



Non-Pharmacological
Intervention Society

Non Pharmacological Interventions Registry

Protocol : EMNO DIET-MED-BED nutritional program for adults with obesity presenting binge eating

Health Problem: Overweight and obesity



Nutritional

Sheet Code

NPIS-0000000116

Designation

EMNO DIET-MED-BED nutritional program for adults with obesity presenting binge eating

Abbreviation

EMNO DIET-MED-BED

Category

Nutritional

Main Health benefit

Sustainable reduction in the frequency and intensity of binge-eating episodes

Explanation

The overall prevalence of binge eating disorder (BED) in the general population is estimated at around 0.9% worldwide, according to a systematic review that combined 32 studies and found a pooled global prevalence of 0.9% (95% CI: 0.7–1.0%) (Erskine 2018). This prevalence is higher in women (1.4%, 95% CI: 1.1–1.7%) than in men (0.4%, 95% CI: 0.3–0.6%) and up to 30% of obese individuals consulting a specialized center (Villarejo 2013). Binge eating disorders are characterized by recurrent episodes of excessive food consumption associated with a loss of control, without regular compensatory behaviors.

The EMNO DIET-MED-BED program reduces binge eating episodes by an average of 40 to 50% after 6 months (Grilo 2017; Ricca 2000; Ghaderi 2003; Carter 1998). This integrative and individualized nutritional management significantly improves behavioral, metabolic, and psychological markers (Hilbert, 2019; Brownley, 2016). People have better food awareness and better emotional regulation by interrupting the vicious cycle of restriction – loss of control – guilt (Duchesne 2007).

Routine Test

Recommended test: EDE-Q (Eating Disorder Examination Questionnaire, version 6.0)

Reference self-report questionnaire to assess the severity of pathological eating behaviors over the past 28 days. It provides a global score and sub-scores (eating control, weight concerns, body concerns, cognitive restraint).

Pathological threshold score: ≥ 2.5 (global score).

Use:

- Systematic administration at the start of the program, at 3 months, and at 6 months.
- Interpretation shared with the patient to reinforce involvement in the change process.

Threshold

EDE-Q

Reduction ≥ 1 point in the overall score between two assessments spaced 3 months apart. A decrease $\geq 50\%$ in the weekly frequency of binge-eating episodes is also considered a criterion for validated partial response (Grilo 2012). Complete remission: no binge-eating episodes in the last 28 days, with an overall score < 2.0 .

Interpretation

This threshold should be combined with qualitative data from the clinical interview and the

food diary. A change is clinically significant if it is accompanied by an improvement perceived by the patient in their daily life, food choices, and quality of life.

Minimal Clinically Important Change

Reduction of binge eating episodes

Secondary benefits

Metabolic benefits

- Weight stabilization and prevention of major weight fluctuations (Grilo 2022).

Psycho-behavioral benefits

- Reduction in self-stigmatization and dichotomous thoughts about eating.
- Improvement in body image, sense of personal efficacy, and self-esteem.
- Reduction in social isolation and improvement in the therapeutic relationship.
- Increase in frustration tolerance and emotional self-regulation abilities. (Duchesne 2007; Ricca 2000, Brelet 2021; Goodrick 1999)

Functional benefits and quality of life

- Reduction in mild to moderate anxiety and depressive symptoms (Duchesne 2007, Ricca 2000, Hilbert 2019)
- Improvement in sleep and circadian rhythms (Duchesne 2007, Tzischinsky 2000, Pendleton 2002, Levine 1996).

Direct Risks

Risk of temporary emotional distress

Some patients may experience a temporary resurgence of shame, guilt, or anxiety when exploring their eating behavior, particularly during the first sessions. This phenomenon is generally temporary and should be accompanied by active listening and emotional regulation techniques.

Risk of excessive cognitive restriction

Misinterpretation of nutritional advice can lead to rigid, counterproductive restriction that promotes binge-eating episodes. This risk is mitigated by a non-prescriptive approach focused on self-regulation and respect for hunger and satiety cues.

