Title	Author
Psychological disorder, symptom severity and weight loss in inpatient adolescent obesity treatment	Van Vlierberghe, L., Braet, C., Goossens, L., Rosseel, Y., & Mels, S.
Lifestyle interventions for youth who are overweight: A meta-analytic review	Kitzmann, K. M., Dalton, W., Stanley, C. M., Beech, B. M., Reeves, T. P., Buscemi, J., & … Midgett, E. L.
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The Effect of Reinforcement or Stimulus Control to Reduce Sedentary Behavior in the Treatment of Pediatric Obesity.	Epstein, L. H., Paluch, R. A., Kilanowski, C. K., & Raynor H. A.
Family-based interventions for pediatric obesity: Methodological and conceptual challenges for family psychology	Kitzmann, K. M., & Beech, B. M.
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Growth Rate Reduction during energy restriction in obese adolescents.	Amador, M., Ramonths, L.T., Morono, M., & Hermelo, M.P.
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Effects of mastery criteria and contingent reinforcement for family-based child weight control.	Epstein, L. H., McKenzie, S.J., Valoski, A., Klein, K.R., & Wing, R.R.

Effects of decreasing sedentary behavior and increasing activity on weight change in obese children.	Epstein, L.H., Valsoki, A., Vara, L., McCurley, J., Wisniewski, L., Kalarchian, M.A.,Klein, K.R., & Shrager, L.R.
Child and parent weight loss in family-based behavior modification programs.	Epstein, L.H., Wing, R.R., Koeske, R., Andrasik, F., & Ossip, D.J.
A comparison of life-style change and programmed aerobic exercise on weight and fitness changes in obese children.	Epstein, L.H., Wing, R.R., Koeske, Ossip, D.J., & Beck, S.
Effects of diet plus exercise on weight change in parents and children.	Epstein, L.H., Wing, R.R., Koeske, R., & Vasloski, A.

A comparison of life-style exercise, aerobic exercise, and calistehenics on weight loss in obese children.	Epstein, L.H., Wing, R.R., Koeske, R., & Valoski, A.
Effects of parent weight on weight loss in obese children.	Epstein, L.H., Wing, R.R., Koeske, R., & Valoski, A.
The effect of diet and controlled exercise on weight loss in obese children.	Epstein, L.H., Wing, R.R., Penner, B.C., & Kress, M.J.
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Stability of food preferences during weight control: A study with 8- to 12 - year olf children and their parents	Epstein, L.H., Wing, R.R., Valoski, A., & Gooding, W.
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An evaluation of enhanced self-regulation training in the treatment of childhood obesity.	Israel, A.C., Guile, C.A., Baker, J.E., & Silverman, W.K.
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Comparison of two hypocaloric diets in ovese children.	Figueroa-Colon, R. von Almen, T.K., Franklin, F.A., Schuftan, C., & Suskind, R.M.
Obesity management via diet and exercise intervention	Hills, A.P., & Parker, A.W.

Year	Journal	Volume	Page No.	DOI
2009	International Journal of Pediactric Obesity	4	36-44	10.1080/17477160802220533
2010	Health Psychology	29	91-101	10.1037/a0017437
2002	Book		532-555	

2004	Health Psychology	23	371-380	10.1037/0278-6133.23.4.371
2011	Couple And Family Psychology: Research And Practice	1	42-62	10.1037/2160-4096.1.S.45
2009	Families, Systems, and Health	27	116-124	10.1037/a0014912
2011	Journal of Health Psychology	16	997-1015	10.1177/1359105310397626
1999	Journal of Pediatric Psychology	24	223-248	
2011	Journal of Research on Adolescence	21	129-152	10.1111/j.153-7795.2010.00719.x

1990	Experimental and Clinical Endocrinology	96	73-82
1975	Journal of Applied Behavioral Analysis	8	269-278
1965	Acta Paediatrica Scandinaciva	54	566-572
1993	Journal of Child Psychology and Psyhiatry	34	1043-1050
1994	Addictive Bheaviors	19	135-145

