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The Effectiveness of Narrative Therapy on Social Self-Efficacy and Identity Crisis in Adolescents with Oppositional Defiant Disorder

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ABSTRACT

The present study aimed to determine the effectiveness of narrative therapy on social self-efficacy and identity crisis in adolescents with oppositional defiant disorder (ODD). This study employed a quasi-experimental design with pretest, posttest, and a one-month follow-up. The statistical population consisted of all female students with oppositional defiant disorder who were enrolled in lower secondary schools in Baghestan, located in the Central District of Ferdows County, during the 2024–2025 academic year. Following screening, 30 students who obtained higher scores on the Oppositional Defiant Disorder Scale were selected and randomly assigned to an experimental group (n = 15) and a control group (n = 15). The narrative therapy intervention was administered to the experimental group in eight sessions, whereas the control group received no intervention. Data were collected using the Oppositional Defiant Disorder Rating Scale developed by Hommersen et al. (2006), the Social Self-Efficacy Scale for Adolescents developed by Connolly (1989), and Ahmadi's Identity Crisis Questionnaire (1997). The data were analyzed using repeated-measures analysis of variance and the Bonferroni post hoc test. The results indicated that, after controlling for pretest effects, there were significant differences between the two groups in posttest mean scores for social self-efficacy, $F = 16.909$, $\eta^2 = .377$, and identity crisis, $F = 72.555$, $\eta^2 = .722$ ($p < .01$). These findings indicate the effectiveness of the intervention in improving the aforementioned variables, with the effects remaining stable at the follow-up assessment. The findings of this study demonstrate that narrative therapy can be used as an effective approach for enhancing social self-efficacy and ameliorating identity crisis among female students with oppositional defiant disorder.

Keywords: narrative therapy, social self-efficacy, identity crisis, students with oppositional defiant disorder.

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Introduction

Adolescence is a critical developmental period characterized by rapid biological, cognitive, emotional, and social changes that require individuals to renegotiate their self-concept, interpersonal relationships, behavioral regulation, and emerging identity. During this period, adolescents are increasingly expected to function independently, establish more complex peer relationships, develop a coherent sense of self, and acquire the psychological resources necessary for effective adaptation to social and academic demands. Although such developmental transitions are normative, they may become particularly challenging for adolescents who experience persistent behavioral and emotional difficulties. Among the disruptive behavior disorders that can interfere with successful adolescent development, oppositional defiant disorder (ODD) is

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of particular importance because of its associations with recurrent interpersonal conflict, impaired emotional regulation, problematic family and peer relationships, academic difficulties, and increased vulnerability to later psychopathology. ODD is typically characterized by a persistent pattern of angry or irritable mood, argumentative or defiant behavior, and vindictiveness toward authority figures or other individuals. Contemporary research suggests that these symptoms should not be regarded merely as isolated behavioral problems, because they may represent broader developmental vulnerabilities that affect social functioning, self-perception, emotional well-being, and identity formation (1-3).

The developmental significance of ODD becomes particularly evident when its longitudinal consequences are considered. Adolescents with persistent oppositional and defiant symptoms are at heightened risk of experiencing a range of adverse outcomes extending into young adulthood, including emotional problems, substance use, behavioral difficulties, and other forms of psychopathology (3). Research examining the heterogeneity of ODD has further indicated that adolescents with different symptom profiles may follow distinct developmental trajectories and may demonstrate different levels of subsequent psychological risk (2). In addition, ODD often occurs alongside other clinical problems, particularly attention-deficit/hyperactivity disorder, and such comorbidity may intensify impairment in behavioral control, executive functioning, and psychosocial adjustment (4). These findings emphasize that ODD should be conceptualized within a broader developmental framework in which behavioral symptoms interact with emotional, relational, and self-system processes. Consequently, interventions limited to suppressing observable oppositional behavior may not be sufficient to address the psychological mechanisms that contribute to the persistence and functional consequences of the disorder.

Interpersonal functioning constitutes one of the central domains affected by oppositional defiant symptoms. Adolescents with ODD frequently experience conflictual interactions with parents, teachers, and peers, and these difficulties can contribute to negative emotional states and reduced psychological well-being. Evidence suggests that interpersonal relationships may mediate the association between ODD symptoms and adolescents' experiences of happiness and depression, highlighting the importance of the social environment in determining the emotional consequences of oppositional behavior (5). Within the family context, insecure or problematic attachment processes may also contribute to ODD symptomatology through deficits in affect regulation. Specifically, affect dysregulation has been identified as a potential mechanism linking adolescent attachment to parents with oppositional defiant symptoms (6). Parenting processes are therefore highly relevant to understanding the development and maintenance of ODD. Patterns of parental behavior, including psychological control and broader parenting styles, can affect adolescents' self-evaluations, behavioral regulation, and oppositional tendencies (7, 8). These findings indicate that ODD develops and is maintained within relational contexts that shape adolescents' beliefs about themselves and their capacity to manage interpersonal challenges.

One psychological construct that may be especially important in this regard is self-efficacy. Self-efficacy refers to an individual's belief in their capacity to organize and perform the behaviors necessary to manage specific situations successfully. In adolescence, self-efficacy is closely linked to adaptive functioning because it influences persistence, problem solving, emotional regulation, decision making, social participation, and reactions to stressful experiences. Social self-efficacy is a more specific form of self-efficacy that concerns perceived competence in establishing and maintaining interpersonal relationships, participating in social

interactions, expressing oneself effectively, handling social challenges, and seeking or providing support. Adolescents who possess strong social self-efficacy are more likely to approach interpersonal situations confidently, remain engaged when difficulties arise, and interpret social experiences as manageable rather than threatening. In contrast, adolescents with lower social self-efficacy may anticipate rejection or failure, withdraw from constructive interactions, respond defensively, or rely on maladaptive strategies when confronted with interpersonal stress.

