

A stylized icon on the left side of the slide. It features a large, dark blue silhouette of a person's head and shoulders, facing right. Inside the blue shape, there is a smaller, orange silhouette of a child's head and shoulders, also facing right. The orange shape is positioned as if being held or supported by the blue shape.

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An Introduction to Autism Spectrum Disorder in Young Children: Part 2

Gilbert M. Foley, Ed.D. & Gerard Costa, Ph.D.

Who We Are

The New York City Perinatal and Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Health Department.

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute for Poverty Policy and Research.

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

TTAC is tasked with building capacity and competencies of mental health professionals and early childhood professionals in family serving systems to identify and address the social-emotional needs of young children and their families.



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Plan

- In part two of this two-part series, the presenters will review screening and the diagnosis of ASD, recent findings about autism in girls, categories of evidence-based interventions and the impact of ASD on the family. Unique features including sensory atypicality, anxiety and the question of attachment and autism will be addressed.
- Autism is a complex disorder of relating and communicating best understood and treated from a multidisciplinary perspective-the prism through which this webinar is presented.

Objectives

As an outcome of attending this presentation, participants will be able to:

- Characterize the “masking” features sometimes observed in girls
- Describe and illustrate Sensory Processing Challenges in ASD
- Understand and describe the relationship between anxiety and ASD.
- Describe the ways in which attachment is manifested in ASD
- Identify currently recommended screening and assessment tools
- Differentiate between behavioral and developmental/relational intervention models
- Describe the challenges and rewards identified by parents rearing a child with ASD

**Thanks to
Sima Gerber, Ph.D., SLP/CCC**



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Agenda

- Reminders from Part 1
- Reflective Questions for Today
- Objectives/Plan
- Autism in Girls
- Autism and Attachment
- Autism and Anxiety
- Sensory Processing and ASD
- Autism and ACEs
- Screening and Assessment
- Overview of Treatment Approaches
- Autism Appreciation



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Reflective Questions

- So, what is “autism” ?
- What does “autism” mean?
- What factors influence the meaning and assignment of the diagnosis?
- Does the term offer any “value added”?

What is your belief about autism?

Is Autism

- A “disorder of behavior”?

Or

- A difference in structure, functioning and processing of the brain and neurosensory system?

Assertion

Your ideas, beliefs and attitudes about Autism will determine to a very large extent, your assessment and intervention planning.

Autism Spectrum Disorder

Neurological disorder, with likely genetic origins, affecting the structure and function of the brain which controls reasoning, problem solving, memory, communication, sensory processing, regulation and motor planning.

Autism in girls (Autism Speaks, Child Mind Institute, UCLA Health)

- Autism in girls is characterized by more subtle signs; intense, socially accepted interests (animals, art, psychology), and masking (imitating peers to hide difficulties).
- Girls are 4 times less likely to be diagnosed, often later than boys, leading to higher rates of anxiety, depression, and exhaustion.
- Current research indicates that as many as **80% of autistic girls** remain undiagnosed by age 18.

Autism in girls

(Autism Speaks, Child Mind Institute, UCLA Health)

Common Signs of Autism in Girls

- **Masking/Camouflaging:** Imitating social behaviors, forcing eye contact, and suppressing natural behaviors to blend in.
- **Intense Interests:** Interests may seem typical (celebrities, horses, fashion) but are pursued with extreme depth and focus.
- **Subtle Social Challenges:** They may have better, yet exhausting, reciprocal conversation skills than boys. They may seem shy or introverted.
- **Emotional Depth/Internalization:** High empathy and sensitivity, often internalizing distress, leading to quiet meltdowns at home rather than outbursts in public.
- **Perfectionism:** A strong need to follow rules perfectly to avoid negative attention, causing high stress.
- **Literal Thinking:** Taking things literally or having limited understanding of sarcasm or social hierarchy.



Autism in girls

(Autism Speaks, Child Mind Institute, UCLA Health)

Differences in Diagnosis and Presentation

- **Delayed Diagnosis:** Girls are often diagnosed later (average age 12-13) or misdiagnosed with anxiety or personality disorders.
- **Social Motivation:** Many autistic girls are motivated to have friends but struggle with the complexity of social interaction.
- **Co-occurring Conditions:** Higher prevalence of anxiety, depression, and potential chronic illnesses like POTS or EDS.
- **Diagnostic Bias:** Standard screening tools are often based on "male-centric" behaviors, such as a fixation on trains or repetitive physical movements like hand-flapping.
- **Subtle Repetitive Behaviors:** Girls may engage in less obvious stimming, such as twirling hair or tapping fingers.
- **Misdiagnosis:** Many girls are misdiagnosed with ADHD, anxiety, depression, or eating disorders before their underlying autism is identified.

