What to know about exposure therapy and medications for treating eating disorders: A practical primer

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ROGERS Behavioral Health

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Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The moderator will review all questions submitted and select the most appropriate ones to ask the presenter.

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Disclosures

Brad ER Smith, MD, and Kaitlin Hill, PhD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Describe at least two reasons for using exposure therapy in the treatment of eating disorders
2. List at least three different themes for exposures common to patients with eating disorders
3. Identify at least two ways in which anxiety medications can assist or interfere with exposure therapy

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What we'll cover in this webinar

Exposure therapy for eating disorders

- Overview of evidence base for exposure therapy in eating disorders
- How to get started with exposure therapy
- Practical, evidence-based strategies to optimize exposure therapy
- Common pitfalls in implementation
- Case example of staff-supported exposure

Medication strategies in the context of exposure therapy

- Overview of empirically supported medications for eating disorders treatment
- Common medication strategies to address psychiatric and medical comorbidities
- Medication strategies that can assist or interfere with exposure therapy

Moderated Q&A

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Exposure therapy for eating disorders

Please use the Q&A feature to send your questions to the moderator.

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Why use ERP to treat eating disorders?

- Conceptual overlap between eating disorders and anxiety (Becker, Farrell, & Waller, 2020)
- Some evidence for an anxiety-driven model of EDs (Schaumberg et al., 2021; Waller, 2008)
- High comorbidity rates of anxiety disorders for individuals with eating disorders (Kaye et al., 2004; Pallister & Waller, 2008)
  - Helpful to have a transdiagnostic approach
- Research supports the use of exposures across ED diagnoses, as well as improving body dissatisfaction in non-clinical population (see Butler & Heimberg, 2020 for a review).
- Exposures are included in evidence-based treatments for EDs, such as CBT-E and FBT (Fairburn, 2008; Griffen, Naumann, & Hildebrandt, 2018; Waller & Mountford, 2015)

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Overview of starting exposure therapy

- Comprehensive assessment of eating disorder behaviors and symptoms
  - Clinical interview and validated assessment measures
- Provide psychoeducation/rationale for use of exposure therapy
- In depth functional assessment
- Focus on reduction of safety behaviors
- Create hierarchy of exposure ideas
- Implement exposures in session
- Assign exposures for homework outside of sessions

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Functional assessment:

The foundation for developing an exposure hierarchy

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Functional assessment

Fear Cues	Feared Consequence(s)	ED-related Safety Behaviors	Function of Safety Behavior
Eating around my friends	When they see what food I choose, they will judge me negatively	Eating only "safe" foods when with friends; avoiding eating with them	*Relieves anxiety-related to perceived judgment*
Feeling my thighs touching each other when I sit or walk	I will become intensely disgusted with my body and I cannot tolerate the emotional distress	Sit or walk with my legs deliberately apart, use pillow between thighs when sitting	*Not having to feel my thighs touch and be disgusted by the sensation*
Eating a food from unknown origin with unknown food preparation	I will get sick and throw up and I cannot tolerate the distress of vomiting	Checking all food, reassurance seeking about preparation, avoiding food I did not prepare myself	*Relieves anxiety about vomiting*

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Functional assessment: Fear cues

Feared foods – can use feared food checklist (*handout available after program*)
- Smells, tastes, textures

Feared eating scenarios
- Other people present – who and how many?
- Level of control, what are other people eating?
- Locations
  - Restaurants, friends' homes, etc.
- Idiosyncratic scenarios
  - Rate, size of bites, first to finish, etc.