1995 Health Psychology 14 109-115

1981 Journal of Consulting and Clinical Psychology 49 674-685

1982 Behavior Therapy 13 651-665

1984 Journal of Consulting and Clinical Psychology 52 429-437

1985	Behavior Therapy		16	345-356
1986	Journal of Consulting and Clinical Psychology		54	400-401
1985	Journal of Pediatrics		107	358-361
1980	Journal of Pediatric Psychology		5	25-36

1987	Behavioral Modification	11	87-101
1985	Behavioral Therapy	16	205-212
1984	Behavioral Therapy	15	101-108
1994	Journal of Pediatric Psychology	19	737-749
1983	Pediatrics	71	515-525

1993	American Journal of Diseases in Children.	147	160-166
1988	Child Care, Health and Devleopment	14	409-416

Population	Method	Analysis
*Adolescence (14-19 yrs) *Possesing psychological symptoms or disorders *66 Participants	Empirical Study; Quantiative Study	* t -tests conducted for YSR and EDE-Q subscales *R - software for statistical computing of graphics was used to account for missing data *3 Regression analysis run (1 month, 4 months, end of treatment)
*Overweight (~20%) *6- 18 years old	Empirical Study; Meta Analysis; Quantiative Study	*Effect Size Analysis Software *SPSS
*Obese Children (5-17 yrs)	Empirical Study	*Between-groups comparisons of previously collected data

*Obese 8-12 year old children *child in 85th BMI percentile	Empirical Study; Quantitative Study	*Graphs and charts of data comparing pre and post treatment outcomes for both groups *Graphs of changes of BMI overtime
*Overweight children from 1-18 years of age	Meta Analysis	Data Based Comparisons
*56 overweight girls (10-18 years)	Qualitative Study	*Data comparison
*obese adolescents (age 5-16 years) *pediatric obesity (12 years and younger)		*evaluated studies psychological interventions combined with dietary and physical activity components *compare studies
*obese children (2-18 years)		*between-study comparison

*Overweight children (0-13 years)	Experimental Design	*weekly sessions
*15 girls *Ages 5-10 *overweiht *no medical, psychological, or psychiatric treatment and not in another weight control program	*Experimental Design *Randomized group *2 week baseline	*12 weekly sessions *Parent only sessions *info about exercise, calisthenics, nutrition, and stimulus control *explained response cost and reinforcement, reponse cost, and waitlist control
*43 participants *ages 8-9 years *overweight child	*Experimental Design *Randomized group	*physical activity 2 times a week for 4 months *no treatment control
* 21 participants *Average percent overweogjt 48.36% *Age 7-13 years	*Experimental Design *Randomized group	*8 weekly, 90-minute group sessions
* 44 participants *74% female, 26% male *Age 8-12 years	*Experimental Design *Randomized group	*26 weekly meetings followed by 6 monthly meetings

* 61 subjects *Age 8-12 years	*Experimental Design *Randomized group	*weekly session for 4 months then 2 month meetings
* 44 participants *74% female, 26% male *Age 8-12 years	*Experimental Design *Randomized group	*14 sessions (8 weekly sessions followed by 6 monthly sessions)
* 51 participants *children 20-80% overweight *Age 8-12 years *no existing psychological/psychiatric condition	*Experimental Design *Randomized group	*8 weekly sessions then 5 maintenance sessions over 4 months
* 53 participants *children 20-80% overweight *Age 8-12 years *no existing psychological/psychiatric condition *no contra-indications for exercise	*Experimental Design *Randomized group	* 8 weekly sessions then 7 sessions over 20 weeks

* 44 participants *children > 20 overweight *Age 8-12 years	*Experimental Design *Randomized group	* 8 weekly sesssions, then 10 monthly sessions
* 41 participants *children 20-80% overweight *Age 8-12 years *children not receiving psychological/psychiatric treatment	*Experimental Design *Randomized group *crossed with parent overweight status	*8 weekly sessions, then 10 monthly meetings
* 23 participants *children 20-80% overweight *Age 8-12 years *no contra-indications for exercise	*Experimental Design *Randomized group after stratification on age, percent overweight, and physical work capacity	*8 weekly sessions then 10 monthly maintenance sessions
* 13 participants *children > 20% overweight *Age 6-12 years *child not receiving medical, psychological/psychiatric treatment	*Experimental Design *Randomized group after stratification by percentage overweight and age	*7 weekly groups, then 3 monthly group sessions

