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Understanding language preference: Autism knowledge, experience of stigma and autism identity

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Abstract

Prior research has studied preferences for identity- or person-first language among persons with an autism diagnosis. The current study differs from this previous body of research by specifically examining quantitative predictors of language preferences through a social identity theoretical approach, thereby leading to a better understanding of psychological and social factors that might underlie language use and preference within the autistic community. Australian adults with an autism diagnosis ($N = 198$) completed the measures of autism knowledge, internalised stigma, and autism identity to determine whether these factors predict language preference. Results indicated a stronger autism identity was associated with a preference for identity-first terms (autistic/autistic person) and finding these less offensive. Contrastingly, stigma was associated with finding identity-first language less favourable and more offensive. Person-first terms (e.g. person with autism) were not associated with any of the predictors. Together, these findings suggest decision-making around identity-first language is influenced by a strong sense of autistic identity and experiences of stigma.

Lay abstract

There is ongoing discussion around what language is acceptable when talking about someone with an autism diagnosis, especially regarding person-first (e.g. person with autism) or identity-first (e.g. autistic person) language. We asked 198 Australian adults with an autism diagnosis what terminology they prefer and what they find offensive. We also asked questions to understand their experience of stigma, their autism knowledge and how much they endorse an autism identity, to investigate if these factors were associated with their language preferences. Overall, there was no significant association between these three factors and person-first terminology. For identity-first terms, those who endorse a stronger autism identity tended to find identity-first terms more preferable and less offensive, whereas those who reported greater experiences and internalisation of stigma tended to find identity-first terms less preferable and more offensive. Previous research has tended to ask what language participants prefer. The findings of this work help provide some context as to why people prefer or find offensive specific terms, at least for identity-first language.

Keywords

autism, autism identity, label preference, stigma, terminology

There is broadening discussion regarding the nature of respectful and neurodiversity-affirming language used in academic and health settings (Alvares et al., 2020; Bottema-Beutel et al., 2021; Dwyer et al., 2022; Keating et al., 2022). Included in this discussion is the usage of identity-first terms (e.g. autistic person) and person-first language (e.g. person with autism) among individuals diagnosed with autism spectrum disorder (ASD; hereafter 'autism'; Shakes & Cashin, 2020). Given the

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importance placed on terminology, what it represents, and the possible impact on well-being (Gernsbacher, 2017), understanding reasons why individuals might choose identity- or person-first language is an important addition to the current conversation. While it is often stated that identity-first language is preferred among those with an autism diagnosis (Bradshaw et al., 2021; Cassidy et al., 2021), empirical research in English speaking countries is more equivocal (Bury et al., 2020; Kenny et al., 2016), and contrary in the Netherlands (Buijsman et al., 2022). While participants in both the United Kingdom (Kenny et al., 2016) and Australia (Bury et al., 2020) showed support for identity-first label (e.g. *Autistic*), both studies also showed significant support for one person-first label (*Person on the Autism Spectrum*), with no significant differences between ratings (Bury et al., 2020). However, when asked to rank labels in order of preference, participants from Bury et al. (2020) ranked *Person on the Autism Spectrum* most preferred overall, and showed a bipolar response for *Autistic*, with a large percentage ranking it most preferred and an almost equal number ranking it as least preferred, with few responses in between. Together these studies indicate there is no clear agreement on preferred terminology, highlighting that what 'is appropriate to one person is offensive to another' (Robison, 2019, p. 1006). While some scholars argue that it is too soon to adopt identity-first language exclusively (Vivanti, 2020) and that there should be individual choice (e.g. Tepest, 2021), yet others have critiqued this position for failing to sufficiently engage with the literature produced by autistic scholars on the topic, or to sufficiently appreciate underlying assumptions associated with the use of person-first language (Botha et al., 2021). Indeed, Botha et al. (2021) argue that maintaining person-first language has the potential for direct harm to autistic people. Thus, Botha et al. (2021) call for research that seeks to 'understand identity first and [person-first language] with more nuance – including why the different person first formulations' (para. 25) are perceived differently by the community. With that in mind, the present study sought to address this gap in the literature by investigating psychological or social factors that might underlie language preference.

Understanding language preference

Responses from participants in qualitative studies help elucidate factors that underpin language preference. Participants often express sentiments about the centrality of autism to their identity (e.g. 'autism is me'; Botha et al., 2020, p. 9; Kenny et al., 2016; Lei et al., 2021; MacLeod et al., 2013); a sentiment endorsed by autism advocates (e.g. Sinclair, 1999). However, other participants express that autism is only part of their identity or stress their humanity first (Frost et al., 2019): 'In my case I prefer people to first and foremost acknowledge that they are a human being on the autism spectrum – autism doesn't define who they are' (Lei et al., 2021, p. 1358). Thus, in line with Sinclair's (1999) argument, some individuals feel autism is core to their identity, whereas for others, autism only represents a part of who they are and how they identify.

Social identity approaches and language preference

Social identity approaches capture the importance of in-group identities to one's self-concept (Dirth & Branscombe, 2018), with burgeoning research supporting the meaningfulness of an autism identity (Cooper et al., 2017; McDonald, 2020). Factors that influence adopting a specific in-group identity include its accessibility or salience, self-perception of belonging (Dirth & Branscombe, 2018) and its perceived homogeneity as a distinct group (Leach et al., 2008). That is, while social factors help define parameters of a social identity, individuals must also perceive that they are a good comparative fit into it. Labels may be an outward representation of how a person has constructed their social identity (Wanzer et al., 2021). Here, we suggest that individuals who endorse a strong autism identity (i.e. see autism as central, fitting and meaningful) would prefer identify-focused labels (e.g. autistic; Hypothesis 1a) while opposing person-first labels that linguistically separate the individual from the identity (e.g. 'with' autism; Hypothesis 1b).

