**Universal Library of Medical and Health Sciences** **Research Article**

**ISSN: 3064-6545 | Volume 4, Issue 2**

**Open Access | PP: 11-16**

**DOI: https://doi.org/10.70315/uloap.ulmhs.2026.0402002**

# Nutritional Minimalism as an Efficiency Model for Sustainable Weight Regulation in Adults with Time Constraints

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## Abstract

*The pace of contemporary urban and professional life leaves most working adults with very little time for planning and preparing meals. This is more than a бытовая inconvenience: chronic time scarcity systematically reshapes eating behavior. People tend to eat what is available, when it is available, and at a speed that leaves little room for reflection or choice. The consequences are well known and widely documented, including excess body weight, metabolic disturbances, and increased cardiovascular risk.*

*This article examines the concept of nutritional minimalism, an approach that combines time-restricted eating (TRE), the strategic reduction of food variety to a nutritionally dense core, and the deliberate rejection of dietary excess. The aim of the study was to systematize existing evidence on the effectiveness of intermittent fasting protocols and to assess their feasibility for individuals who lack the resources for complex dietary planning.*

*The evidence reviewed here comes from randomized trials, systematic reviews, and meta-analyses published between 2018 and 2022. An 8-hour eating window and early TRE both produced meaningful weight loss without asking participants to count a single calorie. Alternate-day fasting worked just as well on the scales but fewer people stuck with it. Layering active calorie restriction on top of TRE did not move the needle much on body weight, though it did nudge some metabolic markers in the right direction.*

*Pick a window. Eat in it. Do that again tomorrow. That is the version of this that survives a busy life - not because it is elegant, but because it does not collapse the first time something goes wrong with the schedule. The research on TRE was not designed with consistency in mind as a variable, but consistency is what separates someone who loses seven kilograms over a year from someone who loses three in the first month and gains them back by summer. A protocol followed imperfectly for six months outperforms a perfect one followed for two weeks. That gap does not show up in trial data. It shows up on the scale.*

**Keywords:** *Nutritional Minimalism, Time-Restricted Eating, Intermittent Fasting, Weight Management, Time Scarcity, Cardiometabolic Health, Calorie Restriction, Treatment Adherence.*

## INTRODUCTION

Dietary behaviour in working adults is determined less by nutritional literacy than by the structure of the day. When the workday ends late, the commute is long, and domestic responsibilities begin immediately upon arrival home, food choices are made not from knowledge but from whatever requires the least time and effort. The information deficit is not the operative problem here - most adults with excess body weight are broadly aware of what constitutes a healthy diet. What they lack is a workable system that does not disintegrate under the ordinary pressures of a full schedule.

Current dietary guidelines do not adequately account for this reality. Recommendations involving five structured meals, macronutrient tracking, and weekly menu planning assume a degree of temporal and cognitive availability that is inconsistent with the daily conditions of most working adults. When these recommendations fail in practice, the failure is routinely attributed to poor motivation or insufficient self-regulation - an interpretation that locates the problem in the individual rather than in the mismatch between the intervention and the context in which it is supposed to operate.

The scale of the resulting public health problem is well documented. WHO data indicate that over one billion adults worldwide currently live with obesity, a figure that has continued to rise despite sustained investment in dietary education and public health messaging. The persistence

**Citation:** Tetiana Postoroniuk, "Nutritional Minimalism as an Efficiency Model for Sustainable Weight Regulation in Adults with Time Constraints", Universal Library of Medical and Health Sciences, 2026; 4(2): 11-16. DOI: https://doi.org/10.70315/uloap.ulmhs.2026.0402002.

of this trend across decades and across diverse healthcare systems suggests that the dominant intervention model is structurally inadequate - that the problem lies not in the volume of advice delivered but in its practical compatibility with how people actually live.

