Evidence Table E3. Loss of control of eating: Children – Part 3

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| First Author's Last NameYear | Co-Interventions | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
| Boutelle, 20111 | Weekly treatment for 8 weeks, in separate but simultaneous parent and child groups of 8-10 members for approximately 45 minutes, and both parents and children were given study-specific workbooks and handouts. Content was similar for children and parents except that child materials were presented in the form of games and discussion in an age-appropriate manner. Following the separate groups, parents and children participated in an experiential exercise for an additional 30 minutes at each session. Both treatment taught the same coping skills (behavioral and cognitive), parenting skills (use of praise, motivation systems, daily meetings, self-monitoring, modeling, shaping behaviors, logical consequences). If a family missed a meeting, they were  | Volcravo: Used cue exposure treatment in session to reduce the strength of the association between the subjective and physiological experiences ("cravings") when exposed to food cues. Children were provided a toolbox of coping skills to "ride the craving wave." Participants were provided information about basic learning theory and how physiological responses to food cues can be broken. Sessions focused on recognizing cravings, identifying antecedents of cravings, and learning strategies to ride out craving waves until urges diminished. Children were asked to ride out cravings only when they were not physically hungry. Parents and children self-monitored their cravings outside of sessions.Experiential exercises were conducted in group format, and parent-child dyads were used to implement cue exposure treatment. Session 1: parents and children identified 7 high-craving foods for the parent and child. Sessions 2-8: parents and children brought a high-craving food and completed a cue exposure treatment exercise, in which they rated their cravings on  | CAAT (Children's appetite awareness training): Focused on hunger and used hunger monitoring to increase sensitivity to hunger and satiety as well as coping skills to manage the urge to eat when not hungry. Adapted from Craighead&Allen 1995, which was designed for adults. Goal is to increase child's perceptions of internal states of hunger and satiety to guide amounts of food consumption. ALl sessions focused on improving awareness of hunger and satiety and learning how to monitor these cutes (using a 1-5 scale to rate hunger). Parents and children also learned about potential overeating situations in which they might not listen to their body's hunger signals and different coping skills to manage these situations. Parents and children self-monitored their hunger outside of class. | NA | NA | NA |

Evidence Table E3. Loss of control of eating: Children – Part 3 (continued)

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| First Author's Last NameYear | Co-Interventions | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
| Boutelle, 20111(continued) | called and mailed the missed materials. All groups were led by doctoral-level psychologists and assisted by master's-level cotherapists and several undergraduate volunteers. All therapists attended a 1-day training regarding the treatments and attended weekly supervision with the first author. | a 1-5 scale while looking at the food, holding, smelling, and taking 2 bites, and then rated their cravings at 30s-intervals for 15 minutes. After cravings were reduced to a 2 or lower, families disposed of the food without eating it. | Experiential exercises were conducted in a group format and used parent-child dyads to practice monitoring hunger during meals. During sessions 2-8, parents and children brought dinner and monitored hunger during this meal with prompts from the staff. Hunger was monitored at the start, middle, and end of the meal by parents and children. In addition, participants were prompted to monitor hunger levels 10- and 20-minutes post-completion of the meal. |  |  |  |

Evidence Table 3. Loss of control of eating: Kids – Part 3 (continued)

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| First Author's Last NameYear | Co-Interventions | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
| Jones, 20082 | NA | Student Bodies 2, 16 week online healthy weight maintanence program intervention that incorporates cognitive-behavioral principles from the self-help manual for binge eating disorder by Fairburn, the adolescent weight loss intervention, Healthy Habits, described by Saelens et al, and hunger and satiety awareness skills; combines psychoeducation and behavioralinterventions such as self-monitoring, goal-setting, stimulus control, and appetite awareness and introducesemotion regulation skills. New topic introducted each week, previous week's content could be accessed any time. | Waitlist Control (WLC); WLC participants were informed at the start of the studythat they would be offered the program at the 9-monthfollow-up assessment, in either online or printed format | NA | NA | NA |

Evidence Table 3. Loss of control of eating: Kids – Part 3 (continued)

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| First Author's Last NameYear | Co-Interventions | Group 1 | Group 2 | Group 3 | Group 4 | Group 5 |
| Tanofsky-Kraff, 20103 | NR | Group IPT-WG (IPT for the prevention of excessive weight gain) based on IPT-Adolescent Skills Training (IPT-AST) and IPT for BED treatment; 12 weekly sessions of 75-90 minutes plus one 90-minute individual pregroup meeting to introduce group format and participation | "Attention-only" comparison: group didactic health education (HE) class based on "Hey-Durham" health program for high school students and covering topics like alcohol, drug, and tobacco use avoidance, identifying signs of depression and suicide, nonviolent conflict resolution, sun safety, domestic violence, and very basic advice about nutritional, body image, and exercise; 12 weekly sessions of unspecified length | NA | NA | NA |
| Tanofsky-Kraff, 20144 | none | Interpersonal Psychotherapy Prevention Program:Adapted from IPT-Adolescent Skills Training for the prevention of depression (Young 2006) and group IPT for BED (Wilfley 2000)Individual 1.5h meeting followed by 12 consecutive weekly 90m group sessions. Each group was cofacilitated by a PhD-level clinical psychologist and a graduate student in clinical psychology. | Health Education Program:Based on the HEY-Durham manual for high school students (Bravender 2005)Individual 1.5h meeting followed by 12 consecutive weekly 90m group sessions. Each group was cofacilitated by a PhD-level clinical psychologist and a graduate student in clinical psychology. |  |  |  |