Risk of disengagement or non-adherence

The frequency and intensity of the disorder can lead to difficulty maintaining motivation, especially in the absence of rapid or visible results on weight.

Personalized motivational support and the use of digital tools help reduce this risk.

Risk of symptomatic transfer

Rarely, an improvement in eating behavior may be followed by a shift in the symptom (increase in addictive behaviors, somatic anxiety). Interdisciplinary vigilance is recommended in these cases.

Risks of interaction

Psychopharmacological interactions

Risk of interaction with certain psychotropic drugs: in patients treated with SSRIs or SNRIs (e.g., fluoxetine, venlafaxine), a rapid stabilization of mood or impulsivity may mask or shift certain binge-eating behaviors. Coordination with the prescribing physician is essential to adapt the therapeutic strategy.

Psychotherapeutic interactions

In the absence of interprofessional communication, a divergence in approach between the nutritional approach (focused on behaviors) and an analytic-type psychotherapy (focused on representations) can create confusion in the patient and reduce adherence. It is recommended to ensure alignment of messages and therapeutic objectives.

Interactions with Other Dietary Approaches

Combining this intervention with a restrictive diet in parallel (e.g., ketogenic, unsupervised intermittent fasting) can lead to cognitive and behavioral destabilization, reinforcing loss of control over eating. Clear framing and prioritization of interventions are therefore necessary.

Sociocultural or Family Interactions

Family or cultural expectations around rapid weight loss may conflict with the goals of emotional and behavioral stabilization promoted by this NPI. This conflict of influence can negatively affect patient engagement and should be identified and addressed through specific psychoeducational work.

Informational interactions

Uncontrolled exposure to nutritional content on a social network, the Internet, or an uncertified platform (dietary injunctions, "before/after", advice from pseudo-experts) can

alter the perception of the EMNO DIET-MED-BED protocol and generate risky behaviors (self-prescription, disengagement, guilt).

Biological and Psychosocial Mechanisms

Biological mechanisms

- Alteration of the homeostatic system of hunger and satiety: Patients suffering from binge eating disorder often show resistance to leptin signals and postprandial hyperactivation of ghrelin. This NPI promotes reconnection with bodily sensations through mindful eating exercises and regular structuring of food intake (Goodrick 1999).
- Low-grade inflammation and insulin resistance: Binge eating disorder is associated with an inflammatory state favored by cycles of restriction/rebound. Normalizing intake and reducing restrictive behavior contribute to the improvement of metabolic sensitivity (Succurro 2015, Pendleton 2002, Čížková 2020).

Psychosociological Mechanisms

- Reduction of pathogenic cognitive restriction: The program deconstructs rigid dietary injunctions (mental dieting) and restores functional permissiveness, thus reducing the risk of compulsion through decompensation (Final Report Article 51 EMNO https://sante.gouv.fr/IMG/pdf/emno_rapport_evaluation_finale.pdf).
- Self-determination: This NPI promotes self-motivation through co-construction of goals, recognition of the patient's competence, and enhancement of their autonomy in decision-making (Duchesne 2007, Ricca 2000, Hilbert 2019).
- Social halo effect and internalized stigma: By restoring a caring and non-blaming discourse around food and body, the EMNO DIET-MED-BED program deconstructs self-devaluation and promotes social reintegration (Duchesne 2007, Ricca 2000, Hilbert 2019).

Responding population

- Individuals aged 18 to 70 years with obesity (BMI ≥ 30 kg/m²) and a diagnosis of binge-eating disorder according to DSM-5 criteria.
- Patient expressing distress related to loss of control over eating, without purging compensatory behaviors (vomiting, laxatives, etc.).
- Person motivated by a non-prescriptive, educational, and progressive approach.
- Commitment to regular follow-up for 6 months in consultation.
- Person able to interact constructively with a healthcare professional (sufficient level of functional and digital literacy).