ASD and Female Expression

Research in 2025 also advanced understanding of sex differences in autism, particularly the biological mechanisms that shape them. Large genomic datasets, built over decades, revealed why females are less frequently diagnosed than males.

Females—especially those with cognitive and motor challenges—carry a higher burden of ***de novo variants*** than males, despite no difference in the specific genes affected. This pattern supports the concept of differential liability, in which females may have greater biological resilience to autism-related risk.

Koko M, Satterstrom FK, Autism Sequencing Consortium, APEX consortium, Warriar V, Martin H. Contribution of autosomal rare and de novo variants to sex differences in autism. *Am J Hum Genet.* 2025;112(3):599-614. doi:10.1016/j.ajhg.2025.01.016

Autism and Attachment (Foley & Baz, 2025)

- A review of 16 studies (N=287) including a quantitative meta-analysis based on 4 samples using the Strange Situation, revealed that slightly greater than half (53%) of children with autism did in fact form secure attachments with their caregivers.
- Although less securely attached to their parents than typical comparisons, the differences “washed” in autistic children with higher cognitive function and less severe ASD symptomatology (Rutgers et al., 2004).

Autism and Attachment (Foley & Baz, 2025)

- A more recent review of 40 studies found similar results with 47% of children and caregivers establishing secure patterns of attachment based on Strange Situation criteria (Teague, et al.,2017).
- A year-long longitudinal study with 30 preschool children using the strange Situation criteria found that 45% of the sample had formed a secure attachment. Parental sensitivity and empathy, even above the child's language level was predictive of a secure attachment and the developmental pattern of secure attachment in children with ASD paralleled that of typical children and caregivers (Rozga, et al. 2018).

Autism and Attachment (Foley & Baz, 2025)

- In a recent prospective study (Martin, et al.2020) of 56 high-risk infants and 39 low-risk infants assessed at 15 months on the Strange Situation and followed for an ASD diagnosis, 16 infants were later classified as high-risk/ASD and 40 as high risk/no ASD .
- When compared to the sample of 39 low-risk/no ASD infants and high risk/no ASD populations, the high risk/ASD population was disproportionately found to be classified as insecurely attached and also more likely to be categorized as having an insecure-resistant quality of attachment vs. secure or avoidant patterns of attachment. The infants categorized with an insecure-resistant type of attachment were nine times more likely to be later diagnosed with ASD.



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Autism and Attachment (Foley & Baz, 2025)

- Parental insight and sensitivity to their child's subjective experience and the degree to which the parents themselves have come-to-terms with their child's diagnosis contribute positively to the formation of a secure attachment (Oppenheim, et al., 2009, 2019).
- Around 50% of children with autism establish secure patterns of attachment compared to about a 66% rate of secure attachment among neurotypical children (Keller, 2018).



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Risk and protective factors in forming a secure attachment

Protective factors in the child include:

- Elevated cognitive and language skills
- Less severe ASD symptomatology
- A capacity for empathy

Protective factors in the parent include:

- Sensitivity in reading and responding to their child's cues
- A capacity for reflective function
- Adaptive adjustment to their child's diagnosis

Risk and protective factors in forming a secure attachment

Risk factors in child and parent include:

- Challenges in bi-directional reading and responding to cues
- Increased anxiety
- Altered reactivity to sensation, physical contact and closeness
- Feeding difficulties found in 70-90% of children with ASD
- Unresolved parental grief
- Reduced feelings of parental satisfaction and efficacy
- Insecure –resistant pattern of attachment
- Disruption of parent-child interactions creating a form of relational and environmental deprivation
- Toxic stress

McKenzie & Dallos (2017) recommend interventions that emphasize dyadic interactive synchrony and caregiver sensitivity to enhance attachment quality in children with ASD.

