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The Cooktown Ten: A Problem Structuring Model for Violence Prevention

Addressing Violence Through Primary Care

William Liley & Anne Stephens

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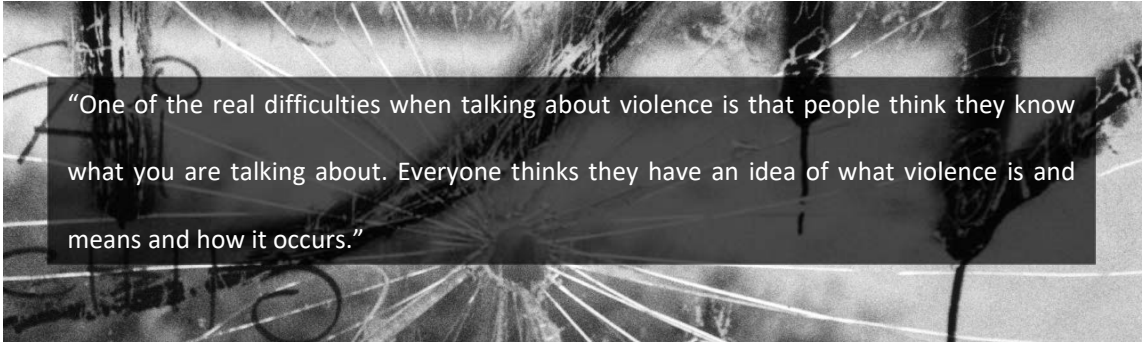
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Abstract

This piece of writing is to provide background and description of our thinking behind The Cooktown-Ten (C-10). The C-10 is a model for use in primary care to encourage the prevention of violence. Understood as a pathogenesis, it can be used by health professionals in primary care settings. The violence that has the potential to be prevented in primary care settings is violence that occurs on a personal scale. This includes a range of significant harms to individuals and groups including self-harm, workplace, domestic, intimate partner, family and community violence, and suicide. The subject of significant attention in Australia, the elimination of violence against women and their children, such as gender-based sexual assault, harassment and domestic violence, is a national priority. In our opinion a significant gap in the suite of prevention efforts is the capacity to work with all people at risk of using violence prior to any event. Yet most practitioners work with those affected after the act. The pathogenesis of violence presented in this paper is based on many years of clinical practice and brings together literature from divergent fields. The C-10 is a problem structuring tool for counselling opportunities to understand, explain and ameliorate all types of violence including physical, psychological, social, and self-directed harms, and to identify and make an effective plan to support people to make positive choices for non-violent action. It has been developed and used in time and resource poor settings with and for General Practitioners (GPs), nurses, allied and other health sector workers. Any such model should be useful to practitioners and be just complex and robust enough to enable an exploration of the variety of nuances within a persons' situation. Our model can be used to explain repetitive cycles and effects of interpersonal violence and self-directed harm. The C-10 can be used with individuals, groups, families and communities. It is intended as a free resource for clinical use. Currently clinical applications are based on Level 5 evidence. It is hoped that ongoing research will build on this evidence base. At a minimum, this model provides a conversation template and a take-home framework to allow individuals to reflect, anticipate and modify their responses to problems—to make deliberate choices to avoid violence in their actions.



“One of the real difficulties when talking about violence is that people think they know what you are talking about. Everyone thinks they have an idea of what violence is and means and how it occurs.”

Firstly, a few words about the first word ...

Cooktown is a unique place in Far North Queensland, Australia, with a rich cultural heritage. It includes a clearing on the bank of the river which according to local history, has for several hundred generations over several thousand years, been a place kept separate and sacred where neighbouring cultural groups of First Australians maintained a lore that no violence was permitted. One day in 1770, in relatively recent history, this place was where Captain James Cook beached his stricken vessel, *The Endeavour*. This might now be seen as an unrecognised act of territorial violation. The boat and its occupants, however, were tolerated by the people already living in the area who adhered to their long-held mores and local law. At this time of writing, Cooktown is a small community which includes people from a wide range of cultural and linguistic backgrounds. It seems fitting that a model developed in this region that encourages violence prevention and ongoing deliberate efforts to avoid violence, acknowledges this rich tradition.

The problem

Almost everyone has an understanding of violence based on their experience and their learning. Defining violence is notoriously difficult [2]. Almost all people have had an intimate experience of violence in their own lives. Various labels, family, domestic and sexual violence are major health and welfare issues in Australia and globally.

The Queensland Coroners Court [3] reported on two five-year periods (2006 to 2015) finding that the rate of domestic and family homicides in Queensland has remained stable at approximately two per month. Of those, where the offender's gender is known, nearly 84% were male and 16% were female. Females are more likely to be victims of intimate partner homicides by a ratio of 4 to 1. Within the broader category of family violence related homicide there is no significant gender difference among victims. Within this group, more than half of the victims of family homicide were children under 18. Another significant group are bystanders, killed by an offender in the context of family violence, but not an intimate partner or family member. In this group, the victims are male and between 2006 and 2016 in Queensland, 17 men are killed in this way [3].

This is repeated Australia-wide with four women dying each month, and 20,100 people hospitalised due to assault [4]. Police are called to a domestic and family violence event at a rate of one every two minutes [5]. One in six women in Australia have been subjected to physical or sexual violence from an intimate partner and one in 19 men [6]. Suicide and intentional self-harm are also significant public health problems in Australia. Since 2000, at least 2,000 Australians have died by suicide each year and 20,000 have been admitted to hospitals as a result of deliberately inflicted self-harm events [7].

