. More frequent clinical contact with Autistic patients was the strongest predictor ($p < .001$) of higher self-efficacy.
- Models predicting autism knowledge and disability attitudes were not significant.

RQ3

- Higher autism knowledge was weakly associated with more positive disability attitudes ($r = -0.18$, $p = .03$).
- Higher self-efficacy was moderately associated with more positive disability attitudes ($r = -0.32$, $p < .001$).
- The relationship between autism knowledge and self-efficacy was small and non-significant.

RQ4

- Clinicians reported communication differences, sensory sensitivities, and time constraints as key barriers. They described practical adaptations (e.g., sensory adjustments, flexible testing), but emphasised unmet training and system-level support needs.

Challenges (n = 148)	Strategies (n = 149)	Support needs (n = 122)
Communication barriers (n = 61)	Providing clear, calm explanations (n = 80)	Need for autism-specific knowledge (n = 72)
Time and service contraints (n = 44)	Adjusting the sensory environment (n = 70)	Call for practical strategies in clinical practice (n = 48)
Sensory related challenges (n = 44)	Adapting clinical testing methods (n = 60)	Greater system level support (n =16)
Procedural anxiety (n = 41)	Enabling patient choice and consent (n = 46)	
Behavioural expressions of distress (n = 29)	Service-level flexibility (n = 39)	

"We don't get any training, so anything would be helpful!"

Conclusion

- Eye care professionals reported relatively high autism knowledge and confidence despite minimal formal autism training.
- Frequent clinical contact with Autistic patients was the strongest predictor of clinician confidence, suggesting experiential learning plays a key role.
- Clinicians described adapting care to address communication and sensory needs, but reported persistent time and system constraints.
- Accessible autism-inclusive eye care therefore cannot rely on individual clinician adaptation alone.

Implications

- Experiential, case-based autism training may be effective, as clinician confidence was strongly linked to clinical contact with Autistic patients.
- Service-level changes such as longer or flexible appointments and appropriate funding are needed, given reported time and system constraints.
- Clinicians' existing adaptations (e.g., sensory adjustments, flexible testing) support embedding autism-informed, person-centred approaches into routine eye care pathways.

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