Nutritional minimalism starts from a different place. Not: what is the optimal diet? But: what is the minimum viable structure that actually holds up on a Wednesday when everything goes sideways? The answer it lands on is not a meal plan or a macronutrient formula. It is a handful of decisions made once - when to eat, which foods to keep around, how much variety is actually necessary versus merely pleasant - so that the same decisions do not have to be made again at 7pm under pressure. Conventional nutrition science treats dietary variety as a virtue. Behaviorally, it is also a source of daily decision fatigue, and decision fatigue is where diets go to die. Predictability is underrated.

The theoretical foundation of this approach lies in the expanding body of evidence on intermittent fasting, particularly time-restricted eating (TRE) in its various protocols. In their seminal review in The New England Journal of Medicine, de Cabo and Mattson described the biological mechanisms through which eating within a defined time window influences metabolism, reduces fat mass, and affects markers of systemic inflammation [4, p. 2542]. Since then, a substantial number of randomized studies with different designs have accumulated, allowing this approach to be viewed not merely as a hypothesis but as a reasonably well-supported practical model with its own indications, limitations, and areas of application.

At the same time, an important question remains, one that is rarely addressed directly in clinical literature: which intermittent fasting protocol is realistic for a person facing chronic time scarcity, unstable schedules, and minimal planning resources? The answer is not straightforward, because effectiveness and feasibility are different dimensions. A study demonstrating excellent metabolic outcomes under a strict protocol in controlled conditions does not necessarily indicate what should be done by someone who has a business dinner at 9 p.m. on Monday and a child's birthday celebration with cake at 6 p.m. on Friday.

This review pulls together what the controlled trials actually show about TRE and related approaches, reads that evidence against what busy adults can realistically do, and tries to say something useful about where the two overlap. It is not a clinical protocol. It is an attempt to translate a research literature into something that makes sense outside a laboratory.

## METHODS

The literature search ran through PubMed and the Cochrane Library. Search terms covered the intervention variants - time-restricted eating, time-restricted feeding, intermittent fasting, alternate-day fasting - and the outcomes that matter: weight loss, cardiometabolic risk, caloric restriction, adherence. The cut-off dates were 2018 and 2022. Not because nothing useful existed before 2018, but because that earlier period was mostly small pilots testing whether the idea was worth pursuing at all. By 2018 the field had moved to properly sized randomized trials with long enough follow-up to say something beyond "this might work." What came after 2022 is a separate question for a later review.

What counted as eligible: randomized controlled trials running at least eight weeks, plus systematic reviews and meta-analyses, all in adults - 18 and older - with a starting BMI of 25 or above. Animal studies did not make the cut, nor did research in children or in people managing active cancer, type 1 diabetes, or renal failure, where the physiology and the clinical stakes are different enough to make comparison meaningless. Studies that did not provide a full text or left too many methodological blanks were also set aside - there is no useful way to evaluate a result you cannot fully trace.

Twelve publications made it through. For each one, the same variables got recorded: what the protocol actually was and how long it ran, who the participants were, what happened to their weight, BMI, and waist circumference, and what the secondary numbers looked like - fasting glucose, HbA1c, lipids, blood pressure, inflammatory markers. Dropout rates and adherence data went in too, because a trial where half the participants quit by week six tells a different story than one where they stayed. No formal meta-analysis - the protocols are too different from each other, the follow-up periods too varied, the measurement approaches too inconsistent to collapse into a single effect size without producing something misleading. The goal was not a number. It was a pattern: under what conditions does a given approach actually work, and for whom does it hold up over time.

The practical feasibility of each protocol under conditions of chronic time scarcity was assessed separately, based on adherence rates, dropout frequency, and participant-reported evaluations where available. Although this dimension is not typically central in clinical reviews of dietary interventions, it is fundamental to the objectives of the present study.

## RESULTS

Among the various TRE protocols, the 8-hour eating window has accumulated the most substantial evidence base and, notably, the highest rates of real-world feasibility. The schedule requires no dietary restructuring: food is consumed between noon and 20:00, and nothing caloric is taken outside that window. For adults whose mornings offer no realistic opportunity for a prepared meal, this structure imposes no additional burden - it formalises what is already happening by default.