Nonresponding population

- Eating disorders such as anorexia nervosa, bulimia nervosa with vomiting, or atypical forms with major psychiatric instability.
- Severe, unstabilized psychiatric comorbidities (major depressive episode with melancholic symptoms, acute phase bipolar disorders, active schizophrenia).
- Individuals with cognitive or developmental disorders making it impossible to understand the program or voluntarily adhere to it (e.g., dementia, severe and unsupported autism spectrum disorder).
- Refusal to work on emotions, approach overly focused on rapid weight control, or exclusive pursuit of a "diet"-type effect.
- Individuals in situations of extreme social vulnerability without sufficient resources to allow regular follow-up (e.g., severe unsupported food insecurity).

Participants

Individual

Duration

6 months

Sessions per week

1 session per month

Procedure

1 initial individual assessment session coordinated by an EMNO nurse (30 minutes) and a referring nutritionist physician (30 minutes). 5 individual follow-up dietary sessions of 45 minutes each provided by a dietitian trained in eating disorders, approximately 1 session every 4 to 6 weeks. 1 medical re-evaluation by the nutritionist physician at the 6th month (30 minutes). Format: in-person, in an individual office within the EMNO-labeled nutrition medical center or equivalent.

Outline and content of dietary sessions

Session 1: Welcome and engagement phase

- Analysis of the food diary prepared with the nurse.
- Qualitative evaluation of the relationship with food (awareness, automaticity, emotions).
- Collection of expressed representations, beliefs, and objectives.
- Co-construction of the therapeutic contract and identification of the first avenues for work.

Session 2: Decoding binge eating episodes

- Mapping of risk situations: places, times, triggering emotions.
- Introduction of self-observation tools (hunger/satiety scale, emotional journal).
- Refocusing on the notion of food permission and breaking restrictive cycles.

Session 3: Work on Regulation Levers

- Learning mindful eating techniques.
- Distinction between physiological hunger and emotional hunger.
- Identification of pre-urge signals and formulation of alternative strategies.
- Integration of regular eating patterns and pleasure into meal planning.

Session 4: Consolidation and Relapse Prevention

- Work on high-risk social contexts (parties, shared meals, criticism).
- Anticipation of stress situations or emotional imbalance.
- Techniques for self-support and self-kindness after a possible episode.
- Review of implemented strategies and adjustment if necessary.

Session 5: Preparation for the end of the cycle

- Self-assessment by the patient (resources acquired, persistent obstacles).
- Discussion of tests, notably the EDE-Q.
- Development of a personalized maintenance plan.
- Guidance towards the next steps:
 - Either towards a new 6-month cycle,
 - Or towards a lower-intensity maintenance cycle,
 - Or towards additional psychological or educational support if necessary.

Follow-up and coordination arrangements

Structured interdisciplinary follow-up:

- Coordination between the nutritionist doctor, the referring nurse, and the dietitian.
- Transmission of evaluation elements and session summaries via the EMNO information system.
- Multidisciplinary consultation meeting possible at mid-term for complex cases.

Traceability:

- Individual follow-up sheet, session notes, structured reassessment at 6 months.
- EMNO digital food diary with sharing functionalities between professionals.

Reassessment of scores:

- Systematic administration of the EDE-Q questionnaires at inclusion, at 3 months, and at 6 months.
- Scores are discussed with the patient to strengthen their self-regulation capacity.

Exit or progression criteria:

- Achievement of a stable level of eating behavior and a reduction in binge eating episodes.

Components

The EMNO DIET-MED-BED program is based on a structured combination of active components, validated in the literature on clinical nutrition and eating disorders (HAS 2010). These components are implemented by a specifically trained professional, in a sequence consistent with targeted therapeutic objectives.

