Scientific Research Publishing

Psychology, 2024, 15, 414-432
https://www.scirp.org/journal/psych
ISSN Online: 2152-7199
ISSN Print: 2152-7180

Recovery in Peer Support Groups for Batterers—A Qualitative Study

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How to cite this paper: Vendrig-de Ron, A., & van Dam, A. (2024). Recovery in Peer Support Groups for Batterers—A Qualitative Study. *Psychology, 15,* 414-432.
https://doi.org/10.4236/psych.2024.153026

Received: February 22, 2024
Accepted: March 26, 2024
Published: March 29, 2024

Abstract

The effects of IPV treatment programs appear to be modest. A possible explanation for the mediocre results may be that the problems for a subgroup of batterers have a more chronic character. Chronic vulnerabilities require other interventions, such as peer support and self-help groups. These interventions have the advantage that they enable more identification between caregiver and client, may take longer and are more flexible than regular care. Since 2015, several self-help groups for batterers based on the 12-step program were established in the Netherlands. The aim of this qualitative study was to investigate to what extent the peer support group contributes to personal recovery, based on the CHIME model, from the perspective of the (former) participants of the peer support group. Aggression regulation problems are regarded by the participants as chronic conditions. Participation in the peer support group increased their ability to control their aggression, but also improved their quality of life. The recovery process described by the participating batterers fits well with the concepts of the CHIME model. Batterer intervention programs may therefore benefit from shifting to a recovery paradigm adopted from programs for chronic conditions.

Keywords

Domestic Violence, Batterers, Peer Support, Recovery, Aggression

1. Introduction

Violence in families is a major problem, causing personal suffering, physical and mental health problems and significant economic expenses (Bosch et al., 2017; Duvvury et al., 2004; Garcia-Moreno et al., 2006; WHO, 2021). In the literature

on violence in the family context, the term domestic violence and intimate partner violence are used. Programs aimed at individuals who use violence in their families are called Batterer Intervention Programs (BIPs) or Perpetrator Intervention Programs (PIPs). We will use the term domestic violence in this article because the violence is not for all participants restricted to the intimate partner and use the term BIP, because the participants that participated in this study preferred this term.

Since 1990, several Batterer Intervention Programs (BIPs) have been developed because changing the batterer's behavior is probably the most relevant strategy to reduce domestic violence (Cunha et al., 2023). In this article, we will describe a specific BIP, a peer support group for batterers called "Men against Aggression (MAA)". Subsequently, we present a study on the contribution of MAA to personal recovery from the perspective of the (former) participants of MAA. Before we describe this method and this research, we first give an overview of the historical context in which this BIP was developed and what the results are of previous variants of this method.

1.1. Batterer Intervention Programs

Initially, in the 1970s, BIPs were developed as part of a larger movement addressing the rights and needs of battered women (Bowen & Gilchrist, 2004; Feazell et al., 1984; Pirog-Good & Stets-Kealey, 1985). These BIPs were based on the Duluth model that considers Intimate Partner Violence (IPV) as a way to assert power and control. It has been successful in increasing awareness of the problems created by IPV, but not in reducing the intensity or frequency of aggressive behavior. It lacks focus on the emotions and needs of offenders, which results in low motivation to change (Gondolf, 1993; Star, 1983). In 1990, IPV perpetrator treatment and treatment protocols based on Cognitive Behavioral Therapy (CBT) were designed. CBT focuses on adjusting cognitions, emotions, coping skills, and anger management techniques and uses a collaborative style in order to engage clients (Day et al., 2009; Eckhardt et al., 2006; Feder & Wilson, 2005).

Although IPV perpetrator treatment programs were solidly substantiated theoretically, reviews conclude that the treatment effects are modest and range from medium positive mean effects to small harmful effects and rates of dropout and recidivism are high (Bowen & Gilchrist, 2004; Day et al., 2009; Cunha et al., 2023; Eckhardt et al., 2006).

A possible explanation for the mediocre results could be that the problems of the offenders are similar to those of other groups of clients for whom behavioral change is difficult, such as addiction. Behavioral change then requires long-term commitment and maintenance. For these types of problems, other interventions are used, such as peer support and self-help groups, which have the advantage that they enable more identification between caregiver and client, may take longer and are more flexible than regular care (Eddie et al., 2019; El-Guebaly, 2012).

