



Disruptive behavior disorders through the lens of Educational Therapy: A nosological, functional and intervention framework

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Abstract

Disruptive behavior disorders (DBDs) constitute an umbrella term for a variety of childhood and adolescent disorders; in particular, they are characterized by persistent oppositionality, defiance, aggression, rule violation or dysregulated behavior. However, from the perspective of Educational Therapy, diagnostic classification alone is not a good explanation for why disruptive behavior occurs in learning environments. This narrative review looks at the nosology of disruptive behavior disorders from an educational therapist's perspective: from the Diagnostic and Statistical Manual of *Mental Disorders* (DSM-5-TR) and/or the International Classification of Diseases, Eleventh Revision (ICD-11), to the neuroscience of attention-deficit/hyperactivity disorder (ADHD) and cognitive disengagement syndrome (CDS). In particular, the author is interested in behavioral phenotype and functional mechanisms. The oppositional defiant disorder (ODD) and conduct disorder (CD) are formal disruptive/dissocial disorders, while ADHD is a neurodevelopmental disorder that may cause disruptive behavior in children and adolescents. CDS, formerly called sluggish cognitive tempo (SCT; Barkley *et al.*, 2022; Becker, 2025), is an emerging research-supported syndrome, and is not considered a DSM-5-TR or ICD-11 disorder. In this review, educational therapists should conceptualize disruptive behavior by considering executive functioning, academic demands, social expectations, and environmental conditions within the application of the Cognition-Conation-Affect-Sensation (CCAS) model. Differentiated educational assessment should then move from observed behavior to antecedents such as functional abilities, learning demands and consequences and be tailored to each student. In this paper, the author has adopted the Educational Therapy model in which differentiated nosology establishes the clinical context, functional assessment identifies learning processes and interventions are made to address the learner's adaptive, academic, behavioral and social skillsets.

Keywords: Disruptive behavior disorders, educational therapy, oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder

Introduction

Disruptive behavior in childhood and adolescence is a huge concern for families, schools and professionals because it may interfere with learning, classroom participation, peer relationships, teacher-student relationships and long-term educational adjustment. The term *disruptive behavior disorders* (DBD) is more a spectrum of different types of behaviors than one disorder (see Figure 1). The current psychiatric nosology distinguishes between oppositional defiant disorder (ODD), conduct disorder (CD; also known as conduct-dissocial disorder [CDD] now), Intermittent Explosive Disorder (IED), and other disorders involving impulse control and conduct. ADHD is classified separately in neurodevelopmental *Mental Disorders* and has been listed under the disability category of Other Health Impairment (OHI) in *The Educator's Diagnostic Manual* (EDM; Pierangelo & Giuliani, 2007) ^[17] according to 20 U.S.C. § 1412 for Section 612 of Individuals with Disabilities Education Improvement (IDEA, 2004) ^[14]. The *Diagnostic and Statistical Manual of Mental Disorders-5th Edition-Text Revision* (DSM-5-TR; American Psychiatric Association [APA], 2022) ^[1] offers a diagnostic classification that distinguishes behavioral syndromes according to their characteristic symptom patterns, development, and functional consequences. The International Classification of Diseases-11 Revision (ICD-11; World Health Organization [WHO], 2024) ^[20] also classifies oppositional defiant disorder (ODD) and conduct-dissocial disorder (CDD) as disruptive behavior and dissocial disorders (DBDD).

Although psychiatric nosology is important to diagnosis and communication among health care professionals, educational therapy requires an additional level of analysis, i.e., differential assessment (+ functional assessment, which is needed for designing an individualized intervention program).

The educational therapist's main concern is how the learner behaves or responds in learning situations: whether the learner can maintain attention, block a response, change tasks, tolerate frustration, understand instructions, start work, control emotions, communicate with others, solve problems, communicate with peers in a healthy manner and adjust to classroom expectations. Hence, the Educational Therapy-related problem is not only "What disorder does this learner have?" but "What functional capacities and environmental conditions are producing, maintaining or amplifying the observed behavior?"

This is particularly important because disruptive behavior could be the behavioral expression of different underlying mechanisms. A child who is not completing work may be exhibiting oppositionality, but the same behavior may also be seen due to the difficulty of the task, language processing problems, poor executive function, anxiety, attentional dysregulation, cognitive disengagement, sensory overload, poor differentiation of instruction or a history of reinforcement for escape behavior. Behavioral similarity does not imply nosological similarity.