* 41 participants *children 20% -80 % overweight *Age 8-12 years *child not receiving medical, psychological/psychiatric treatment	*Experimental Design *Randomized groups crossed with parent overweight status (yes/no)	*8 weekly sessions, then 10 monthly sessions
* 19 participants *children 20% -80 % overweight *Age 5-8 years *obese girls reffered by school nurse or physician	*Experimental Design *Randomized group	*5 week camp, then 9 monthly maintenance sessions
* 19 participants *children 20% -80 % overweight *Age 5-8 years	*Experimental Design *Randomized group	*5 weeks of 2 days/weel of camp
* 20 participants *children > 20% overweight *Age 8 years, 11 months - 13 years, 0 months	*Experimental Design *Randomized group	*8 90-minute group sessions, then 9 biweekly sessions
* 38 participants *average percent overweight = 55.7% *Age 12-16 years	*Experimental Design *Randomized group	* 45 to 60 minute group sessions for 1 year (16 weekly sessions, then 1 session every 2 months

* 19 participants *average percent overweight = 80.4 % *Age 7.5 - 16.9 years	*Experimental Design *Randomized group	*ten outpatient sessions, followed by monthly sessions for 1 year
* 20 participants *child above 95th percentile for percent overweight *average BMI > 25 *Age: prepubertal	*Experimental Design *Randomized group	*food recording *dietitian consult

Measures	Results
*Eating Disorder Examination *Structured Clinical Interview for DSM -IV *Youth Self-Report *BMI *Percent Overweight	*Severly overweight children are sucessful in loosing weight *After 4 months, boys had lost more weight than girls *psychopathology not found to significantly predict weight loss *those with eating disorders decreased binge eating episodes *~50% of adolescents entering treatment with at least one psychological disorder kept atleast one psychiatric diagnosis at the end of the program *Girls and severley obese adolescents require long-term care
*Between-groups differences in weight-related outcomes *Between-groups differences in health related behaviors at end of treatment *BMI *Percent Overweight	*Interventions for overweight adolescents are effective under a wide range of conditions *Improved eating habits *Parents showed better weight management themselves *key component - parent involvement in program *weight management bettered
*Percent Overweight *Different treatment outcomes *BMI	*Most successful programs include multidisciplinary design with diet, exercise, and application of behavior modification principles *exercise interventions alone do not have impact on weight change *exercise combined with diet enhances weight loss and improves long-term maintenance *less structured, more flexible lifestyle exercise may be more effective than higher intensity aerobic exercise *Reduce sedentary activity with use of structured eating plan *Including parents in family-based behavioral intervention strengthens short and long-term weight loss *Percent overweight decreases as duration of treatment increases

*Daily food intake recorded *Habits book - recorded target sedentary behavior times *BMI calculated and compared to CDC growth charts * Weight and Height *METs calculated daily	*Decrease in percent overweight *Decrease in sedentary behavior/ intake of high density foods *Increase in servings of fruits and vegetables *Increase in percent of time above 3 METs *Increase in moderate to vigorous physical activity
*Content of intervention *Weight/Height *BMI *Nutrion Measurment in logs *Exervise Logs *Therapy sessions	*Most programs include parents in behavioral or cognitive-behavioral approaches to behavior management in order to change childs eating habits *Some research states that the more a parent is envolved doesn't always mean the outcome will be better *Family-based research can be more effective if aspects such as variability in parent and family function is taken into account
*Percent Overweight *Exercise *BMI *Eating Habits	*~6% weightloss of initial body weight for 6 weeks of attendance *changes in obesity-related comorbidities (hypertension, insulin resistance, sleep apnea)
*Change of weight and BMI *Percentage overweight *dietary intake *physical activity *fitness *screen time (tv/computer, etc.) *compared weight loss interventions of several studies.	*firm conclusions about the effectiveness of psychological interventions for childhood obesity can not be made *interventions aimed atreducing sedentary activities/increasing physical activity level effective *multi-component family-based behavioral interventions are effective *well-established treatments for intervening with pediatric obesity in children between the ages of 8 to 12 years
*current definitions of childhoos and adolescent overweight and obesity *demography od obesity in U.S. *psyhcosocial correlations of childhood and adolecent obesity	*several studies were found the reduced BMI with pharmaceutical, physical activity, reduce sedentary, and lifestyle interventions.