No group appears to be free from the problem of violence. Medical service providers and primary health care teams are situated within the expression of these problems and fundamental to the social and community-wide responses. There have been calls for health care professions and primary care specialists to be actively engaged in population based efforts to prevent and decrease violence [8]. A lesser known but disturbing realm of violence exists within the medical profession itself. There is a

culture of unspoken tolerance toward violence shown recently as Stone, Douglas, Mitchell, and Raphael [9] bravely lift the covers of silence around the gendered violence within the medical professions in Australia, reflecting and confirming similar experiences world-wide [10, 11].

Primary prevention is an effort to prevent the emergence of a particular disease or disturbance or harm before it occurs [12]. Within the wider community, we can see a growing awareness of the need for individuals and communities to take action to prevent violence before it occurs [13]. Yet to be developed, however, are widely available, specific, practical, clinical tools that are efficient and effective in generalist practice settings. These tools are vital because when it comes to harm and violence, we often miss primary preventative opportunities.

There are multiple efforts to attempt to address violence at the secondary and tertiary prevention levels. These include targeted interventions aimed at minimising recurrent or escalating acts of harm, preventing death, severe disturbances or harms. Every state of Australia has concerted and often government funded campaigns as part of the national response to the alarming levels of violence in Australia. The *Our WATCh*¹ campaign is an example of a national campaign to tackle the problem of gender-based violence. It situates women's social and economic inequality as theoretically prime and correlated to domestic violence. It has multi-layered, multi-pronged, well-resourced programs and encourages everyone to be active in violence prevention in their own local contexts. This work is to be encouraged and is creating change.

The Queensland Domestic and Family Violence Death Review and Advisory Board [14] have called for innovative approaches that are flexible, responsive and focus on strengths if we are to achieve better outcomes responding to family violence, especially in services provided to Aboriginal and Torres Strait Islander people. The Special Taskforce on Domestic and Family Violence [15] in Queensland points to

¹ <https://www.ourwatch.org.au/>

the problem of acute need prioritisation, the predominant focus of many current service agencies' responses and recommended breaking away from an incident focussed response system (p. 46).

Addressing the needs of those who have experienced harm in their homes and communities, most likely women and their children continues to be a vital task. Responding after a violent action or only after a complaint has been made is not sufficient. We need to find new processes and bring attention to opportunities for early intervention, action and education, that 'emphasise prevention *in the first place*' [16].



The C-10 model is for use in clinical practice to complement the variety of initiatives developed to tackle violence in our communities. The model has been developed in reflective clinical practice and is the result of generative and systemic activity. It has been informed by literature from various disciplinary fields including the micro-sociology of violence of Randal Collins [17], behavioural psychology [18, 19], intersectional theory [20] and other critical theories (feminism, critical race theory etc).

The work to date that has been done captures 'Level 5' evidence: single case anecdotes from clinicians using the C-10, accompanied by their expert opinion and the personal observations from colleagues, patients and, on occasions, their families or partners. We believe that health professionals have a powerful role in making decisions and interpretations about the meaning of experiences, signs and symptoms of others who come for care. While the practitioners are important, they are perhaps not the most important 'expert' when it comes to the effective use of the C-10. For practitioners, the C-10 encourages the expression of cultural humility, recognising that the people who come to them for help are experts in their own culture and lived experience. This practice of cultural humility requires a deep respect [21]. The authors expressly endorse an ethical use of clinicians' interpretation and explanation capacity, also known technically as hermeneutical power. The ethical use of hermeneutical power is summarised by Vattimo [22] as a philosophical position that embodies the deliberate softening of strong and aggressive identity, the rejection of violence and the recognition of other. Extending that recognition to the point where power will be used to benefit the other. This process has the intention of enabling and engendering 'inhabitability' [23]. Inhabitability, contrary to the multiple types of uninhabitable, requires more of a state of balance to meet the needs of all living people and things within a particular environment. The ongoing problem of intimate partner, domestic and community violence, including pets and other animals, renders homes and workplaces hostile environments, which become uninhabitable and requires deliberate, thoughtful and respectful processes and efforts to change.

Pathology is the study of suffering and as discussed above, violence is a ubiquitous pathway to suffering. The word violence comes from the Latin *viola* – to violate or breach. It is appropriate to continue to use this word as it implies and conveys the unwelcome and 'breaking-into' aspect of harm. A functional pathogenesis describes the necessary conditions and processes that lead to problem states [24]. To understand how violence emerges, erupts or occurs, it is important to have a pathogenesis of violence itself. Developing a useful pathogenesis is an important stage in intervention design. From understanding the process of emergence, opportunities to change the situation become

clearer. When those deliberate change actions are effective, they may become treatments. Once we have an effective treatment for a problem, only then can the process of screening for the early stages of that problem be of any use [25]. What we currently lack in violence prevention is a clear, generic pathogenesis for violence and interpersonal level harm. Models like ours proposed here, need to reflect the scholarship devoted to explaining the social constructs, risk factors and social determinants, as well as build on more individual level emotional and psychological learning, models hypothesis and work [13, 26].

[What some others have said about what causes violence](#)

The Prevention Institute [27] in the United States assert that violence is a learned behaviour that can be unlearned or not learned in the first place. This organisation recommends an integrated framework of programs, practices and policies at local, regional state and national levels. The Spectrum of Prevention tool [28] is recommended and at the first level is strengthening individual knowledge and skill, to enhance an individual's capacity to prevent injury and promote safety. The prevention spectrum model builds on the Haddon Matrix from 1964 [29], which recommends an ecological approach to prevention understanding time, setting, resources and opportunity influence outcome and harm.