Stigma and identity threat

Adults with an autism diagnosis have identified the potential for language to be stigmatising or to be used in a stereotyped manner (Lei et al., 2021). However, this can occur not only for person-first labels – 'calling it a disorder to me makes it sound like there's something wrong with that person' (i.e. Person with ASD) but also for identify-first labels – 'the word "autistic" conjures up many negative ideas in people's minds due to what they have seen or read on media – mostly negative' (Lei et al., 2021, p. 1356). When minority group members experience group-based stigma or discrimination, those who identify strongly with the in-group tend to reaffirm their identity through positive affirmation, whereas others may attempt to distance themselves from the identity (Barreto & Ellemers, 2011; Dirth & Branscombe, 2018). Prior research indicates that adults experiencing autism-related stigma may try to hide or camouflage their autism (Botha et al., 2020; Perry et al., 2022), a strategy that might be utilised more frequently by women than men (Cook et al., 2021; Hull et al., 2020). Some people may also deliberately use identity-first language to reclaim autism from stigma (Botha et al., 2020). We suggest that perceived stigma of autism will be generally associated with preferences for person-first labels that downplay autism (Hypothesis 2a), and lower preference for identity-first labels (Hypotheses 2b). However, for

individuals with a strong autism identity, perceived stigma will be related to stronger preferences for identity-first labels (Hypothesis 3).

Autism knowledge

Another factor that may influence label preference is one's understanding of autism and how this applies to the self. Receiving a diagnosis itself can be othering and lead to the negative assessment of one's self (e.g. different, damaged; Humphrey & Lewis, 2008), though it can also be affirming and increase self-compassion (Leedham et al., 2020). Qualitative research suggests that how and where one learns about autism and the type of information provided, can be an important part of how one develops an autism identity (MacLeod et al., 2013; Riccio et al., 2021). Indeed, we have reported elsewhere that the source from which autistics/people diagnosed with autism receive knowledge about autism (e.g. medical professional, parents, social media) was found to be associated with autism identity, the accuracy of their autism knowledge and levels of internalised stigma (Bury et al., 2022).[1] One's understanding of autism and how it applies to the self, especially if this view is based on stereotypes that are incomplete or negative, could influence how one wishes to express one's autism diagnosis. For example, definitions of the self that included autism-based strengths were reported more frequently by participants whose parents express similar views when discussing autism (Riccio et al., 2021). Thus, we would posit that those who have more accurate knowledge of autism, would be more immune to negative autism stereotypes, and express this through the endorsement of identity-first language (Hypothesis 4).

Current study

The current study extends the current understanding of why individuals with an autism diagnosis choose specific labels, using quantitative methods to investigate psychological and social factors (i.e. autism knowledge, stigma, autism identity) that may underpin language preference. Using a sample of Australians with an autism diagnosis, we situate these findings in a social identity approach that helps explain why individuals prefer or oppose certain language to describe autism. Specifically, we hypothesise as follows:

1a. Stronger autism identity would be associated with higher preference (and lower offensiveness) for identify-first labels, with the opposite pattern for person-first labels (1b).
2a. Overall, a greater experience and internalisation of stigma would be associated with higher preferences for person-first labels, and lower preference for identity-first labels (2b).
3. However, there will be an interaction between autism identity and stigma, whereby for participants with a stronger autism identity, perceived stigma will be related to stronger preferences for identity-first labels.
4. More accurate autism knowledge would be associated with greater preference of identity-first language.

Table 1. Demographic data.

	N	%
Sex assigned at birth		
1 = Male	62	31.3
2 = Female	133	67.2
3 = Intersex/indeterminate/unknown	3	1.5
Gender identity		
1 = Male	58	29.3
2 = Female	111	56.1
3 = Trans male/trans man	1	0.5
4 = Trans female/trans woman	0	0
5 = Genderqueer/gender non-conformist	20	10.1
6 = Different identity[a]	8	4.0
Reported autism diagnosis		
1 = ASD	93	47.0
2 = Asperger disorder	97	49.0
3 = PDD-NOS	1	0.5
4 = Other	7	3.5
Autism	(4)	
Autistic disorder	(1)	
ASD with ADHD	(1)	
PDD-NOS and ID	(1)	
Highest education level		
1 = Primary school	1	0.5
2 = High school	28	14.1
3 = Vocational or trade school	39	19.7
4 = Some university	43	21.7
5 = Bachelor	48	24.2
6 = Postgraduate	39	19.7

ASD: Autism spectrum disorder; ADHD: attention-deficit/hyperactivity disorder; PDD-NOS: pervasive developmental disorder–not otherwise specified; ID: intellectual disability.
[a]Non-binary – *n* = 5; Unsure – *n* = 1; No identity – *n* = 1; Gender-neutral – *n* = 1.

Methods

Participants

Participants were 198 autistic adults (51.9% female, M_{age} = 34.89, *SD* = 12.34 years, range = 18–71 years). Table 1 summarises the demographics of the sample. Participants reported a formal diagnosis of autism and were, on average, diagnosed in adulthood (diagnosis age: *M* = 27.36,

SD = 16.23 years), with the majority reporting a diagnosis of Asperger syndrome or ASD. Participants generally had at least some post-secondary education, and 51% indicated that they were employed. Participant demographics, label preference ratings and rankings, and qualitative data have been reported previously (Bury et al., 2020); this article extends this research by investigating potential predictors of label preference ratings.