Therefore, the perspective taken from the domain of educational therapy has to turn from psychiatric or

psychological diagnosis to differential and functional assessments. Diagnostic assessment establishes the clinical and developmental context, the differential assessment is to identify the specific challenging behavioral issue of concern, and functional assessment is concerned with the learner-task-environment interaction. This distinction is consistent with evidence that ADHD, ODD and CD have significant overlap in inhibitory control domains, and that

apparently similar behavioral problems may stem from partially overlapping mechanisms (Bonham *et al.*, 2021) [8]. The purpose of this review paper is to examine the nosology of disruptive behavior disorders (DBD) in the context of educational therapy. It combines DSM-5-TR and ICD-11 classification with the state-of-the-art information about ADHD and CD and comes up with a more accurate interpretation for assessment and intervention.

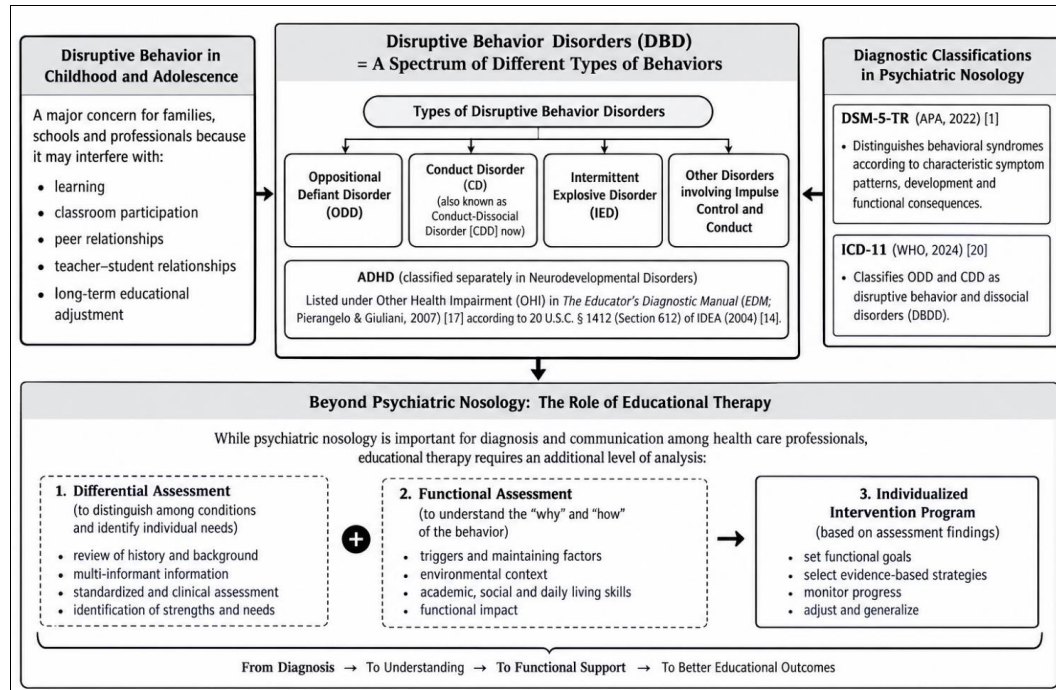


Fig 1: Disruptive Behavior Disorders from Psychiatric Classification to Educational Therapy

Literature Review

1. Nosological foundations of disruptive behavior

The DSM-5-TR [1] classifies ODD, CD, intermittent explosive disorder (IED), pyromania, kleptomania, and other specified or unspecified disruptive, impulse-control and conduct disorders in a chapter on disruptive, impulse-control and conduct disorders (APA, 2022) [1]. Thus, the classification includes conditions which are considerably different in their behavior and functional character. ODD is characterized primarily by a long-term angry or irritable mood, argumentative or defiant behavior and vindictiveness. CD is characterized by aggressive behavior towards people or animals, destruction of property, deceitfulness or theft and serious violations of rules. IED is characterized by recurrent impulsive aggressive outbursts that are disproportionate to the circumstances. Pyromania and kleptomania are more specific forms of recurrent impulse-control behavior.