More recent work adds value to these foundations. Randal Collins [17] recent work describes a microsociology of violence. Through his detailed reconstructions and analysis of actual violent events, he demonstrates some of the immediate factors necessary for violent acts. From the available information obtained via CCTV, social media, contemporary video, photographs, witness recall and police reports, he presents a comprehensive understanding of violent acts from multiple standpoints. His work is not dependent on just mediated versions of events from the news media. Deliberately focussing on a microanalysis of many different types and instances of violence, Collins does two very significant things. Firstly, he demonstrates that contrary to many widely held myths in popular culture, violence is not easy. Collins highlights that the precursors to actions, in what becomes a violent

situation, is confrontational tension, fear and heightened emotion. He shows that this tension and fear actually block practiced, planned or imagined responses.

“I have argued that people are not good at violence; the big barrier that any violence must find it's a way around is confrontational tension/fear. This is what they are chiefly afraid of – not the fear of being hurt, fear of sanctions from the larger society, fear of being punished.”

[17 pp. 148-149]

Secondly, Collins explores various situational process of transforming the confrontational tension/fear into acts of violence. For example, he describes ‘forward panic’ and ‘ritual repetitive emotional control’ and other strategies used to penetrate the regular barriers that usually counter-act and block violence from happening. We are, therefore, of the view after reading Collins [17], that the low hanging fruit in violence prevention may be an understanding of just how difficult violence is to initiate. This emotional barrier to violence is the feature to concentrate primary prevention effort toward. As we will go on to explain, if just one of the factors of violence is kept below its threshold, violence may be averted. The importance of Collins’ work is to show that emotional tension must be overcome for violence to emerge, and that this emotional tension can be reinforced and enhanced where possible to avoid, delay and prevent emergent violence. Efforts to increase the awareness of risk, i.e., to make it harder for violence to emerge, are likely to be effective at relatively low cost. For example, the relative low cost of primary violence prevention efforts have been shown in a randomised control trial of an emergency department intervention where the authors conclude that the cost to prevent an episode of youth violence or its consequences is less than the cost of placing an intravenous line [30].

The positive behaviour approach has been in continuous use for over 30 years and was developed by the Institute for Applied Behaviour Analysis (IABA) [31, 32]. The positive behaviour approach responds to problem situations in complex social circumstances characterised by significant levels of

The Period of PURPLE Crying® program

This is an effective example in a particular area of specific violence prevention that is used widely across the world, including here in Australia. This positive and strengths focussed primary prevention program designed to educate all parents and families with a newborn. It is a resource to assist parent learning about their baby's early development and their pattern of increased crying in the first few months of life. The resource identifies the situations and consequences of responding to this crying with frustration and teaches baby soothing and carer self-control strategies to help individuals and families better understand and care for themselves and their new infants. The program demonstrates the viability and value of a positive intervention aimed at education, developing resilience and identifying key factors that lead to the tragic occurrence of an inflicted infant head trauma event. [1]

disturbance and harms. Their approach informs our primary prevention pathogenesis and is distinct from categorical models that posit people who perpetrate violence as inherently damaged or evil.

From developmental psychology, a significant contribution to understanding violent action in this field is through the Tompkins Institute and the work of Daniel Nathanson. Nathanson, a clinical professor of psychiatry and human behaviour at Jefferson Medical College, built on Tompkins' theory of affect as part of the George Bush Senior's National Campaign Against Youth Violence 2003 [19, 33]. This body of work explores an individual's reactions when their situation disrupts their connections with others and aligns with the significant body of work around the pathology of social exclusion, for example see DeWall et al and Wesselmann, Wirth and Bernstein [34-36].

[Is this a good idea for doctors who are already busy? We think yes](#)

The C-10 model enables clinicians to address these challenges with people who are able to reflect on their situation. It is not intended to be an alternative to post-event crisis intervention but to inform primary care prevention. Working through the C-10 model people are able to more clearly understand their situation and

its potential for violence and then take pre-emptive action to prevent or interrupt its emergence. This enriched understanding enables reflective adjustment within situations, changing attitudes and identifying opportunities to make violence less likely.

General practitioners and other health care providers working in primary care settings are in a unique position for the primary prevention of violence. They have the potential capacity to implement both broad based, and targeted, positive prevention strategies and initiatives in Australia. Addressing the potential for violence, in a caring and sensitive manner is difficult, and depends on effective partnerships between clinicians and the people seeking help [37]. Our work aims to foster and strengthen those relationships particularly enabling an effective problem structuring conversation about any situation that may lead to violence. This seems to us to be completely within the remit of a professional group that provides whole-of-person, whole-of-life care [12, 38]. Some responsibility for this work appropriately belongs to generalist doctors and other health professionals who work to minimise suffering in all of their different community and workplace contexts, rather than what might be seen as the exclusive domain of psychologists, social workers and violence response professionals. In particular, in more resource poor settings, the remote primary health care clinic may be the only available setting for this work.

[The Cooktown Ten - a pathogenesis, problem structuring model \(C-10\)](#)

There are ten concepts drawn together within this model. The C-10 takes an educational opportunity to describe and recognise four generic processes of a rich and diverse life that will proceed with or without violence, within the situation at hand. Paraphrasing an ancient African legend [39] life's rich diversity revolves around four ongoing processes that are simplified for our model, use, convenience and counselling:

- inputs (nutrition and resources input) - partaking
- outputs (waste and produce management) - pooping

- social action (moving, meeting and mixing with others and in groups) - procreating
- palliation (managing heritage, legacy and tradition) - passing on

Accepting this ancient wisdom, these processes always require future action. In real life, problems emerge within the daily activity of these processes, and there is always a range of learned cultural responses to these problems. Potentially, it is within these responses that the factors necessary for violence to begin are identified. A rich picture is a systemic tool used to explore, acknowledge, and define a situation and create a mental model of what is going on [40]. As a visual prompt and to map the process, the clinician creates a C-10 rich picture (see Figure 1 below). The rich picture will explicitly show in the final product, the vectors, influence opportunities, capacities and experiences that might move someone and their immediate group toward or away from an expression of violence.