Procedure

Participants were recruited as part of a broader study of autism identity and disclosure, approved by the University Ethics Committee and conducted between February and August 2019. Researchers contacted universities, autism advocacy and community groups, and employers throughout Australia and asked them to share study information within their networks via email, social media and on their websites. Participants accessed the study information and questionnaire online (Qualtrics, 2017) and indicated informed consent via a checkbox after being presented with study information and before accessing the questionnaire. Those who reported being below 18 years of age, not an Australian citizen or permanent resident, or not having a formal diagnosis of autism were excluded from the study. Participants received a AU $10 voucher as compensation for their time.

Measures

Participants first responded to demographic questions before moving to the main measures of interest, which included the following.

Autism traits. The Abridged Version of the Autism-Spectrum Quotient (Hoekstra et al., 2011) is a 28-item, self-report measuring the extent of autism traits in individuals with an Intelligence Quotient in or above the average range (Baron-Cohen et al., 2001). Participants responded to statements on a 4-point Likert-type-scale (1 = *definitely agree*, 4 = *definitely disagree*; range = 28–112), with higher scores indicating higher autism traits. The McDonald's Omega value (Hayes & Coutts, 2020) of the current sample indicated internal reliability was high (ω = 0.845).

Preference and offensiveness. Participants were asked 'Please indicate your preference for the following labels used to describe autism' and responded using a 7-point Likert-type-scale (1 = *strongly dislike*, 7 = *strongly like*) to each item. They were also asked 'How offensive do you find the following terms used to describe autism' (1 = *not at all offensive*, 7 = *strongly offensive*), to each item. Terms were those most commonly used in research and practice settings and included four person-first language: *Person with Autism, Person on the Autism Spectrum, Person with Autism Spectrum Disorder* (*Person with ASD*) and *Person with Autism Spectrum Condition* (*Person with ASC*); and two identity-first language: *Autistic* and *Autistic Person*. Asperger syndrome was not included in the current study to reflect the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (*DSM*-5) diagnostic criteria (American Psychiatric Association, 2013). Means and standard deviations are reported here (Bury et al., 2020). Participants were also asked to rank items most to least preferred and offensive, and to nominate labels that were not included that they prefer, with this information reported here (Bury et al., 2020).

Autism knowledge. The Autism Awareness Scale (AAS; Gillespie-Lynch et al., 2015) is a 13-item measure that assesses a person's knowledge of autism. Participants were asked to consider their understanding of autism more broadly (i.e. 'Please indicate your understanding of autism more generally, not necessarily how it applies to yourself') and respond to each statement (e.g. 'People with autism are generally disinterested in making friends') according to their degree of accuracy on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). A mean score of autism knowledge was generated with higher scores indicating greater knowledge of autism. The McDonald's Omega value of the current sample indicated internal reliability was high (ω = 0.805).

Internalised stigma of autism. Internalised stigma was measured using an adapted version of the Internalised Stigma of Mental Illness Inventory (ISMI; Ritsher et al., 2003). The ISMI has been adapted for a range of minority groups (e.g. epilepsy, ethnicity; see Boyd et al., 2014 for a review) and was adapted in this study by replacing 'mental illness' with 'autism spectrum' (e.g. 'Stereotypes about people with autism apply to me'; 'People discriminate against me because I am on the autism spectrum'). Seven items from the original scale were excluded because they were not appropriate for the autism context. Participants indicate how strongly they agree with each of 21 statements on a 4-point Likert-type-scale (1 = *strongly disagree*, 4 = *strongly agree*). A mean total score was calculated with a higher score reflecting greater experience and internalisation of stigma. The Omega value of the current sample indicated an internal reliability was high (ω = 0.841).

Autism identity. Autism identification was measured using a version of a multi-dimensional scale of social identity developed by Leach et al. (2008), tailored to reflect an autism identity. Participants respond to 14 statements (e.g. 'Being on the autism spectrum is an important part of how I see myself'; 'People with autism are very similar to each other') on a 7-point Likert-type-scale (1 = *strongly disagree*, 7 = *strongly agree*). A

higher total mean score indicates higher endorsement of an autism identity. The McDonalds Omega value of the current sample indicated that internal reliability was high (ω=0.894).

Data cleaning and analysis

One item for one participant on the AQ-Short was missing and was imputed with the mean of adjacent variables. AQ-Short mean scores were comparable to previous samples (M=85.44, SD=11.21; range, 49–108; Hoekstra et al., 2011). Despite recording a total of eight participants under the clinical cut-off (>65) for autism on the AQ-Short (scores=49, 51, 54, 59, 60, 61, 62, 64), consistent with previous research (Kenny et al., 2016) and given that all participants had reported being formally diagnosed with ASD, these eight participants were retained in the study. Normality of the variables was assessed by visually inspecting P–Plots and histograms. Several variables violated the assumptions of normality; thus, 1000 bootstrap samples and bias-corrected and accelerated 95% confidence intervals (BCa 95% CI) were used to account for skewness (Field, 2018). No outliers were identified on any of the potential predictors. All analyses were conducted in SPSS Version 27 (IBM Corp., 2021).

Due to insufficient numbers in the intersex/indeterminate/unknown category of *Sex* (n=3), this was dropped for analyses with male coded '1' and female coded '2'. Similarly, non-binary gender responses were combined to a single category for statistical power; this was then dummy-coded into two variables (Gender – Non-Binary; Gender – Female) with male as the comparison group. A *time since autism diagnosis* (year) variable was created by subtracting diagnosis age from birth age to investigate whether the recency of diagnosis influences label preference, with higher scores indicating more years since diagnosis.