The development of self-efficacy in adolescence is influenced by both personal experiences and environmental resources. Mastery experiences and perceived social support have been shown to explain substantial variation in adolescents' self-efficacy, suggesting that successful experiences and supportive relationships contribute directly to adolescents' beliefs in their own competence (9). Self-efficacy is also associated with emotional well-being. Lower levels of self-efficacy may coexist with greater anxiety symptoms, whereas stronger self-efficacy can function as an adaptive psychological resource in coping with emotional distress (10). Furthermore, self-regulatory self-efficacy appears relevant to the management of aggressive behavior in adolescence, including both online and offline forms of aggression (11). These relationships are particularly meaningful for adolescents with ODD, whose interpersonal experiences may repeatedly involve criticism, punishment, conflict, rejection, and failed attempts to regulate behavior. Over time, such experiences may strengthen negative beliefs about personal competence and reduce confidence in the ability to interact effectively with others. Low self-efficacy may therefore become both a consequence of oppositional difficulties and a factor that perpetuates problematic social responses.

The psychological risks associated with ODD can also extend beyond interpersonal problems to more severe forms of distress. Recent evidence has demonstrated complex associations among oppositional defiant disorder, impaired self-control, problematic behavioral patterns, and suicidal ideation in adolescents (12). Such findings underline the importance of examining psychological variables that may contribute to resilience and healthier adaptation among adolescents with ODD. Psychological capital and related positive psychological resources, including confidence in one's abilities, may be relevant to therapeutic outcomes and broader adjustment (13). From this perspective, increasing adolescents' perceived capacity to manage social interactions may represent a meaningful intervention target. An adolescent who develops stronger social self-efficacy may become better able to reinterpret conflict, seek support, communicate needs, and participate constructively in relationships rather than relying on oppositional or defensive behavioral patterns.

Alongside self-efficacy, identity development represents another major psychological task of adolescence. Identity formation involves constructing a relatively coherent and integrated understanding of who one is, what one values, how one relates to others, and what directions one intends to pursue in life. It requires adolescents to explore alternatives, evaluate personal and social commitments, integrate past experiences, and develop continuity between their current sense of self and their anticipated future. Identity development is not a static process, and both adaptive and disturbed identity dimensions may change considerably across adolescence. Longitudinal evidence indicates that identity trajectories are associated with self-esteem, resilience, depressive symptoms, and features of borderline personality disorder, demonstrating the central role of identity organization in adolescent mental health (14). When this developmental process becomes

disrupted, adolescents may experience uncertainty regarding values, goals, relationships, future roles, and personal meaning, a condition commonly described as identity crisis.

An identity crisis may manifest in confusion about long-term goals, uncertainty regarding educational or occupational decisions, unstable relationships, difficulty establishing values and moral commitments, negative self-perception, reduced initiative, and problems organizing daily life. Although some degree of exploration and uncertainty is expected during adolescence, prolonged or intense identity disturbance can compromise psychological adjustment. Representations of adolescent identity crisis in psychological and literary analyses likewise highlight internal conflict, instability of self-definition, and difficulty integrating competing expectations into a coherent sense of self (15). Adolescents with ODD may be especially vulnerable to such difficulties because persistent conflict with authority figures and repeated negative interpersonal feedback can become incorporated into their self-narratives. Being repeatedly described as disobedient, problematic, aggressive, or difficult may gradually lead an adolescent to organize identity around problem-saturated labels rather than around abilities, aspirations, relationships, and exceptions to problematic behavior.

The relationship between ODD and identity development can also be understood through the effects of parental and relational processes on self-esteem. Parental psychological control has been associated with changes in children's self-esteem, including among children displaying oppositional defiant problems (8). Because self-esteem is closely linked with identity development, repeated experiences of coercion, invalidation, or conflict may interfere with the adolescent's ability to construct a stable and positive sense of self. At the same time, disturbed identity dimensions may reduce resilience and increase susceptibility to emotional symptoms (14). This reciprocal pattern suggests that adolescents with ODD may become trapped in a cycle in which oppositional behavior generates negative relational responses, negative relational experiences reinforce maladaptive self-beliefs, and these self-beliefs in turn contribute to further emotional and behavioral dysregulation. Effective psychological interventions should therefore address not only overt behavior but also the meanings adolescents assign to themselves, their relationships, and their life experiences.

Narrative therapy is particularly relevant to this need because it conceptualizes identity as shaped through stories that individuals construct about themselves and their experiences. Rather than treating the person as equivalent to the problem, narrative therapy encourages individuals to externalize difficulties, examine dominant problem-saturated stories, identify overlooked exceptions, and reconstruct more adaptive and empowering narratives. This process allows clients to reconsider rigid self-descriptions and to develop alternative accounts that emphasize competence, agency, values, relationships, and preferred directions in life. Narrative approaches are therefore especially compatible with adolescent developmental needs because adolescence is a period in which self-meaning, identity, and future orientation are actively being reconstructed. Contemporary discussions of narrative counseling emphasize its potential to facilitate reconstruction of self-meaning among adolescents and to support more coherent and personally meaningful understandings of experience (16).

Narrative therapy may also be particularly suitable for girls navigating the transition from adolescence toward adulthood because it provides a structured context in which identity-related meanings, cultural expectations, relationships, and emerging adult roles can be explored. Narrative therapeutic approaches

have been proposed as useful for supporting teenage girls during identity development and the transition into womanhood by helping them articulate personal stories and reorganize the meaning of developmental experiences (17). This aspect is directly relevant to adolescent girls with ODD, for whom identity development may be complicated by behavioral difficulties, interpersonal conflict, social labeling, and negative feedback from authority figures. By separating the individual from the problem and highlighting alternative narratives, narrative therapy may weaken internalized negative labels and allow adolescents to perceive themselves as capable of change rather than as inherently oppositional or deficient.