Gabel et al. examined this protocol in a 12-week pilot study involving adults with obesity who received no instructions regarding diet composition or caloric targets [7, p. 348]. Mean weight loss reached 2.6% of initial body weight. Participants reduced daily energy intake by approximately 350 kcal relative to baseline - not through conscious restriction, but as

a direct consequence of having fewer hours available to eat. The finding is mechanistically significant: the weight loss was not produced by dietary substitution or caloric calculation, but by a structural constraint on eating opportunity. That distinction matters for anyone designing an intervention around time scarcity rather than dietary knowledge.

A subsequent study by the same research group confirmed the safety of the protocol and documented additional metabolic effects, including reductions in systolic blood pressure and serum triglyceride levels [6, pp. 107–108]. Importantly, no adverse changes in lean body mass, bone density, or nutritional status were observed - issues frequently raised in clinical discussions of fasting. For an adult who simply delays breakfast by several hours and avoids eating after eight in the evening, these findings indicate tangible metabolic benefits without substantive dietary restriction as such.

There is a more aggressive variant of TRE that deserves separate attention: shifting the entire eating window to the morning. Jamshed et al. tested exactly this in a 2022 trial - 90 adults with obesity, 14 weeks, eating window from 7:00 to 15:00 [8, pp. 955–958]. Both groups ate the same number of calories. The eTRE group still lost more weight, more fat, and came out with better insulin sensitivity and lower blood pressure than the control. Same food, same amount - different clock. That is not a small finding. It means the body is not simply a calorie-counting machine, and that when you eat matters in ways that do not reduce to how much.

The mechanism underlying this effect is linked to circadian biology. Metabolic activity in organs and tissues is not constant throughout the day: the pancreas secretes insulin more effectively in response to food in the morning than in the evening; the thermic effect of food - the energy expended on digestion - is higher earlier in the day; and adipose tissue is more responsive to lipolysis during the overnight fasting period. Evening eating is metabolically disadvantageous for reasons that are independent of caloric quantity. Pancreatic insulin secretion in response to glucose is attenuated in the late hours; diet-induced thermogenesis is lower; adipose tissue lipolysis is suppressed. The same meal consumed at 13:00 and at 21:00 generates a different metabolic response, and the evening version is the less efficient one by several measurable parameters. Circadian misalignment in eating timing has been associated with impaired glycaemic control and greater fat accumulation independent of total energy intake - a finding that reframes late eating not as a behavioural problem but as a physiological one.

The adherence ceiling of eTRE is, however, determined largely by social structure rather than individual motivation. An eating window closing at 15:00 is incompatible with the majority of shared evening meals, professional social obligations, and family routines that are organised around dinner. Dropout attributable to social incompatibility is documented across multiple intervention studies and represents a genuine constraint rather than a failure of commitment. The clinical question that remains inadequately answered is how much of the circadian benefit survives a compromise window - one shifted earlier relative to the individual's habitual pattern but not aligned with the strict eTRE schedule. The available data do not resolve this cleanly, but the direction of evidence suggests that earlier eating, even when partial, produces measurable metabolic advantages over the unrestricted default.

Cienfuegos et al. (2020) examined the effects of further shortening the eating window to four and six hours per day, respectively [2, pp. 368–372]. Participants - adults with obesity - followed one of the two protocols for eight weeks without any restrictions on diet composition. Both schedules produced greater weight loss than the control condition, approximately 3–4%, and were accompanied by reductions in fasting insulin and improvements in blood pressure. No significant difference in weight loss was observed between the four-hour and six-hour windows, although the six-hour protocol showed better adherence and fewer reports of late-day hunger.