CD is also differentiated developmentally by childhood-onset and adolescent-onset presentations, and the DSM-5-TR contains a limited prosocial emotions specifier. This distinction is important as development onset and prosocial-emotional characteristics may inform behavior, risk formulation and intervention planning rather than symptom severity.

The ICD-11 [20] is somewhat different. Its category of disruptive behavior and dissocial disorders (DBDD) includes ODD (6C90), conduct-dissocial disorder (6C91), other disruptive behavior or dissocial disorder (6C9Y), and unspecified disruptive behavior or dissocial disorder

(6C9Z). The ICD-11 [20] allows for the specification of chronic irritability-anger and prosocial-emotional characteristics in ODD and distinguishes childhood-onset and adolescent-onset conduct-dissocial disorder (CDD), with limited or typical prosocial emotions (WHO, 2024) [20]. Hence, both nosological systems are complementary, but not interchangeable. The DSM-5-TR [1] and ICD-11 [20] have different organizational structures, terminology and coding systems, and diagnostic equivalence should not be assumed.

2. Educational significance of oppositional defiant disorder

ODD is particularly relevant from the perspective of Educational Therapy because many of its defining traits are in interpersonal and instructional contexts. Argumentativeness, refusal to comply, irritability and deliberate provocation can be apparent in transitions, school work, correction, group activities or situations of perceived loss of control. An educational therapist, however, should not take refusal to be an act of defiance by default. A functional analysis is needed to examine what preceded the behavior, what the learner has to do, what cognitive and emotional resources are required, and what consequences follow the behavior. For example, repeated refusal when writing work could indicate oppositional behavior, but it can also mean language-based learning difficulty, poor handwriting fluency, working memory overload, inadequate task segmentation or avoiding repeated failure.

There have been evidence-based interventions for ODD and disruptive behavior including parent-management

approaches, parent-child interaction therapy, collaborative problem solving, Incredible Years, Triple-P and other behavioral management programs (Kaur *et al.*, 2022) ^[15]. Recent meta-analytic research done by Groenman *et al.* (2022) ^[13] also indicates that interventions involving parents or caregivers, either alone or in multicomponent interventions involving children and teachers, can reduce disruptive behavior in the context of developmentally and contextually directed intervention.

For practitioners in the field of Educational Therapy, this advocate and supports an approach in which intervention extends beyond the therapy room. When possible, behavioral expectations, reinforcement systems, communication strategies and task adaptations should be integrated with caregivers and educational personnel.

3. Educational significance of conduct disorder

Conduct Disorder (CD) represents a qualitatively broader pattern of behavioral difficulty because it involves aggression, property destruction, deceitfulness or theft and serious violations of rules. Educational therapists should differentiate between isolated behavioral incidents and a persistent developmental pattern that is diagnostic.

An educational therapist's responsibility is not to diagnose CD independently unless they are fully credentialed and trained in the relevant professional field. Rather, the educational therapist can describe the functional behavior phenotype and its educational effects. These include aggression in social situations with peers, persistent rule violation, deliberate destruction, dishonesty with regard to academic or social pressures, truancy-like school avoidance and difficulty solving social problems.

The psycho-educational formulation should also consider protective factors and developmental capacities. These can be attachment to significant adults, response to the routine of a regularized life, empathy, learning from consequences, problem-solving skills, communication skills and responsiveness to reinforcement. This information is often more directly useful for psycho-educational intervention than the diagnostic label itself.

For students with severe or persistent conduct problems, Educational Therapy should also be conducted in a multidisciplinary context involving relevant mental-health, medical, social-care and safeguarding professionals. Psycho-educational intervention should not substitute for specialist treatment where there are serious risks of aggression, victimization, criminal behavior or serious harm.

4. ADHD as a neurodevelopmental condition associated with disruptive behavior

ADHD requires particularly careful nosological positioning. It is not a disruptive behavior disorder. The DSM-5-TR ^[1] classifies ADHD within the neurodevelopmental *Mental Disorders*, with predominantly inattentive, predominantly hyperactive/impulsive and combined presentations (APA, 2022) ^[1]. Nevertheless, ADHD is highly relevant to educational therapy because difficulties with attention, inhibitory control, activity regulation and executive functioning may manifest behaviorally as interruption, impulsivity, failure to follow instructions, incomplete work, leaving one's seat, emotional reactivity or conflict with adults.