Empirical studies provide support for the broader application of narrative therapy to psychological and educational problems in children and adolescents. Narrative therapy has been associated with improvements in emotional intelligence, anger management, and social adjustment among children with attention-deficit/hyperactivity disorder, suggesting that narrative processes may contribute to improvements in emotional and interpersonal functioning in populations characterized by behavioral regulation difficulties (18). Narrative approaches have also demonstrated potential in improving perceived self-efficacy and vitality among adolescent girls from single-parent families, indicating that reconstructing personal meaning may strengthen adolescents' perceptions of personal competence (19). Similarly, group counseling based on narrative therapy and other postmodern approaches has been applied to improve academic resilience among adolescents exposed to bullying, further suggesting that therapeutic reconstruction of personal narratives may enhance adaptive psychological resources under conditions of adversity (20). Narrative therapy has additionally been investigated among students with dyslexia, illustrating its potential utility across diverse educational and psychological contexts where negative self-perceptions and repeated experiences of difficulty may become embedded within an individual's self-story (21).

These findings are theoretically consistent with the assumption that changes in narrative organization can affect both self-efficacy and identity. When adolescents learn to externalize a problem, they are encouraged to recognize that oppositional behavior is not the entirety of who they are. When they identify unique outcomes and exceptions to problem-dominated patterns, they acquire concrete evidence that they are capable of acting differently. Such experiences may function in a manner similar to mastery experiences, which are considered central to strengthening self-efficacy (9). In addition, the reconstruction of personal narratives can enable adolescents to identify values, commitments, achievements, relationships, and future goals that had previously been obscured by conflict and negative labeling. This process may facilitate greater continuity and coherence in identity, thereby reducing identity crisis. Narrative work may therefore simultaneously influence adolescents' perceived social competence and their broader organization of self-meaning.

Despite the promise of narrative therapy, the treatment of ODD remains complex, and therapeutic outcomes may differ across individuals. Research comparing interventions for oppositional defiant disorder has demonstrated that child and family characteristics can predict or moderate response to treatment, indicating the importance of considering interventions that target multiple psychological mechanisms rather than assuming a uniform response across all adolescents (22). The complexity of ODD is further reflected in evidence regarding different symptom patterns, comorbidities, interpersonal mechanisms, and developmental trajectories (2, 4). Accordingly, there is value in investigating interventions that can be flexibly adapted to individual experiences while simultaneously addressing shared developmental concerns.

Narrative therapy may provide such flexibility because it does not impose a fixed deficit-based explanation but instead works collaboratively with the adolescent's own meanings, relationships, strengths, and preferred identity.

Furthermore, existing literature has often examined ODD primarily in relation to symptom severity, comorbidity, behavioral outcomes, parenting factors, or later psychopathology (1, 7, 12). Although these areas are essential, comparatively less attention has been directed toward positive developmental capacities such as social self-efficacy and toward identity-related difficulties among adolescents with oppositional defiant symptoms. This represents an important gap because both social self-efficacy and identity organization are highly relevant to adolescent adaptation. Social self-efficacy may shape how adolescents approach interpersonal challenges, whereas identity coherence may determine how they interpret their experiences and envision their future. An intervention capable of strengthening both domains may therefore have benefits that extend beyond the immediate reduction of oppositional behavior.

The need for such research is especially important in school settings, where adolescents interact continuously with peers, teachers, counselors, and institutional rules. Adolescents with ODD may encounter repeated disciplinary interactions that reinforce problem-saturated identities and reduce opportunities for positive social mastery. At the same time, schools offer an accessible context for structured group interventions that can support social learning, self-reflection, and identity reconstruction. Improvements in social self-efficacy may help students participate more effectively in peer groups and school activities, while reductions in identity crisis may support more stable goals, values, and self-perceptions. Given evidence that interpersonal relationships, affect regulation, self-esteem, and social support are closely related to the psychological functioning of adolescents with oppositional and behavioral difficulties (5, 6, 8), school-based narrative therapy may provide a developmentally appropriate framework for addressing several interconnected dimensions of adjustment.

Taken together, the literature indicates that ODD is associated with significant developmental, interpersonal, emotional, and behavioral risks; that self-efficacy serves as an important psychological resource for adolescent adaptation; that identity formation constitutes a central developmental task vulnerable to disruption; and that narrative therapy offers a theoretically appropriate method for reconstructing maladaptive self-meanings and strengthening personal agency. Existing evidence regarding narrative therapy in adolescents and other psychologically vulnerable groups suggests beneficial effects on self-efficacy, resilience, social adjustment, emotional functioning, and identity-related processes (16-19). Nevertheless, direct examination of the effects of narrative therapy on the combination of social self-efficacy and identity crisis among adolescent girls with oppositional defiant disorder remains limited, thereby warranting focused empirical investigation.

Therefore, the present study aimed to determine the effectiveness of narrative therapy in improving social self-efficacy and reducing identity crisis among adolescent girls with oppositional defiant disorder.

Methods and Materials

Study Design and Participants

The present study employed a quasi-experimental design with pretest, posttest, and one-month follow-up assessments and a control group. The statistical population consisted of all female students with