Autism and Anxiety (Foley & Baz, 2025)

Prevalence rates vary:

- Nadeau et. al. (2011) reported as high as 80% of children with ASD present with clinically significant anxiety with a subgroup (38%) showing symptoms consistent with separation anxiety the highest of four anxiety types identified.
- Rudy, et al. (2013) reported approximately 40-55% prevalence rate of comorbid anxiety in ASD with phobias most common (30-44%).
- Kent & Simonoff (2017) reported a 42-79% rate of comorbid anxiety as an aggregate prevalence rate in ASD
- Kirsch, et al. (2020) in a longitudinal sample of a thousand individuals with ASD found that 22% of the sample presented with comorbid anxiety by age 30.

Autism and Anxiety (Foley & Baz, 2025)

- A review of 44 articles related to comorbid anxiety in young children with ASD (under age 6) found an overall prevalence rate in the range of 1.6-62%. Sixteen of 17 studies found that young children with ASD had higher levels of anxiety compared to neurotypical samples.
- A longitudinal sample of 61 toddlers followed through age 13 for predictors and subtypes found that 39% presented with separation anxiety in adolescence, 28 % social anxiety and 18% general anxiety (Ben-Itzhak, et al., 2020).

Autism and Anxiety (Foley & Baz, 2025)

- Separation anxiety was associated with lower cognitive functioning and more severe restrictive and repetitive behaviors in toddlerhood.
- Higher cognitive and adaptive functioning in toddlerhood were associated with greater general anxiety symptoms and lower adaptive skills and restrictive and repetitive behaviors were associated with elevated social anxiety in adolescence (Ben-Itzhak, et al. 2020).
- Although reported prevalence rates vary, anxiety is found to be the most common mental health problem in ASD (Avni, et al. 2020; Kerns, et al. 2021).

Causes of excessive anxiety in Autism

There is no apparent single unitary cause for excessive anxiety in autism but rather the result of multiple transacting factors

- Poor neural integration in the prefrontal lobes, decreased amygdala and cortical volume associated with autism (Gibbard, et al., 2018; Herrington, et al, 2017)
- High levels of anxiety correlated with sensory over-responsivity, sleep disturbance, angry/defiant behavior patterns, comorbid ADHD (Vasa, et al. 2020).
- Difficulty identifying feeling states and intolerance for uncertainty (Smith & Rodgers, 2017)

Causes of excessive anxiety in Autism

- A range of individual differences including auditory processing, visual-spatial and navigational constrictions, motor planning and postural deficits, literalness, language/pragmatic challenges.
- Stigma, bullying, isolation
- Reduced symbolic and expressive capacities impacting the child's ability to communicate anxiety states and triggers in language and play
- Increased risk of exposure to ACEs
- The added challenges and stressors of navigating daily life with ASD.

“95% (n = 267) of the sample of children with ASD were rated as having some degree of difference in sensory processing”

-Tomchek, S.D. & Dunn, W. (2007)



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Stanley Greenspan, "The Challenging Child"

"Imagine driving a car that isn't working well. When you step on the gas the car sometimes lurches forward and sometimes doesn't respond. When you blow the horn it sounds blaring. The brakes sometimes slow the car, but not always. The blinkers work occasionally, the steering is erratic, and the speedometer is inaccurate. You are engaged in a constant struggle to keep the car on the road, and it is difficult to concentrate on anything else."



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Combining what we know about the stress systems, communication difficulties and neurosensory differences:



Children with autism have brain differences that may lead them to respond to “normal” events as if they were traumatic.



In these situations, the child likely has neurobiological vulnerabilities that transform typical experiences into ones which are experienced as powerful and dangerous stimuli and which overwhelm the child’s capacity to regulate his or her emotions and behaviors.