Bivariate correlations were used as an initial inspection of associations between demographics (age, gender, time since diagnosis, highest level of education) as possible covariates and between key variables; specifically autistic traits, autism knowledge, internalised stigma and autism identity, with the preference and offensiveness ratings for each of the six identity terms. Hypothesis testing was done using multiple regression models to examine the cross-sectional predictors of identity label preference and offensiveness (Hypotheses 1, 2 and 4). The PROCESS macro for SPSS (Hayes, 2018) was also used to test the interaction between stigma and autism identity on label preference (Hypothesis 3).

Community involvement

Two autistic academics advised on the approach and value of the language preference component of this study prior to data collection, with one academic providing verbal feedback on the broader identity study.

Results

Correlations

Independent variables: Table 2 reports the correlations between demographics and potential predictors of label preference. Age was negatively correlated with time since diagnosis and identifying as non-binary, and positively correlated with education and autism traits. Time since diagnosis was negatively associated with being born female and identifying female over male, education level, autism traits and identity, and positively associated with stigma. Autism knowledge was positively correlated with being born female and identifying as non-binary, as well as autism traits. Autism knowledge was negatively correlated with stigma and positively correlated with autism identity. Autism identity was positively correlated with autism traits, identifying as non-binary and stigma.

Label preference/offensiveness. Table 3 reports the correlations between demographics and other potential predictors of label preference and offensiveness (see Supplemental Materials for complete report of analyses). Age, sex and identifying as female/woman were not significantly associated with any label preference. Identity-first label (*Autistic, Autistic person*) preference was significantly and moderately correlated with autism identity, and weakly positively related to identifying as non-binary, autism traits, and level of autism knowledge. Time since diagnosis was negatively related to a preference for being labelled *Autistic* and *Autistic Person.* Person-first label preferences did not show as cohesive a pattern of associations as compared to the identity-first label preferences. Identifying as non-binary was negatively associated with person-first label preferences for *Person with Autism* and *Person on the Autism Spectrum*, but not *Person with ASC* or *Person with ASD.* Education level was negatively related to a preference for *Person with ASD*. Accuracy of autism knowledge was significantly negatively related to a preference for *Person with ASD.* Internalised stigma had a positive significant relationship to a preference for the labels *Person with ASD* and *Person with ASC.* Autism identity was negatively related to preferring *Person with ASD.*

No potential predictors were associated with the offensiveness ratings of the term *Person with Autism* (Table 3). Education level attainment and autism identity were significantly positively related to the offensiveness of *Person with ASD*. The offensiveness of the term *Person with ASC* was only significantly positively related to autism identity. Identity-first label offensiveness for both *Autistic* and *Autistic Person* was significantly positively associated with internalised stigma and time since diagnosis, and negatively with autism identity and autism knowledge.

Table 2. Means, standard deviations, range and correlations of suggested independent variables with 1000 bias-corrected and accelerated 95% bootstrap confidence (95%BCa) intervals.

	M (*SD*)	Range	1	2	3	4	5	6	7	8	9
1. Age (years)	34.94 (12.35)	18–71	–								
2. Time since diagnosis	7.58 (8.14)	0–40	**−0.22**** **[−0.34, −0.11]**								
3. Sex[a]	–	–	−0.04 [−0.19, 0.11]	**−0.28***** **[−0.41, −0.13]**	–						
4. Gender non-binary	–	–	**−0.19**** **[−0.06, 0.23]**	−0.03 [−0.16, 12]	**0.14** **[0.01, 0.25]**	–					
5. Gender female	–	–	−0.08 [−0.08, 0.23]	**−0.24***** **[−0.38, −0.11]**	**0.76***** **[0.68, 0.84]**	**−0.47***** **[−0.55, −0.38]**	–				
6. Education	4.14 (1.35)	1–6	**0.35***** **[0.19, 0.49]**	**−0.23***** **[−0.37, −0.08]**	0.14* [−0.003, 0.28]	**0.18*** **[−0.31, −0.05]**	**0.18*** **[0.03, 0.31]**	–			
7. Autism traits	85.44 (11.21)	49–108	**0.22**** **[0.08, 0.36]**	**−0.15*** **[−0.31, −0.01]**	0.03 [−0.11, 0.18]	0.12 [−0.00, 0.25]	−0.02 [−0.15, 0.13]	0.10 [−0.04, 0.24]	–		
8. Autism knowledge	4.30 (0.45)	2.33–5.00	−0.02 [−0.16, 0.13]	**−0.22**** **[−0.37, −0.08]**	**0.29***** **[0.15, 0.44]**	**0.21**** **[0.12, 0.29]**	0.13 [−0.02, 0.23]	**0.15*** **[0.02, 0.29]**	**0.16*** **[0.02, 0.32]**	–	
9. Stigma	2.47 (0.54)	1.24–4.05	−0.11 [−0.24, 0.03]	**0.24***** **[0.12, 0.34]**	**−0.19**** **[−0.32, −0.05]**	−0.08 [−0.21, 0.06]	−0.09 [−0.23, 0.04]	**−0.14*** **[−0.27, −0.01]**	0.14 [−0.02, 0.28]	**−0.35***** **[−0.47, -0.21]**	–
10. Autism identity	4.58 (1.11)	1.50–7.00	0.08 [−0.05, 0.21]	**−0.28**** **[−0.12, −0.42]**	0.06 [−0.069, 0.19]	**0.15*** **[0.02, 0.29]**	0.02 [−0.11, 0.16]	0.06 [−0.08, 0.19]	**0.25***** **[0.09, 0.40]**	**0.17*** **[0.02, 0.31]**	**−0.22**** **[−0.37, −0.06]**

Bolded numbers represent 1000 95%BCa intervals that do not cross zero.
[a]Intersex/indeterminate/unknown ($n = 3$) not included due insufficient numbers
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

Table 3. Correlations between individual differences variables and preference for and offensiveness of autism labels with 1000 bias-corrected and accelerated 95% bootstrap confidence (95%BCa) intervals.