oppositional defiant disorder (ODD) enrolled in lower secondary schools in Baghestan, located in the Central District of Ferdows County, during the 2024–2025 academic year. Convenience sampling was used to recruit participants. After obtaining the necessary permissions from school authorities and securing informed consent from the students and their parents, the Oppositional Defiant Disorder Rating Scale was administered to 88 female students who expressed willingness to participate in the study. Of these students, 57 obtained relatively high scores on the ODD measure and were subsequently considered for eligibility screening. Based on the predefined inclusion and exclusion criteria, 30 eligible students were selected and randomly assigned to an experimental group (n = 15) and a control group (n = 15) using simple random assignment. The inclusion criteria comprised the presence of symptoms consistent with oppositional defiant disorder, voluntary willingness to participate in the study, and commitment to regular attendance at the therapeutic sessions. The exclusion criteria included insufficient cooperation with the researchers during the study, absence from two consecutive intervention sessions or five sessions in total, a history of receiving a similar psychological intervention during the preceding several months, voluntary withdrawal from the study, the presence of comorbid disorders such as autism spectrum disorder, and severe sensory or motor impairments. Before the intervention, participants in both groups completed the measures of social self-efficacy and identity crisis as pretest assessments. The experimental group subsequently received the narrative therapy intervention, whereas the control group received no therapeutic intervention during the study period. One week after the completion of the intervention, both groups completed the posttest assessments, and one month after the end of treatment, the same measures were administered again as the follow-up assessment. Throughout the study, major ethical principles were observed, including providing participants with sufficient information about the nature and procedures of the intervention, maintaining the confidentiality of personal information and responses, and informing participants that participation was voluntary and that they could withdraw from the study at any stage without adverse consequences. The research instruments consisted of the Oppositional Defiant Disorder Rating Scale, the Social Self-Efficacy Scale for Adolescents, and the Identity Crisis Questionnaire.

Data Collection Tools

The Oppositional Defiant Disorder Rating Scale was developed by Hommersen, Murray, Ohan, and Johnston (2006) on the basis of the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) for identifying children with oppositional defiant disorder. The scale is available in both other-report and self-report formats. In the other-report version, parents or teachers evaluate the child's behavior, whereas in the self-report version, children or adolescents complete the scale themselves. The self-report version was used in the present study. The instrument consists of eight items rated on a 3-point Likert scale ranging from 0 (not at all) to 2 (often), with 1 representing sometimes, and is intended for use with children and adolescents aged approximately 5 to 15 years. According to the diagnostic scoring criterion, endorsement of sometimes or often on at least four items is considered indicative of clinically relevant symptoms of oppositional defiant disorder. Hommersen et al. (2006) reported a Cronbach's alpha coefficient of .92 for the scale, indicating excellent internal consistency. Evidence of construct and concurrent validity has also been reported, as the scale has demonstrated significant correlations with the subscales of the Child Behavior Checklist (Raine, Ling, Streicher, & Leo,

2022). In an Iranian psychometric evaluation, Abedi (2008) reported a Cronbach's alpha coefficient of .93 and a test–retest reliability coefficient of .94. The content validity of the Persian version was additionally confirmed by a panel of five psychologists and psychiatrists (Aghaei, Abedi, & Mohammadi, 2011). In the present study, the instrument was primarily employed during the screening stage to identify students with elevated symptoms of oppositional defiant disorder and determine eligibility for participation.

The Social Self-Efficacy Scale for Adolescents was developed by Connolly (1989) to assess adolescents' perceived competence and confidence in managing social situations and interpersonal interactions. This self-report instrument consists of 25 items rated on a 7-point Likert scale ranging from 1 (impossible) to 7 (extremely easy), with respondents indicating the degree to which they perceive themselves as capable of performing the social behaviors described in each item. The instrument assesses five dimensions of social self-efficacy, including social assertiveness, performance in social situations, participation in social groups, friendship and intimacy, and giving or receiving help. The scale was originally standardized across three samples of adolescents. The first sample consisted of 87 adolescents aged 14–19 years, the second consisted of 76 adolescents aged 13–16 years, and the third included 79 adolescents aged 12–18 years who were receiving services at a mental health treatment center. Cronbach's alpha coefficients for the total scale were reported as .90, .92, and .95 in the three samples, respectively, demonstrating high internal consistency. In addition, the two-week test–retest reliability coefficient was .94, indicating strong temporal stability (Connolly, 1989). In an Iranian study conducted by Hosseini Iraj, Mahdian, and Jajarmi (2020), Cronbach's alpha coefficients for the subscales ranged from .76 to .82, further supporting the reliability of the Persian version of the instrument. In the present study, higher scores on the scale indicated greater perceived social self-efficacy.

The Identity Crisis Questionnaire is a paper-and-pencil instrument developed by Ahmadi (1997) to assess the extent of identity crisis among adolescents. The questionnaire evaluates difficulties in identity development across 10 distinct domains, including problems related to long-term goals, uncertainty regarding occupational choice, lack of an appropriate model for friendship, inappropriate sexual behavior, difficulties in religious understanding and identification, insufficient attention to moral values, failure to fulfill group commitments, negative self-perception, lack of initiative and striving, and difficulties with time management. Each domain is represented by a specific item with four response alternatives reflecting increasing levels of difficulty or impairment. The first response option indicates the absence of a problem, whereas the final option represents the most severe degree of difficulty. Responses are scored from 0 to 3, yielding a total score ranging from 0 to 30. Higher total scores indicate a greater degree of identity crisis and greater difficulties in identity acquisition, whereas lower scores indicate stronger identity development and more successful identity formation. The questionnaire has demonstrated satisfactory reliability. Ahmadi (1997) reported a Cronbach's alpha coefficient of .86, indicating acceptable internal consistency among the items. Bouali-Dad and Komani (2001) subsequently reported a Cronbach's alpha coefficient of .89. Furthermore, a split-half reliability coefficient of .95 has been reported for the instrument, providing additional evidence of its reliability.