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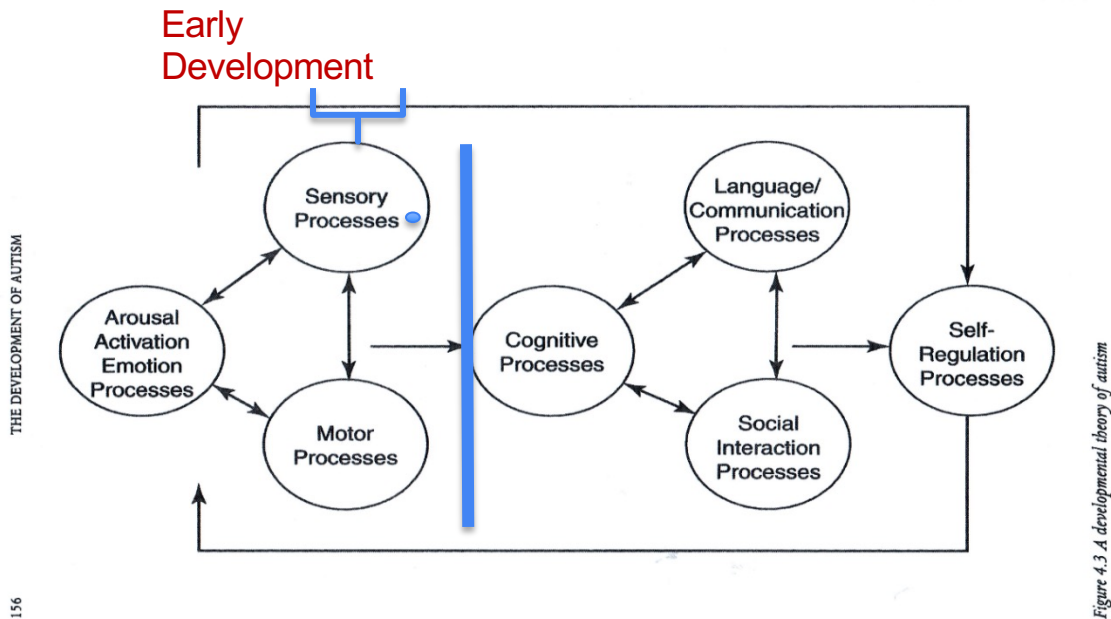
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From Whitman (2004): A Self-Regulatory Model of Autism



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Autism and ACE exposure (Vogel, 2024)

- Autistic youth have a higher prevalence for experiencing multiple ACEs than their neurotypical peers with 20% of adolescents with ASD exposed to 4 or more ACEs as compared to 8.5-9.8% of neurotypical adolescents (PubMed Central [PMC.gov]).
- Neglect is the most common maltreatment identified in the preschool and early school-age years with higher prevalence rates found among the following diagnoses: Intellectual disability (ID), language delays/disorders and learning disabilities (LD) (Vogel, 2024)
- These elevated levels of ACE exposure by diagnosis hold even when environmental risk factors for maltreatment are controlled such as living in chronic poverty and/or living with a young single mother with limited education.
- Heightened maltreatment reports have been identified among preschoolers with ASD but only one study (McDonnell et al., 2019) found prevalence rates higher than among community peers.

Autism and ACE exposure (Vogel, 2024)

- Interactional pathways with developmental disabilities contributing to maltreatment include: family poverty and lower maternal education consistent with low functioning in the child over a 36-M period.
- There is evidence that the impact of neglect can be mitigated and improved function can be achieved if the child is removed from the depriving environment by age 2 and provided with high -quality care (Nelson et al., 2019; Vogel, 2024).
- Children with disabilities have higher frequencies of healthcare needs, extended NICU exposure, more injuries, medical visits, medical procedures, emergency room visits and hospitalizations than typical children also contributing to ACE exposure.

Autism and ACE Exposure (Vogel, 2024)

- ASD and a co-occurring stress, trauma and deprivation diagnosis amplify and complicate the existing ASD symptom profile including: heightened anxiety, sensory and arousal atypicality, repetitive behaviors confounded by trauma re-enactment, dissociation and avoidant patterns of interaction (Peleg, Binya & Foley, 2025).

Autism and ACE Exposure (Vogel, 2024)

Trauma treatments for young children with co-occurring trauma and ASD

- **Trauma-Focused Cognitive Behavior Therapy (TF-CBT)** can be used for children as young as young as 3-5 but the child must have memory of the trauma that they can accessed verbally and sufficient verbal skills to create a short trauma narrative (Pollio & Deblinger, 2017) making it applicable to only a limited number of young children on the spectrum.

Autism and ACE Exposure (Vogel, 2024)

Trauma treatments for young children with co-occurring trauma and ASD

- **Child Parent Psychotherapy (CPP)** is an attachment and play-based dyadic treatment approach that is of the longest duration but addresses the widest range of issues. It has the most published (but limited) data concerning its applicability to young children with co-occurring developmental disability and trauma.