Body image-related cues
- Seeing reflection
- Other people see body image
  - Wearing swimming suit
- Certain clothing types
  - Form-fitting tops
- Postures/positions

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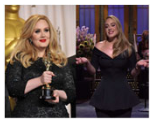
Functional assessment: Fear cues

Internal stimuli
- Feelings of fullness, nausea, bloating, warmth, hunger
- Worrisome thoughts
- Body awareness (sweat, skin touching)

Environmental / Social stimuli
- Media depiction of "thin, fit ideal" ("hot" = happy)
- Others' comments about eating, weight, shape

Binge eating / Purge cues
- Foods typically consumed during binge
- Locations where binges or purges often take place
- Emotional antecedents to binge eating
- Laxative or diet pill containers



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Functional assessment: Feared consequences

A special note about feared foods:

- Many patients report "classic" fear of weight gain
- Other patients may describe different concerns
  - *"I will lose control and binge on _____."*
  - *"I will feel unbearably guilty for (breaking dietary rule)."*
  - *"People will judge me for being unhealthy and I'll feel more shame about my fat body."*
  - *"I'll choke and die."*
  - *"I'll get nauseous and vomit."*
  - *"I will get sick from germs left on the food by others at the supermarket"*

In addition to weight gain, common feared consequences connected to fear cues often relate to social judgment or rejection, self-worth/self-perception, negative emotional states/distress, disgust reaction, loss of control, perfectionism/productivity

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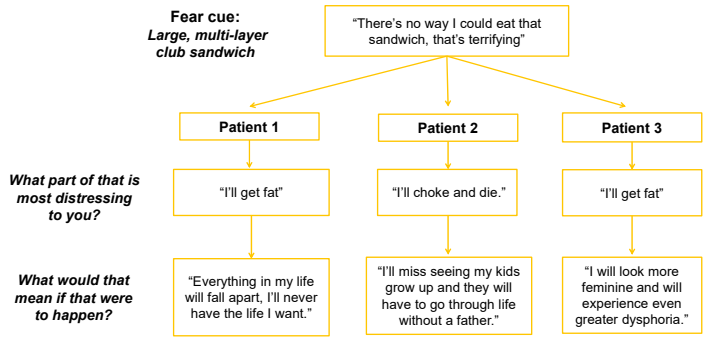
Functional assessment

Feared consequences and downward arrow



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How to identify ED safety behaviors

Ask about eating disorder "rules" *(handout available after program)*

"What are things your ED or anxiety tells you that you have to do on a regular basis when it comes to…"

- Food (e.g., eating situations, quantity of food, the way you eat)
- Exercise (e.g., the way you exercise, when you exercise, what happens if you don't exercise)
- Purging
- Spending time with friends
- Enjoying things
- Productivity, etc.

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How to identify ED safety behaviors

"What are things you do to try to reduce your anxiety in the moment?"

"What are things you've stopped doing or have changed since the ED started?"

"What are things that other people have expressed concern about?"

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Safety behaviors

Weight control behaviors

- Restriction
- Excessively drinking liquids ("hydro-loading")
- Abusing diet pills, laxatives / diuretics
- Purging
- Excessive exercise
- Fasting
- Eating the same foods each day
- Only eating at certain times of the day
- Over/under dressing
- Food-related research and advance planning
- Calorie / exercise tracking
- Repeated / ritualized weight checking
- Negative self-talk ("Eating disorder voice")

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Safety behaviors

Eating-related behaviors

- Slow/quickened pace of eating
- Excessive small bites of food
- Breaking / cutting food into pieces that would not normally be broken / cut (e.g., bagel)
- Odd mixing of foods (e.g., peanut butter + cottage cheese)
- Odd utensil use (e.g., using a fork to eat yogurt)
- Eating foods in a certain "safe" order
- Always leaving some food on plate

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Safety behaviors

Body image-related behaviors

- Checking appearance in mirror
- Extreme avoidance of body image
- Poking/pinching various body parts
- Attempts at manipulating body areas (e.g., pushing stomach to be flat)
- Adjusting body posture
- Seeking reassurance from others
- Using clothing to check for weight gain/shape changes
- Comparing self to others
- Hiding body from others (e.g., wearing oversized clothes)
- Overcontrol of image on social media or in social situations (e.g., photo editing, deleting pictures, excessive grooming)
- Avoidance of others in larger/smaller bodies