Interventions

Participants in the experimental group received group-based narrative therapy according to the therapeutic framework developed by White and Epston (1990). The intervention consisted of eight 120-minute sessions conducted over approximately six weeks and was delivered at the school by a counselor and an educational psychologist. The first session focused on establishing a safe and trusting therapeutic environment, familiarizing participants with the narrative therapy approach, facilitating introductions among group members, clarifying the goals and rules of the sessions, explaining the therapeutic model, and encouraging participants to begin describing their personal narratives. The second session focused on identifying dominant narratives and personal problems through externalization, exploring dominant stories, identifying problem-saturated narratives, examining the influence of the problem on the individual and the individual's responses to the problem, and discussing the processes through which personal stories are constructed. The third session concentrated on analyzing critical experiences and alternative perspectives by identifying the principles underlying participants' storytelling, exploring peak and low-point experiences, and encouraging participants to view their stories from different perspectives. The fourth session aimed to reduce the perceived power of the problem and modify its meaning through naming the problem, deconstructing problem-dominated narratives, weakening the authority attributed to the problem, and using re-meaning or re-authoring techniques. The fifth session focused on identifying challenges and positive and negative influences within participants' narratives by encouraging members to challenge dominant assumptions, identifying constructive and adverse factors embedded within their stories, examining major life challenges, and identifying previously marginalized or "shadow" narratives that had been obscured by problem-saturated accounts. The sixth session focused on constructing an alternative narrative based on personal priorities and future goals by examining unique outcomes, incorporating new elements into the emerging narrative, exploring participants' priorities, aspirations, goals, and significant relationships, and reframing their broader understanding of life experiences. The seventh session was directed toward strengthening personal resources and consolidating the newly constructed narrative by emphasizing participants' strengths, analyzing the relationship between the alternative narrative and their everyday lives, facilitating the continuation and expansion of the new narrative, and identifying critical turning points that could support change. The eighth and final session focused on consolidating and implementing the newly developed narrative by reviewing participants' revised life stories, anticipating possible future difficulties, making final revisions to the new narratives, using role-play to practice functioning within the revised life story, and developing concrete plans for applying the newly constructed narrative to everyday life. Throughout the intervention, participants were encouraged to distance their identities from their problems, identify exceptions to problem-dominated patterns, recognize personal strengths and competencies, and construct more adaptive and empowering accounts of themselves and their relationships.

Data Analysis

Statistical analyses were conducted using IBM SPSS Statistics, Version 26. Data analysis was performed at both descriptive and inferential levels. Descriptive statistics, including means and standard deviations, were calculated to summarize participants' scores on social self-efficacy and identity crisis across the pretest, posttest, and one-month follow-up assessments. To examine changes in the dependent variables over time

and determine whether the pattern of change differed between the experimental and control groups, repeated-measures analysis of variance was employed. This analysis enabled the examination of within-subject effects across the three measurement occasions, between-group effects, and the interaction between time and group membership. When statistically significant differences were detected across measurement occasions, Bonferroni-adjusted post hoc comparisons were performed to identify the specific assessment points between which significant differences occurred while controlling for inflation of the familywise Type I error rate. Statistical significance was evaluated at the conventional alpha level, and the analyses were used to determine both the immediate effectiveness of narrative therapy and the maintenance of treatment effects at the one-month follow-up.

Findings and Results

Table 1 presents the means and standard deviations of the study variables separately for the experimental and control groups.

Table 1. Means and Standard Deviations of the Study Variables in the Experimental and Control Groups

Variable	Group	Pretest, M ± SD	Posttest, M ± SD	Follow-up, M ± SD
Social self-efficacy	Experimental	93.86 ± 21.80	108.40 ± 21.01	125.14 ± 16.77
	Control	84.13 ± 12.19	89.60 ± 10.88	97.12 ± 11.35
Identity crisis	Experimental	11.46 ± 6.45	5.46 ± 5.20	2.00 ± 2.00
	Control	15.12 ± 3.68	16.13 ± 4.05	19.86 ± 6.25

As shown in Table 1, the experimental group exhibited greater changes than the control group in social self-efficacy and identity crisis across the assessment stages. Specifically, social self-efficacy showed an increasing trend in the experimental group, whereas identity crisis demonstrated a decreasing trend. The results of the Shapiro–Wilk test also indicated that the data for each group were normally distributed at the different assessment stages ($p > .05$). Accordingly, the assumption of normality was satisfied, permitting the use of parametric statistical tests. Levene's test was used to examine the homogeneity of error variances. The nonsignificant results of this test at each assessment stage for both social self-efficacy and identity crisis indicated that the assumption of homogeneity of variances was met ($p > .05$). In addition, Box's M test was conducted to assess the assumption of homogeneity of the variance–covariance matrices. The result was statistically significant for social self-efficacy ($p < .05$) and nonsignificant for identity crisis ($p > .05$). Therefore, in reporting the multivariate effects of the intervention, Wilks' lambda was considered for social self-efficacy, whereas Pillai's trace was considered for identity crisis. Mauchly's test of sphericity yielded $W = .26$, $p = .001$ for social self-efficacy and $W = .87$, $p = .15$ for identity crisis, indicating that the assumption of sphericity was violated for social self-efficacy but satisfied for identity crisis.

Table 2. Results of Repeated-Measures Analysis of Variance for the Experimental and Control Groups Across Pretest, Posttest, and Follow-up Assessments

Scale	Source of Variation	Sum of Squares	df	Mean Square	F	p	η^2
Social self-efficacy	Time	7370.967	1.215	6067.081	22.738	.001	.448
	Time × Group	1254.610	1.215	1032.676	3.870	.050	.121
	Group	7996.061	1	7996.061	16.909	.001	.377
Identity crisis	Time	118.468	2	59.234	3.362	.040	.107
	Time × Group	756.682	2	378.341	21.471	.001	.434
	Group	2591.368	1	2591.368	72.555	.001	.722

Given that Mauchly's test of sphericity indicated a violation of the sphericity assumption for social self-efficacy and satisfaction of this assumption for identity crisis, the appropriate corrections were applied when reporting the repeated-measures analysis of variance results presented in Table 2. For social self-efficacy, the Huynh–Feldt epsilon estimate was higher than the corresponding Greenhouse–Geisser and lower-bound estimates; therefore, the Huynh–Feldt correction was used. For identity crisis, the sphericity-assumed results were reported. The results of the repeated-measures analysis of variance indicated that narrative therapy had a statistically significant effect on social self-efficacy and identity crisis over time ($p < .05$). Thus, significant differences were observed in mean social self-efficacy and identity crisis scores across the pretest, posttest, and follow-up assessments. Furthermore, the between-subjects effects indicated significant differences between participants in the narrative therapy group and those in the control group with respect to social self-efficacy, $F = 16.909$, $\eta^2 = .377$, $p < .01$, and identity crisis, $F = 72.555$, $\eta^2 = .722$, $p < .01$. To further examine the pattern of group differences across the assessment stages, the results of Bonferroni-adjusted post hoc comparisons are presented in Table 3.