Autism and ACE Exposure (Vogel, 2024)

Trauma treatments for young children with co-occurring trauma and ASD

It has been suggested that when applying CPP to young children with comorbid DD and Trauma the clinician has:

1. A strong knowledge base in typical development and developmental disabilities, their impact on development, relationships, family and the interaction of developmental disorders and mental health,
2. The impact of medical trauma on the child and family,
3. knowledge of service delivery systems and eligibility criteria,
4. ability to support families across the life span, address developmentally changing needs and help them navigate service delivery systems,
5. the ability to work collaboratively with multiple disciplines and knowledge of the roles and functions of all members of the team,
6. the ability to communicate the nature and impact of trauma and the tenants of trauma-informed care to other providers and service delivery systems (Williams et al., 2014; Vogel 2024).

Autism and ACE Exposure (Vogel, 2024)

Trauma treatments for young children with co-occurring trauma and ASD

- **Parent Child Interaction Therapy (PCIT)** is an interactive/coaching therapy developed to treat children between 2 and 7 with disruptive behavior and has been used to treat children with ASD and ID but the children must have a language comprehension level of 2 years-old. There is a brief additional module developed specifically to address trauma. Although trauma symptom reduction has been reported children may require additional intervention for behavior regulation and stabilization.

Autism and ACE Exposure (Vogel, 2024)

Trauma treatments for young children with co-occurring trauma and ASD

- **Parent-Child Care (PC-Care)** is a parent-coaching time limited 6 session intervention to enhance parent child interaction and behavior management for 2-10-year-olds. There is a session-by-session modification for application to children with ASD and ID. Although reported to be used with ASD/ ID and co-occurring trauma, differential outcome data is not available.
- **Attachment and Biobehavioral Catch-up (ABC)** is and attachment focused treatment for infants through age 2 who have been exposed to trauma employing psychoeducation and a ten-session home-based moment-to-moment caregiver coaching approach aimed to enhance parent sensitivity, responsiveness and synchrony. There has been one pilot study working with with 3 infants global delays with reported clinical improvements in attachment and parental sensitivity (Mohamed et al., 2023)



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Selective Screening and Assessment Tools



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Autism Screener

Modified Checklist for Autism in Toddlers, Revised (MCHAT-R) (2009 Robins, Fein, & Barton)

- Parent report screening tool
- 20 questions
- Intended for toddlers 16 to 30 months of age
- Can be administered and scored as part of a well-child care visit
- Used by professionals to assess risk for ASD

Autism Observation Measure

Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2) (2012, Lord, et al.)

- A systematic method for obtaining direct observation of the individual's social and communication behaviors, as part of a comprehensive evaluation.
- Should not be used alone to make a diagnosis, as it does not account for the presence or absence of stereotyped behaviors and interests, and does not include information about the developmental history.
- Intended for use with ambulatory children with a developmental age of at least 12 months through adults

(CARS®2) Childhood Autism Rating Scale, Second Edition (2010)

WPS

by Eric Schopler, PhD, Mary E. Van Bourgondien, PhD, Glenna Janette Wellman, PhD, and Steven R. Love, PhD

- Helps to identify children with autism and determine symptom severity through quantifiable ratings based on direct observation. (2 years and older)
- Available in English, Bulgarian & Italian
- SCORES: Cutoff scores, standard scores, and percentiles
- Two 15-item rating scales completed by the clinician (each designed for a different population); and an unscored Parent/Caregiver Questionnaire
- Since its original publication, the CARS has become one of the most widely used and empirically validated autism assessments.

The diagnosis of autism is a clinical multidisciplinary endeavor.



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Overview of Treatment Approaches



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Comparative Approaches

	<u>Behavior-Based</u>	<u>Relationship- Based</u>
General Model of Development	Mechanistic	Organismic
Basic Metaphor of Human Nature	Machine - Reactive - Input/Output	Organism - Active - <i>A-priori</i> qualities
Core Tendency	To maximize reinforcement.	To establish relatedness through the achievement of developmentally organized goals.
Core Characteristics	Primary Drives Reinforcement	Constitutional/Sensory Profile Stages of Functional - <u>Emotional Development</u>
Peripheral Characteristics	Learned Behaviors, Discriminative Control Secondary Reinforcement Response Generalization	Stage of Development Sensory/Constitutional Profile
Developmental Statement	Development is the product of learned behaviors, discrimination and generalization. Principles of classical and operant conditioning explain behavioral change. Development is continuous and quantitative:	Development is a process of the the unfolding capabilities of the person, unique sensory and constitutional characteristics, and the caregiving environment. Development is discontinuous (e.g. stages) and qualitatively different over time. (ontogeny)
Principal Behavioral Focus	The “what” of behavior.	The “how” and “why” of behavior.

