doi: 10.1111/j.1369-7625.2008.00490.x

Being 'fat' in today's world: a qualitative study of the lived experiences of people with obesity in Australia

Samantha L. Thomas PhD,* Jim Hyde PhD,† Asuntha Karunaratne BMedSci (Hons),‡ Dilinie Herbert MBioMedSci (Part 1)‡ and Paul A. Komesaroff MB BS FRACP PhD§

*Senior Research Fellow, Centre for Ethics in Medicine and Society, Monash University, Melbourne, Australia, †Director, Public Health, Department of Human Services, Victoria; and Honorary Senior Lecturer, Centre for Ethics in Medicine and Society, Monash University, Melbourne, Australia, ‡Research Assistant, Centre for Ethics in Medicine and Society, Monash University, Melbourne, Australia and §Professor of Medicine, Director, Centre for Ethics in Medicine and Society, Monash University, Melbourne, Australia

Correspondence
Samantha Thomas
Centre for Ethics in Medicine and Society
Monash University
Alfred Hospital
Prahran
Victoria 3181
Australia
E-mail: samantha.thomas@med.monash.edu.au

Accepted for publication
21 November 2007

Keywords: lived experiences, obesity, public health, qualitative research, social and cultural factors, stigma and discrimination

Abstract

Objective To develop an in-depth picture of both lived experience of obesity and the impact of socio-cultural factors on people living with obesity.

Design Qualitative methodology, utilizing in-depth semi-structured interviews with a community sample of obese adults (body mass index ≥30). Community sampling methods were supplemented with purposive sampling techniques to ensure a diverse range of individuals were included.

Results Seventy-six individuals (aged 16–72) were interviewed. Most had struggled with their weight for most of their lives ($n = 45$). Almost all had experienced stigma and discrimination in childhood ($n = 36$), as adolescents ($n = 41$) or as adults ($n = 72$). About half stated that they had been humiliated by health professionals because of their weight. Participants felt an individual responsibility to lose weight, and many tried extreme forms of dieting to do so. Participants described an increasing culture of 'blame' against people living with obesity perpetuated by media and public health messages. Eighty percent said that they *hated* or *disliked* the word obesity and would rather be called *fat* or *overweight*.

Discussion and Conclusion There are four key conclusions: (i) the experiences of obesity are diverse, but there are common themes, (ii) people living with obesity have heard the messages but find it difficult to act upon them, (iii) interventions should be tailored to address both individual and community needs and (iv) we need to rethink how to approach obesity interventions to ensure that avoid recapitulating damaging social stereotypes and exacerbating social inequalities.

Introduction

The obesity 'epidemic' is one of the most pressing contemporary public health problems. However, in spite of good intentions, public health and social marketing efforts have had virtually no effect on the increase of obesity worldwide.[1–4] This may be because these interventions in the main (i) concentrate on those factors that account for around 30% of the cause – high energy intake and lack of physical activity and (ii) place the onus on individual responsibility for weight loss and prevention.[5,6] Public health efforts that have shown promise have taken a more comprehensive approach involving not only education but also targeted interventions that address the socio-cultural infrastructures of communities.[7] Ironically, at the same time, the broader public discourse about obesity focuses on medical formulations and concepts (such as the *obesity epidemic*, the *obesogenic environment*, and the WHO's *globesity*.[8]) Calls for sensitivity to the cultural roots of the problem are not being heeded.[9] Dietary habits and lifestyles have strong underlying socio-cultural, socio-demographic, environmental and at times, psychological dimensions. It is paramount to take into account the lived experiences of those who are currently overweight and obese, to identify how we may engage communities, and to help with the cultural tailoring of messages, messengers, and interventions in combating obesity.[10,11]

Methods

Approach

This study, based in Victoria, Australia, aimed to develop a picture of both lived experiences of obesity and the impact of socio-cultural factors on obesity. Given the absence of information about these two issues, we employed a qualitative research design. A broad interview schedule was developed by the authors after a review of research literature and consultation with public health experts, qualitative researchers and people living with obesity. Topics included early experiences with weight, attitudes towards 'obesity', attempts to lose weight, impact on relationships, societal attitudes, interactions with health professionals and attitudes and opinions about interventions to help people living with obesity.

We sought to interview individuals from a broad range of backgrounds and experiences of obesity. This was to build up a comprehensive picture of people's experiences with their weight over a number of years.