Table 3. Bonferroni Post Hoc Comparisons of Between-Group Differences in Social Self-Efficacy and Identity Crisis Across Assessment Stages

Variable	Assessment Stage	Group (i)	Group (j)	Mean Difference	Standard Error	*p*
Social self-efficacy	Pretest	Narrative therapy	Control	9.732	6.450	.140
	Posttest	Narrative therapy	Control	18.800*	6.110	.005
	Follow-up	Narrative therapy	Control	28.023*	5.229	.001
Identity crisis	Pretest	Narrative therapy	Control	-3.662	1.919	.060
	Posttest	Narrative therapy	Control	-10.667*	1.704	.001
	Follow-up	Narrative therapy	Control	-17.867*	1.696	.001

As shown in Table 3, the differences between the experimental and control groups in social self-efficacy and identity crisis were statistically significant at posttest compared with pretest ($p < .01$). Significant differences were also observed at follow-up relative to the earlier assessment stages. Specifically, the mean social self-efficacy score increased at posttest and follow-up relative to pretest, whereas the mean identity crisis score decreased across these assessment stages in the narrative therapy group ($p < .01$).

Discussion and Conclusion

The present study investigated the effectiveness of narrative therapy in improving social self-efficacy and reducing identity crisis among adolescent girls with oppositional defiant disorder. The findings indicated that narrative therapy produced significant changes in both dependent variables. Compared with the control group, participants who received narrative therapy demonstrated significantly higher levels of social self-efficacy at posttest and follow-up and significantly lower levels of identity crisis. The repeated-measures findings also showed significant changes across time, suggesting that the effects of the intervention were not restricted to the immediate post-intervention stage but were maintained during the follow-up period. These findings support the assumption that narrative therapy can influence not only behavioral or emotional difficulties but also broader self-related and interpersonal constructs that are highly relevant to adolescent development.

The first major finding was that narrative therapy significantly increased social self-efficacy in adolescent girls with oppositional defiant disorder. This result is consistent with previous findings showing that narrative-based interventions may improve perceived self-efficacy and other positive psychological resources in adolescents. Soroush Oskouei et al. reported that narrative therapy was effective in enhancing perceived self-efficacy and vitality among adolescent girls from single-parent families, indicating that reconstruction of personal narratives may strengthen adolescents' beliefs in their ability to cope with life challenges and act effectively (19). The present result is also compatible with findings regarding the role of narrative therapy in improving social adjustment, emotional intelligence, and anger management in children with attention-deficit/hyperactivity disorder (18). Although the target populations differ, both studies suggest that narrative interventions may promote adaptive psychological functioning among children and adolescents who experience behavioral and interpersonal difficulties.

One explanation for the improvement in social self-efficacy is that narrative therapy provides adolescents with opportunities to identify and reconstruct dominant problem-saturated stories that have shaped their perceptions of themselves in social contexts. Adolescents with oppositional defiant disorder may repeatedly receive negative feedback from parents, teachers, and peers and may gradually internalize descriptions of themselves as difficult, aggressive, disobedient, incapable of cooperation, or socially problematic. These repeated evaluations can become incorporated into a dominant personal narrative and weaken confidence in the ability to communicate effectively, participate in groups, manage conflict, or develop supportive interpersonal relationships. Narrative therapy, particularly through externalization, separates the adolescent from the problem and allows the problem to be understood as something influencing the individual rather than defining the individual. This distinction can create psychological space for adolescents to identify alternative competencies, successful interactions, and previously overlooked experiences of cooperation, self-control, or social effectiveness.

This interpretation is consistent with evidence indicating that self-efficacy in adolescence is strongly associated with mastery experiences and social support (9). During narrative therapy, the identification of unique outcomes and exceptions to problem-dominated stories may serve a function comparable to mastery experiences. When adolescents recognize occasions in which they successfully managed conflict, communicated effectively, sought help, supported others, or acted contrary to the dominant problem narrative, they accumulate evidence of their own competence. Repeated attention to these experiences may strengthen expectations of future success in interpersonal situations. Furthermore, the group format of the intervention may have provided additional opportunities for interpersonal validation and social support, both of which can facilitate self-efficacy development. In this sense, improvement in social self-efficacy may have emerged from both cognitive reconstruction of personal meaning and direct relational experiences within the therapeutic group.

The finding is also compatible with research showing that self-efficacy is associated with emotional adjustment and adaptive behavior among adolescents. Mousset et al. demonstrated an association between self-efficacy and anxiety symptoms, supporting the broader role of self-efficacy as a psychological resource related to emotional functioning (10). Likewise, Favini et al. emphasized the importance of self-regulatory self-efficacy beliefs in understanding aggressive behaviors during adolescence (11). These findings are particularly relevant to adolescents with oppositional defiant disorder because emotional reactivity, anger,

defiance, and interpersonal conflict may frequently undermine their sense of competence. By helping adolescents reorganize how they interpret difficult interactions and recognize alternative responses, narrative therapy may strengthen both their perceived control over social situations and their confidence in managing future interpersonal demands.

