Dear Editor,

We (autistic and non-autistic researchers) commend Abdelrahman et al (1) on their recent publication in the latest Radiography issue. As there is a paucity of radiography research exploring the topic of autism, we are very pleased to see two articles (1,2) in this issue adding to the knowledge and evidence base. However, we were concerned with the language used by Abdelrahman et al (1) around autistic identity.

Terminology

Guidance from NHS England (3), National Autistic Society (4), Autistica (5) and The National Institute for Health and Care Excellence (NICE) (6) stipulates avoiding the use of terms such as "autism spectrum disorder". This is because "autism spectrum disorder" or "ASD", although the likely diagnosis written on millions of medical records around the world, is a loaded term for many autistic people. Historically, the scientific community viewed autistic people as subhuman (7,8). This view informed medical perceptions and, unfortunately, subsequent training, resulting in the pathologisation of autism and a focus on prevention, eradication and "treatments" for autistic people (i.e., applied behavioural analysis or ABA, now a highly contested method), that extinguished the very sense of what makes a person who they are (7–9).

The neurodiversity movement gave rise to the belief that being autistic does not mean a person is disordered, broken or inherently damaged (10). The neurodiversity model removes autism from the medical model that perpetuates stigma and stereotypes (11,12), and regards it as a mere difference in the way one experiences and navigates the world. In this perspective, the challenges that autistic people face originate from a lack of reasonable adjustments in a society that is not accommodating of neurodiversity. Some autistic people identify as disabled and recognise the cause of this disability as the outcome of the lack of proportionate accommodations in society.

Identity-first Language (IFL)

Furthermore, many autistic people view being autistic as an integral part of their existence and a central part of their personhood (13). It is not something they can split themselves away from (14,15). Thus, identity-first language (IFL) is preferred, i.e. autistic person, rather than, a person *with* autism. A preference of the autistic community for this type of self-identification and language used was established in the UK in 2016 in a study by Kenny and colleagues (14). It is not universally agreed upon, but a majority of participants in studies since have corroborated the finding (13,16).

Whilst the majority of autistic people prefer IFL, other stakeholders (parents, healthcare professionals, etc) often think otherwise (14,16). It may also be counter-intuitive for healthcare professionals, as we usually employ person-first language, e.g. a person *with* dementia or someone *with* cancer, as in the medical model. This is to separate the person from their pathology and see them as a whole. Person-first language is so widely used, that it has become the default way of communication in healthcare. However, if we truly understand and respect autism as a unique personal characteristic, rather than a pathology, then the way we talk about it should also reflect this perception, e.g., be more akin to being left-handed. I.e. a left-handed person, rather than a person *with* "left-handed-ness". The use of this inclusive language is associated with less stigmatisation, more empowerment of autistic people and active recognition and support of their rights, as equal co-humans (15).

It is important to acknowledge that what the guidance, the studies and we argue for is a standard of respectful language when a preference of the individual or group of individuals is unknown. It may be the case that particular autistic people prefer using the medical model and person-first language, in which case, their personal preference should always be respected and no assumptions should be made (17).

Conclusion

As we strive to be person-centred in the way we deliver healthcare, we should respect the preferences of the group with which we are working, researching, imaging or treating. We believe it is the best

approach to recognise what is the majority preference of the autistic community when talking about autistic people. Avoiding negative and pathologising terminology, using identity-first language and employing an approach informed by the social model of disability, shows an understanding of the context and history of autism research and respect towards autistic people's rights (18). Therefore, this should be the default language used unless requested otherwise by the specific individual or group of individuals to which you refer.

As a society, we should be transitioning from tolerance and awareness towards affirmation. We should not just accept their existence but actively value and celebrate autistic people's differences as central to society's progress, embracing them as key stakeholders to address the complex challenges facing humanity. The right approach with language and terminology may seem like a small step, but it is a small step in the right direction.

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