*weekly sessions *calroie intake log *BMI measurement	*Males lost 3.2 kg after 4 weeks of treatment *Females lost 2.9 kg after 4 weeks of treatment *males lost 7.6 kg after 6 months *females lost 8.1 kg
*Change of weight and BMI *Percentage overweight *dietary intake	*response cost and reinforcement group lost 11.3 lbs *response cost group lost 9.5 lbs *waitlist control gained 0.9 lbs *patients still lost weight eight weeks from post-treatment
*Physical activity level *weight loss *BMI	*Gained 0.8 kg *no follow up
*stimulus crontrol *monitoring food & activity *goal setting and postivie reinforcement *relaxation training *cognitive restructuring *problem solving *selving-reinforcement	*Group 1 demonstrated a 0.9% decrease in percent over weight *Group 2 demonstrated a 7.8% decrease in percent over weight *Significant decrease in percentage of overweight individuals in both groups
*traffic light diet *lifestlye exercise *parents trained in behavior management * parents and children seen in separate groups	*6 months from pre-treatment group 1 demonstrated 30.1% decrease in percent overweight *6 months from pre-treatment group 2 demonstrated 20% decrease in percent overweight *Twelve months from pre-treatment Group 1 demonstrated a 26.5% decrease in percent overweight * Twelve months from pre-treatment Group 2 demonstrated a 16.7% decrease in percent overweight

	*4 months from pre-months for group 1 there was approxiately a 21% decrease in overweight *4 months from pre-months for group 2 there was approxiately a 13% decrease in overweight
*traffic light diet *behavioral contracting *reinforce decreased sedentary activity * reinforced increased physcial activity combined with behavioral contrast and decreased sedentary activity	*4 months from pre-months for group 3 there was approxiately a % decrease in overweight * 12 months from pre-months for group 1 there was approxiately a 19% decrease in overweight * 12 months from pre-months for group 2 there was approxiately a 8% decrease in overweight * 12 months from pre-months for group 3 there was approxiately a 11% decrease in overweight
*traffic light diet *aerobic exercise plan *behavioral modification *parent and child targeted weight loss *psychiatric treatment *parent participation	*significant decrease inpercentage of obesity for all groups (1,2,3) *41 % of children were less than 20% overweight
*traffic light diet *behavior contracting *behavioral modification *parent and child seen in different groups * diet and lifestyle exercise (group 1) *diet and programmed exercise (group 2) *lifestyle exercise (group 3) *programmed exercise (group 4)	*at the end of maintenance group 1 was -19% overweight *at the end of maintenance group 2 was -10% overweight *at the end of maintenance group 3 was 13-% overweight *at the end of maintenance group 4 was -14% overweight
*traffic light diet *token economy *parent and child seen in different groups * diet and lifestyle exercise (group 2) *diet (group 1) *waitlist control (group 3)	*group 1 demonstrated approximately -15% overweight *group 2 demonstrated approximately -16% overweight *group 3 demonstrated approximately + 2% overweight