In response to this, some models of treating IPV perpetration also aim to treat comorbid addiction and substance abuse behaviors (Klostermann et al., 2010; Kraanen et al., 2013; Ronel & Claridge, 2003). Grace therapy (Ronel & Claridge, 2003), for instance, utilizes a similar structure as 12-step programs, such as Alcoholics Anonymous (AA), to address both addiction and battering. Senior members serve as positive role models and supporters, a role comparable to senior members in self-help 12-step groups who serve as mentors (Ronel & Claridge, 2003).

1.2. Self-Help Groups for Batterers

Self-help groups for male batterers, based on the 12-step program (Batterers Anonymous, BA), started four decades ago. Goffman (1980) was one of the first to propose batterers' self-help groups and advocated a model similar to Parents Anonymous. Parents Anonymous (PA) is a self-help group based on the 12-step program for parents with the goal of preventing child abuse and providing support for parents. Unlike traditional twelve-step programs, PA mandates professional involvement.

BA-program management is facilitated by a group leader, selected by the members, and a sponsor, who is a professional or paraprofessional trained to provide guidance and support for group members. Members maintain their anonymity and respect the confidentiality of material shared (Goffman, 1980). BA group members support one another in identifying and developing positive alternatives to the abusive behavior. They share phone numbers so they can support and advise one another in times of crisis. The participation in this group was proved to be effective in helping individuals find alternative ways for violent and domineering behavior (Hamm & Kite, 1991).

Edleson and Syers (1991) developed and tested a self-help group that was minimally structured and facilitated by a former batterer. The group members defined the topics to be discussed; however, four topics were discussed by either the facilitator or the consultant at some point during the length of the group. These four included: 1) personal responsibility for violent behavior, 2) developing a personal plan for being nonviolent, 3) use of time-out as a way to diffuse tension, and 4) how violence develops. The authors state that the self-help model used here was similar to the large number of self-help programs currently available to batterers in this country. Although self-help groups are usually offered as aftercare programs for men who first complete more structured groups, self-help was used in this study as the primary intervention for men randomly assigned to receive it. They concluded that the self-help group was effective in reducing violence and threat but that these reductions were larger and more stable in a combination between a self-help group and a psychoeducation group.

In 2010, a self-help group (Grace Therapy) for men who successfully received therapy for domestic violence was established in Israel (Gold et al., 2017). The group members are supported by a social worker who also participates in the group and forms the leadership of the group with one of the group members.

The group members learned to lead the meetings, and some members completed a training of the 12-step program for treating domestic violence to enhance their ability. In a qualitative study group members indicated to experience more personal empowerment and quality of life which reduces triggers for domestic violence. *The support they received in the group* also inspired the members to help other men who use domestic violence (Gold et al., 2017).

1.3. Men against Aggression

Since 2015, several self-help groups based on the 12-step program were established in the Netherlands (van Dam et al., 2015; van Dam & Habra, 2022). The self-help groups are called "Men against Aggression (MAA)" and are, like the groups in Israel, meant for men who successfully received therapy for domestic violence (van Dam et al., 2008, 2009; van Dam & Habra, 2022). The leadership of the group is formed by one or two former batterers who are established in their recovery. The MAA members prefer to call themselves "batterers", as a way to remind themselves that they have a chronic vulnerability to relapse in using violence. The group members meet weekly in a community center to support each other to refrain from aggression and improve their communication with their social network. In these meetings, they learn to express emotions better and endure triggers for aggression, like uncertainty and rejection, without losing their temper. They also have each other's phone numbers so they can call each other when they need support. The peer support worker who leads the group has the opportunity to consult a psychologist with experience in providing anger management training. The program of MAA is closer to the original 12-step program compared to the BA groups and Grace Therapy. The steps have been adapted, by a team of former batterers and professionals, to be more applicable to aggression regulation problems rather than addiction and also the religious connotations of the original 12 steps have been reformulated in a neutral way at the request of the group members (see **Table 1**).

MAA has features of remedial peer support and is based on the recovery values of hope, self-determination over a person's life, participation in organizations, reciprocity, and the use of experiential knowledge to help each other (Slade et al., 2014). Recovery is described by Anthony (1993) as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning". Although using domestic violence is not an illness but a behavioral problem, it can also be seen as a vulnerability that is often related to mental health problems (Sesar et al., 2018). The definition of recovery may therefore also apply to learning alternative coping so that the use of violence can be avoided.