	Person with autism		Person on the autism spectrum		Person with ASD		Person with ASC		Autistic		Autistic person	
	P	O	P	O	P	O	P	O	P	O	P	O
Age	0.07 [−0.06, 0.20]	−0.10 [−0.23, 0.04]	0.13 [−0.01, 0.27]	−0.11 [−0.24, 0.02]	−0.05 [−0.19, 0.09]	0.05 [−0.09, 0.20]	0.07 [−0.09, 0.22]	−0.03 [−0.17, 0.11]	0.04 [−0.10, 0.18]	−0.05 [−0.20, 0.09]	0.01 [−0.13, 0.15]	−0.01 [−0.17, 0.13]
Time since diagnosis	0.11 [−0.04, 0.25]	0.02 [−0.12, 0.17]	−0.01 [−0.05, 0.23]	0.13 [−0.02, 0.29]	0.09 [−0.05, 0.22]	−0.09 [−0.21, 0.04]	0.02 [−0.11, 0.15]	0.02 [−0.11, 0.16]	**−0.21**** **[−0.34, −0.07]**	**0.29**** **[0.13, 0.43]**	**−0.25***** **[−0.38, −0.12]**	**0.28***** **[−0.29, −0.02]**
Sex	−0.13 [−0.26, 0.01]	0.06 [−0.07, 0.20]	−0.08 [−0.15, 0.14]	0.03 [−0.12, 0.19]	−0.03 [−0.17, 0.10]	0.06 [−0.08, 0.20]	−0.05 [−0.19, 0.08]	0.03 [−0.10, 0.18]	0.12 [−0.01, 0.26]	−0.11 [−0.26, 0.03]	0.10 [−0.28, 0.25]	−0.13 [−0.28, 0.004]
Gender – Non-binary	**−0.20**** **[−0.32, −0.06]**	0.12 [−0.05, 0.28]	**−0.18*** **[−0.34, −0.01]**	0.10 [−0.06, 0.24]	−0.09 [−0.25, 0.07]	0.05 [−0.10, 0.18]	−0.08 [−0.20, 0.05]	0.01 [−0.14, 0.15]	**0.21**** **[0.06, 0.33]**	−0.08 [−0.22, 0.08]	0.14* [−0.02, 0.28]	−0.12 [−0.25, 0.04]
Gender – Female	−0.03 [−0.17, 0.11]	−0.003 [−0.16, 0.17]	0.04 [−0.10, 0.17]	−0.01 [−0.15, 0.12]	−0.03 [−0.15, 0.11]	0.07 [−0.07, 0.22]	−0.05 [−0.19, 0.10]	0.06 [−0.08, 0.21]	0.01 [−0.13, 0.17]	−0.07 [−0.22, 0.06]	0.03 [−0.11, 0.17]	−0.07 [−0.20, 0.06]
Education	0.02 [−0.12, 0.16]	−0.05 [−0.21, 0.10]	0.05 [−0.09, 0.18]	−0.11 [−0.24, 0.05]	**−0.18*** **[−0.30, −0.03]**	**0.18*** **[0.02, 0.34]**	0.003 [−0.15, 0.15]	0.06 [−0.11, 0.21]	0.11 [−0.04, 0.26]	−0.06 [−0.21, 0.08]	0.14 [−0.002, 0.28]	−0.10 [−0.25, 0.03]
Autism traits	−0.07 [−0.21, 0.07]	0.03 [−0.14, 0.16]	0.001 [−0.14, 0.13]	0.001 [−0.16, 0.15]	−0.09 [−0.21, 0.07]	0.10 [−0.05, 0.24]	−0.02 [−0.15, 0.12]	0.06 [−0.10, 0.21]	**0.22**** **[0.08, 0.35]**	−0.12 [−0.26, 0.02]	**0.20**** **[0.06, 0.32]**	−0.07 [−0.21, 0.06]
Autism knowledge	−0.08 [−0.23, 0.07]	0.004 [−0.15, 0.17]	−0.03 [−0.17, 0.11]	−0.01 [−0.17, 0.12]	**−0.16*** **[−0.31, −0.03]**	0.13 [−0.03, 0.29]	−0.09 [−0.25, 0.05]	0.04 [−0.12, 0.21]	**0.22**** **[0.08, 0.37]**	**−0.20**** **[−0.34, −0.08]**	**0.20**** **[0.06, 0.35]**	**−0.23***** **[−0.36, −0.10]**
Internalised stigma	0.15* [−0.02, 0.30]	−0.06 [−0.19, 0.08]	0.03 [−0.11, 0.16]	0.10 [−0.04, 0.24]	**0.22**** **[0.07, 0.35]**	**−0.14** **[−0.28, −0.003]**	**0.16*** **[0.01, 0.30]**	−0.04 [−0.18, 0.10]	**−0.26***** **[−0.39, −0.13]**	**0.29***** **[0.16, 0.40]**	**−0.18*** **[−0.31, −0.05]**	**0.31***** **[0.20, 0.41]**
Autism identity	−0.10 [−0.24, 0.04]	0.13 [−0.03, 0.30]	0.06 [−0.08, 0.20]	−0.04 [−0.24, 0.14]	**−0.16*** **[−0.30, −0.01]**	**0.19**** **[0.05, 0.35]**	−0.10 [−0.23, 0.03]	**0.20**** **[0.06, 0.36]**	**0.52***** **[0.42, 0.61]**	**−0.39***** **[−0.50, −0.27]**	**0.52***** **[0.42, 0.62]**	**−0.31***** **[−0.44, −0.18]**