Recruitment

A brief report about the study was published in a daily newspaper. Over 5 days, 90 people enquired about the study. They were given a brief description of the research and were asked some screening questions to assess their body mass indexes (BMI) and basic demographic characteristics. This allowed us to build a profile of those responding and to diversify our sampling methods where needed through purposive sampling. Individuals were invited to participate in a 1-h interview, either face to face or by telephone for those in rural areas or uncomfortable with travel.

Data collection

Interviews were conducted in September and October 2006 by a team of five experienced qualitative researchers and took 60–120 min. A conversational style of interviewing was used, supported by the themes developed in the interview instrument. ST and AK monitored the quality of telephone and face to face interviews to ensure that there were no inconsistencies in the quality of the data between the two approaches. Interviews were audio-taped and transcribed within a week of being conducted by a professional transcribing service.

Data analysis

Data analysis was conducted by ST, JH, AK and PK and based on rigorous qualitative analysis techniques – including a constant, con-

tinuous, comparative method of analysis – to develop analytical categories, test our processes of analysis and then provide an explanation of why categories occurred. In particular, the analyses explored differences between groups. While data were managed using QSR NVivo 7,[12] we conducted most of the analysis by hand, reading and re-reading, developing codes and themes and discussing transcripts at team meetings. Although this was a lengthy process, it allowed us to take a more interpretive rather than descriptive approach to the data.

Results

General characteristics

A total of 76 individuals participated in the study. Their general characteristics are reported in Table 1. Of the 90 respondents, 17 people refused participation after receiving further information about the study (11 people thought that we were offering a 'cure' for obesity, three wanted to speak about experiences of gastric bypass surgery and were under the BMI cutoff and three were not interested in talking about their experiences). Eight individuals did not turn up for the interview. Eleven individuals were purposively sampled from the Alfred Hospital Obesity Clinic, and from referrals from study participants to diversify the sample. We have included a selection of quotes from participants (Box 1) to illustrate some of the key findings.

Table 1 Participant characteristics

Characteristic	
Age	
Range	16–72
Average	47
Marital status	
Single	27 (36%)
Married	31 (41%)
Divorced	12 (16%)
Widowed	6 (8%)
Geographical location	
Rural	28 (37%)
Weight (kg)*	
Range	72–225
Mean	119
Obesity classification*	
Obese	32 (42%)
Morbidly obese	43 (57%)
Gender	
Female	63 (83%)
Education	
At least completed high school	34 (45%)
Employment status	
Unemployed	39 (51%)
BMI*	
Range	30–72.1
Mean	42.5

*One missing as not willing to report weight and height.

The average age of participants was 47 years (range 16–72) and the majority were women (63, 83%). The older age of participants may be explained by our call for participants who had struggled with their weight for at least 5 years. A third (27, 36%) had never married and a third (28, 37%) came from rural and remote areas. Participants had a mean BMI of 42.5, and over half were morbidly obese (43, 57%) (BMI ≥40). Weight and height were self reported, and we consider that these figures are underestimates. However, given the anxiety participants expressed about being weighed, we believe that asking for self-reported details was appropriate.

Early experiences with overweight and obesity

About two-thirds of the participants (41 women and four men) stated that they had been overweight as children. Of them, 26 were now morbidly obese. The words *hurt* or *hurts* were used 98 times by 32 participants in relation to childhood experiences of their weight. Most of these participants had experienced stigma and discrimination as children ($n = 36$). Experiences included social isolation ($n = 31$), being bullied or teased ($n = 27$) and deliberate exclusion from recreational activities ($n = 6$), all of which intensified when they reached high school ($n = 41$). Women in particular were acutely aware of their weight, particularly as they reached adolescence ($n = 19$). Some stated that the effects of childhood experiences had long-term emotional consequences ($n = 8$), particularly for those who were constantly compared to 'normal weight' siblings ($n = 15$). Nineteen

Box 1

Early experiences of weight

At school I was always picked on for my weight. You never had friends. They never mucked around with the fat girl. You were all on your own. You learn it hurts very much. (57 year old female)

It wasn't until I had my baby that I ballooned. I lost the weight, fell pregnant, put it all back on and now I just can't move it. (29 year old female)

Weight loss attempts

I was always on some kind of diet. The first one was Jenny Craig when I was twelve. (28 year old female)