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Safety behaviors

Exercise-related behaviors

- Excessive bending / stretching
- Purposely choosing longer route to walk somewhere
- Tensing muscles
- Standing when sitting would be appropriate
- Extraneous movement (e.g., bouncing legs)
- Walking on toes
- Ritualized and/or excessive exercise regimens

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Safety behaviors

Neutralizing thoughts or mental rituals

- "I'm never going to eat this after treatment."
- "My therapist wouldn't have me eat something or do something that would be harmful to me."
- "It's okay to eat this now because I'm going to restrict/exercise later."
- Negative self-talk, body shaming, "ED voice" (e.g., as a way to combat fears of loss of control overeating or weight)
- Self-reassurance about potential weight gain

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Functional assessment

It is critical to identify the ***function* of the safety behaviors**

- It is possible that different patients *to use the same safety behavior for different functions*
- Understanding the function of the behavior *will allow for more precise exposure exercises that target the person's unique concern*

Example: Your patient cuts a sandwich into very small pieces before eating…

- What could be several potential functions of this behavior?
- Based on these functions, how might you frame an exposure task to target the concern?

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Some notes about safety behaviors

- As we do with anxiety disorders (and in particular OCD), it can be helpful to start by having the patient focus on self-monitoring use of safety behaviors before you start any exposures to:
  - Build awareness into the avoidance and safety behavior patterns
  - Create sense of self-efficacy in resisting urges prior to starting exposures
- Have patient continue to track this throughout treatment
- What if they are not able to completely resist a safety behavior?
  - They can start by delaying – and then work to gradually increase amount of delay between the urge and giving into the behavior

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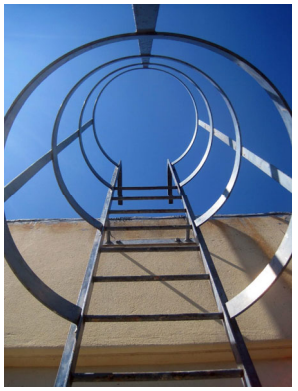
ED exposures

Think of the exposure hierarchy like a "fear ladder" – the goal is to climb the "rungs" on the ladder to get to the top



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Tips for maximizing effectiveness of exposures

- Repeated trials
- Vary the context and stimuli
- Combine different fear cues together
- Maximize expectancy violation (increase difference between anticipated/feared outcome and what actually happens)
  - Need to have high enough anxiety to solidify learning, but not so much anxiety (e.g., panic attack) that it impedes learning
- Start with highest rated items patient can do while still resisting all safety behaviors

Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014; Reilly, Anderson, Gorrell, Schaumberg, & Anderson, 2017

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Case example

Devi is a 30-year-old, gender expansive Indian-American presenting with a history of binging and purging with frequent dieting and periods of restriction. They report subjective binges most days and objective binges about 1x/week. Purging frequency varies, but currently is about 2-3x/week. They have diagnoses of bulimia nervosa, depression, and social anxiety. They report their queer identity and fluid gender expression is one of the things that brings them confidence and enjoyment in their body, and one of the few things in their life they feel secure about. Their BMI is in the overweight range and has been since early childhood.

Devi reports significant distress related to:

- Feelings of fullness, tightness, and bloating → increased purge urges
- Body image → Avoid full length mirrors, tight clothes, tank tops, and shorts
- Weight gain and the fear they will gain weight indefinitely if they give up weight-control behaviors (e.g., restrictive dieting, purging and laxative use, calorie tracking, food research, weighing themself multiple times per day, and only eating 1-2 meals per day)
- Feeling out of control related to binging and unable to trust themself around certain foods (e.g., chips and snack foods, cookies, desserts, and fast food)

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Collaborative weighing

Powerful exposure exercise focused on maximizing expectancy violation and habituation to hearing weight (reducing power of the number)

- Patient is weighed once a week with therapist
  - **Before weighing:** Discuss patient's predictions about weight, factors contributing to that prediction and specific fears about weight, and strength of belief in prediction
  - **After weighing:** Discuss any differences between specific prediction and actual weight, elicit any helpful reasoned conclusions, in the moment thought challenging
  - Chart patient's predictions over time along with actual weight and periodically use this in sessions