Cognitive components

- Therapeutic food education focused on the mechanisms of hunger, satiety, and food pleasure.
- Deconstruction of dysfunctional beliefs (notions of "good"/"bad" foods, dichotomous view of the body or nutritional success).
- Identification and restructuring of thought automatisms related to food compulsion or post-meal guilt.

Behavioral components

- Digital food diary used as a self-observation tool, not for judgment.
- Restoration of functional eating regularity, independent of weight.
- Supervised role-playing or simulated scenarios to prepare for risky situations.
- Monitoring of progress through self-measurement (EDE-Q scores).

Bodily and sensory components

- Mindful eating: focusing on internal sensations of hunger/satiety/pleasure during meals.
- Work on eating rhythm and chewing tempo to prevent impulsive intake.
- Indirect bodily reconnection through verbalization and guided visualization (not exposed in this protocol to direct bodily confrontation).

Relational components

- Strong therapeutic alliance between patient and dietitian, based on the co-construction of the meaning of changes.
- Unconditionally caring attitude: weight neutrality, absence of judgment, support focused on the patient's skills.

- Implicit motivational mobilization according to the principles of motivational interviewing (reflective listening, affirming reformulation, support for change).

Systemic and organizational components

- Interdisciplinary EMNO coordination between doctor, nurse, and dietitian.
- Structured and secure framework: frequency, duration, and sequence of sessions known in advance.
- Use of standardized and traceable tools (session sheets, EMNO platform, reproducible psychometric tests).

Equipment

The EMNO DIET-MED-BED program utilizes a set of standardized educational, digital, and clinical materials, used routinely and accessible to all professionals trained within the EMNO network.

Materials for the professional

- EMNO Binge Eating Screening Sheet adapted from DSM-5 criteria to validate the indication.
- Standardized Dietary Summary Grid: used at each session to track the evolution of eating behaviors, associated emotions, and strategy adjustments.
- Internal technical sheets (risk situation management guide, reformulation templates, self-regulation tools).
- EMNO internal guide on non-purging eating disorders (printed or digital version).

Digital tools

- NUVEE: e-ETP system with obesity program
- MAELA - DOCTOLIB platform (professional and patient interface):
 - Filling out and monitoring the digital food diary.
 - Self-administration and archiving of EDE-Q scores and The Three-Factor Eating Questionnaire-R18 (TFEQ-R18).
 - Secure transmission of summaries between professionals.
- Secure digital patient space: availability of validated complementary psychoeducational content.

Materials to give to the patient

- Food diary (paper or digital) with legend, observation areas, non-prescriptive markers.
- Target emotion tracking sheets (emotion/behavior/strategy diagram).
- Simplified mindful eating tools ("sensory pause" sheet, chewing markers, hunger-satiety scale).
- Personalized maintenance plan to be developed in session 5.

Additional resources

- Simple language documents to explain binge eating (2024 version "Understanding and Soothing Your Eating").
- Possibility to use, if needed, the [NUVEE](#) platform on eating behavior disorders for patients (duration: 5 minutes, validated in therapeutic education).

Location

EMNO-labelled center or equivalent

Best implementation practices

The EMNO DIET-MED-BED program requires a precise procedural, ethical, and organizational framework to guarantee its effectiveness, safety, and reproducibility (Gauthier 2022; Poussier 2025). The following elements constitute the necessary conditions for implementation in accordance with EMNO standards and the principles of the NPI applied to the field of eating disorders.

Involved Professionals

- The intervention must be conducted by a qualified dietitian specifically trained in the management of eating disorders.
- Awareness of weight-related stigma and its counterproductive effects is essential.

Organization of the program

- The EMNO structure commits to adhering to the 6-month protocol sequence, including the initial medical-nursing session, the 5 dietary sessions, and the medical reassessment at 6 months.
- The systematic use of the EMNO digital record is mandatory to track the program, session reports, and psychometric tests.
- The schedule of sessions must be set as soon as the patient is enrolled and validated with them.