I've been abusing my body for the last 7 years trying to figure out what to do. (30 year old female)

Social experiences

I've been for job interviews and they said you're not what we're looking for. When I asked why, they said 'well your size, we want someone who's appealing greeting our customers'. (29 year old female)

I was on the train the other night and this woman sat beside me and said to her friend 'This is the trouble with obese people, they take up too much room on the train'. Now that obese is out there, everybody thinks they can say it to your face [crying]. (52 year old female)

Attitudes towards obesity

Morbidly obese I hate it. I hate that term. It just plays hell with my mind. I'm not morbid, I'm not ugly, I'm not a morbid person, I'm a happy person. (32 year old female)

Experiences with health professionals

Over my whole 40 year dieting history I found two doctors who have said 'well, come back once a week or once a fortnight and I will weigh you'. I found that very helpful and useful, because you feel like somebody is on your side. (65 year old female)

They have helped because they guided me and pointed things out and they were there for me. If I've got questions they are helpful. (28 year old female)

Oh well, I have spoken to my doctor about it and he just says get more exercise. I did mention it to one other doctor and he said there is only one way to lose weight and that's meal replacement drinks or tablets. So I never went back to him because I don't agree with that. (49 year old male)

My doctor keeps saying, you need to lose weight. And I say, yes, I know that and I want to and I try to watch what I am eating, but it is just getting harder and harder. (59 year old female)

participants stated that their mothers had tried to intervene by taking them to diet groups, or to their general practitioner (GP) for help with their weight, which often made them feel more isolated and different from their peers. About half of the participants ($n = 34$) described that while they had very little takeaway or convenience food in their house, they ate large amounts of meat and dairy products. This was particularly common in those from rural areas. Many described large portion sizes and that parents expected them to *clear their plates* before they were allowed to leave the table.

Participants who described an onset of weight gain as adults generally fell into three categories. First those describing a transition from active childhoods to more sedentary lifestyles as adults (five men and eight women). Some commented that they 'overate' as children but the amount of activity they participated in had compensated for their eating habits. The second group consisted of women who were unable to lose weight gained after pregnancy ($n = 7$), especially after a second or later pregnancy. The final group were those who had gained weight after physical health problems ($n = 6$). These were predominantly injuries, which again led to decreases in physical activity. The common factor among all these groups was the gradual nature of the weight gain. Participants stated that they did not notice, were able to ignore, or denied about how much weight they had gained over time. By the time they attempted to lose weight, they felt emotionally and physically *daunted* by the amount they had to lose.

Weight loss attempts

All participants had attempted to lose weight numerous times in their lives. Even those who stated that they were not bothered by their weight had tried to lose weight on many

occasions. Most described the considerable time and money they had spent on 'fad' diets. A quarter of individuals stated they had been on diets for most of their lives. Over half of the women ($n = 41$), and a third of the men ($n = 5$) stated that they constantly thought about their weight, and about how they could lose it.

In general, the women had tended to start dieting in their early teens, and men in their early 20s. While diets had given some short-term benefits they were unsustainable over time and many participants stated that they had gained weight after dieting. Despite unsuccessful attempts at dieting, most continued to spend large amounts of money on different diets, weight loss techniques and complementary medicines and therapies in mostly vain attempts to lose weight. Some stated that they had 'abused' their bodies through dieting. The most popular diets were Weight Watchers, Jenny Craig and slimming milkshakes. A third of participants ($n = 26$) stated that their GP or physicians had recommended *Optifast* (a low calorie meal replacement) as the most effective way of losing weight. Over a quarter ($n = 20$) of participants stated that they had regularly tried to *starve themselves*. Six women stated that they had been bulimic as teenagers to try and lose weight. Fifteen participants commented that if they lost large amounts of weight, friends and family members would comment that they *looked sick* and try to encourage them to stop dieting. In some cases participants stated that they felt family members and friends would try to *sabotage* their attempts to lose weight.

The majority of participants had also tried pharmaceutical medications for weight loss. One in three women had been prescribed Phentermine (an amphetamine) by a GP for weight loss. A quarter of participants had taken, or were taking Orlistat. Thirty-seven had tried herbal or complementary weight loss supplements. About a quarter ($n = 19$) had investigated bariatric surgery, although this was beyond the financial reach of most participants. Eight participants stated that although they could afford bariatric surgery, they were unwilling to have such invasive surgery to combat their obesity.