For anyone who skips breakfast because there is no time, eats lunch at a desk at 14:00 if they are lucky, and treats that as a personal failure - these numbers reframe the situation. Two or three meals inside a six-hour window is not dietary chaos. It is, structurally, close to what the research is testing. The only question worth asking is whether those meals actually contain enough protein, fat, and micronutrients to cover what the body needs. If yes, the compressed schedule is not a problem to fix. It is already the strategy.

Alternate-day fasting sits differently in this landscape - not better or worse, but built around a different kind of discipline. It is effective but requires a different form of discipline: not daily restriction, but restriction every other day. Park et al. (2020), summarizing data from 12 randomized controlled trials, found that ADF produces weight reduction of roughly 3–8%, depending on intervention duration, along with improvements in lipid profiles and fasting glucose [11, p. 154336]. Cui et al. (2020) reached similar conclusions in a broader synthesis of studies, noting that the effects of ADF are comparable to those of continuous caloric restriction, while participants often report a lower sense of constant dietary limitation [3, p. 586036].

In its strict form - involving complete or near-complete fasting on designated days - ADF also presents a clear behavioral challenge. Fasting days often fit poorly into the social structure of everyday life: business lunches cannot always be scheduled for feeding days, and explaining to colleagues at the table that one is not eating that day can be socially awkward in most professional settings. In a 2020 systematic review, Welton et al. observed that modified ADF - allowing approximately 500–600 kcal on fasting days - shows the highest long-term adherence among intermittent fasting approaches [12, pp. 120–122]. This is a practically important detail: the option of a small meal, even if metabolically modest, reduces the psychological sense of extreme restriction and makes the protocol more sustainable over time.

The question of whether time-restricted eating should be combined with active calorie counting is one of the most practically relevant in this field. For individuals with limited time resources, the answer is crucial: if time-restricted eating alone produces satisfactory outcomes, the additional burden of calorie tracking is not merely unnecessary but may undermine the sustainability of the approach. In a large randomized controlled trial published in The New England Journal of Medicine in 2022, Liu et al. directly compared time-restricted eating with caloric restriction to time-restricted eating without it in 139 participants with obesity over a 12-month period [9, pp. 1497–1501]. The difference in weight loss between groups was not statistically significant, with both producing reductions of roughly 7–8 kg over the year. The combined-intervention group, however, showed somewhat better glycemic control and lipid levels, which may be clinically relevant for patients with early disturbances in carbohydrate metabolism.

A similar conclusion was reached by Enríquez Guerrero et al. in a 2021 meta-analysis that pooled data from 27 studies: intermittent fasting and continuous caloric restriction yielded statistically comparable results for body weight, BMI, and waist circumference [5, pp. 1028–1031]. Where the groups did differ was in how the experience felt from the inside. People doing intermittent fasting described less of a sense of being constantly denied something, compared to those who tracked every meal. That gap matters more than it might seem. Feeling chronically restricted is one of the most consistent early warning signs that someone is about to quit - not because the diet stopped working, but because living inside it became too uncomfortable to sustain.

Then there is the TREAT trial, which Lowe et al. published in 2020, and which landed awkwardly in the field [10, pp. 1493–1496]. TRE in a mixed overweight and obese sample did not beat regular three-meal eating on any weight outcome. The paper got a lot of attention, some of it treating it as a definitive refutation of the whole approach. A closer look at the design makes that reading harder to defend. Participants received no guidance on diet quality; some adopted a late eating window from 12:00 to 20:00, which does not align with optimal circadian timing; and the control group also spontaneously reduced caloric intake during the study. The TREAT findings therefore do not refute the effectiveness of time-restricted eating but rather highlight the conditions under which it may fail to produce measurable benefits.