This distinction is clinically and educationally important. A learner may appear "defiant" because the learner repeatedly fails to follow a multi-step instruction owing to working-memory or attentional limitations. Another learner may interrupt because inhibitory control is weak rather than because the learner intends to challenge the teacher. Consequently, educational therapy should distinguish non-compliance arising from unwillingness from non-compliance arising from inability, overload or inadequate self-regulation.

Research supports the relevance of behavioral intervention to ADHD and associated ODD/CD symptoms. An individual-participant meta-analysis found small-to-medium effects of behavioral interventions on ADHD symptoms, ODD, CD and impairment among children and adolescents with ADHD (Groenman *et al.*, 2022) ^[13]. More recent school-based evidence indicates that school interventions can improve ADHD symptoms, academic performance and social skills and reduce externalizing problems, although effects vary by outcome and intervention target (Bussanich *et al.*, 2026) ^[9]. Thus, the educational therapist should treat ADHD-related behavior primarily through functional support of attention, inhibition, executive functioning, task engagement and self-regulation, rather than interpreting every disruptive behavior as a conduct problem.

5. Cognitive Disengagement Syndrome and educational functioning

Cognitive Disengagement Syndrome (CDS), previously known as Sluggish Cognitive Tempo (SCT; Barkley *et al.*, 2022; Becker, 2025) ^[4, 5], is an emerging construct of excessive daydreaming, mental confusion or foginess, decreased alertness, withdrawal and hypoactivity. An international expert group recommended the term CDS and concluded that the construct has sufficient evidence to warrant recognition as a separate syndrome and that there is still great research to be done on its nosological status (Becker *et al.*, 2023) ^[7].

CDS should not necessarily be presented as a DSM-5-TR ^[1] or ICD-11 ^[19] diagnosis. However, present evidence is that CDS can be distinguished from ADHD symptoms and is associated with functional impairment. A 2024 study (Becker *et al.*, 2024) ^[6] provided psychometric support for caregiver and youth versions of the Cognitive Disengagement Syndrome-Clinical Interview (CDS-CI).

The psycho-educational implications are enormous. A learner with CDS may be passive, unmotivated, slow to respond, disengaged and unaware. From the perspective of Educational Therapy, these behaviors should not be viewed as laziness, oppositionality or deliberate disobedience. Studies of academic functioning have shown correlation between CDS symptoms and poorer academic performance (Becker *et al.*, 2024) ^[6], but there is heterogeneity with ADHD symptoms, intelligence, demographic factors and the academic outcome (Fredrick & Becker, 2023) ^[7, 12]. Therefore, psycho-educational assessment should examine whether the disengagement is related to task complexity, attention level, processing demands, working memory, motivation, emotional state, sleepiness, instructional pacing or other contextual factors.

6. From categorical diagnosis to functional psycho-educational formulation

Table 1 below shows the central contribution of Educational Therapy is the translation of diagnostic information into an analysis of functional psycho-educational needs (Formisano, 2024) ^[11], such as the specific learning, emotional, behavioral, and social support needs, which an individual

need to function effectively in school, work, or daily life. A useful formulation can be represented as: diagnostic condition → behavioral phenotype → functional capacities → environmental demands → behavioral response → educational consequences → intervention targets. This model prevents a diagnostic category from becoming an explanation in itself.

Table 1: Analysis of Functional Psycho-Educational Needs in Different Diagnostic/Clinical Contexts

Diagnostic / clinical context	Diagnostic / clinical context	Functional questions	Targets of Educational Therapy
ODD	Refusal, arguing, irritability, conflict	▪ Frustration tolerance? ▪ Flexibility? ▪ Communication? ▪ Reinforcement?	Emotional regulation, problem solving, compliance, and communication
CD	Aggression, rule violations, deceit, property destruction	▪ Social cognition? ▪ Impulse control? ▪ Environmental risk? ▪ Prosocial development?	Social problem solving, self-regulation, prosocial behavior, and safety
ADHD	Impulsivity, interruption, incomplete work, excessive activity	▪ Inhibition? ▪ Working memory? ▪ Sustained attention? ▪ Task organization?	Executive functioning, attention, self-monitoring, and task management
CDS	Daydreaming, slow engagement, mental foggy, passive behavior	▪ Alertness? ▪ Cognitive engagement? ▪ Task initiation? ▪ Processing demands?	Engagement, activation, task initiation, and instructional pacing
ADHD + ODD/CD	Mixed externalizing presentation	▪ Which behaviors reflect ADHD? and ▪ Which reflect oppositional / conduct processes?	Integrated executive, and behavioral and socio-emotional intervention

The table demonstrates why educational therapy requires a differential-functional approach rather than a purely categorical behavioral approach.