A conceptual framework to investigate recovery processes is the CHIME model, which distinguishes the factors of Connectedness, Hope, Identity, Meaning in Life and Empowerment (Leamy et al., 2011).

Table 1. The twelve steps of the Men against Aggression (MAA) program (van Dam et al., 2015, 2023).

Step	Motto	Text read at the beginning of the session
Step 1: Honesty	I have a problem with aggression	This first step is about admitting that you have a problem with aggression. This is also what brings us together in this group. Recognizing that you have a problem controlling your aggression is difficult. Many people with an aggression regulation problem minimalize or justify their violence. It is not severe or it is the fault of others if violence is used. It takes courage to be honest about aggression. About the seriousness of the violence, the circumstances under which it takes place (sometimes under the influence of substances) and the damage it causes others and yourself. We are gathered here in this group because we all have a problem with aggression. We have insufficient control over the aggression we use and it is disproportionate. Through this aggression we harm ourselves and others. Good intentions alone are not enough to control aggression. We must face this honestly in order to move forward. We have a problem and we cannot solve it alone.
Step 2: Hope	I am not alone	The second step is about the help you can get from others to learn to control your aggression. You cannot solve your problems with aggression alone. Fortunately, there are resources you can use. Some people seek this in faith, others seek it in contact with other people. In any case, you can look for it in this group. We are here together to help each other. The group has the ability to take you one step further. You don't have to do everything alone. Everyone does it at his own pace. We are here to help each other. As a group we are stronger than each individual. Even if you fall back into old habits, you can count on the group. The group members know from their own experience what it is like to have no control over your aggression. But they also know what it is like to regain it and what effort it takes. Talking to your group mates can give you hope and strength.
Step 3: Trust	I accept help in learning to control my aggression	The third step is about learning to accept help. People who have problems want help. But getting help is harder than it looks. The ideas that we have about ourselves, such as pride, the idea of not needing anyone, of knowing ourselves better, can really get in our way. It's important to let go of these ideas about ourselves and to accept that we can't do it all on our own. And that's not a bad thing either. We must learn to trust others. With an open attitude, try to see that help and let go of defined ideas about how that help should come out. You can learn. So far, your efforts to change have not yielded enough. So try to be open to new suggestions. Change is difficult and comes in small steps. Take one step at a time. Big steps go wrong easily. Also try new things, even if they feel uncomfortable. With the help of others, new ways are possible.
Step 4: Courage	I acknowledge the consequences of my actions	In the fourth step, you acknowledge the consequences of your behaviour. You look honestly at the things that didn't go well. And then look honestly at your own part in it. Be careful not to justify your own behaviour or to put the blame entirely on others. Despite everything you've been through in your life, the responsibility for how you deal with it lies with you. You cannot change others and circumstances. The only thing you can change is your own behaviour. Look honestly and without self-pity at your own share of your problems. This is not easy. This takes courage. It can help if you hear from your group members how they did it. In addition to all these negative things, it is also important to look at the positive things that you have done in your life. That can give hope for the future. In any case, it is positive that you came here today. It proves that you have the courage to change your life. At least today you help your fellow group members. Your personal experiences are valuable to all of us.