The effectiveness of narrative therapy in enhancing social self-efficacy may also be understood within the broader relational context of oppositional defiant disorder. Previous research has shown that ODD symptoms are closely related to interpersonal relationships and emotional well-being. Ding et al. found that interpersonal relationships mediated associations between oppositional defiant symptoms and children's feelings of happiness and depression (5). Craig et al. similarly showed that affect dysregulation played an important mediating role in the relationship between parent attachment and ODD symptoms among adolescents (6). These findings suggest that adolescents with ODD do not experience their symptoms in isolation; rather, oppositional behaviors occur within reciprocal relational patterns involving conflict, attachment, emotional regulation, and social interpretation. Narrative therapy may be especially effective because it allows adolescents to reconsider these relational patterns and construct alternative ways of understanding themselves in relation to parents, teachers, and peers.

The second major finding of the study was that narrative therapy significantly reduced identity crisis among adolescent girls with oppositional defiant disorder. This finding is consistent with the theoretical foundations of narrative therapy, which conceptualize identity as constructed and maintained through personal and social narratives. Adolescence is a period in which individuals actively organize experiences into increasingly coherent understandings of who they are, what they value, and what they expect from their future. When identity becomes dominated by negative labels or fragmented experiences, adolescents may have difficulty developing coherent commitments and stable self-definitions. Narrative therapy directly addresses such processes by enabling individuals to examine dominant stories, challenge restrictive identity labels, and develop alternative narratives that more accurately reflect personal values, abilities, goals, and preferred ways of living.

The result is supported by literature emphasizing the relevance of narrative approaches to adolescent identity formation and self-meaning. Kristiana et al. highlighted the role of narrative counseling in reconstructing self-meaning among vocational high school students, suggesting that narrative work can facilitate reinterpretation of personal experiences and development of more adaptive self-understanding (16). Lee and Beckenbach also described the application of narrative therapy to support teenage girls during developmental transitions and identity formation into womanhood (17). These studies are closely aligned with the present findings because they emphasize the capacity of narrative approaches to influence identity-related processes during adolescence. In the present study, adolescents with ODD may have benefited from a therapeutic context in which they could reconsider problem-focused identities and develop alternative accounts that emphasized strengths, values, aspirations, and competence.

The reduction in identity crisis may be particularly significant in adolescents with oppositional defiant disorder because repeated behavioral conflicts may become deeply integrated into self-concept. ODD is associated with persistent patterns of argumentativeness, irritability, defiance, and conflict that can generate repeated negative responses from adults and peers. Over time, the adolescent may begin to interpret such reactions as evidence of a stable personal identity rather than as responses to specific behavioral patterns.

This may lead to global self-definitions such as “I am a problem,” “I cannot get along with others,” or “people always expect me to fail.” Narrative therapy challenges this fusion between person and problem. By externalizing the difficulty and investigating how the problem has influenced different areas of life, the adolescent is encouraged to distinguish between personal identity and problematic behavior. This separation may reduce the degree to which oppositional symptoms dominate self-definition and may create opportunities for a more complex and coherent identity.

This explanation is supported by findings on the developmental significance of identity trajectories. Bogaerts et al. showed that adaptive and disturbed identity dimensions during adolescence are associated with self-esteem, resilience, depressive symptoms, and borderline personality features (14). These associations indicate that identity disturbance is not an isolated developmental issue but is closely connected to broader psychological adjustment. Accordingly, reducing identity crisis may contribute to improved emotional and behavioral functioning beyond the immediate outcomes measured in the present study. The finding is also conceptually compatible with observations regarding identity crisis as a condition marked by conflict, instability, and uncertainty in self-definition (15). Narrative therapy may reduce these difficulties by helping adolescents connect previously fragmented experiences within a more organized and personally meaningful account of themselves.

The present findings can also be interpreted in light of the relationship between ODD, self-esteem, and controlling relational environments. Tang et al. reported that parental psychological control is related to children’s self-esteem and examined these processes among children with and without oppositional defiant problems (8). Repeated experiences of control, criticism, punishment, and conflict may negatively affect the way adolescents evaluate themselves and may complicate identity development. Similarly, parenting style has been examined as an important factor in relation to oppositional defiant disorder (7). Narrative therapy may provide a corrective context in which adolescents are not reduced to externally imposed labels but are invited to participate actively in defining the meanings of their experiences. This collaborative and nonpathologizing stance may be particularly important for adolescents whose interactions with authority figures have frequently been characterized by control and conflict.

Another relevant interpretation concerns the developmental heterogeneity of ODD. Research has demonstrated that oppositional defiant disorder does not follow a single developmental pattern and that adolescents with different symptom profiles may have different later psychological outcomes (2). Longitudinal evidence also indicates that trajectories of ODD severity from adolescence into young adulthood are associated with later substance use, mental health problems, and behavioral difficulties (3). Furthermore, comorbid ODD may increase the clinical and neuropsychological complexity of other disorders, such as attention-deficit/hyperactivity disorder (4). These findings support the importance of interventions that do not focus exclusively on symptom suppression but instead address broader developmental processes. By targeting self-concept, meaning, agency, and interpersonal interpretation, narrative therapy may influence psychological mechanisms that are relevant across different ODD profiles.

The significant effects observed at follow-up are also noteworthy. Maintenance of changes suggests that participants may have continued to use the alternative narratives and interpretive strategies developed during treatment after the formal sessions ended. Narrative therapy is not merely intended to produce temporary emotional relief; rather, it seeks to alter the way individuals organize experiences and understand

their relationship with problems. If adolescents adopt a more empowering narrative in which they recognize competence, choice, values, and preferred future directions, the influence of this new narrative may continue beyond therapy. The continuation of improved social self-efficacy and reduced identity crisis at follow-up therefore supports the possibility that the intervention contributed to relatively stable changes in self-perception rather than only short-term situational improvements.