Interdisciplinary coordination

- The protocol relies on effective coordination among the three participants: doctor, referring nurse, and dietitian.
- Formal exchanges are expected at mid-program for patients with atypical or complex progress.

- A quarterly multidisciplinary meeting is recommended in EMNO centers to standardize practices and discuss sensitive cases.

Professional posture and therapeutic relationship

- The helping relationship is based on a non-stigmatizing attitude, focused on expressed needs, mobilizable skills, and the patient's values.
- The objectives should never be exclusively weight-based, but should aim for behavior changes, a reduction in compulsive intake, and an improvement in the relationship with food.
- Implementation must integrate the acceptance of relapses as a possible element of the change process, and not as a failure.

Quality monitoring and supervision

- Professionals should have access to a space for supervision or peer exchanges at least once a year.
- EMNO structures are encouraged to monitor impact indicators: retention rate, EDE-Q test completion rate, rate of continuation or progression of the care pathway.
- Any local adaptation of the protocol must be documented and discussed with the EMNO quality team to ensure overall coherence.

Best practices for sustainability

The sustainability of this NPI relies on its ability to integrate durably into the functioning of EMNO centers, to be appropriated by the teams, and to be adaptable without loss of quality or coherence. Several organizational, human, and methodological levers ensure stability, continuous quality, and skill development around this intervention.

Organizational Anchoring

- The intervention must be officially referenced within the EMNO intervention catalog.
- It is integrated into the center's quality system, with standardized planning, document archiving, and reporting procedures.
- A digital version of the procedure must be kept up to date in the shared document system.

Continuing education

- A continuing education plan for new professionals (dietitians, doctors, nurses) must be planned, with validation of acquired skills and accreditation criteria.
- Feedback from teams (quality committee, multidisciplinary meetings, supervision) must be systematically collected to improve content and adjust practices.
- Summary implementation sheets can be distributed internally to consolidate skills.

Stability and scalability of the model

- This NPI is designed to be applied in different EMNO structures (fixed centers, mobile units, hospital collaboration programs) provided the minimum implementation conditions are respected.
- A “light” version (3 sessions instead of 6) can be considered in certain clinical situations or logistical contexts, after medical validation and according to defined criteria.
- An enhanced version (8 sessions instead of 6) can be deployed in centers with a unit specialized in severe eating behavior disorders.

Traceability and monitoring of results

- Activity and impact data must be reported annually to the EMNO quality management.
- Anonymized results can be used for scientific or institutional dissemination (communication, publications, efficiency indicators).
- Quality audits can be organized at regular intervals (at least once every two years) to ensure compliance with the standard protocol.

Team engagement and shared culture

- A shared understanding of issues related to binge eating, beyond just the weight aspect, is an essential factor for sustainability.
- The EMNO culture values long-term support, individualized follow-up, and the acknowledgment of the suffering associated with eating behavior disorders.
- These principles must be regularly reiterated in team meetings and incorporated into the onboarding guides for new professionals.

Precautions

Dietary intervention for patients with binge eating disorder must be conducted within a rigorous and safe clinical framework. Certain individual situations or specific contextual characteristics may require adjustments, specific support, and increased vigilance in order not to worsen symptoms or cause unwanted side effects.

Unstable psychiatric comorbidities

- In cases of severe associated psychiatric disorders (major depression with inhibition, bipolar disorder in an acute phase, unstable psychosis), a psychiatric opinion is necessary before starting the protocol.
- Dietary follow-up should never replace psychotherapeutic or psychiatric care when it is indicated.
- Lack of adherence or rapid deterioration of the patient's relational functioning should lead to a temporary interruption of the intervention and a multidisciplinary

reassessment.

Mixed or atypical eating behavior disorders

- If the diagnosis of binge eating disorder is uncertain or if there are elements of a mixed presentation (alternating with bulimia nervosa, intermittent purging behaviors, atypical forms), inclusion in the protocol must be subject to consultation.
- The intervention is not suitable for patients with anorexia nervosa or with extreme weight control behaviors (vomiting, pathological physical hyperactivity, laxative compulsions).