Continued

Step 5: Reliability	I admit my mistakes	The fifth step is about acknowledging what you did wrong and talking about it with people you trust. This can be people in the group but also outside it. It's not just about mentioning events where you feel you misbehaved. It's also about telling how it feels for you right now. It is important to talk about it with others. Not because others need to know exactly what you have done, but for yourself. If you don't talk about your experiences, your mind may run wild or you may overlook certain things. By talking, you force yourself to put the events in order. You will find that every time you talk about it, you discover new facets to what happened. In this way you get a different more realistic picture of yourself and you release your secrets. This brings relieve. Others can help you by supporting you when you are struggling or pointing out when you justify your deeds. You can help others by listening to their stories. There are many similarities in the stories told in the group. Sharing these stories creates connection.
Step 6: Willingness	I'm willing to look at the tough sides of my character	The sixth step is about looking closely at your own character. To start working on the negative sides and deal with them more positively. One of the most difficult tasks is to look honestly at yourself. It's very tempting to fall into self-pity (I'm not good at anything anyway) or overestimate yourself (from today everything will be different). Changing your character is difficult, but you can explore your possibilities and limitations. When you gain more insight into yourself, you get the chance to develop new norms and values. You can't do that alone and you can't learn that from a book. There are no rules for it. For a better understanding of yourself you need the power of the group. Everyone in the group tells their story bit by bit and discovers more about themselves. By listening to each other, we learn what is important and what is good and what is not. Also for ourselves.
Step 7: Humility	I face my shortcomings and try to do something about them	Step seven is about recognizing and admitting your mistakes and shortcomings and trying to do something about them. This is not just about aggression but all kinds of things that you have not done well in your life. Seeing your own part in all those things that didn't go well gives rise to modesty. Apparently you don't know it all as well as you thought. So stop blaming others for what they didn't do right, and look at what you yourself could change. Be inspired by others and accept that you are not perfect.
Step 8: Charity	I am willing to make amends with people I have mistreated	Step eight is about taking responsibility for the harm we have caused others. Through our behaviour we have hurt or harmed many people. Sometimes the people closest to us. The damage can be caused by what we have done, for example with our aggression, but also by things we have not done but should have done. If we are not willing to make up for it, we will always be afraid of meeting some people. This leads to unhealthy tension. We shouldn't just go up to people to make things right. Many people are not waiting for this and it can cause even more damage. It is a willingness to take responsibility for what others have suffered as a result of your behaviour. Not everyone will trust you right away. After all, you cannot change the other. You cannot demand or enforce trust, you can only be reliable.
Step 9: Justice	I clean up and settle my debts if possible	Step nine is about actually making things right with people. Before you do that, it is important to first talk about it with someone you trust. In some cases, people will like that you want to make things right. They will appreciate you taking responsibility for your behaviour and making excuses. If there is material damage, you could compensate or make an arrangement. With others you can't or only partially make up for it. It is possible that contact with you reopens old wounds. If you expect that, you shouldn't make contact. Check that this is really the case by talking about it with someone else and don't use it as an excuse for not having to do anything. Sometimes it can help to write a letter first. Some contacts are really lost. These people don't want anything to do with you anymore. That can be sad, hurts and brings disappointment. It can strengthen you that you have at least taken an action and taken your responsibility.

Continued

Step 10: Perseverance	I stay alert to my behaviour	Step 10 is about staying alert to falling back into old behaviour. Changing behaviour is difficult. When things go well for a while, people tend to let their attention slacken a bit. Then the chance of relapse is the greatest. Risk factors also include stress and uncertainty. If there are conflicts, for example at home or at work, or if there is uncertainty due to, for example, financial problems or physical complaints, then the chance that you will revert to old behaviour is bigger. If you feel you are in a risk situation or have relapsed into old behaviours, talk to someone in the group about it. It's not that bad to make mistakes, it's even unavoidable. But as soon as you notice it or someone else makes you aware of it, acknowledge them and take a different path. In addition to learning from our mistakes, we also learn to be open to the opinions of others. Not to blindly follow what others say, but to include the vision of others in your own considerations.
Step 11: Reflection	I think about my life	Step 11 is about making it a habit to think about your life. You may have lived impulsively in your past and went from one situation to another. It is now important that you keep a closer eye on your life. That you think about where you are now and where you want to go. It may be that it is sometimes a bit "quieter" in your life, that it is less exciting. Then don't try to find the tension of your old life again, but think about how you feel now. For some people this can be done through meditation and prayer, for others by talking about it. If you are having a hard time, go to your group members. They will recognize your experiences.
Step 12: Service	I help others with their aggression problem	At step 12, you try to be an example for others. You have had many negative experiences in your life. You've done things you're not proud of and perhaps ashamed of. You can now turn these negative experiences into something positive. By working on your problems you have gained new insights. Because you can now control your aggression better yourself, you can set an example for others. Your past allows you to help others with an aggression problem. You are doing something positive with your negative past. This makes your past valuable again. The best way to help others is by being honest and open about your experiences. The other learns from it and no longer feels so alone with his problems. In addition, you can help others think about themselves. By helping another, you help yourself. You will become richer, wiser and happier.

The aim of this study is to investigate how the MAA participants experience recovery and to what extent the peer support group contributes to it. Furthermore, we evaluate whether their experience of recovery is in line with the theoretical CHIME model. Because the focus of the primary question was on the participants' perspective on recovery, a qualitative, phenomenological research design was chosen. For the second question, a thematic analysis of the applicability of the CHIME framework to "recovery" in relation to acts of violence was performed.