	*2 months from pre-treatment group 1 was -11% overweight
*self monitoring	*2 months from pre-treatment group 2 was -13% overweight
*traffic light diet	*2 months from pre-treatment group 3 was -11% overweight
*modeling	* 6 months from pre-treatment group 1 was -17% overweight
* parent behavioral management	*6 months from pre-treatment group 2 was -20% overweight
*behavioral contracting	*6 months from pre-treatment group 3 was -16% overweight
*diet and programmed aerobic exercise (group 1)	
*diet and lifestyle exercise (group 2)	
*diet and calisthenics exercise (group 3)	
*traffic light diet	
*lifestyle exercise program	
*parent and child seen in different groups	
* parent control training, parent overweight (group 1)	
*child self-control training, parent overweight (group 2)	
*parent control training, parent not overweight (group 3)	* no differential effect of parent vs. child control
*child self-control training, parent not overweight (group 4)	*groups 1 & 2 demonstrated -7.7% overweight
	*groups 3 & 4 demonstrated -16.3% overweight
	* 3+4 > 1+2
	*2 months from pre-treatment group 1 was -17% overweight
*traffic light diet	* 2 months from pre-treatment group 2 was -12% overweight
*behavioral management	*6 months from pre-treatment group 1 was -28% overweight
*parent and child seen in different groups	* 6 months from pre-treatment group 1 was -19% overweight
* diet and aerobic exercise (group 1)	
* diet alone (group 2)	
*traffic light deit	
*exercise instruction and calisthenics or walking in sessions	
*self monitoring, stimulus control, behavioral contracting, therapst phone contact (group 1)	* percent overweight group 1 -9.7%
*nutrition and exercise education only	*percent overweight group 2 -4.7%

*traffic light deit * parents and children seen in separate groups *behavioral modifications * parent control training, with parent overweight (group 1) *child self-control training, with parent overweight (group 2) *parent control training, with parent not overweight (group 3) * child self-control training, with parent not overweight (group 4)	* no differential effecr of parent vs. child control * group 1 & group 2 approximately - 8% overweight *group 2 & group 3 approximately - 18% overweight * 3 + 4 > 1+ 2
*traffic light diet *parents seen in separate groups * behavioral management and diet and exercise program (group 1) *diet and exercise program (group 2)	* 4 months from pre-treatment group 1 showed -20% overweight * 4 months from pre-treatment group 2 showed -13% overweight
*traffic light diet *nutritional education * experimental:baseline, treatment, reversal, treatment, reversal (group 1) *control: baseline; treatment = random reinforcement of physical activity; reversal = reinforcement of sharing (group 2)	* Pre-post change: -4.9 lbs across groups * 1 = 2
* parent and child seen in separate groups * monitoring, cue control, rewarding weight control behaviors, parent emphasis (group 1) *same as (1) except child-control emphasis; child self management training (group 2)	* group 1 demonstrated -12.5% *group 2 demonstrated -15.6% *significant decrease from pre-treatment in both groups 1=2
*adolescent in treatment alone (group 1) *adolescent and mother attended together (group 2) * adolescent and mother attended separately (group 3)	*group 1 shows -6.8% overweight *group 2 shows -7.0% overweight *group 3 shows -17.1% overweight

*protein-sparing modified fast (group 1) *hypocaloric diet (group 2)	*ten weeks from pre-treatment group 1 showed -29.5% overweight *ten weeks from pre-treatment group 2 showed -13.8% overweight
*sixteen weekly, 50-minute exercise sessions (reinforcement and monitoring of home exercise; prescription of 20 minutes of exercise 3-4 X per week) (group 1) *no exercise (group 2)	*group 1 showed -5.5 kg *group 2 showed +2.6 kg *No significant change in either group

Summary

*Girls and severly obese require long-term care due to discouragment halfway through treatment.
*Psychopathology not linked with predicting weight loss

*Parents role in treatment is extremely important for adolescent

*Combining nutrition, exercise, and application of behavior modification produces most successful outcomes
*Parents must be included in intervention process
* Exercise must be combined with diet to lead to weight loss

*Boys twice as likely to substitute physical activity than girls
*Effects of study enhanced when participants engage in physical activity to keep busy from sedentary behaviors

*Parents do need to be envolved in intervention to some degree
*Variability in parent and family function must be taken in consideration for each individual case

*Well structured diet, exercise and group therapy are sucessful when compined

*family-based, multi-component behavioral interventions are effective

*still needs more research