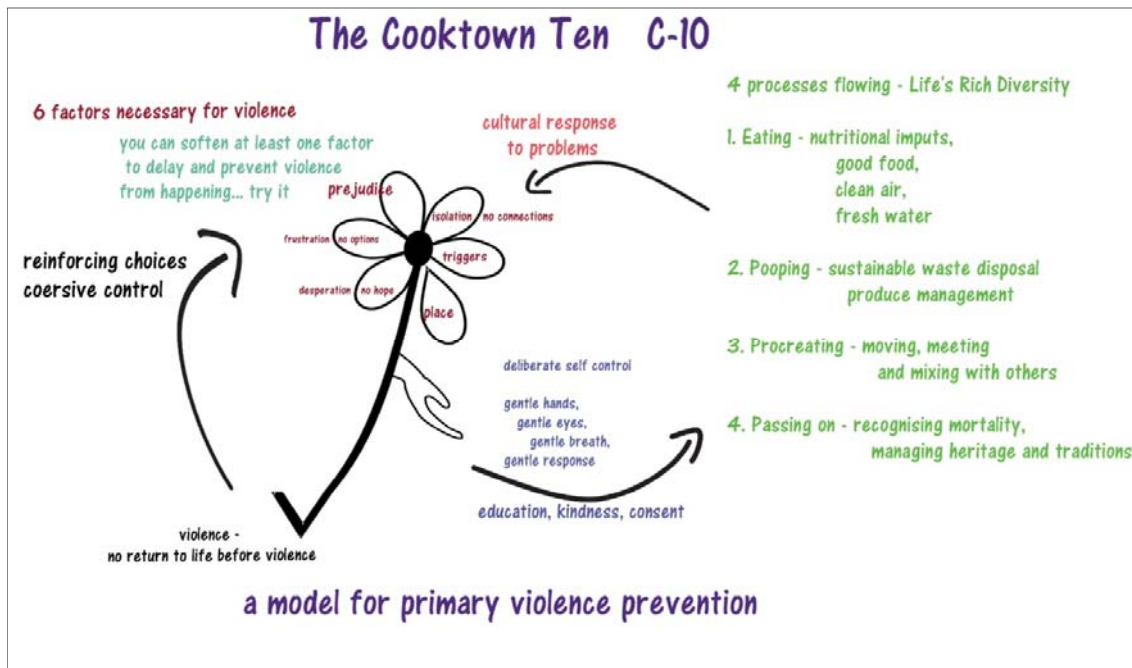


Figure 1. The Cooktown Ten model

In green, the four basic life processes. On the left of the diagram are the 6 factors necessary for violence. Making explicit the connections and processes to shift from one state to another is the 'how' of the Cooktown Ten as a diagnostic tool for clinicians.

The four basic life processes are labelled on the right, and six factors necessary for violence, depicted to look a bit like the petals of a flower, are also drawn and discussed. These six factors are: isolation, frustration, desperation, prejudice, place and triggers. Each will be elaborated in the section below. The overall purpose of the diagram is to prevent, avoid and minimise the chances of violent expression, represented in the rich picture as a 'V' at the foot of the flower's stem. It points away from the whole situation and emphasises that an act of violence is a violation. Once perpetrated every act of violence cannot be undone. The 'V' which is an imagined future violent act and represents the crucial event to be prevented.

The four process and six factors make the ten elements of the C-10. Explicitly, these are analysed with the situation and person in focus to enable effective problem structuring. This allows the situation to be understood and to design future actions and plans that don't include violence. Connecting flows or influence vectors demonstrate to the patient or client how to shift from the left to the right side of the picture, without resorting to interpersonal power abuse or violating others or self. This model is used to show how opportunities might be developed to return to the life process side of the rich picture. Emphasis is drawn to express that the life processes always continue. Potential changes can affect each person's experience of their connectedness and enjoyment within their situation and among their community or family group.

When you look back at the rich picture with the person in the session, you can emphasise the positive elements and highlight areas that require deliberate effort for change. Within the take home rich picture there are seven elements of positive action and reflection without violence that can be highlighted as a visual prompt or to do list—maintaining and building hope, creating and increasing connections, recognising and developing options, and engaging in activities of daily living for partaking, pooping, procreating, and passing on. The other three—prejudice, place and triggers—require deliberate violence avoidance efforts. A review of the particular expression of these concepts and the connections between them, in a real life situation, provide clinicians with an opportunity to

improve the understanding of that situation as a system with their patients, clients and their families. The next section of this discussion paper describes in turn each factor for violence.

The 6 factors necessary for violence

There are six factors above a necessary threshold for an act of emergent, entrained, and likely incompetent, violence to be initiated. It is our contention that if all six are necessary for an initiating an act of violence, then if any one of these factors is kept below threshold, violence can then be prevented primarily. To re-emphasise, we believe primary care is an important context to teach people about these opportunities.

Isolation – lack of connection

One of these necessary factors for the initiation of a violent act is a level of perceived isolation. In this context isolation is a private and internal sense that develops when and wherever somebody feels cut off from the pathway, processes and opportunities that they were expecting to be a part of [17]. There is a mismatch between their expectations and their life experience. In colloquial terms, the person feels that: *there is no one who will help me with this*.