Research Method and Materials

This review paper was structured using a narrative review approach based on the Scale for the Quality Assessment of Narrative Review Articles (SANRA; Baethge *et al.*, 2019) ^[3] for narrative reviews. The review was designed to integrate psychiatric classification with the concepts derived from Educational Therapy, and not to attempt to estimate the treatment effect sizes or identify diagnostic prevalence. Primary classification sources were the DSM-5-TR ^[1], EDM ^[17], and ICD-11 ^[20] clinical descriptions and diagnostic requirements. Literature on ADHD, CD, CDD, CDS, DBD, DBDD, IED, ODD, SCT, behavioral interventions, school-based interventions, executive functioning, and externalizing behavior is carefully considered. Moreover, the author has made particular reference to the literature mainly from 2020 onwards (though a few in-text citations are dated back to 2004-2019) and has kept the original literature used to explain how the important constructs developed.

The literature was interpreted within the domain of educational therapy for which there are five complementary questions the author asked: (1) What is observable? (2) What functional capacities can affect the behavior? (3) What academic or social demands precede it? (4) What consequences can be sustained? and (5) What teachable replacement skills can be developed?

The purpose of this review was not to create a new psychiatric classification but to develop a clinically

informed educational approach that can work alongside existing diagnostic systems.

Findings and Discussion of Findings

1. Finding 1: Disruptive behavior is a phenotype, not a single mechanism

The review highlights that disruptive behavior should not be considered as a unitary phenomenon. ODD, CD and IED have different defining characteristics and ADHD and CDS may have behavioral characteristics that overlap with aspects of disruptive behavior.

The psycho-educational implication is that behavioral similarity does not establish causal similarity. Two learners who both refuse work may require entirely different interventions. One can require behavioral regulation and compliance training, while another may require literacy intervention, task modification or executive-function support.

2. Finding 2: Educational assessment should complement diagnostic assessment

A psychiatric assessment of a challenging behavioral condition often asks if diagnostic criteria are met. Psycho-educational assessment (consisting of differential and functional assessments) is about which specific issue of behavioral concern has been identified (being differentiated from others) and how the learner functions in specific environments. They are not in opposition to each other but complementary forms of assessment.

Therefore, a comprehensive Educational Therapy-based assessment should look at the following functioning domains of concern as shown in Table 2 below:

Table 2: Comprehensive Functional Assessment Domains

Functional Domains	Functioning factors
▪ Cognitive functioning	Reasoning, working memory, processing efficiency, attention and executive functioning
▪ Academic functioning	Reading, writing, mathematics, oral language, task completion and curriculum access
▪ Behavioral functioning	Antecedents, observable behavior, consequences, frequency, duration and intensity
▪ Affective functioning	Frustration tolerance, emotional regulation, anger responses, anxiety and perceived competence
▪ Conative functioning	Initiation, persistence, motivation, goal-directed behavior and self-monitoring
▪ Sensory & physiological functioning	Arousal, sensory load, fatigue and environmental overstimulation when appropriate
▪ Social functioning	Communication, perspective taking, conflict resolution, peer interaction and prosocial behavior
▪ Environmental functioning	Classroom structure, teacher expectations, task demands, reinforcement contingencies, peer relationships and family-school consistency

This broader analysis prevents us from making the mistake of interpreting a complex learning problem only in terms of behavior.

3. Finding 3: Educational therapists should distinguish skill deficits from performance deficits

One of the most important educational distinctions is between not knowing how to perform a behavior and knowing how but failing to perform it consistently. A learner with a skill deficit may truly lack the executive, academic, language or socio-emotional capacity needed for good behavior. Intervention should therefore teach the missing skill. Another learner with a performance deficit may have the skill but fail to utilize it consistently because of motivation, reinforcement history, emotional arousal, environmental conditions or competing contingencies. Intervention needs to be made through reinforcement, prompting, self-monitoring and environmental structure.