(See Fairburn, 2008 and Waller et al., 2013 for a more in-depth discussion)

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Interoceptive exposures

Pair interoceptive exposures with imaginal or *in vivo* exposures

Examples:

- Gulping/water loading with still or carbonated water
- Jumping up and down
- Wiggling the body
- Pushing stomach out
- Wearing tight clothing, particularly around stomach
- Sitting or lying on a beanbag or inflatable chair which makes the body feel heavy

Becker, Farrell, & Waller, 2020; Schaumberg et al., 2021

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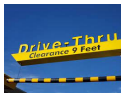
Cue exposures

- Many patients who binge eat develop associations between various environmental cues and binge-eating episodes
  - Highly palatable, rich foods
  - Emotional cues (often negative emotions)
  - Other situational cues (physical contexts in which bingeing occurs)



- During exposure to these cues, patients are encouraged to focus attention on their thoughts and the intensity of their cravings
- Goal is to reduce cravings in response to cues (*extinction)*

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Mirror exposure

- For patients who were weight suppressed, wait to start once patient is within (or close to) biologically appropriate weight range
- Full-length mirror is used to allow patient to look at their full body
  - **"Pure"** → patient comments on thoughts and emotions experienced while viewing body
  - **Mindful/nonjudgmental/functional** → patient directed to describe appearance of body in neutral, nonjudgmental, or functional terms

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Common pitfalls

Relatively common mistakes that reduce the efficacy of exposures

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Common pitfalls

- Mistaking forced contact with exposure
- Therapists' own anxiety about exposure leading to more cautious approach
- Assigning exposures without truly understanding underlying core fear
  - Risk not actually addressing core factors maintaining ED
- Patients using safety behaviors and neutralizing the exposures without therapist knowing
- Starting exposures without having buy-in from the patient
- Assigning exposures for homework, but not spending time in session doing exposures with the patient
  - Or alternatively, only doing exposures in session without assigning homework

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Common pitfalls

- Focusing too much on expectancy violation of feared outcome instead of other effects of exposure (e.g., increased tolerance or self-efficacy)
- Not considering exposures through a justice-informed lens
  - Shying away from exposures with certain populations (e.g., avoiding mirror exposure, collaborative weighing, or exposures to eating "unhealthy" foods for patients in larger bodies)
  - Blindly assigning exposures across all body-related concerns regardless of source of anxiety (e.g., Transgender or non-binary patient who fears return of period or softer/thinner body)
  - Exposures that reinforce harmful stereotypes or further subject patients to messages of marginalization
  - Overly adhering to overcorrection model without reflection as to whether the exposure is actually necessary or may be harmful

see Pinciotti, Smith, Singh, Wetterneck, & Williams, 2021 for discussion related to ERP for OCD

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Medication strategies in the context of exposure therapy

Please use the Q&A feature to send your questions to the moderator.

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Overview of empirically support medications

FDA approved medications by diagnosis

Diagnosis	FDA approved medication
Anorexia Nervosa	NONE
Bulimia Nervosa	Fluoxetine
Binge Eating Disorder	Lisdexamfetamine dimesylate
ARFID	NONE

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Anorexia Nervosa (off label)

- NONE FDA approved
- Antipsychotics as a class
- Olanzapine
- Mirtazapine
- Cyproheptadine
- Cannabinoids
- Zinc

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Antipsychotics

- 2011 Aigner et al: World Federation of Societies of Biological Psychiatry – a task force on eating disorders – systematically reviewed all studies for the pharmacological treatment of ED published 1977-2010
  - Olanzapine: Grade B evidence (limited positive evidence from controlled studies)
  - Other second-generation antipsychotics: Grade C evidence (positive evidence from uncontrolled studies/case reports/expert opinion)

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Olanzapine

- 2007 Dunican and DelDotto: Literature search for any and all studies related to olanzapine for anorexia nervosa
  - Case reports and clinical trials
  - Preliminary evidence to support olanzapine can help with weight restoration and psychological symptoms
- 2008 Bissada et al: Double blind placebo-controlled trial
  - N=34, olanzapine plus day treatment vs placebo plus day treatment
  - Faster weight restoration and improved obsessional thinking