This idea resonates with Nathanson [33] and the Tomkins Institute [19] construct of shame and with the notion of being cut off from the herd [41]. Clinicians might also bear in mind that memories created by exclusion and social pain have been shown to be more disruptive, more intense and more easily recalled than memories invoked by physical pain [42, 43]. There is an increasing imperative to act to change your situation as this deep sense of separation becomes intolerable. We see this reflected in violence demographics and statistics with increasing geographical, social and economic isolation [44]. This sense of isolation feeds on itself and interacts with the other factors. If deliberate effort to improve social connection and contact with others to relieve any sense of pathological isolation, violence might be avoided.

Frustration – lack of options

Frustration is a feeling of being upset or annoyed as a result of being unable to change or achieve something [45]. It is a common emotional response to the failure of another to meet one's expectations and arises when somebody perceives resistance to the fulfilment of an individual's will or goals—it is likely to increase when a will or goal is blocked [46-48].

Frustration, and the belief that one has exhausted all other options, is another factor that must reach above a threshold to enable violent action [17]. It is the result of an ongoing perception of the absence of viable options. Frustration embodies a sense of disappointment at previously ineffective actions for change. The anticipation of ongoing frustration is another debilitating internal position [17].

An expectation of ongoing frustration into the future and the perception that the situation or another person will continue to do what they are they doing, is relevant to this factor. The person involved believes that the others in the situation will continue acting in a predictable and unwanted manner [49]. The development of patience is multidimensional and complex. Patience depends on rich resources of frustration tolerance. Frustration tolerance is a strength but when spent, is a clear factor in the emergence of violence [50].

Desperation – no hope

Desperation results from an ongoing experience of feeling deprived of hope [17, 51]. It is the perception that the situation you are in is so bad, that it is impossible to deal with. A sense that there is no hope that anything will change. Our model posits that as a trio, isolation, frustration and desperation, reinforce one another: an absence of meaningful connections to others; an anticipation that there will be no change in the future, and that previous efforts to make a difference have not resulted in altering the outcome. Collins [17] shows repeatedly that without the three elements of isolation, frustration and desperation co-existing, violent actions do not proceed.

An awful effect of ongoing violence in the home is illustrated by McGee [52]. People who experience ongoing violence themselves become isolated, frustrated and desperate. Their strength within this situation, ironically, is often a barrier for accessing help [52, 53] Women and children who are perceived to be strong and coping with their situation are not prioritised for intervention either by themselves or service providers [52].

Prejudice – reinforced by media, pornography, self-opinion, racism & sexism

Prejudice is what you actually believe to be true. It is an important concept in the C-10. Prejudicial thinking is another key factor that must be present above a necessary threshold for violence to occur. A significant factor needed for an act of violence in this model is the intuition or knowledge that a person brings into a situation. Prejudice is a firmly held belief which is often unacknowledged; that your own ideas are worth more than others in your environment.

Prejudice is a judgement made prior to an event or a situation that helps people make sense of a situation. It is forming a decision or opinion based on knowledge brought to the situation by the individuals involved and is reinforced by people's experiences, capacities and preferences to reflect on their experiences. Modifying prejudice challenges one's opinions and those of their perceived authority figures. Prejudice is not always malevolent, however, the prejudicial thinking that informs malevolence or harm to others is what we are particularly interested in exploring and analysing [54-58].

Significant reinforcers of social and situational prejudice include the media, and in particular for domestic and sexual violence, and pornography is a major influence [59, 60], as are the broad intersectional flows [20] (i.e. sexism, racism, ableism, ageism). Another significant part of prejudice, in our context, includes a person's beliefs about themselves, their own capacity and their opportunities, expectations and experiences. We recognise that it is difficult for everyone to challenge their own prejudices. The Our WATCh project in Australia is hoping to encourage everyone to

challenge their own beliefs about gender equality. The aim of that project is to decrease the level of violence experienced by women and children in Australia [61].

Place – of relative stability

The IABA approach underpins the two remaining factors [32]. In this framework for primary prevention a key factor is the setting, which includes time, place and circumstances [62]. A shared setting is a physical space or place where a person feels comfortable enough to act. A protagonist's sense of, and confidence in, their physical and emotional stability within a place is key to reaching the threshold of this factor. Even a momentary and transient stability may be enough for a violent act to occur. Places of familiarity, routine and relative security are predictable social environments. They are more likely to match the places where violence first occurs and are ubiquitously familiar places such as the home, car, work place, Centrelink office, areas of public entertainment (i.e. bars, nightclub precincts), school and, for those who live in them, prisons.

The importance of stability can also be seen from a strictly bio-mechanical perspective [63]. No one is able to move except from a position of stability, even if this is momentary and transient. Because it is hard to be violent and one needs to overcome the barriers of confrontational tension, fear and heightened emotion [17], it is more likely that violence will occur in environments where a person feels more secure, stable and able to summon the focus necessary to initiate the act. This explains why so much violence occurs in the home. In some situations going to another place may be the easiest option available to the person who might otherwise act in a violent manner.

Triggers – context specific

Drawing on the work of IABA, actions and behaviours can be triggered by a particular moment, event, situation or stimulus. These events focus a person's thinking on their prejudice, frustration, desperation and isolation, and creates a sense of stability from which a person acts. Triggers are situation and person specific. The trigger can be complex or quite simple. Many triggers are well

recognised, and may range from a crying infant, to a harshly spoken word or challenging eye contact, while others maybe more individual.

Sensitivity to triggers is related closely to cognitive arousal and inhibition [18, 19, 32]. Impulse control is an important concept here. Substances and situations that decrease your inhibition also change impulse control. For example, alcohol and hypnotic drugs decrease your resistance to your reflective inhibitions where other substances, like stimulants, heighten impulsivity. Substance use does not cause violence in and of itself but decreased inhibition and/or increased impulsivity. Our model enables recognition of the influence of substances and situations that increase a persons' sensitivity to their likely triggers needed for a violent act [64]. Other clinical situations (e.g. from within psychiatric settings, or for some people living with an acquired brain injury), where impulse control and the capacity for reflection prior to action are limited, are often characterised by violent acts.