This distinction is particularly relevant to ODD and ADHD. A child who cannot reliably inhibit a response may need explicit inhibition training and environmental supports. A child who has the skill but deliberately violates expectations across contexts may need a different behavioral formulation.

4. Finding 4: Educational intervention should be multi-level

Behavioral and psychosocial intervention research (e.g., McCart & Sheidow, 2016; Reinke *et al.*, 2009; Selph *et al.*, 2026) [16, 18, 19] indicates that disruptive behavior is best addressed through interventions that involve multiple components and relevant environmental partners. Recent meta-analytic evidence has shown decreases in disruptive behavior from parent-only and multicomponent interventions involving children and parents, caregivers or teachers (Groenman *et al.*, 2022) [13].

Educational therapy can help at several levels as shown in Table 3 below

Table 3: Four-Tier Framework for Behavioral Support and Intervention Strategies

Level	Behavioral Support	Intervention Strategies
1	Environmental prevention	Predictable routines, clear instructions, visual schedules, appropriate task difficulty, transition preparation and positive reinforcement
2	Skill development	Emotional regulation, executive functioning, communication, social cognition, problem solving and academic skills
3	Individualized behavioral intervention	Functional behavior assessment, antecedent modification, replacement behaviors, and self-monitoring
4	Multidisciplinary intervention	Working with psychologists, psychiatrists, pediatricians, occupational therapists, speech-language therapists, teachers and caregivers where appropriate

Therefore, an educational therapist occupies a very important position between diagnostic knowledge, differentiated understanding, and day-to-day functional intervention.

5. Finding 5: Intervention should target replacement behavior rather than behavior suppression

A purely suppressive approach seeks to stop undesirable behavior. To approach the behavioral issue of concern, an educational therapist should approach ask: “What behavior should it replace?” Some examples provided by the author include the following:

- Aggression → requesting assistance or using a break strategy;
- Refusal → negotiating task modification or requesting clarification;
- Leaving the classroom → using the agreed movement-break routine;
- Interrupting → using a visual waiting cue;

- Task avoidance → using task segmentation and initiation prompts;
- Argumentative response → using a taught disagreement script; and
- Impulsive action → Stop–Think–Act routine.

This transition from behavior elimination to functional replacement is consistent with the educational principle that adaptive behavior must be explicitly taught, practiced and reinforced.

6. Finding 6: Educational Therapy should integrate academic intervention with behavioral intervention

One of the main takeaways from the perspective of Educational therapy is that behavior and academic learning cannot always be separated. Academic failure can increase avoidance, frustration and conflict; behavioral dysregulation may reduce instructional exposure and learning opportunities.

To begin with, psycho-educational intervention should address: access to instruction → engagement → task completion → mastery → confidence → adaptive behavior. For instance, a student who gets disruptive on writing tasks might require both behavioral regulation and direct written language intervention. Just increasing behavioral consequences without addressing the academic bottleneck may leave the functional cause unchanged. School-based evidence in ADHD also indicates that intervention can

affect academic, social and externalizing outcomes simultaneously (Bussanich *et al.*, 2026) ^[9].

An Educational-Therapy Model of Disruptive Behavior

A useful educational formulation can be represented as a Functional Nosology-to-Intervention Model (as shown in Figure 2 below). This model places diagnosis at the beginning of the formulation but functional learning needs at the center of intervention.