P: preference; O: offensiveness. Bolded numbers represent 1000 95%BCa intervals that do not cross zero.
*$p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Regression

To isolate the potential impact of specific individual difference variables, 12 separate multiple linear regression models (see Supplemental Materials for complete report of analyses) were calculated with the label preference and offensiveness of each term as the dependent variable with demographics (age, gender identity, time since diagnosis, highest level of education), autistic traits, autism knowledge, internalised stigma and autism identity entered together into the model (see Table 4 for a summary of results). We interpret consistent significant results across the four person-first, or the two identity-first labels, as evidence for the hypotheses (as such, it does not require an alpha adjustment; Rubin, 2021).

All identity-first preference and offensiveness regression models were significant. The model explained 30% of variance in preference for the Autistic term, $F(9, 187) = 10.321$, $p < 0.001$, and 27.7% of variance in preference for the Autistic person term, $F(9, 187) = 9.329$, $p < 0.001$. Autism identity consistently emerged as a moderately strong positive predictor of preference for both identity-first labels. Internalised stigma was a weak negative predictor of preference for the Autistic term, but not significantly predictive of preference for Autistic person.

The regression model explained 18.6% of variance in offensiveness of the Autistic term, $F(9, 187) = 5.975$, $p < 0.001$, and 15.7% of variance in offensiveness of the Autistic person term, $F(9, 187) = 5.054$, $p < 0.001$. Consistent across both terms, autism identity negatively, and internalised stigma positively, predicted the perceived offensiveness of the identity-first labels.

None of the person-first term offensiveness regression models were significant. Two person-first term preference models were significant: *Person with Autism* and *Person with ASD*. The *Person with Autism* preference model explained 9.2% of variance, $F(9, 187) = 2.117$, $p = 0.030$, with non-binary gender being a unique significant negative predictor. The *Person with ASD* preference model explained 4.6% of variance, $F(9, 187) = 2.061$, $p = 0.035$; however, there were no positive predictors.

There was no interaction between autism identity and stigma on either the preference for or offensiveness of identity-first labels (all ps = 0.058–0.823).

Discussion

Given the ongoing discussion around label preferences in the autism community, this research investigated some of the potential psychological and social predictors of preference for, or offensiveness of, the most common identity- and person-first autism labels in an Australian sample. In line with Hypotheses 2a, participants with lower levels of experienced/internalised stigma also reported more favourable preferences towards the label *Autistic*. As predicted (Hypothesis 1a), stronger identification with an autism identity was significantly associated with preferring identity-first terms (both *Autistic* and *Autistic Person*) and being less likely to rate these terms as offensive. Participants were also more likely to find both identity-first terms offensive if they had been diagnosed earlier in life. While experiences of stigma and endorsement of an autism identity helped explain the preferences and offensiveness ratings for the identity-first labels, contrary to predictions (Hypothesis 2a), these were not significant predictors of any person-first terms. Furthermore, levels of autism knowledge were not associated with label preferences or offensiveness for any label (Hypothesis 4). The identity-first labels were most divisive among autistic adults in previous research with this sample (Bury et al., 2020); this study provides some explanation for the disparity in these ratings.

Of the predictors explored in this study, a stronger sense of autism identity emerged as most consistent in understanding a preference for identity-first labels and being less likely to find these labels offensive. Integrating autism closely as part of one's self-concept is consistent with the reasons offered for the use of identity-first terms in prior research (Bury et al., 2020; Kenny et al., 2016; Lei et al., 2021; Sinclair, 1999). Use of identity-first language for these participants may help express a close and positive connection with this aspect of self, and with the autism community. The choice to use identity-first language has been described in the broader disability literature as an act of autonomy, allowing individuals to positively claim their disability, make choices about how this is expressed (Botha et al., 2020; Brueggemann, 2013) and claim connection to others with similar experiences (Dunn & Andrews, 2015). A sense of social identity is associated with better well-being across the broader population (Dirth & Branscombe, 2018). In autism, in-group self-esteem is linked to well-being (Cooper et al., 2017) and it has been suggested that the use of person-first language might impact well-being (Gernsbacher, 2017). Therefore, efforts to support development of a positive autism identity may be important.

This integration of 'being autistic' as central to one's identity might be more available to those who have been less impacted by stigma. In fact, experiences of stigma were negatively associated with autism identity within this sample. Experiences of stigma have previously been suggested to have the potential for people to distance themselves from or camouflage autism (Botha et al., 2020; Branscombe & Ellemers, 1998; Perry et al., 2022), which might contribute to a preference for person-first language. While our correlation data supported a weak association between stigma and person-first labels, this relationship was not significant once all variables had been entered into the model. Instead, experiences of stigma were more strongly and significantly associated with identity-first labels, specifically higher ratings of their offensiveness.