Confluence of the 6 factors

An important notion for people to recognise is that the six factors may co-exist, that each factor will have a threshold which, when exceeded, an act of violence is more likely to be initiated, yet the threshold of each will be context specific. When the six factors reach threshold, strong emotions of contempt and condemnation arise just prior to a violent act [65]. This point is crucial and is represented by the dark space at the centre of the 'flower' in the rich picture. This represents when and where the factors conflate and converge. At this point, the only person who can prevent the violence is the one who would perform it. A deliberate rejection of violence is an option that depends on the recognition of the vulnerability of all the participants and their relative power and capacity to change the situation. If this moment is not recognised and this opportunity is not taken, an act of violence may occur. In our rich picture, this is drawn as a 'V' below the confluence of the six factors at the edge of the diagram (see Figure 1 above). It serves as a reminder that the act of violation cannot be undone and that there is no return to a situation where any involved person or relationship does not include at least a memory of an act of violence. This experience of violence cannot be taken out

of the memories of those in a relationship after it has occurred; there is never any going back. Crucial trust and innocence can never be completely restored [66]. If at the penultimate moment one of the pathways away from a violent act is chosen, becoming a perpetrator has been avoided.

In practice, the conversation is introduced and started by taking a sheet of paper, holding it in landscape orientation and drawing a 'V' marked 'violence' near the bottom left corner of the page. The topic is introduced by saying something like:

Many people in this situation end up being violent. In fact, lots of people become violent – even though it is really hard to do. What I'd like to do is go through the process of how violence occurs, and what we can do to make sure this doesn't happen with you.

Choice opportunities become apparent and are illustrated within the rich picture as the conversation evolves and the picture is drawn.

There are two significant vectors left for us to describe. One is the vector which demonstrates acts of deliberate self-control, kindness, consent or self-education which shifts the situation from one of impending violence to a healthy expression of the four processes of life. This links the stem below the petals, away from the potential act of violence, to enable positive re-engagement in the processes of a rich and diverse life. These future actions are illustrated and discussed within the 'equality' nonviolence Duluth Wheel [67].

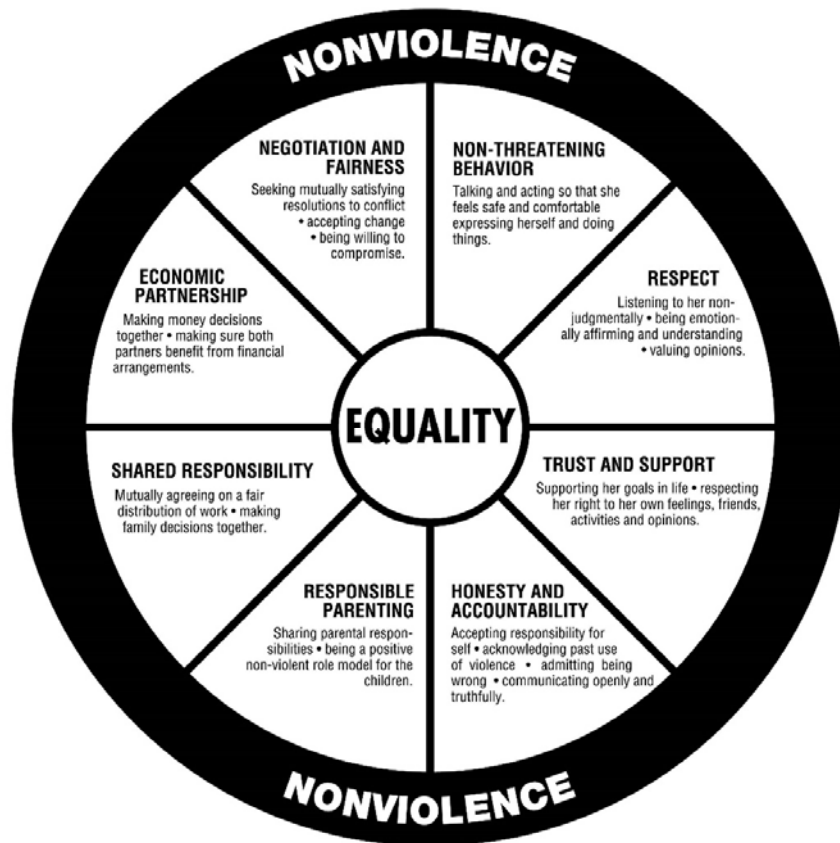


Figure 2. Duluth wheel of equality

Source: Domestic Abuse Intervention Program <https://www.theduluthmodel.org/>

For a person who can easily recognise their situation as potentially sitting within the dark confluence of all of these factors, but who asks: *well what can I do now?*, they may be helped by one particular strategy that we have used and taught elsewhere. It is a mindful, self-calming technique called the ‘Gentle Hands’ strategy [68, 69]. The hand off the stem symbolises an open, relaxed and calm disposition. The Gentle Hands strategy involves a person deliberately relaxing their hands, softening their gaze and deliberately breathing deeply and slowly. This technique is an example of deliberately mindful self-control.

The other important vector is drawn from the left side of the rich picture linking the ‘V’ to the confluence of the factors. This vector shows that if violence is not avoided, there is great potential for styles and types of violence to become recurring or reiterating. Assuming there has been a violent act,

and we have missed the opportunity for primary prevention, the C-10 model also illustrates just how easily violent acts reinforce the prejudice factor, and that recurring cycles of violence can be understood, imagined and explained. These cycles are all too clearly experienced by many, and very well represented by the power and control Duluth wheel [67].

