THE LEAST RESTRICTIVE MODEL
AND FUNCTIONAL ANALYSIS

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I consider the concept of "Functional Analysis" to be the major advance in the field of behavior management in the last decade. Functional Analysis is in many ways now replacing the "Least Restrictive Model" as a basis for deciding on appropriate treatment strategies.

For years, the hallmark of Behavioral Therapies was that they directly treated observable behaviors, not theoretical conceptualizations about what was going on in the mind or what Behaviorists liked to call "the Black Box". Give me some M&M's (and maybe a Time Out Room) and I could change any behavior. The origin or reason for the behavior was not considered important. Freudian Analysis may help us understand behavior, but it does not necessarily help us change behavior.

For years, our only guideline for deciding on a behavior strategy was the "Least Restrictive Model of Treatment" or as I like to paraphrase it: "Don't use a sledge hammer to hit a tack". For the Behaviorist, it meant trying the M&M's before the Time Out Room (or shock device); the more intrusive and traumatic techniques could be justified (and often times were), but only if all other less intrusive and traumatic (less restrictive) techniques had proven ineffective.

To apply the Least Restrictive Model, we developed "Hierarchies of Intervention". Rewarding behavior using such things as tokens was placed low on the hierarchy, punishing behavior using a token fine was placed in the middle of the hierarchy and using time-out and various aversive (painful/unpleasant) techniques was placed high on the hierarchy. With increased concern about the extensive use of psychotropic medications (mind altering drugs such Haldol and Mellaril) and their potential side effects, they also were placed high on the hierarchy, i.e., considered to be highly restrictive and a last resort technique.

The use of the Least Restrictive Model has become less significant with the advent of "Functional Analysis". Behaviorists are now beginning to return to a more Medical Model and seeing behaviors as symptoms with an underlying cause and/or serving some purpose. A more appropriate and effective treatment will be determined if we can figure out a behavior's cause and/or purpose.

People do not engage in 'maladaptive behavior' (the old buzzword for behaviors we thought needed to be reduced). The behavior may seem maladaptive to others, but to the person it must be in some way adaptive (serve some purpose) or they wouldn't do it.

If we figure out the 'function' (or purpose) a behavior serves, then we can figure out the best and most effective treatment for it. In many cases, but not always, it turns out this also will be the least restrictive.

Consider the following scenario:

> John hits his ear repeatedly; it started a week ago and is getting worse; no behavioral interventions have yet been tried.

Which of the following is an appropriate first intervention according to the Least Restrictive Model?

> (a) reward John with an M&M for every 15 minutes with no ear hitting;

> (b) give a mild verbal reprimand each time John hits his ears;

> (c) administer a mild electric shock each time John hits his ear.

Hopefully, you selected (a). According to the Model, if (a) does not work, you may be justified in going to (b) and if it does work even trying (c).

BUT what if I now tell you a Doctor examined John and he says John has an ear infection. Does even choice (a) now make sense? An antibiotic, not M&M's (or reprimands or shock) would appear the appropriate solution to John's ear hitting. In this case, hitting his ear was probably caused by the infection. The purpose (or function) of the behavior was to make the pain go away. Functional Analysis in this case leads us to medication, not M&M's!