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Olanzapine

- 2011 Kafantaris et al: Double blind placebo-controlled trial
  - N=20, olanzapine vs placebo, both receiving care in treatment setting
  - No difference in weight restoration, trend in metabolic side effects in olanzapine group
- 2019 Attia et al: Double blind placebo-controlled trial
  - N=152, olanzapine plus weekly sessions vs placebo plus weekly sessions
  - Improved weight restoration, no clear improvement in obsessions

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Mirtazapine

- Widely tried due to side effect profile
- No clear RCT supporting
- Case reports and retrospective studies
- Lack of evidence, yet widely attempted

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Cyproheptadine

- 2019 Blanchet et al: Multidisciplinary overview of meta-analyses and systemic reviews
  - Purported to stimulate appetite in children with asthma
  - 2 RCT's demonstrated no efficacy
  - Seemed to worsen course for those with binge/purge behaviors

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Cannabinoids

- Can stimulate appetite
- 2019 Blanchet et al:
  - 2 RCT's
  - Possible quicker weight restoration in one study
  - Side effects of dysphoria and very limited evidence of efficacy preclude standard use

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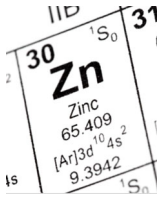
Zinc



- 2011 Aigner et al: Task Force on Eating Disorders of the World Federation of Societies of Biological Psychiatry
  - Grade B evidence
- 2002 Su & Birmingham: review of literature
  - Evidence for zinc improving weight restoration, mood, anxiety
  - Low toxicity helps form recommendation despite limited evidence

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Bulimia Nervosa

- Fluoxetine (FDA approved)
- Tricyclic antidepressants (off label)
- Topiramate (off label)
- Naltrexone (off label)

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Fluoxetine

- FDA approved
- 2011 Ainger et all recommended Grade A
- 7 RCT's, 6 showing superiority
- 60 mg dose appears as target

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Tricyclic antidepressants

- 2011 Ainger et al recommended Grade A (with caution)
- 4 RCT's supporting imipramine
- 6 RCT's supporting desipramine
- Side effect profile challenging for those without bulimia
- Side effect profile more dangerous for those with bulimia
  - QT prolongation, heart block, arrhythmias, constipation, orthostasis

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Other antidepressants

- Fluvoxamine: 3 RCTs, 2 showing efficacy
- Sertraline: 1 RCT showing efficacy
- Trazodone: 1 RCT showing efficacy
- Phenelzine: 3 RCT's showing efficacy, but caution due to side effects
- Bupropion: 1 RCT showing efficacy, but high incidence of seizures – Contraindicated
- Citalopram: no clear efficacy in studies

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Topiramate

- 2011 Aigner et al suggested Grade A recommendation
- 2 RCTs showing efficacy
- 2003 Hoopes et al: Median dose 100 mg
- Side effects common at higher doses

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Naltrexone

- 1987 Jonas and Gold: RCT, n=10, of high dose naltrexone, showed efficacy
- 1995 Marazzi et al: RCT, n=19, 200 mg, showed efficacy
- Normal dosages did not seem to show efficacy

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Binge Eating Disorder

- Lisdexamfetamine dimesylate (Vyvanse)
- Topiramate
- Antidepressants
- Naltrexone

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Lisdexamfetamine dimesylate

- FDA approval for adults (2015)
- Phase II: RCT, n=260, doses of 50 mg and 70 mg showed efficacy
- Phase III: 2 RCT's, n=374 and n=350, 50 mg and 70 mg showed efficacy
- Meta-analysis of Phase II and Phase III showed number needed to treat for response was 3; for remission was 4; while number needed to treat to harm was 44

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Topiramate

- 2011 Aigner et al: Grade A recommendation
- 3 RCT's showing efficacy
- 2017 McElroy points out side effects and high discontinuation rates