Dieting was reported as having had immense emotional effects on participants' lives. Many felt that they had been exploited by weight loss companies, that effective weight loss interventions were inaccessible and unaffordable and that there was little long-term support for those who needed to lose large amounts of weight. For individuals on restricted incomes, the financial cost of weight loss interventions and perceived expense of fruit and vegetables were particularly evident.

Social experiences – the effects of obesity on daily life

Almost all participants ($n = 72$) had experienced stigma and discrimination because of their weight. Of the four participants who had not experienced stigma or discrimination, all were men. Most participants ($n = 59$) stated that strangers often commented on their weight, particularly when they were buying food or clothing. About a quarter of individuals ($n = 19$) stated that they thought they had been refused or fired from a job because of their weight. Participants described an emerging culture of blame against obese people. Some felt that this was highlighted by medical professionals, policy makers and the media, who constantly spoke about the *burden* that obese people were placing on health-care systems and on society. Participants employed a variety of strategies to deal with stigma, including *making fun of myself*, *switching off* or *ignoring* the discrimination. While a small minority of participants ($n = 7$) said that they had become socially isolated, rarely interacting with other individuals, the majority of participants were still able to carry out their daily activities, and over half ($n = 40$) said that they felt comfortable with eating in public. Participants also spoke about the day to day impact of obesity on their lives, including being unable to buy clothes to fit them ($n = 32$), to use seatbelts in cars because they were not long enough ($n = 5$), or to go to the theatre or university lectures because the seats were too small ($n = 6$). The airline industry came under intense criticism from participants

($n = 11$) because of the additional financial cost of having to pay for two seats, and the negative attitudes of flight attendants when participants had to ask for seatbelt extensions.

It was also encouraging that when participants were asked to chose three words to describe themselves, the vast majority used positive description. The most commonly used words were 'kind', 'loving', 'generous', 'outgoing', 'fun', 'patient' and 'determined'.

Participant attitudes towards obesity

Participants were asked to describe why they thought they were obese, and why they thought Australia was becoming 'larger' as a society. These reasons were diverse and are included in Table 2.

There were numerous emotional pressures on individuals caused by being labelled 'obese'. Eighty percent of those interviewed said that they *hated* or *disliked* the word obesity and would rather be called *fat* or *overweight*. Most stated that while the word was a medical term, they believed that the label of obesity increased society's disapproval of overweight people. About half ($n = 37$) of the participants described poor mental and emotional health outcomes associated with their obesity. These included low self esteem, eating disorders, depression, social isolation and an inability to form and maintain intimate relationships. Participants talked extensively about fractured relationships because of their obesity – between individuals, within families, within communities and with the medical profession.

Experiences with health professionals

There were mixed experiences with health professionals. About three quarters of participants had sought help with their weight from GPs. Two key themes stood out in participants' descriptions of interactions with their GPs. When approaching GPs, participants tended to speak about their emotional difficulties rather than focusing on their weight. It was not surprising then, that many participants stated that GPs had prescribed them anti-depressant medication rather than focusing on their weight. Secondly, most participants approached their GPs after years of dieting and trying to lose weight on their own. Very few participants stated that the GP broached the subject without their raising it. Accordingly there was little early intervention from GPs and by the time the discussion took place they were seriously overweight and there was little their GPs could do to help. As a result participants reported high levels of dissatisfaction with the ability of GPs to intervene – particularly when the main recommendations were for further dieting, prescribed pharmaceutical drugs, or interventions such as gastric banding which they could not afford. Despite this, many participants ($n = 33$) also stated that their GPs were the only health professionals who they could turn to for support, and were in fact appreciative of the time GPs

Table 2 Perceptions of individual and community causes of obesity

Individual reasons for obesity	Reasons why Australia is becoming larger
Emotional and mental health issues: 'Eating for comfort' and 'stress'	Convenient lifestyles
Overeating	Sedentary lifestyles: impact of technology – internet and television – on communities
Genetic factors	Urban planning: Lack of places for people to play
Hormonal problems	Advertising industry: targeting of unhealthy food to children
Poor dietary habits	Availability and affordability of fast food
Price of healthy food	Financial stress on modern families: Both parents working
Cost of weight loss remedies	
Lack of support and accessible, affordable interventions	

had spent talking to them about their overall health and wellbeing. Those who had the highest levels of satisfaction with GPs were those who had GPs who spent time counselling them and monitoring their weight.