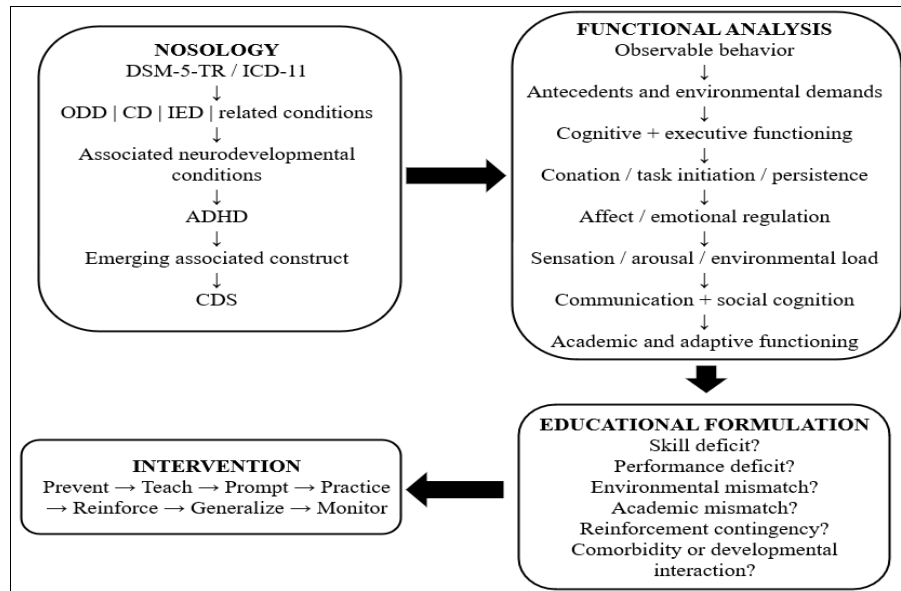


Fig 2: Functional Nosology-to-Intervention Model

Integration with a CCAS Educational-Therapy Perspective

The CCAS concept involving Cognition, Conation, Affect and Sensation (Chia, 2015) ^[10] is useful for translating disruptive behavior into functional educational contexts.

- **Cognition [C]:** Cognition is attention, reasoning, working memory, processing efficiency, language, problem solving and executive processes. In ADHD, for example, attentional and inhibitory difficulties can lead to behavioral dysregulation. In CDS, disengagement, mental foginess and reduced alertness may interfere with academic engagement. These processes should be assessed separately from intentional oppositionality.
- **Conation [C]:** Conation is about the initiation, motivation, persistence, goal-directed behavior and self-regulation. A learner may know what to do, but fail to initiate or sustain the behavior. Educational therapy can therefore focus on task initiation, goal setting, self-monitoring, persistence and behavioral routines.
- **Affect [A]:** Affect is particularly relevant for irritability, frustration, emotional lability, anger and the development of prosocial behavior. Educational intervention should teach emotional identification, regulation, frustration tolerance, perspective taking and socially appropriate expression of disagreement.
- **Sensation [S]:** Sensation is the learner's interaction with sensory and physiological demands. Sensory overload, excessive stimulation, fatigue or poor

regulation can affect arousal and behavioral availability. Sensory factors should therefore be investigated where clinically relevant, but not under the assumption that sensory difficulty is ODD or CD.

The CCAS formulation allows the same observable behavior to be analyzed across different domains rather than assigning the behavior automatically to a single diagnostic category.

Implications for Educational-Therapy Practice

The first implication is that educational therapists should take a nosology-informed but function-oriented approach. Diagnostic as well as differentiated information should be respected, but the intervention plan should be based on the learner's actual functional profile.

Second, educational therapists need to avoid equating disruptive behavior with intentional misconduct. Behavioral observations should be taken in the context of developmental expectations, academic demands, communication skills and executive functioning.

Third, assessment (be it diagnostic, differential or functional) should be multi-informant and multi-contextual. Behavior that happens in one environment but not another may provide important information about antecedents and maintaining contingencies. Where possible, parents, teachers and learners should be consulted.

Fourth, educational therapists should establish measurable functional goals. Instead of a global goal like "reduce disruptive behavior", goals might include "initiates assigned

work within three minutes”, “uses an agreed help-request strategy before leaving the task”, “waits for a conversational turn” or “uses a taught regulation strategy following frustration”.

Fifth, individualized intervention should be coordinated with teachers and caregivers. New evidence is in favor of interventions that include parents, caregivers and teachers, rather than individual child intervention (Groenman *et al.*, 2022) ^[13].

Finally, severe behavioral presentations should trigger appropriate multidisciplinary referral. Educational therapy is not a substitute

for psychiatric assessment, psychotherapy, safeguarding procedures or medical intervention when these are indicated.

Procedure in Educational Therapy-based Evaluation

The following sequence of steps taken in an Educational Therapy-based evaluation for a learner, who presents symptoms of DBD, contains substantial abductive reasoning but not every step is itself abductive. Abduction is the inference of the most likely explanation for an event based on information available to the educational therapist (e.g., “What best explains this behavior?”).