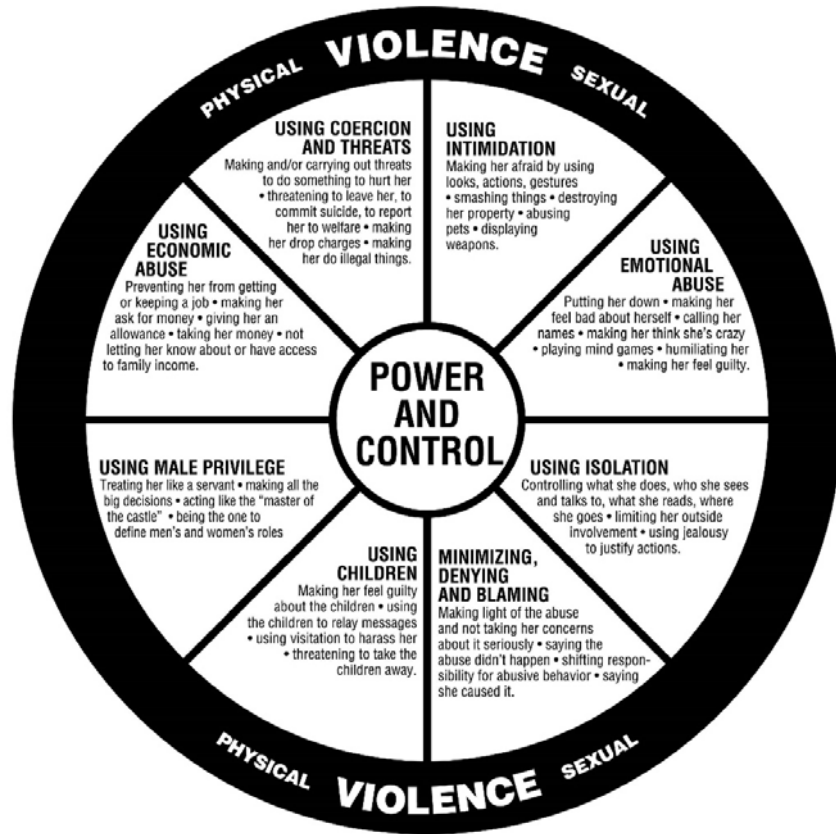


Figure 3: Duluth wheel of power and control

Source: Domestic Abuse Intervention Program <https://www.theduluthmodel.org/>

The purpose of our primary prevention work is to avoid any more people living and dying within cycles of violence.

On conclusion of this education intervention, the rich picture is taken by the person in focus. We are told by several people that the picture is taken home to post on the fridge, keep next to the bed, or kept in a pocket, as a reminder of the conversation. This then enables individuals to make modifications to any factors to move their situation away from the escalating potential for harm and

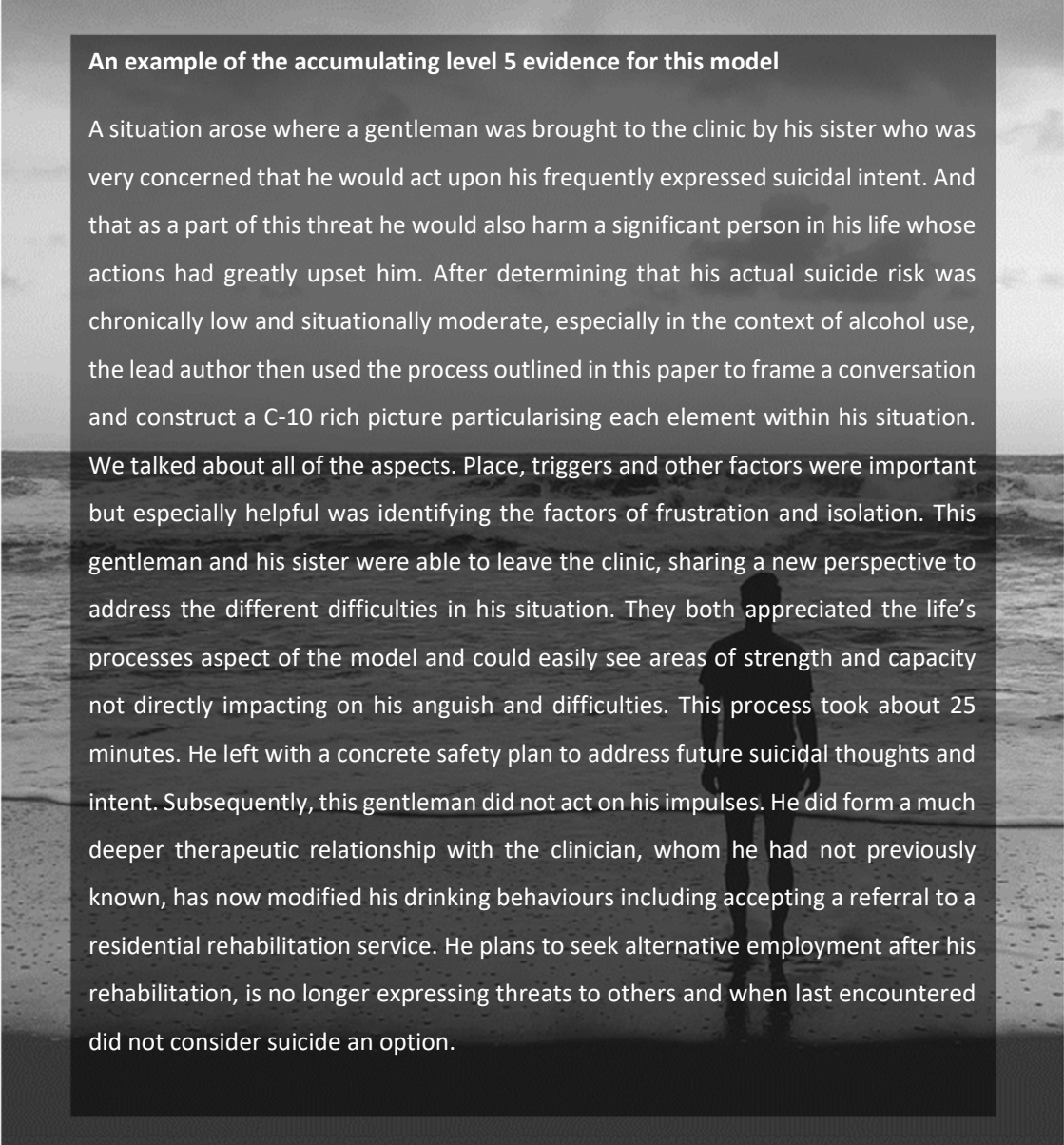
violence. A factor modification might include deliberately seeking connections and decreasing a sense of isolation. Another example might be to pursue options to minimise a sense of frustration. Another important modification might be to understand the influence of alcohol and drug use on lowering the thresholds of each factor.