Half of participants ($n = 38$) stated that they had been humiliated or had derogatory comments made about their weight by health professionals. These included experiences of humiliation from nurses ($n = 17$), hospital physicians ($n = 11$), radiographers ($n = 9$), anaesthetists ($n = 7$), dieticians ($n = 6$) and ambulance drivers ($n = 4$). However, many participants ($n = 27$) were also able to recount very positive experiences with health professionals, and that health professionals had also been strong advocates for their treatment and care. Participants believed that medical professionals – in particular GPs – were vitally important in helping people with obesity. However, most stated that this help had to be given in conjunction with long-term weight loss support from nutritionists or dieticians and exercise consultants, and emotional support from psychologists or counsellors. The lack of affordable interventions meant that for most individuals this combination was not a realistic option. Participants stated that they wanted to be treated as 'individuals' rather than be prescribed a blanket remedy for their obesity. Many stated that they were frustrated that they were constantly told what to do about their obesity but not given support to implement diet/exercise regimes.

Discussion

It is important to recognize the limitations of the study. Given the 'opt-in' nature of this research, it is important to recognize that there may be a self-selection bias within the sample. In particular, those who chose to participate may have had more negative or extreme experiences than those who did not respond. While a number of men responded to the study, they were considerably outnumbered by women. Furthermore, we sought to include participants who had lived with obesity for a number of years. This may explain the slightly older age of participants. Despite this, the study is based on sound and rigorous qualitative methods, and has attracted a diverse range of participants and provides important insights into the experiences of people living with obesity.

Responses to the problem of obesity must not only encompass technical strategies but also resonate with the lived experiences of those affected by it: the individual sufferers, their families and the local and broader communities. Too often, however, both the clinical and the public health responses have neglected to take into consideration these experiences. Instead, there has been an emphasis on 'quick fix' responses which assume that individuals in isolation are able to respond effectively to the manifold and complex issues associated with obesity. Although some degree of individual responsibility is, of course, appropriate, it is necessary also to recognize that there is a systematic cultural component underlying the obesity epidemic, as a result of which a significant part of the challenge at both the clinical and the public health levels is the restoration of a sense of individual empowerment and agency.

Voluntary lifestyle choices account for only a small part of the problem. Individuals have relatively little control over large scale social and cultural factors such as the physical environments and urban planning,[13] mounting financial pressures on families associated with increasing costs of housing and social services, intensifying ethnic and socio-economic disparities,[14] the lower cost of energy dense in comparison with energy rich foods,[15] the persuasive marketing of commercial diets and weight loss remedies,[16] targeting of food advertising to children, children's ability to influence parental food purchases,[17] and the psychological impact of stigma and discrimination.[18] Enhanced knowledge and awareness of the lived experiences of people with obesity may significantly enrich the resources available to a wide range of professionals in the fields of public health, health promotion and clinical practice. A good example of this is the language that those living with obesity prefer in referring to their weight. Our findings not only support others who have shown that the word 'obesity' is disliked by those living with the

condition,[19] but also the use of qualitative methods has given us in-depth detail about why they dislike the word, and the impact it has on their health and social experiences. This information is useful particularly for health professionals, in understanding how they may be able to approach the subject of 'obesity' with their patients, and involve them more directly in discussions about their health and health care.

This study has suggested four key conclusions which can contribute to the planning of long term, sustainable responses to the problems associated with obesity:

The experiences of obesity are diverse but there are common themes

There is no single 'lived experience' of obesity, and there can be no 'one size fits all' solution to the problem. For the participants in this study, obesity was the outcome of a variety of convergent social, cultural and biological factors, and this diversity in turn generated a wide range of experiences. Among these experiences there were many recurring themes, related to discrimination, constant unsuccessful weight loss attempts, social isolation and feelings of being misunderstood by health professionals. The development of effective interventions requires recognition of both the variety of individual experiences and their common, abiding themes.

People living with obesity have heard the messages but find it difficult to act upon them

Messages about obesity need to be clear and consistent.[6] In addition, they need to communicate effectively with individuals in a wide range of settings. To ensure this, they should be developed through a process of community consultation and after a detailed examination of the reasons why people with obesity find it so difficult to lose weight, of how they respond to public health messages about obesity, and of the support they need to help them address their problems.