2. Methods

2.1. Procedures

Participants were invited to participate in the study, providing their written informed consent after explaining the objectives and the voluntary and anonymous nature of the study. Participants could withdraw from the study at any time, and no identifying information was collected. No incentives or remuneration were granted to the participants. Ethics procedures concerning privacy and data

protection established by the Dutch legislation and by the Ethics Committee of Tilburg University were followed. The study protocol was approved by the Scientific Committee of Mental Health institution GGZ WNB.

2.2. Participants

A convenience sample consisting of eight participants (five current participants and three former participants) of the MAA group was invited for an interview. An informed consent was provided, enabling the participants to make a well-considered decision to participate. Five participants agreed to participate in the study. Three participants from the target population did not participate in the study. One former participant was shocked by the formal nature of the informed consent and withdrew. A second current participant was about to emigrate and indicated that he had no time to participate. A third former participant did not respond to various invitations. Characteristics of the participants are presented in Table 2. All participants successfully received a CBT-based therapy for domestic violence prior participation in MAA.

2.3. Data Collection and Analysis

In-depth interviews were conducted through open questions, so that the respondent experienced ample answer options that could be explored in more detail (Baarda et al., 2005). The interviews lasted between twenty-five and forty-seven minutes. (P1: 25 minutes, P2: 47 minutes, P3: 45 minutes, P4: 35 minutes, P5: 30 minutes). The CHIME recovery concepts were included in a topic list (Table 3). The opening question was: "Can you tell me how the MAA group contributes (has contributed) to your recovery?" If the topics on the topic list were not discussed spontaneously, they were specifically asked about at the end of the interview. The interviews were recorded, transcribed and coded in the NVivo software program. Colaizzi's (1978) seven-step model was used as a data analysis method. For each of the following steps that represent Colaizzi's process for phenomenological data analysis, it is indicated how they were applied in this

Table 2. Characteristics of participants.

Participant	Age	Education	Marital status	Children living at home	Employed	Current membership	Length of current/previous MAA membership
1	50 - 60	Middle	Married	No	Yes	Yes	2 years
2	30 - 40	Middle	Living together	3 (Ages: 8, 10, 12)	No	No	4 years
3	30 - 40	Middle	Married	2 (Ages: 5, 9)	Yes	Yes	4 years
4	40 - 50	Middle	Single	No	Volunteer	Yes	1 year
5	20 - 30	Middle	Single	No	Yes	Yes	3 years

Table 3. Recovery processes adapted from the British journal of psychiatry by Leamy et al. (2011).

CHIME recovery processes	
Connectedness	Peer support and support groups
	Relationships
	Support from others
	Being part of the community
Hope and optimism about the future	Belief in possibility of recovery
	Motivation to change
	Hope-inspiring relationships
	Positive thinking and valuing success
	Having dreams and aspirations
Identity	Dimensions of identity
	Rebuilding/redefining positive sense of identity
	Overcoming stigma
Meaning in life	Meaning of mental illness experiences
	Spirituality
	Quality of life
	Meaningful life and social roles
	Meaningful life and social goals
	Rebuilding Life
Empowerment	Personal responsibility
	Control over life
	Focussing on strengths

study. Step 1: Transcribe & Familiarize: Each transcript was read through several times by both authors to obtain a general understanding of the data. Step 2: Extract Significant Statements: Significant statements that pertain to the phenomenon under study were identified and labeled by the first author (AR) and discussed with the second author (AD). Step 3: Formulate Meanings: Meanings were formulated from the identified significant statements by both authors and discussed until consensus about the meanings of the significant statements was reached. Step 4: Cluster Themes: Meanings found throughout the data should were clustered and categorized into common themes by both authors. These themes were compared by both authors to the themes of the CHIME model. The authors reached consensus about the relation between the meanings and the core elements of the CHIME theoretical model. Additionally, both authors noticed that the meaning of "recovery" was rather specific for the participants. We therefore added this theme to the description of the CHIME elements in the re-

sults section. Step 5: Create Exhaustive Description: The findings of the study were written into a description of the phenomenon by AR. Step 6: Describing the fundamental structure: AR described the essential structure of the phenomenon related to the recovery concept and the CHIME model. Step 7: Validate findings: Present fundamental structure to participants and verify results with their experiences. The results were presented to the group of participants for validation. All participants agreed with the way we understood and labeled their experiences.