The cardiometabolic effects of time-restricted eating and alternate-day fasting extend beyond purely quantitative changes in body weight and warrant separate consideration. In a randomized controlled trial published in 2022, Chair et al. documented significant reductions in triglycerides, LDL cholesterol, and systolic blood pressure in the intermittent fasting group compared with the control group [1, p. e185]. These changes occurred alongside weight loss but were partly independent of it, suggesting that fasting exerts metabolic effects that cannot be explained solely by reduced caloric intake. Mattson describe a cascade of adaptive responses triggered during fasting, including reduced insulin and IGF-1 levels, activation of autophagy, increased fatty acid oxidation, improved mitochondrial function, and reduced oxidative stress [4, pp. 2543–2546]. Each of these processes has independent relevance for the prevention of chronic disease.

Weight reduction and cardiometabolic risk modification are typically framed as distinct clinical objectives with partially overlapping but not identical intervention strategies. TRE is unusual in that it appears to address both simultaneously through a single structural change in eating behaviour. A person who adopts a restricted eating window because it reduces the daily logistical burden of food management does not need to separately pursue a lipid-lowering or antihypertensive dietary strategy - the same time constraint that simplifies the schedule also initiates the metabolic cascade described above. The pragmatic motivation and the clinical outcome converge on the same behaviour.

## DISCUSSION

Taken together, the studies reviewed form a fairly coherent picture, yet one that is not uniform - and this heterogeneity is itself informative. Time-restricted eating protocols demonstrate consistent effectiveness under controlled conditions, but real-life settings systematically differ from those of randomized trials. Participants in clinical studies are aware that they are being observed, maintain regular contact with research teams, and often display elevated motivation simply by virtue of participation. None of these factors is present in everyday life. The Hawthorne effect - improved performance under observation - is a persistent methodological companion of dietary research, and its influence on the real-world effectiveness of intermittent fasting outside clinical settings remains uncertain.

Adherence may be the single most important issue in this entire discussion. A protocol abandoned in the fourth week cannot compete with a less optimal but sustainable approach. Data from Welton et al. [12] and Enríquez Guerrero et al. [5] suggest that intermittent fasting generally shows acceptable adherence in the short term. However, most studies last only 8–14 weeks, which is a substantial limitation. The 12-month data reported by Liu et al. [9] are a rare exception and indicate that even over this longer period, completion rates were significantly lower in the combined-intervention group. This indirectly supports the argument that a more complex protocol - when outcomes are comparable - is the poorer choice for long-term use.

Baumeister et al. established two decades ago that self-regulatory capacity is a depletable resource, and subsequent research has confirmed that dietary decisions made late in the day - when cognitive resources are already taxed by accumulated demands - are systematically less consistent with stated health intentions than decisions made earlier. A protocol that requires repeated daily judgements about

food quantity and composition places its highest demands precisely at the point of lowest regulatory capacity. TRE shifts the locus of control to a single temporal boundary set in advance, outside conditions of depletion. Within the eating window, no additional dietary rules apply. The self-regulatory demand is front-loaded into one decision rather than distributed across multiple vulnerable moments throughout the day, which is a structurally different kind of ask from continuous caloric monitoring.

Another dimension that rarely receives central attention in studies of effectiveness is the impact of dietary strategies on individuals' subjective sense of control over their bodies and daily lives. Busy adults often describe their eating patterns as chaotic and reactive, something that "just happens," and this is experienced as a source of background stress. A structural approach to eating - even one as simple as a defined time window - can create a sense of predictability and agency in this domain. This effect is not measured in kilograms, yet it is important for the durability of behavioral change.

Food environment shapes dietary behaviour independently of intention. Access, availability, and the cognitive effort required to obtain an adequate meal within a given schedule are proximal determinants of what gets eaten - more proximal, in many cases, than nutritional knowledge or stated preference. Reducing the habitual food repertoire to a small set of nutritionally dense items addresses this constraint directly: a limited, predictable inventory requires less planning to maintain, less time to prepare, and less cognitive effort to reproduce across varying contexts - a work canteen, a hotel breakfast, a supermarket with an unfamiliar layout. The argument for dietary variety is well established in nutritional science, but variety also generates a daily menu-planning burden that compounds with other sources of decisional load. A narrower repertoire of adequate quality is more portable and more resistant to disruption than a diverse one that depends on stable conditions to execute.