Interventions targeted at individuals are likely to fail if they do not take into account the nature and effects of eating habits of families and peer groups or the ability of socio-cultural infrastructures to counteract effectively individual motivations and attempts to lose weight. They are also likely to fail if they do not provide individuals with the support they need to respond at the personal, family and community levels, at critical phases in their struggles with their weight and other problems. Recognition of the deep social factors at play in relation to obesity may facilitate the success of more narrowly conceived medical approaches and behavioural interventions.

Interventions should be tailored to address both individual and community needs

Obesity is not 'caused' by culture but arises within and is shaped by it. Effective strategies against obesity require the careful mapping of these cultural forces so that their impact can be attenuated. Lessons from previous large-scale successful public health campaigns, such as those against HIV and smoking, show that not only should the messages be responsive to the needs and circumstances of specific cultural communities but that prevention efforts must also take into account wider structural and environmental factors.[20,21] For example, the way in which HIV models of care were developed were patient led, and prevention aspects of HIV were community based. This model led to a genuine partnership between clinician and consumer/patient which predated more formal models of patient self management. Health professionals should be encouraged to look at these models and assess their transferability and applicability to obesity models of care and prevention strategies.

One of the challenges presented by the obesity epidemic is that there is no formal 'community' of obese people. Furthermore, although many groups and individuals claim to represent the interests of people with obesity – for example, the weight loss industry, support groups, pharmaceutical companies and bariatric surgeons – all of these have their own interests and apply their own particular perspectives. For clinical interventions or public health programmes to be effective, it is essential that they are founded on

reliable information and are crafted in relation to the specific needs of the individuals they are intended to address. For this, it is generally necessary for members of the target communities to be consulted and where possible included actively in the development process. The outcomes of this process should be rigorously evaluated and themselves fed back to the local communities for further comments and suggestions. This interactive process of building intervention strategies is admittedly more costly and time consuming than conventional approaches. However, in the case of obesity, the benefits in relation to the restoration of community trust, the development of resilient social structures and the achievement of effective outcomes are likely to make this time and money well spent.

We need to rethink how to approach obesity interventions

As already discussed, efforts to combat obesity need to recognize both individual and environmental factors, both of which have strong sociocultural roots. Interventions should be timely, accessible, practical, sustainable and affordable. They should avoid recapitulating damaging social stereotypes and they should include strategies that support both primary and secondary prevention.

Excessive weight gain can occur at different times in people's lives, for different reasons and with different emotional and physical consequences. The availability of help when it is needed in an accessible, non-judgemental form is likely to increase beneficial outcomes. In our study many participants had sought assistance from their GPs at an early stage but were dissatisfied with the responses they received, finding that the GPs had insufficient time to spend on counselling and were ill-equipped to help them to address the complex array of issues as they were developing. It would appear that there is a need for specific training of primary practitioners to identify and respond to eating and weight problems as they develop.

While individual treatment programmes are potentially effective, however, their costs may be prohibitive, especially to disadvantaged groups. For example, while bariatric surgery may well be effective for those who are seriously over their ideal weight, even bariatric surgeons recognize that preventative strategies need to be our primary focus.[22] If these strategies do not take into account distinct social and cultural factors, then they may indeed exacerbate socioeconomic and health inequalities.[23,24] To avoid this there is a need to emphasize prevention efforts based around multidisciplinary approaches. This in turn will require adequate, sustainable funding for health promotion and prevention campaigns.

Conclusion

In conclusion, the obesity 'epidemic' has arisen out of, and continues to have an impact upon, social and cultural structures. We are moving towards a differentiated, multidimensional approach to the problem and this requires research into the cultural dimension of obesity and the needs of obese people themselves. While strategies directed at individuals and at populations are important so too are those which respond directly to the social and cultural dimensions of communities and clusters of individuals. It is only with such a flexible and diverse array of approaches that we will be able to respond to the social, personal and emotional impact of obesity and the consequences – intended and unintended – it has generated.

Conflicts of Interest

None declared.

Ethical Approval

Alfred Hospital, Victoria and Monash University Ethics Committees.

Acknowledgements

We are grateful to the generous funding for this study provided by Bellberry Ltd through the Monash Foundation. Thank you to A/Prof

Max de Courten for comments on earlier drafts of this paper. Most importantly we would like to thank the individuals who had the courage to share their stories.

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