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Antidepressants

- Imipramine: 2 RCT's showing efficacy
- Citalopram/escitalopram: 2 RCT's showing efficacy
- Sertraline: 2 RCT's showing efficacy
- Fluoxetine: Mixed results
- Fluvoxamine: Mixed results
- Atomoxetine: 1 RCT showing efficacy
- Venlafaxine: 1 case series showing efficacy
- Bupropion: 1 RCT failed to show efficacy, but commonly utilized due to lack of weight gain side effects

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Naltrexone

- 2017 McElroy review of literature
- 1 RCT, 88 BED, 60 BN from 1991 (Alger et al)
- Efficacy of naltrexone for reducing binge duration and frequency
- Combined with bupropion for weight loss medication

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ARFID

- Very little consensus in treatment approaches in literature
- 2017 Brewerton and D'Agostino: Retrospective chart review
  - N=9
  - Suggests olanzapine may help
- 2018 Gray et al: retrospective chart review of mirtazapine
  - N=14
  - Suggests mirtazapine may help speed up weight restoration

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EDs and psychiatric comorbidities

- Anxiety disorders
- OCD
- Mood disorders
- PTSD
- Substance use disorders
- Personality disorders

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Common psychiatric medications
(based on comorbid diagnoses)

- Selective serotonin reuptake inhibitors (SSRI's)
- Serotonin-norepinephrine reuptake inhibitors (SNRI's)
- Tricyclic antidepressants (TCA's)
- Other antidepressants
- Mood stabilizers (lithium, lamotrigine, divalproex, carbamazepine, oxcarbamazepine)
- Antipsychotics
- Stimulants
- Benzodiazepines

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Psychiatric symptom management

Anxiety: Acute anxiety reduction before meals/snacks

- Benzodiazepines
- Antihistamines (hydroxyzine FDA approved, cyproheptadine off label)
- Gabapentin, pregabalin (off label)
- Antipsychotics (off label)

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Common medical issues

- **Gastroparesis:** metoclopramide, erythromycin
- **Constipation:** polyethylene glycol, docusate sodium
- **GERD:** proton pump inhibitors, H-2 blockers, antacids
- **Other GI**: ondansetron, promethazine, probiotics
- **Edema:** diuretics
- **Osteopenia/Osteoporosis:** estrogen, bisphosphonates
- **Diabetes:** insulin, metformin or other oral medications
- **Vitamins/minerals/electrolytes:** supplements

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Medication strategies:

Medications which can assist with exposure therapy

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D-cycloserine

- N-methyl-D-aspartate (NMDA) receptor modulator
- Augments glutamatergic function – increases efficiency of fear extinction
- 2008 Norberg et al: meta-analysis from 1998-2007
  - D-cycloserine enhances fear extinction/exposure therapy in animals and humans
  - Increases speed and efficiency of improvement
  - Effects decrease over time and repetition

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D-cycloserine for ED ERP

- 2007 Steinglass et al, n=11
  - Double blind placebo-controlled study with inpatients with AN
  - Exposure therapy effective at improving intake
  - D-cycloserine failed to demonstrate additional benefit
- 2015 Levinson et al, n=36
  - RCT with PHP patients
  - Exposure therapy effective
  - D-cycloserine demonstrated additional benefit

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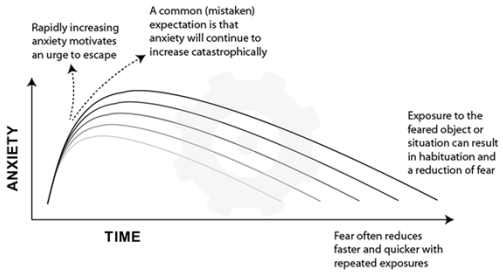
Antidepressants and ERP

- Can assist with bringing down global anxiety
- Can assist via treating co-morbid depression
- Can reduce OCD related symptoms to gain traction
- APA practice guidelines note that SSRI + ERP works better than either technique alone for severe OCD



