

It is important to observe that even in the normocaloric diet (diet A) there are products with low fat content, as skimmed milk, thin meat, and so on, because the reduction of the dietary fat constitutes a healthy alimentary practice. The advice for eat less fat have been accomplish for international associations of health, that has focussing your attention in the development of strategies for stimulate better eat pattern; nevertheless the public in general seems to ignore as having success with this recommendation<sup>48</sup>.

In spite of the importance of the demonstration of a healthy alimentary pattern for healthy individuals (diet A), without doubt, the most interesting point of this model is the comparative analysis of the diets B and C, once this model is addressed for the obese individuals' dietary treatment.

Through the proposed model analysis it is possible to visualize that a diet of 2435 Kcal (normocaloric) and a diet of 1210 Kcal (hypocaloric) can use the same foods, but just having quantitative reduction. Besides that, the use of small amounts of simple sugar is allowed, without harming the treatment, improving the palatability of diet. This can have a quite positive repercussion about the acceptance of the patient to the dietary proposal, once the notices that will not be necessary to do great qualitative restrictions or to exclude some food group to reach the goals of treatment.

The comparison among the diets A, B and C allow the observation that in most of the meals proposals the diet C, that is visually similar to diet B, has energy value very superior to this diet, that had a similar energy value before the addition of fats. The diet C, that has a volume twice lesser than diet A, acquire the same energy value of this, after additional of fats.

The meal with larger discrepancy of energy value is the snack, whose qualitative alteration of the diet provokes an increase in more than 200% of the energy value comparing with the equivalent meal of the diet A and of more 400% in relation to the meal equivalent on diet B. It is also noticed, that the difference among total energy value of the diets B and C (1235 Kcal) is superior to it's initial energy value (1210 Kcal), and the diet C reaches a energy value practically identical to the diet A (2435 Kcal). In such case, it is plenty clear that the proposal of a hypocaloric diet can be ruined due to qualitative changes related to the increase of the fats in the diet.

Using this model, the health professional can simulate other examples about qualitative diet errors that are common in patient's alimentary routine and to explain the importance of fat restriction in order to prevent diseases and weight loss.

Thus, with the use of this visual model, the health professional has in its hands a clear, easy and understandable instrument for advice your patients, that demonstrates the need of following the dietary proposal in details. One advantage of using this model is that the patients can understand the real importance of advises done by health professionals as: to avoid fries, sweet candied, addition of fatty sauces, mayonnaise, and so on; that usually had its relevance underestimated by the patients, regarding that in their point of view these changes seem too subtle for interfere significantly on the weight loss.

Generally, when the patient diminishes significantly the size of meals, as demonstrating in the Diet B, but do not diminish its energy density as in Diet C, he becomes disappointed because the patient did not lose any weight, despite of its efforts. This occurs because the patient do not perceive that the energy value of diet with fat meals is very high, even having low volume. It is noticed in the clinical practice, that this fact is one of the main responsible for patients and professionals discouragement. They constantly look for the diet error that could justify the failure on the treatment, but generally they do not. Due to the exposed above, patients

frequently omit these "details" related to the additional of fats, considering that they judge its irrelevant. So, through the comparative visual analysis among the diets B and C the deleterious effect of these increments is practically self-explanatory.

Anyway, it is important that the nutritionist being meticulous in the investigation of the patient's alimentary habits, to notice earlier and eliminate dietary factors that can be harmful to treatment.

Therefore, to achieve the goals of dietetic treatment, it is important that the patient learns to identify high fat meals in its diet, process that can be facilitate through the analysis of diet C.

### Handling the model for nutritional education

This model was developed for nutritional education of healthy and obese individuals, as well to patients with diabetes, dyslipidemia and other ones when weight loss or less intake of fat is need. Independent of the case, the nutritionist should apply this model, not only showing a healthy dietary pattern, but also giving a wider information about feeding and health, detaching the paper of each alimentary group, its sources, and cares and hints about each one, what is important for an appropriate alimentary selection.

To facilitate this practice and amplify the memorization, the proposed plate model can be complemented with the information, at the moment of discussion with patient. After first counseling, the nutritionist should make brief investigations to verify the degree of theoretical learning and its use in the alimentary practice; understanding this as a gradual process, and that fundamentally it depends on a good professional-patient relationship.

The purpose of demonstrating to the patient the areas on the plate destined to each alimentary group in the main meals, and the visualization of the correct size of the servings of the foods of the intermediary meals is to facilitate an appropriate measure of these for the patient. However, initially, until that the patient familiarizes with the method, he can use quantitative utensils, as cups and spoons, that is part of the proposal of the list of exchange meals even so, with the practice, it is waited that only the visual of the plate guide their alimentary choices. Then, is important to reinforce the orientation on division lines that theoretically divide the plate in areas that should be occupied with the different alimentary groups.

This ability that can be acquired by the patient is very positive, because when familiarized, the patient probably won't have difficulties in determines with the necessary precision the size of the suitable portion. This is because the patient will have a visual model to be based and to consult whenever doubts appear, without that he receives subjective instructions in relation to the size of the servings as small, medium or large, what is considered very susceptible to mistakes<sup>49</sup>, nor instructions about the weight of the portion, that can be complicated, because not always the patient will have a balance to aid him.

This way, through the aid of this visual model adapted for obesity, the patient can acquire autonomy in its qualitative and quantitative dietary handling, what is fundamental for the success of any treatment for weight loss.

### FINAL CONSIDERATIONS:

It is important to elucidate that in proposed model, only diets A and B can be used as a healthy diet, because in these, all recommendations for a balanced diet were reached. The Diet C has the important function of showing clearly to the patient the damages to the treatment for weight loss caused