Three clinical categories require specific attention before any TRE-based intervention is considered. Pregnancy and lactation impose energy and micronutrient demands that sustained fasting periods cannot accommodate without risk to maternal and foetal outcomes. A history of restrictive or binge-purge eating disorder is a relative contraindication of a different order: temporal food restriction in this population does not simply fail to help - it may actively worsen the underlying behavioural pathology, and the absence of calorie counting does not make the protocol safe by default. Pharmacological management of type 2 diabetes with insulin secretagogues or exogenous insulin creates hypoglycaemia risk during fasting intervals that requires adjustment of medication timing or dosage before any eating pattern change is introduced. Identifying these groups at the point of clinical assessment is not optional. A recommendation that does not specify who it excludes is an incomplete recommendation.

A further limitation of the existing evidence base is its demographic narrowness. Most of the included studies were conducted in the United States or China, often with predominantly female or mixed middle-aged samples. The extent to which these findings generalize to other cultural and dietary contexts - particularly to countries with different meal traditions or workday rhythms - remains uncertain. Moreover, almost none of the studies specifically focused on individuals with chronic time scarcity as a distinct category, representing a methodological gap that directly relates to the focus of the present article.

Finally, the long-term durability of achieved outcomes remains a weak point across the field. Most studies conclude after 12–14 weeks - precisely when participant motivation is still relatively high and when weight loss is typically most pronounced. What happens after one or two years - whether weight is regained, stabilizes, or continues to decline - remains largely unknown. The only way to answer this question is through studies with extended follow-up periods and sufficiently large samples, which are currently scarce.

## CONCLUSIONS

The 8-hour window works. Early TRE works better on paper and worse in practice for most people, but it works too. Alternate-day fasting produces comparable numbers on the scale, and the modified version - where restriction days allow 500 to 600 calories rather than nothing - holds up longer without meaningfully sacrificing the outcome. None of this is theoretical. These are results from randomized trials in real adults with real excess weight, and the effect sizes are large enough to matter clinically.

Liu et al. found no statistically significant difference in weight loss between participants who combined TRE with caloric restriction and those who followed TRE alone over 12 months [9, pp. 1497–1501]. The combination did produce modest improvements in glycaemic markers, which may carry clinical relevance for individuals with pre-existing metabolic disturbances. For the broader population of adults without such comorbidities, however, the data do not support the addition of active energy tracking as a necessary component of an effective protocol. A single temporal constraint on eating - consistently applied - produces weight outcomes comparable to a substantially more demanding combined intervention. The implication for clinical practice is that complexity should be added only where it generates a measurable return, and in most cases of straightforward overweight, it does not.

Metabolic optimality measured in a controlled trial is a poor proxy for clinical utility in an uncontrolled life. The protocol that produces the best results under research conditions - with regular contact with investigators, structured support, and participants selected for motivation - is not necessarily the protocol that performs best when none of those conditions apply. Adherence over time is itself a clinical outcome, and a moderate intervention sustained across twelve months generates greater cumulative benefit than a rigorous one discontinued at week five. The selection

criterion that matters most in practice is therefore not which protocol is physiologically superior, but which one a given person can maintain without restructuring their entire social and professional life around it.

What the field is missing is not more 12-week trials. It is data on what happens at month 18, at month 24 - whether the weight stays off, whether the eating window holds, and what distinguishes people who maintain the protocol from those who quietly revert. That follow-up horizon is where the clinical story actually gets told, and almost none of the existing literature reaches it. There is also a more fundamental gap: no study in this review specifically recruited participants on the basis of time scarcity. Chronically busy adults are the primary target population for everything discussed here, yet they have never been studied as a defined group with their own inclusion criteria, their own baseline measures of schedule load, and their own adherence trajectories. That is a substantial mismatch between the research that exists and the practice it is supposed to inform.

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