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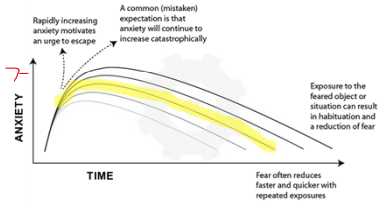
Anxiety reducing medications

Acute reduction

- Benzodiazepines
- Gabapentin/pregabalin
- Antihistamines
- Antipsychotics

May make exposure tolerable



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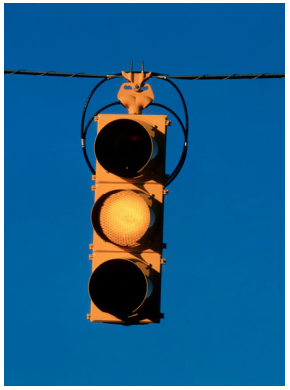
Medication strategies:

Medications which can interfere with exposure therapy



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Three primary concerns of interference

1. Inhibition of learning and memory
2. Interference with rise and fall of anxiety during ERP
3. Medication becomes a “safety behavior” or state dependent learning

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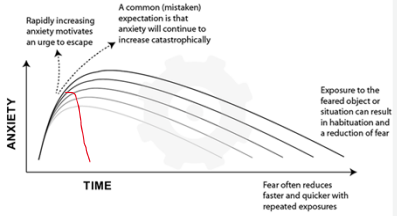
Anxiety reducing medications

Acute reduction

- Benzodiazepines
- Gabapentin/pregabalin
- Antihistamines
- Antipsychotics

May reduce anxiety too much



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Medication as a “safety behavior”

- Acute anxiety reducing medications
  - Conditioned as a safety behavior if given in proximity of exposure
  - Can prevent habituation (no rise and fall of anxiety)
  - Can prevent the learning that anxiety can be tolerated
- Antidepressants
  - Not likely to become safety behavior because they act in more preventive fashion and not linked in proximity of exposure
  - Could reduce habituation
  - Could reduce tolerance

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Benzodiazepines

Usual side effects/risks: Dependence, addiction, cognitive slowing, memory problems

- 1999 Kilic et al: 3.5 year follow-up
  - Alprazolam appeared to interfere with memory and learning
- 2007 Watanabe et al: Systemic review of combination of psychotherapy and benzo's
  - Noted combination may be better for initial stages, and therapy alone better longer term
  - Relative paucity of good studies to substantiate the concerns related to benzo's interfering with psychotherapy

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Benzodiazepines (cont'd)

- 2020 Melani et al: Systematic review of RCT's
  - 12 RCT's of exposure-based interventions in anxiety and PTSD
  - 9 studies showed benzo's did not interfere
  - 2 studies showed benzo's
  - 1 study showed benzo's interfered
  - 11 studies had follow up after benzo's stopped
    - 6 showed benzo's had not interfered with long term gains
    - 5 showed benzo's did interfere with long term gains

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Case example

- 24-year-old African-American transgender female
- Diagnoses: Anorexia Nervosa, restricting type; OCD
- Panic attacks at each meal, some snacks; restriction anxiety based on body image and contamination fears; intake only a few hundred calories/day
- Current medications: Fluoxetine 10 mg (2 months), estradiol, spironolactone
- Options as ERP is started??

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Time for questions and answers…

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Take-home messages

ERP for eating disorders

- Exposure therapy can be a helpful adjunct treatment for eating disorders
- Do a thorough functional assessment to help guide creation of exposure hierarchy and ensure targeting core fear
- Include focus on resisting safety behaviors in approach to exposure with EDs
- Utilize components of inhibitory learning model to maximize exposure effectiveness

Medications for eating disorders

- Stay cognizant of how ERP works
- Consider co-morbid psychiatric conditions
- Consider antidepressants and augmentation medications for preventative treatment of anxiety and mood symptoms, especially for severe symptoms
- Consider acute anxiety reducing medications to make ERP possible in early stages – "challenging but manageable"
- Stay cognizant of risks of interference of ERP

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About the presenters….

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