Table 4: Education Therapy-based Evaluation Procedure

Steps	What each Step does	Questions asked	What the Steps are about
1	Set the presenting behavior.	What happens?	Steps 1-3: Mainly descriptive / assessment reasoning.
2	Establish developmental and diagnostic context.	Are ODD, CD, ADHD, ASD, learning disorders, anxiety, mood difficulties or other conditions already diagnosed or suspected?	
3	Assess functional abilities.	What does the learner know? What can the learner actually do?	
4	Spot the triggering demands.	Does behavior occur during literacy, math, transitions, social interaction, independent work, correction or unstructured time?	Steps 4-5: Strongly abductive; the educational therapist has to identify triggers and consequences to infer what function may best explain the behavior.
5	Decide consequences.	Does behavior result in escape from work, adult attention, peer attention, access to preferred activities or sensory regulation?	
6	Find replacement skills.	What adaptive behavior would meet the same functional need more appropriately?	Step 6: Abductive plus functional reasoning: infer the replacement skill that could satisfy the same need.
7	Create an individualized intervention program.	--	Step 7: Intervention / application based on the inferred explanation.
8	Watch generalization.	Does improvement happen across therapist, classroom, home and community contexts?	Step 8: Hypothesis testing / generalization: Checking whether the proposed explanation and intervention hold across contexts.

This process converts a diagnostic concern into a practical educational formulation. More precisely, this is also a functional assessment process that incorporates abductive reasoning, rather than a purely abductive-questioning framework, as the educational therapist evaluates the case/situation to better understand the client’s behavioral issues.

Limitations

The author acknowledged the following several limitations of this review.

First, educational therapy is not a single internationally standardized professional discipline with one universally accepted scope of practice. As a result, the specific assessments and intervention responsibilities of educational therapists vary across jurisdictions and professional contexts.

Second, the diagnostic systems that are considered in this review are clinical classification systems and were not developed for educational therapy. Their categories therefore cannot be assumed to correspond directly to educational intervention categories.

Third, there is still a lack of evidence for some constructs. This is especially true for CDS, for which modern research supports a distinct syndrome but still explores its developmental course, mechanisms, nosological status and intervention implications (Becker, 2025) ^[5].

Fourth, disruptive behavior is strongly influenced by context. A diagnostic formulation cannot explain all behavior observed in classrooms, families and peer groups. Cultural expectations, educational structures, family circumstances, teacher practices and environmental contingencies may greatly impact behavior.

Finally, the proposed educational-therapy framework is a conceptual synthesis rather than a validated diagnostic instrument or intervention protocol. Studies with a specific focus on the educational-therapy framework are needed to assess the impact of this functional approach on educational outcomes in comparison to conventional diagnostic or behavior-management interventions.

Conclusion

The nosology of disruptive behavior disorders (DBD) is an essential tool for educational therapists to understand ODD, CD and other related challenging behavioral disorders, but it does not explain why a learner’s behavior operates in an educational setting. From the perspective of Educational Therapy, disruptive behavior should be understood as a developmental and functional phenotype derived from the interaction between learner characteristics and environmental demands.

ODD and CD are still important formal diagnostic categories, while ADHD should be considered as a neurodevelopmental disorder where disruptive behavioral presentations can be very similar. CDS should be viewed as

a new research-driven syndrome and not as a formal DSM-5-TR^[1] or ICD-11^[20] diagnosis. Such distinctions are important because if educational therapists conflate diagnostic as well as differential categories at the wrong time it will result in inappropriate intervention in treating the challenging behavioral issues.

The field of Educational Therapy adds a functional layer to psychiatric nosology by exploring executive functioning, academic competence, social functioning and environmental demands within the context of Cognition-Conation-Affect-Sensation (CCAS) model (Chia, 2015)^[10]. The resulting formulation moves from “What disorder does the learner have?” towards “What functional difficulties are producing or maintaining the observed behavior, and what skills and environmental changes will enable more adaptive participation in learning?”

The most appropriate psycho-educational response is consequently neither purely disciplinary nor purely diagnostic. It is a structured process of differential assessment, functional formulation, skill development, environmental adaptation, behavioral support, collaboration and progress monitoring. In this model, diagnostic and differential assessments help to establish the context, functional assessment establishes the psycho-educational needs, and educational therapy translates those needs into teachable and measurable intervention targets.

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