Type of Intervention	Exemplars (Same class of approaches; Not identical)
Applied Behavioral Analysis (ABA)	- Discrete Trials Learning - TEACCH - Applied Verbal Behavior (AVB) - Pivotal Response Treatment - Incidental Teaching
Affect/Social/ Relational/ Developmental Based	- Developmental, Individual-difference, Relationship-based (DIR)/Floortime - Social-Pragmatic/ Communication-based - Options Therapy/Son-Rise - Relational Development Intervention (RDI)
Sensory Modulation/ Processing -Based - Sensory Integration Training (SIT) - Auditory Integration Training	- Sensory Integration Therapy - Sensory Processing Disorder (SPD) Treatment - Auditory Integration Training - The Miller Method
Pharmacological	- Various classes of medications that target symptoms (e.g. Secretin for gastrointestinal disorders) - Dietary/allergens



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Dr. Sima Gerber and Team

Illustration of a DIR-informed Intervention



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Six Developmental Milestones of Emotional Development

1. Self-Regulation and Interest in the Word
2. Forming Relationships: Attachment
3. Intentional Two-way Communication
4. Complex Communication
5. Emotional Ideas
6. Emotional Thinking

Stanley Greenspan, MD



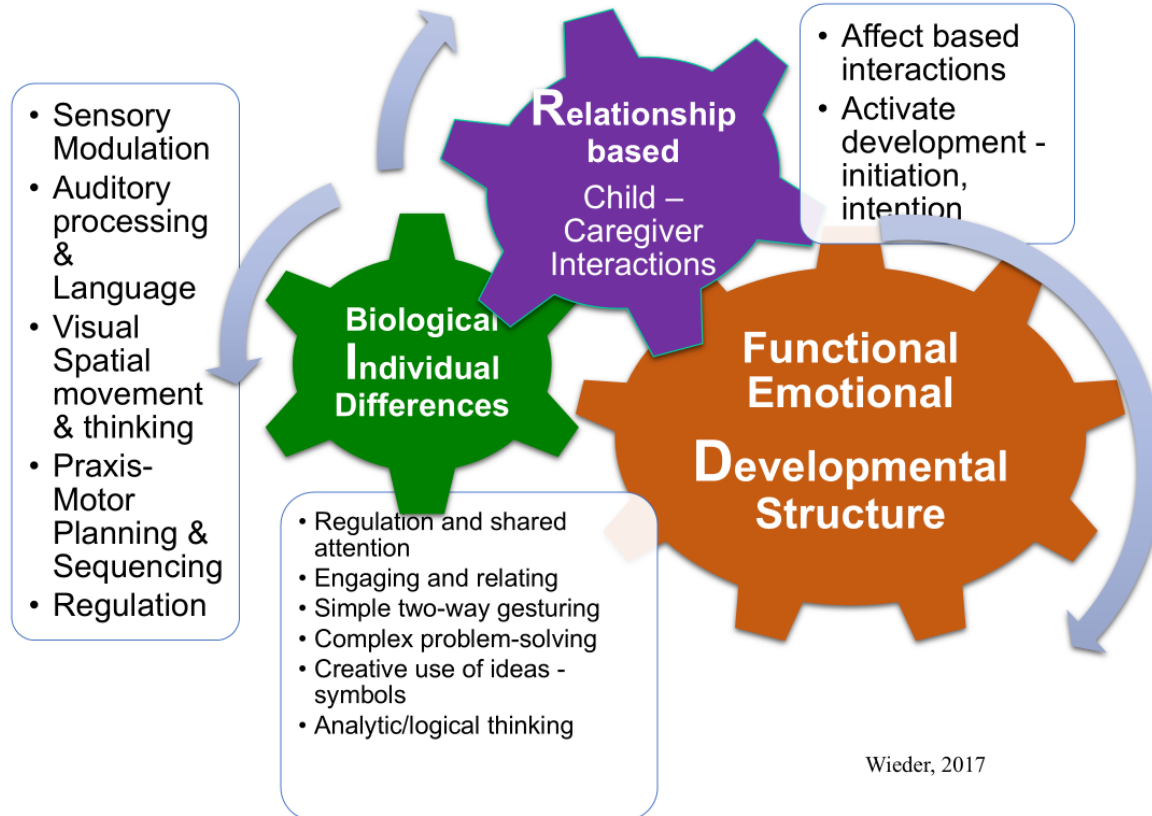
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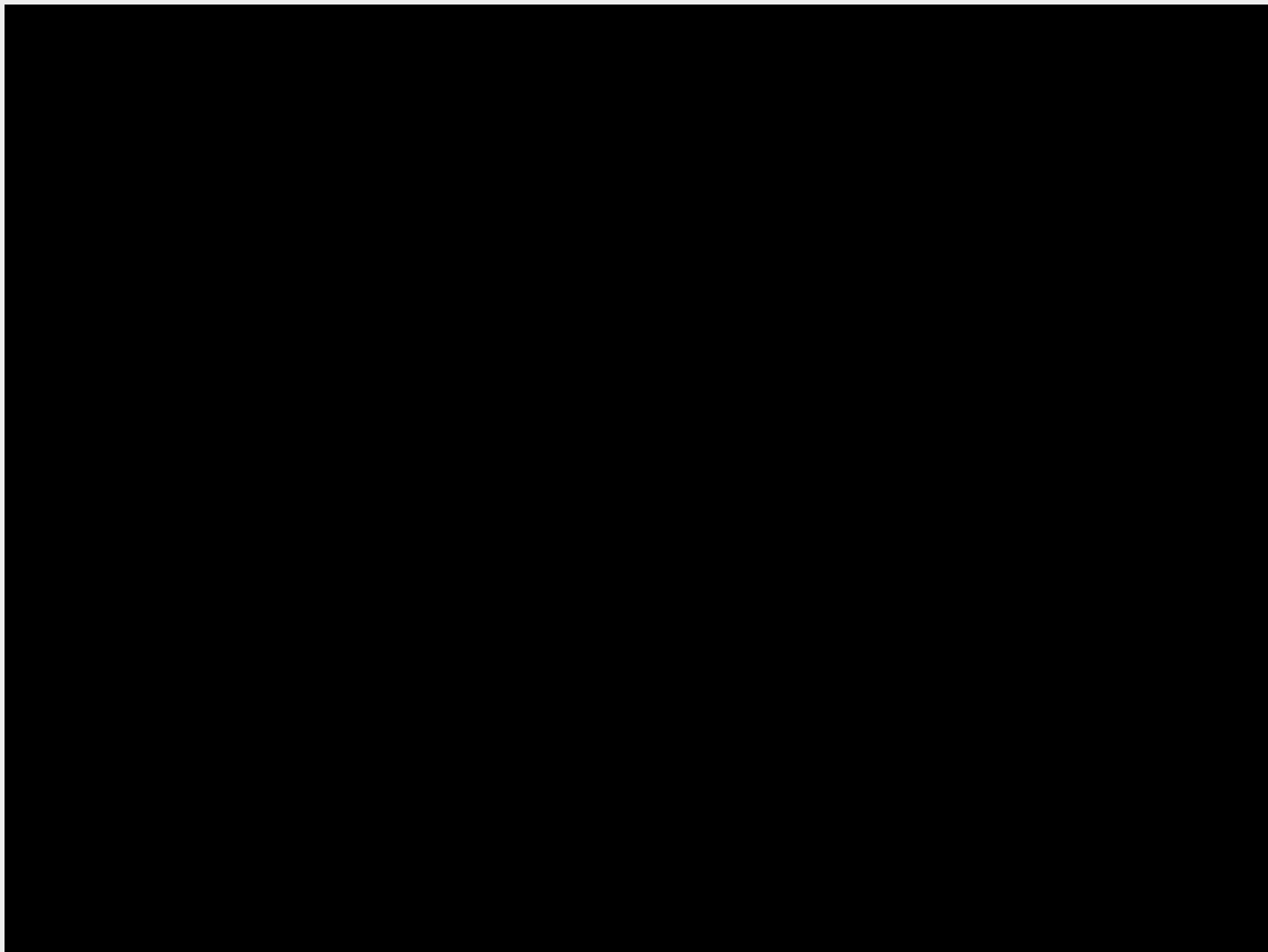
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DIR: Pioneered A Dynamic Multidimensional Systems Model of Development