Regarding issues of reflexivity, the following factors may come into play. The 2nd author of this article was involved in the founding and development of MAA. This could possibly influence the participants' response to the interview and the interpretation but also bias the interpretation of the results by the second author. It was therefore decided to have the interviews and the first steps in the analysis done by the first author, who is not familiar with or involved in the MAA method. Another possible issue may be that participants find it shameful to talk about their behavior to a female interviewer. She has tried to reduce the influence of this shame by telling participants that she finds it courageous that these men are willing to talk about their problems and that she is open to hearing their experiences. It is possible that this comment from the interviewer in itself contributes to recovery by tapping into the factors of identity and empowerment by rebuilding a positive sense of identity and focusing on strengths.

3. Results

Almost all information was obtained from the first part of the interview following the opening question. All participants mentioned themes related to the CHIME model spontaneously. The topic list was only used for checking and asking for additional details, without significantly changing the content. The meanings of the significant statements appeared to overlap with the themes of the CHIME model. The meaning of "recovery" was rather specific for the participants. We therefore added this theme to the description of the CHIME elements in the results section.

3.1. Recovery

For MAA participants, recovery means recognizing that they have a problem with aggression regulation and take responsibility for it. For the MAA participants, level of recovery is related to the level of control over the aggression. Control over aggression is described by them as the ability to endure triggers for aggression without losing your temper. On top of that, they consider it a sign of recovery if someone also takes responsibility for the damage he has caused to others. All MAA members indicate that they maintain a certain susceptibility to aggressive behavior throughout their lives. One participant compares it to an addiction. It is a process of falling back and getting back up again. For the group members, MAA serves as a mean to maintain and personalize the skills learned in previous

treatment. The participants learn from and with each other. In the MAA meetings, they also learn to make conscious choices on other matters, which increase the control over their lives.

> "The main purpose of attending MAA is that I don't show the behavior anymore and control the aggression." (P1, P3 and P5)
> It is remarkable that three participants worded this sentence exactly the same way, indicating that there is a high degree of consensus among the participants regarding the purpose of attending MAA.
> "My goal is dealing with the problem in a different way, so that life does not disrupt due to aggression." (P4)
> "Learning to deal with and accept the inflicted damage caused by my aggression." (P2)

3.2. Connectedness

The MAA members do not judge each other, which makes them feel accepted, heard and understood. This invites them to discuss what they are experiencing. Tension is reduced by sharing their experiences. They know from each other what they have gone through, what loss experience they have had and how hard someone works to change his behavior. Recognition creates a bond and trust, and advice is taken to heart. The MAA members are part of a community, where they experience that they are not alone in their problems. By regularly receiving feedback and advice during the meetings, certain routines are broken through and participants learn to change behavior.

> "It's really a point to be able to let my tension flow away with like-minded people." (P1)
> "That you are not alone; just know that it's not just you that is a fool." (P2)
> "And then you also hear how someone else would deal with that. That's all information that I try to apply to my own situations." (P3)

3.3. Hope and Optimism about the Future

By systematically working on recovery, members gain insight into their own thinking and actions and they become aware that behavioral changes are possible that can improve their quality of life. The participants indicate that they no longer want to go back to their old life. They have had many loss experiences. Their successes in controlling aggression motivate them to keep working on themselves.

The relationships between MAA members are aimed at supporting others and learning from each other's experiences. The MAA members help each other to positively label new behavior. Through what they achieve in everyday life, they manage to continue this desired behavior.

The dreams and ambitions of the participants are partly related to the positive experiences they have gained in working on their aggression problem. They want to give back to society and help others manage their aggression. Two partici-

pants indicated that they want to work partly as a peer support worker and set up MAA groups in other cities. An ex-participant indicated, however that he no longer wants to participate in the MAA group, because it reminds him of his "old" life; he mainly wants to look ahead and focus on his family life. An important aspiration mentioned by several members was to have harmonious relations with their family members.

"What I want is for those kids to get into middle age well and for us to have a good time, have fun, and have nothing to do with the rest of the world." (P2)

"So saying no, but also asking for help, negotiating, that sort of thing, there is still a lot to learn about that, so to speak." (P4)

"It reminds me of where I came from myself and that I never want to go back there." (P4)

"Now you see that you can also achieve a better result with certain detours. And you learn that there." (P1)

"What I want for my kids is to grow up well and for us to have a good time, have fun, and don't let that spoil it by having trouble with others." (P2)

3.4. Identity

MAA members gain insight into their functioning and realize what impact this has (had) on themselves and their loved ones. Participants learn to forgive themselves, which leads to a more positive self-image. They also indicate that it is important to get forgiveness from those close to them, but they have to learn to accept that this is not done by everyone. This helps them to see themselves not only as a perpetrator of violence but someone with multiple sides.