Risk of reinforcing cognitive restriction

- Any normative or prescriptive dietary formulation (quantities, exclusions, injunctions) should be avoided, as it can reinforce cognitive restriction and pose a risk of binge eating rebound.
- The use of a food diary should be carried out in an exploratory, non-punitive manner. It is not a monitoring tool but a tool for understanding.

Traumatic episodes associated

- A history of abuse, mistreatment, or an unstable family environment can influence the relationship with food.
- In these situations, it is necessary to remain vigilant regarding withdrawal reactions, dissociative episodes, or retreat behaviors, and to offer a psychotherapeutic referral in cases of blockage or persistent psychological distress.

Misunderstanding of the intervention framework

- If the patient expects a diet prescription or rapid weight loss, it is necessary to explicitly restate the objectives and framework of the protocol.
- Preliminary work with the referring physician may be useful before starting the cycle with the dietitian.

Social or material vulnerabilities

- In cases of food insecurity, housing instability, or significant social disruptions, the intervention must be adjusted with partner social or medico-social services.
- The objective of food regularity or specific purchases should not worsen the economic situation or induce guilt-inducing pressure.

Regulatory specification

The EMNO DIET-MED-BED program falls within the framework of regulated practices in therapeutic nutrition, mental health prevention, and therapeutic education (HAS February 2024; HAS November 2024). It complies with the legal frameworks governing the

professions involved as well as the ethical and deontological principles in force.

Supervision of professional practice

- The intervention is delivered exclusively by a State-certified dietitian, whose practice is governed by Article L4371-1 of the Public Health Code.
- The professional acts under their own responsibility, in compliance with the ethics of their profession and EMNO internal procedures.
- The protocol provides for a complementary role of the prescribing nutritionist physician and the coordinating nurse, each within the defined scope of their regulatory competencies.

Status of the Intervention

- This intervention is an NPI, structured, codified, and reproducible, meeting the criteria defined by the Haute Autorité de Santé (2011) and the NPIS Registry.
- It does not constitute a standardized dietary prescription act, but a personalized therapeutic support protocol targeted at an identified behavioral disorder, binge eating.
- The intervention does not replace a medical diagnosis nor specialized psychotherapeutic care if such care is required.

Data protection and patient record

- All exchanges, reports, and follow-ups are conducted via the secure information system EMNO, compliant with the GDPR (EU Regulation 2016/679).
- The collection and analysis of questionnaires are carried out with the patient's informed consent.
- In case of participation in analysis or research work, the data is anonymized in accordance with internal procedures approved by EMNO's governance committee.

Link with institutional arrangements

- The intervention can be part of a patient therapeutic education program, declared to the Regional Health Agency and coordinated by EMNO, if the patient is included in this program (https://www.sante.fr/etp-obesite-surpoids-emno-dijon-valmy-espace-medical-nutrition-et-obesite#q=recherche/trouver/cartographie_ETP/Dijon%2C%20C%3%B4te-d%27Or).
- The protocol is compatible with the directions of Article 51 pathways, or city-hospital coordination experiments around obesity and eating disorders, subject to contractual adaptation and attachment to accredited structures (EMNO, GPSO, TIMEO, PACO specifications).

Main Initiator

Qualification required

- Registered dietitian trained in eating disorders and at the NPI
- Registered nurse trained in eating disorders and at the NPI
- Registered physician trained in eating disorders and at the NPI

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Author(s) of the Sheet

Creation Date : **23/04/2026**

Revision Date : **27/04/2026**

Version : **V01**

EMNO DIET-MED-BED nutritional program for adults with obesity presenting binge eating, NPIS reference document for INM, Code sheet NPIS-000000116, Version V01, 2026.

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Contact the NPIS

5, rue des Reculettes, 75013 Paris - France

Phone: +33 (0)1 56 79 17 91

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