Wieder, 2017



Wieder, 2017



Challenges of Rearing a Child with ASD

(Dharanidharan & Kuruveettissery, 2025; Mo, et al, 2025; Saeed & Devdutt, 2025; Turnage, et al., 2025)

- Research consistently indicates that parents of children with ASD, when compared to parents of neurotypical children experience higher levels of stress even when compared to parents of children with other developmental disabilities (Hayes & Watson, 2013; Pottie & Ingram, 2011).
- This heightened stress stems from various factors including: the child's behavioral challenges (dysregulated, aggressive and repetitive behavior), communication difficulties, challenges in social interaction; sensory atypicality, the need for on-going supervision, financial burdens, and the complexities of accessing appropriate educational and therapeutic resources.

Challenges of Rearing a Child with ASD

(Dharanidharan & Kuruveettissery, 2025; Mo, et al, 2025; Saeed & Devdutt, 2025; Turnage, et al., 2025)

- A systematic review by Corcoran (2015) identified that parents report persistent feelings of isolation, anxiety and worries about their child's future.
- High levels of chronic stress and exhaustion can not only compromise personal well-being but impact family dynamics (Dunn, et al., 2001). Parents may have less time and personal resources to devote to the family and may impact the marital relationship. Siblings may feel resentful, jealous and isolated.

Challenges of Rearing a Child with ASD

(Dharanidharan & Kuruveettissery, 2025; Mo, et al, 2025; Saeed & Devdutt, 2025; Turnage, et al., 2025)

- ASD symptoms can be unpredictable and puzzling (individual differences), making it difficult for parents to establish consistent routines and long-term plans
- The long-term nature of ASD, coupled with no definitive cure, creates ongoing stress that can evolve into chronic burnout.
- Societal stigma and misconceptions about ASD significantly impact parental well-being.
- The daily challenges of managing daily life, maintaining work-life balance, therapy appointments, coordinating school accommodations, and handling unpredictable behaviors can lead to emotional exhaustion and burnout.

Rewards, Strengths and Protective Factors

(Curley, et al., 2025)

- Joy in watching a child learn and grow, and feelings of pride when seeing a child accomplish important milestones
- Holding an optimistic viewpoint can increase parents' well-being and quality of life. Hope, self-efficacy, and optimism protect against the development of post-traumatic stress disorder by strengthening resilience.
- Cultivating moral principles and virtues that focus more on psychological growth and developing inner strengths such as courage, hope, perseverance, and optimism, instead of placing pressure on their children to fit social norms or expectations promote well-being.
- Sharing experiences and building strong social networks among parents of children with ASD created hope, new ways of seeing ASD and reframing life experiences as well as a sense of connectedness.



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Rewards, Strengths and Protective Factors

(Curley, et al., 2025)

- Cultivating religious or spiritual beliefs, participating in structured intervention programs, engagement in advocacy and transforming personal conflict into a source of strength and empowerment can all be both positive and protective outcomes of rearing a child with ASD.

Whitman Postulates

- Problems in arousal/activation and emotion system may have a major influence on the development of the sensory, motor, cognitive, language, social and self-regulatory systems.
- Children with autism may be especially vulnerable to stress if their arousal and state-regulation systems are dysfunctional, environmental stressors are too intense and prolonged, and/or their self-regulatory system is poorly developed.

Self-Regulation – Dr. Stuart Shanker

- *An individual (be they a child, parent or educator) exposed to too much stress in the early years, may develop a “kindled alarm system,” in which even relatively minor stressors can send them into fight-or-flight or freeze.*
- There are five domains in the Self-reg™ Framework: biological, emotional, cognitive, social and prosocial
- The Self-reg™ framework is not a program—it is a practical paradigm through which parents and teachers can better understand a child or student and others.
- Self-reg™ is a five-step method to enhance self-regulation in children, youth, young adults, and adults

Autism Awareness?



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Autism Understanding!



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Autism APPRECIATION!

Self –
advocacy
movement!

Neurodiversity

Open Discussion

COMPLETE EVALUATION



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Leave-Taking



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Perinatal and Early Childhood
Mental Health Network
Training and Technical Assistance Center



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