Table 4. Regression (β) results with preference for and offensiveness of autism labels as the dependent variable with 1000 bias-corrected and accelerated 95% bootstrap confidence (95%BCa) intervals.

	Person with autism		Person on the autism spectrum		Person with ASD		Person with ASC		Autistic		Autistic person	
	P	O	P	O	P	O	P	O	P	O	P	O
Constant[a]	2.68 [−1.24, 6.65]	3.08 [−1.21, 7.27]	3.18 [−1.11, 7.40]	1.01 [−2.70, 4.86]	**5.44*** **[1.16, 10.52]**	−0.38 [−4.76, 3.91]	3.30 [−0.73, 7.38]	0.13 [−3.89, 3.77]	−0.92 [−4.80, 3.16]	**−4.68*** **[0.75, 8.91]**	−1.09 [−4.90, 2.22]	**3.56** [0.06, 7.51]
Age	0.08 [−0.01, 0.04]	−0.08 [−0.04, 0.01]	0.11 [−0.01, 0.05]	−0.03 [−0.02, 0.02]	0.01 [−0.02, 0.02]	−0.01 [−0.03, 0.02]	0.07 [−0.01, 0.04]	−0.04 [−0.03, 0.02]	−0.04 [−0.03, 0.01]	0.03 [−0.02, 0.03]	−0.09 [−0.04, 0.01]	0.06 [−0.02, 0.04]
Time since diagnosis	0.06 [−0.02, 0.05]	0.07 [−0.03, 0.07]	0.01 [−0.04, 0.04]	0.12 [−0.01, 0.07]	−0.03 [−0.05, 0.03]	0.03 [−0.03, 0.05]	−0.05 [−0.05, 0.03]	0.11 [−0.01, 0.07]	−0.01 [−0.03, 0.03]	**0.16*** **[0.01, 0.08]**	−0.09 [−0.06, 0.01]	**0.16*** **[0.002, 0.07]**
Gender – Non-binary	**−0.23**** **[−2.28, −0.23]**	0.16 [−0.18, 2.03]	**−0.21*** **[−2.27, −0.28]**	**0.19** **[0.003, 1.86]**	−0.11 [−1.69, 0.49]	0.10 [−0.41, 1.57]	−0.11 [−1.58, 0.42]	0.05 [−0.63, 1.11]	0.12 [−0.10, 1.64]	−0.02 [−1.01, 0.80]	0.07 [−0.63, 0.64]	−0.07 [−1.32, 0.64]
Gender – Female	−0.11 [−1.08, 0.24]	0.08 [−0.28, 0.88]	−0.06 [−0.86, 0.45]	0.10 [−0.02, 0.03]	−0.02 [−0.83, 0.68]	0.07 [−0.40, 0.98]	−0.09 [−1.05, 0.35]	0.08 [−0.30, 0.90]	0.03 [−0.52, 0.75]	−0.01 [−0.65, 0.57]	0.00 [−0.63, 0.64]	−0.02 [−0.69, 0.56]
Education	0.03 [−0.04, 0.01]	−0.04 [−0.02, 0.04]	0.02 [−0.04, 0.02]	−0.09 [−0.02, 0.03]	−0.13 [−0.04, 0.02]	0.13 [−0.02, 0.05]	0.02 [−0.83, 0.59]	0.03 [−0.02, 0.03]	0.05 [−0.003, 0.06]	0.04 [−0.04, 0.01]	0.10 [−0.01, 0.04]	−0.03 [−0.03, 0.02]
Autism traits	−0.09 [−0.18, 0.25]	0.05 [−0.32, 0.20]	−0.05 [−0.20, 0.26]	0.03 [−0.31, 0.05]	−0.06 [−0.41, 0.03]	0.07 [−0.04, 0.45]	−0.05 [−0.20, 0.25]	0.05 [−0.19, 0.30]	0.12 [−0.13, 0.28]	−0.06 [−0.14, 0.25]	0.07 [−0.05, 0.37]	−0.02 [−0.03, 0.02]
Autism knowledge	0.05 [−0.58, 0.91]	−0.06 [−1.11, 0.79]	0.02 [−0.69, 0.87]	0.02 [−0.62, 0.77]	−0.05 [−1.05, 0.38]	0.04 [−0.58, 1.12]	−0.01 [−0.83, 0.59]	0.00 [−0.75, 1.01]	0.03 [−0.39, 0.78]	−0.05 [−0.92, 0.39]	0.04 [−0.35, 0.83]	−0.07 [−0.94, 0.23]
Internalised stigma	0.14 [−0.02, 1.08]	−0.05 [−0.85, 0.44]	0.05 [−0.41, 0.77]	0.08 [−0.29, 0.83]	0.16 [−0.01, 1.24]	−0.07 [−0.89, 0.37]	0.15 [−0.17, 1.19]	−0.01 [−0.64, 0.62]	**−0.16*** **[−1.31, −0.13]**	**0.17*** **[0.06, 1.34]**	−0.04 [−0.62, 0.36]	**0.20*** **[0.23, 1.30]**
Autism identity	−0.02 [−0.36, 0.24]	0.13 [−0.05, 0.58]	0.09 [−0.13, 0.44]	0.00 [−0.32, 0.34]	−0.09 [−0.46, 0.10]	0.15 [−0.01, 0.60]	−0.06 [−0.41, 0.18]	**0.22*** **[0.14, 0.66]**	**0.43***** **[0.66, 1.07]**	**−0.29***** **[−0.81, −0.27]**	**0.45***** **[0.62, 1.07]**	**−0.20*** **[−0.65, −0.10]**

P: preference; O: offensiveness. Bolded numbers represent 1000 95%BCa intervals that do not cross zero.
[a]Unstandardised betas reported.
*$p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

Previous research has suggested some autistic people reclaim identity-first labels in response to stigma (Botha et al., 2020). While this is in line with models of identity formation whereby experiences of stigma contribute to a sense of connection with other members of a minority group and reaffirm identity (e.g. rejection-identification model; Bogart et al., 2018), moderation analyses did not support this in the current data (Hypothesis 3).