By paying more attention to other roles, such as that of father, friend, employee volunteer or MAA member, they discover their strengths and how they can positively influence situations. This makes them feel that they can mean something to someone else, which increases their self-esteem.

"I just can't do a lot of things due to circumstances, so it's really nice when you have something again. That you feel that you are useful again." (P4)

3.5. Meaning in Life

The participants indicated that they experienced life as more meaningful because they felt more connected to others. This manifested itself in being able to feel more empathy for others, but also actually wanting to do something for someone else. Because their experience with their own aggressive behavior now enables them to help others, it gives them the feeling that all the misery they experienced and caused was not in vain.

"I just love being able to help others with that and even if you help others, you help yourself with that too, so that's a nice combination." (P5)

"Acting based on a philosophy of life contributes to the quality of life." (P4)

3.6. Empowerment

The participants experience that the trust of the other MAA members enhances their self-confidence and increases their ability to make choices and control their behavior. In this way they get a grip on their lives, which offer perspective for the future. The participants are aware of their vulnerability and pitfalls. They are now better able to think before doing something and therefore make better choices. They experience that they are responsible for the choices they make in their lives and the influence they can exert on their own behavior.

> "If I notice that things are not going well, I now know what to do. Then I just call on the MAA group members for help." (P1).
> "You have to look at yourself; you can only change yourself. When you are in such a group, you will see it at some point." (P2)
> "It is good to realize that I am not only a bad person, but also someone who is able to help others." (P5)

4. Discussion

The aim of this study was to investigate to what extent peer support groups for batterers contribute to personal recovery, based on the theoretical CHIME model, from the perspective of the (former) participants of the peer support group MAA.

Participants of the MAA support group say that MAA increases their ability to control their aggression, but also that it improves their quality of life. Quality of life improves because they feel more connected to both the MAA group members and the people in their social system. In addition, they also feel more capable of solving problems in general. They also report that their self-image has changed. The contact with other batterers made them feel less alone and by experiencing that they could help others, they could also see that they were not only bad, but also had positive qualities. These findings are in line with studies on recovery in Anonymous Alcoholic support groups (Kelly et al., 2009) and other support groups for batterers (Broady et al., 2014; Gold et al., 2017). Support groups appear to have broader effects on quality of life than reducing the problematic behavior.

Our findings are also in line with the definition of recovery formulated by Anthony (1993) as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. The concepts of the CHIME model (Leamy et al., 2011) also fit well with how the MAA members experience their recovery process and are in line with Anthony's (1993) definition of recovery. Dealing with the limitations of a disease means that members of these support groups must always be alert not to relapse into aggressive behavior. Aggression regulation problems are regarded by the MAA members as chronic conditions. Although using domestic violence is not an illness but a behavioral problem, it is regarded by the participants as a chronic vulnerability to relapse in using domestic violence. The CHIME concept of "empowerment" expressed by the factors

"personal responsibility" and "control over life" appeared to be regarded as the central factor in recovery by the MAA members. This approach to recovery is similar to the recovery processes in addiction (El-Guebaly, 2012). Addiction recovery is defined as a long-term and ongoing process that does not have an end point (McLellan et al., 2000; Laudet, 2007; Ries et al., 2009). This may also account for recovery of aggression regulation problems.

This chronic nature of aggression regulation problems for at least a part the domestic violence batterers may be a reason for the modest results of batterer intervention programs (Bowen & Gilchrist, 2004; Day et al., 2009; Cunha et al., 2023; Eckhardt et al., 2006; Edleson, 2012). Batterer intervention programs may therefore benefit from shifting to a recovery paradigm adopted from addiction recovery programs. El-Guebaly (2012) provides guidelines and points of attention for designing and organizing care for chronic problems and states that recovery programs should shift their focus from a model of acute biopsychosocial stabilization to a model of sustained recovery management, with "recovery-oriented stages of care". These stages of care start with: 1) pre-treatment support services that strengthen the engagement and motivation process and remove environmental obstacles to recovery, 2) in-treatment support services aim to enhance treatment retention and the acquisition of skills transferable to one's community, and 3) post-treatment recovery management involving extended monitoring, use of incentives, and consequences or performance, recovery education and coaching, active linkages to communities of recovery, and early reintervention (El-Guebaly, 2012; McKay et al., 2009). The MAA support group is now administered as a post-treatment intervention. It is possible that the MAA support group may also contribute to recovery in the pre-treatment and in-treatment phases, like the Anonymous Alcoholic support groups (Kelly et al., 2009).