The persistence of treatment effects is also consistent with studies indicating that narrative approaches can strengthen resilience and adaptive psychological resources. Oktava et al. found that narrative therapy and other postmodern counseling approaches were effective in improving academic resilience among students who had experienced bullying (20). Lau's work on narrative therapy among students with dyslexia similarly illustrates how narrative methods may be applied when repeated experiences of difficulty contribute to negative self-understandings (21). In both situations, individuals may have developed restrictive stories about themselves as a consequence of repeated difficulties or stigmatizing experiences. The therapeutic reconstruction of these meanings may allow more enduring change because it modifies the interpretive framework through which future events are understood.

The present results are also meaningful in relation to the clinical complexity of ODD treatment. Dedousis-Wallace et al. emphasized that treatment outcomes for oppositional defiant disorder may be influenced by predictors and moderators, suggesting that therapeutic response varies according to individual and contextual factors (22). This variability implies that interventions capable of adapting to personal meaning systems may be especially valuable. Narrative therapy is inherently individualized even when delivered in groups, because each adolescent is encouraged to identify personally relevant stories, exceptions, values, relationships, and aspirations. Such flexibility may help explain why the intervention was able to affect both social self-efficacy and identity crisis, two related but conceptually distinct domains.

The findings can additionally be situated within a positive psychological perspective. Chan highlighted the relevance of psychological capital and therapeutic approaches that strengthen adaptive internal resources (13). Rather than conceptualizing adolescents with ODD exclusively in terms of behavioral deficits, narrative therapy emphasizes capacities, competencies, preferred identities, and alternative possibilities. This perspective may be especially important because adolescents with oppositional behavior are often exposed to deficit-oriented descriptions. Strengthening social self-efficacy represents a shift from viewing the adolescent primarily as behaviorally problematic toward recognizing the adolescent as capable of effective interpersonal functioning. Similarly, reducing identity crisis supports a movement from fragmented or negative self-definition toward a more coherent and agentic sense of self.

The importance of such an approach is reinforced by the broader risks associated with ODD. Raine et al. emphasized the importance of valid assessment of conduct and oppositional defiant symptoms as part of understanding disruptive behavior disorders (1). Keshky further demonstrated that ODD in adolescence may be linked with clinically significant concerns such as internet gaming disorder and suicidal ideation, with self-control playing an important role in these relationships (12). These findings demonstrate that oppositional symptoms can coexist with serious psychosocial vulnerabilities. Although the present study did not assess such outcomes directly, improvements in social self-efficacy and identity coherence may represent potentially protective psychological changes. Adolescents who perceive themselves as more competent in

relationships and who possess a more coherent identity may be better positioned to manage social stress, seek support, regulate responses, and pursue adaptive goals.

Overall, the findings support the conceptualization of narrative therapy as a developmentally appropriate intervention for adolescent girls with oppositional defiant disorder. Its effectiveness may derive from several interconnected processes: externalizing the problem, reducing identification with negative labels, recognizing unique outcomes, strengthening perceptions of competence, reconstructing personal meaning, identifying valued goals, and developing more coherent preferred identities. These mechanisms are particularly relevant during adolescence, when self-efficacy and identity are still developing and remain sensitive to social experiences. The results therefore extend previous evidence on narrative therapy by demonstrating its potential usefulness for simultaneously improving social self-efficacy and reducing identity crisis in adolescents with oppositional defiant disorder.

A number of limitations should be considered when interpreting the findings of this study. First, the sample was relatively small and consisted exclusively of female lower secondary school students from a specific geographical area, which limits the generalizability of the findings to male adolescents, other age groups, students from different educational settings, and adolescents from different sociocultural backgrounds. Second, participants were initially recruited through convenience sampling, which may have introduced selection bias despite subsequent random assignment to the experimental and control groups. Third, the study relied primarily on self-report measures, and participants' responses may have been influenced by social desirability, response tendencies, or temporary emotional states. Fourth, the follow-up period was limited to one month, and therefore the long-term persistence of the observed treatment effects remains uncertain. Fifth, the control group did not receive an active comparison intervention, making it difficult to separate the specific effects of narrative therapy from nonspecific therapeutic factors such as attention, group participation, therapist contact, and expectations of improvement. Finally, variables such as family functioning, parenting practices, severity of ODD symptoms, comorbid psychological problems, treatment adherence, and socioeconomic status were not examined as potential moderators of intervention outcomes.

Future research should replicate the present study with larger and more heterogeneous samples, including male and female adolescents from different regions, educational levels, and cultural contexts. Randomized controlled trials with active comparison conditions would provide stronger evidence regarding the specific effectiveness of narrative therapy relative to other psychological interventions. Longer follow-up periods, such as three, six, or twelve months, are recommended to determine whether improvements in social self-efficacy and identity remain stable over time. Future studies could also incorporate multi-informant assessments involving parents, teachers, counselors, and clinicians to complement adolescents' self-reports and reduce common-method bias. It would also be useful to investigate possible mediators and moderators of treatment effectiveness, including emotion regulation, self-esteem, family relationships, social support, anger, self-control, ODD symptom severity, and therapeutic alliance. Qualitative interviews could additionally be used to explore how adolescents themselves experience narrative change and which components of the intervention are perceived as most influential in changing self-concept and interpersonal functioning.

In practice, the findings suggest that narrative therapy can be incorporated into school counseling and adolescent mental health services for students who display oppositional and defiant behavioral patterns. School counselors, educational psychologists, and child and adolescent therapists may use narrative techniques such as externalization, deconstruction of problem-saturated stories, identification of unique outcomes, re-authoring, and strengthening preferred identities to help adolescents develop more adaptive understandings of themselves. Group-based implementation may be particularly useful in educational settings because it allows adolescents to share experiences, receive interpersonal validation, observe alternative coping strategies, and practice new forms of self-expression in a supportive context. Practitioners should also consider involving families and school personnel when appropriate so that newly developed narratives are reinforced across important relational environments. Emphasis should be placed not only on reducing defiant behavior but also on strengthening adolescents' sense of competence, agency, belonging, future orientation, and coherent identity.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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