One interesting finding is the positive association between the time since receiving an autism diagnosis and the offensiveness of identity-first terms and stigma, and negative association with autism identity. Dunn and Burcaw (2013) propose that the formation of a disability identity is a process that evolves over time. They suggest that those who grow up *after* shifts away from a medicalised view of disability are exposed to more positive and strengths-based ideas, and therefore might endorse a more positive disability identity (and express this). Given the rise of the neurodiversity movement and strength-based advocacy for autism (den Houting, 2019), those who received their diagnosis more recently may have been exposed to more positive perceptions of autism in their lifetime, which is likely to be protective against stigma, and facilitative of identification with the diagnosis and identity-first language. Indeed, internalised stigma may reflect the psychological impact of lived experiences with society-wide stigma (Ritsher et al., 2003). Ritsher et al. suggest that although one's individual history of discrimination may affect their morale and view of their disability, the impact of stigma on well-being is malleable. It might also be that for those who receive their diagnosis later in life, the diagnosis can represent a sense of relief or sense-making about their experience (Harmens et al., 2022; Oredipe et al., 2022) or include sources of information that are more neurodiversity-affirming (e.g. social media; Bury et al., 2022), and thus be more positively associated with their own identity.

For the person-first terms, the predictors explored in this study tended not to explain why someone might prefer these or find them offensive. Person-first language arose with the move away from a medical model to the social model of disability (Dunn & Andrews, 2015), to celebrate the individual above the clinical diagnosis. This was reflected in prior qualitative work (Bury et al., 2020), in that those who tended to prefer person-first language had more pronounced desires for common humanity, uniqueness and diversity. However, this diffusion of or distancing from autism identity, was not captured in preference for person-first language in this current study. Despite its good intentions, person-first language is primarily used for people who differ from the norm, which has led to some people suggesting person-first language signals that this difference is bad or stigmatised (Gernsbacher, 2017). While experiences of stigma were weakly correlated with preference for some person-first terms, this was not significant with all predictors in the model.

One exception to the above findings was non-binary gender which was negatively associated with a preference for two person-first terms, namely, *Person with Autism* and *Person on the Autism Spectrum*, but not person-first language with diagnostic information. Given the significant (yet weak) association with non-binary gender and autism identity, this may reflect their support for the centrality of being autistic to their identity. While the intersectionality of an autistic and non-binary identity is an emerging field (Botha & Gillespie-Lynch, 2022), more research in this area might help explain these findings.

Limitations to this research include the high portion of participants who had undertaken some university study (45%) or had a postgraduate qualification (20%). This indicates the findings likely represent the views of a more specific cohort of autistic adults affecting the generalisability of the findings to the broader autistic population. Given that intelligence quotient (IQ) was associated with a preference for identity-first language in Buijsman et al., (2022), future research could use alternate methods that allow a more diverse population access to the study materials to gain a broader understanding of language preference. This research was also cross-sectional, so cannot speak to the causal relationships between individual differences and language preference.

In addition, to maintain consistency with *DSM*-5 (American Psychiatric Association, 2013) diagnostic categories, we chose not to include Asperger syndrome (or its variations) in the study. In hindsight, this decision limited our ability to investigate a term that is still important to a small, but sizable group of participants (13.5% in our study) which has implications to their sense of identity (e.g. Smith & Jones, 2020) and their concerns about stigma (Linton et al., 2014). Thus, this is a limitation of our study and future research should consider the preferences of the autistic community and how they see and speak about themselves, rather than how they are defined by others (Botha et al., 2021). With that in mind, we acknowledge that our study would have benefitted from greater community involvement, and we are currently putting procedures in place to improve this in future research. Other research has noted that autism was not often included in participants' self-descriptions, which has been interpreted to suggest that autism as a descriptor might be more important to researchers than participants (DeNigris et al., 2018; Riccio et al., 2021), but given the recent push from autism advocates for identity-first language, these labels at least are important to some. One additional limitation is our reliance on the AQ to assess autism traits in the present sample. The validity of the AQ as a measure of autistic traits has been recently critiqued (Lundqvist & Lindner, 2017), highlighting the difficulty with many measures of autistic traits.

Like prior research (e.g. Bury et al., 2020; Kenny et al., 2016), this study further highlights that the choices around person- and identity-first language are not straightforward or

linear. Where the present findings differ is that they provide new insight into psychological factors as to why autistic adults prefer or oppose identity-first terms, specifically in terms of experiences of stigma, autism identity and changes over time. These findings contribute to the greater discussion about respectful autism language in academic and health settings (Bottema-Beutel et al., 2021; Dwyer et al., 2022) by providing greater theoretical understanding and by highlighting some of the potential challenges in reaching a consensus on which language to use to describe autism.

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Research involving human participants and/or animals

All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional and/or National Research Committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by La Trobe University's Human Research Ethics Committee (HEC18515).

Informed consent

Informed consent was obtained from all individual participants included in the study.

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Supplemental material

Supplemental material for this article is available online.

Note

1. Note that this finding was drawn from the same sample as the present study.

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