A finding that may be at odds with recovery according to CHIME is that the participants continue to call themselves batterers even though they no longer use violence. They prefer that term in line with some readings of the 12-step model for substance use, that one is always a batterer—someone at risk of relapse without due attention and support. The question is whether this approach maintains stigma in a certain way. After all, self-stigma can play an important role in hindering recovery (Park et al., 2019). There are also other approaches to the 12-step method that regard self-forgiveness as a crucial factor in recovery (Webb & Toussaint, 2018). Particularly, Steps 8 and 9 are also regarded as forgiveness steps (Hart, 1999). MAA participants also said they learned to forgive themselves, which led to a more positive self-image. This helps them to see themselves not only as perpetrators of violence, but as someone with multiple sides. Yet they wanted to stick to the term batterer to protect themselves against relapse. Although the combination of self-forgiveness and the use of the term batterer did not pose any problems according to the participants in MAA, it would be useful to investigate whether this designation of themselves is also experienced as helpful by them in the long term.

Although our study provides insight into recovery processes in a 12-step peer

support group for male batterers, this study also has limitations that should be considered. First of all, the sample size was rather small. Although there were not many differences between the participants on how they experienced recovery and recovery processes in MAA, it cannot be excluded that a larger number of participants would have revealed additional experiences that could have enriched our findings. The same applies to the selection of participants. Although there are both participants and ex-participants in the sample, it cannot be completely ruled out that a selection may have taken place because participation in the study was voluntary and the people who wanted to talk about their experiences may have been more satisfied with the group than those who did not want to participate in the study. It is remarkable that one participant withdrew because he was shocked by the formal nature of the informed consent. Several studies have shown that researchers must be careful not to overload participants with information, or else they might decide to drop out and that there may be a need to adjust the handling of informed consent procedures in scientific studies to the needs of different subgroups (Helgesson & Eriksson, 2011; Swartling & Helgesson, 2008). Fortunately, in our study, only one participant withdrew for this reason, but this is something to take into account in future research.

Another limitation is that the duration of the interview varies between participants and for some (P1 and P5) it is quite short. The interviewer (A1) had the impression that the participants with the shortest interview duration were somewhat nervous during the interview. A possible factor here is that talking about domestic violence can be shameful for perpetrators, especially if the interviewer is a woman (Brown et al., 2010; Brown, 2004). It cannot be said with certainty whether the length of the interview and the tensions among the participants influenced the results. It is possible that the answers of these participants are more socially desirable and incomplete than if they had been interviewed by a male or a peer support worker. Another suggestion for future research is to offer additional sessions in an effort to build rapport, which may lead to more in-depth information. The limited depth of the interviews may also have limited the full phenomenological understanding of the recovery concept in this group.

Another limitation is that our sample consisted entirely of Dutch white men. Therefore, we do not know whether the results are generalizable to individuals from other cultural or ethnic groups or women batterers.

Despite these limitations, this pilot study shows that support groups for batterers can be a valuable addition to the approach to reducing domestic violence and in the recovery of batterers. The latter is important because recovery not only contributes to a better quality of life for batterers, but may also reduce the risk of recidivism (Pollak et al., 2018; Bredenoort et al., 2022). This study also shows that the recovery of batterers is comparable to recovery processes for other long-term behavioral problems, especially addiction. However, more research is needed to gain more insight into which batterers can benefit from a support group and whether there are also batterers for whom a peer support approach is not appropriate. More insight is also needed into the long-term effects of these

support groups and it is important to investigate the effects of participation in the support group on the social environment of the participants in addition to the participants' experience.

Nevertheless, this research shows that support groups for batterers based on a 12-step program are a promising addition to the programs aimed at reducing domestic violence. It is also hopeful and encouraging that there are batterers who take responsibility for their behavior and undertake a long-lasting endeavor to refrain from violence.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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