The contention is that if a factor is kept below the required threshold, the act of violence is delayed, then avoided, and does not occur. *Violence has then, in fact, been prevented.*

Clinical use of the C-10

The C-10 is being used in clinical application by professionals in Far North Queensland, including the lead-author, and has been utilised to enable problem structuring and program design around nonlethal self-directed harm, interpersonal family community violence prevention and alcohol and prescription drug misuse, with patients from mainstream Australian, Aboriginal and Torres Strait Islander, and culturally and linguistically diverse communities. The challenge for all of us interested in minimising or avoiding the harm of violence is helping people recognise the finality of their misuse of power. Much of the prevention literature and problem structuring in our contemporary understanding of violence, especially against women and their children, focusses on these cycles of recurring and developing interactions (i.e. coercive control and power misuse).

The C-10 violence prevention model rests on the belief that for each individual and their various relationship with others, there is a time before any act of violence has occurred. It is imagined that this model will inform education efforts. These efforts should be targeted and developmentally appropriate where necessary for high-risk groups. It is a counselling tool to prevent subsequent acts of violence if the opportunity is recognised and the chance is taken to improve the situation.



An example of the accumulating level 5 evidence for this model

A situation arose where a gentleman was brought to the clinic by his sister who was very concerned that he would act upon his frequently expressed suicidal intent. And that as a part of this threat he would also harm a significant person in his life whose actions had greatly upset him. After determining that his actual suicide risk was chronically low and situationally moderate, especially in the context of alcohol use, the lead author then used the process outlined in this paper to frame a conversation and construct a C-10 rich picture particularising each element within his situation. We talked about all of the aspects. Place, triggers and other factors were important but especially helpful was identifying the factors of frustration and isolation. This gentleman and his sister were able to leave the clinic, sharing a new perspective to address the different difficulties in his situation. They both appreciated the life's processes aspect of the model and could easily see areas of strength and capacity not directly impacting on his anguish and difficulties. This process took about 25 minutes. He left with a concrete safety plan to address future suicidal thoughts and intent. Subsequently, this gentleman did not act on his impulses. He did form a much deeper therapeutic relationship with the clinician, whom he had not previously known, has now modified his drinking behaviours including accepting a referral to a residential rehabilitation service. He plans to seek alternative employment after his rehabilitation, is no longer expressing threats to others and when last encountered did not consider suicide an option.

The C-10 is generating interest in the non-government and social justice sectors including youth services and prisoner repatriation programmes. An earlier version of the C-10 is included in the Rural Doctors Family and Domestic Violence Education Package for members of the Australian College of Rural and Remote Medicine (www.acrrm.org.au) and is the subject of ongoing trial and development in partnership with the Rural Doctors Association of Queensland Foundation (RDAQF).

Another area where the C-10 model has proved useful in clinical practice by the primary author is the retrospective analysis of a surprisingly violent event. For example, following an unpredicted suicide of a family member several different family members have presented with various responses of anguish, disquiet and upset. The lead author has used the C-10 to structure a conversation around the events and influences that might have been modified and may have led to a different outcome.

At a macro level, there is an emerging interest among professional bodies involved in the selfregulation of the medical profession whose response will need to strengthen the capacity to recognise and respond with effective primary prevention action to stop violence within the medical workplace setting. We believe the C-10 may inform some of these responses.

Violence prevention in Australia requires robust and ongoing effort to make any difference. At this stage of this violence prevention project, we have very little level 1, 2 or 3 evidence. At this stage we have only level 5 evidence, however, the problems are so significant and pressing with appropriately philosophically sound and responsible use, clinical endeavour is justified.

We suggest that GPs can use the model as a tool for developing a dialogue of analysis and reflection for a holistic approach. It looks into the opportunities, constraints, and relationships of the people, structures and events that make up the situation in focus. This is a systemic empowerment approach intended to capture the importance of problem structuring and situation mapping by individuals and collectives, to foster a range of outcomes that are desired.

Finally, a word about the flower ...

We are often asked about the flower that features strongly in the rich picture of the C-10. We believe this serves two purposes. Firstly, it is a strategy to create cognitive dissonance and encourage thought because people are not expecting you to draw a flower when talking about the potential to do violence. Secondly, when the person leaves the clinic they have not performed imagined acts of violence, and they leave with a symbol of great hope. The flower is a symbol of the belief of the clinic

staff in the value and worth of the person who has come for care, that despite the difficulties and complexities of the situation, they can participate in life's rich diversity without resorting to acts of violence.

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