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PSYCHOTHERAPY AS A SUPPORTIVE METHOD IN DEFECTOLOGICAL TREATMENT

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SUMMARY

Psychotherapy was, at the very beginning, only a method of treating neurotic disorders in psychiatry, but over time it has gone beyond medicine and become accepted in solving everyday life problems and improving the quality of life of well-adjusted people, too. In this way, it imposed and fought for its place in all developed cultures. Besides, because of its broader connection with many social and human sciences (pedagogy, sociology, ethics, law, linguistics, philosophy, religion, psychology, art, defectology, etc.), it is considered to be a certain civilization achievement that significantly marks the modern age.

In addition to the general problems of psychotherapy as a supportive method in defectological treatment, we have paid special attention to behavioral therapy and its application in defectology within each of its branches. Based on the analysis performed, it is generally concluded that, despite the relevant results of the relatively widespread use of behavioral-cognitive therapies in working with children and young people (as well as adults) with disabilities, there is a lack of a more comprehensive theory on the development and elimination of sensory, cognitive and social disabilities, as well as the treatment of mental disorders in the population of individuals with developmental disabilities. Therefore, we need appropriate research that will provide new insights and more accurate data on the true value, as well as disadvantages and advantages in relation to other approaches in the treatment of this population.

Key words: supportive method, psychotherapy, behavioral therapy, disorders in development

INTRODUCTION

Psychotherapy is in its basis an ancient healing skill whose beginnings date back to primitive social communities. However, psychotherapy took its definitive form as a healing skill only in the late 19th and early 20th centuries with the development of psychoanalysis and psychoanalytic psychotherapy by a well-known Viennese physician, professor of psychiatry, Sigmund Freud (Sigmund Freud 1856-1939), who is considered the teacher of all psychotherapists. In the last ten years of the 19th century, based on the experience of numerous predecessors (first of all, physicians, philosophers, and scientists), he presented his theory, psychoanalysis, which sought to challenge the exclusive primacy of biological factors in the emergence and treatment of psychological disorders and to draw attention to the importance of psychological factors. Freud emphasized that psychiatric disorders do not represent only certain brain diseases, but that they must be viewed through the relationship of organic and psychic, body

and soul, that is, viewed in the light of -and-and relations, and not at all -or-or relations because psychopathological phenomena can best be understood only if viewed both ways.

Certain studies carried out at the end of the 20th century indicated that psychotherapy was not an impressionistic discipline based on hypothetical constructs of psychoanalysis and speculation, but rather that it became a scientific discipline. Also, the findings confirmed the fact that all mental disorders arise as a result of the interaction of three factors: congenital dispositions, developmental traumas, and social factors. This interaction is best represented in an already classic bio-psychosocial model that imperatively imposes the need for all disorders to be treated with an integrative approach without the existence of -or-or division. Certainly, grandiose studies of brain plasticity have provided all of this additional confirmation of the scientific basis and its apparent and biological activity, which have shown that the brain is constantly responding to all external stimuli, including words, which are the basic instrument in psychotherapy.

The term "psychotherapy" today encompasses more than 400 theoretical directions, procedures, forms and methods of treatment, of which there is a very extensive literature. What characterizes each approach are the theoretical basis, the specific methodology, and technique of work, the way of evaluation who can be treated, the effects of that treatment, as well as the appropriate procedures for acquiring knowledge and skills for successful treatment of psychotherapy.

The issue of defining psychotherapy has been relevant since its beginning and application in treatment, but, up to date, no commonly accepted definition has been established. For this reason, the conceptual definition of psychotherapy also acquires a philosophical dimension, as pointed out by some well-known psychoanalysts (Alexander, 1957).

In the Encyclopedia of Psychiatry, we find the following definition of psychotherapies: "In a broad sense, psychotherapies encompass all methods of treating psychiatric and even somatic disorders by psychological procedures, or, more precisely, by the relationship between therapists and patients (J. Laplanche and J.B. Pontalis) In this sense, psychoanalysis is one form of psychotherapy" (Poro, 1990: 538).

From the beginning of psychotherapy to these days, there have been attempts by several authors to classify groups and forms of psychotherapy, however, up to date, no proposal has become universally accepted.

At the end of this part of the paper, we would list contemporary classifications of psychotherapy as Eric cites them, grouping them into five broad groups: dynamic, cognitive-behavioral, humanistic-existentialist-phenomenological, integrative, and sociotherapy.

Table 1. *Classification of forms of psychotherapy - Lewis Wolberg (Lewis Wolberg, 1970), T.B. Karasu (T.B. Karasu, 1977) and World Alliance for Psychiatry, 1996*

Dynamic forms
Freud's psychoanalysis
Cleinian psychoanalysis
Ego analysis
Neo-Freudian or No-Freudian psychoanalysis
Alfred Adler's Individual Psychology
Analytical, complex, psychology of Karl Gustav Jung
Character analysis or orgone therapy by Wilhelm Reich
Dynamic Cultural School of Psychoanalysis
Karen Horney School
Harry Stack Sullivan School
Existential analysis
Psychoanalytic Psychotherapy
Short Dynamically Oriented Psychotherapy
Supportive analytical psychotherapy
Group analytic psychotherapy
Cognitive-behavioral therapies
Behavioral therapy
Cognitive therapy
Cognitive analytic therapy
Humanistic psychotherapies
Family therapy
Partner therapy
Gestalt therapy
Transactional analysis
Psychodrama
Constructivist psychotherapy
Integrative psychotherapy
Integrative Gestalt psychotherapy
Integrative dynamic psychotherapy
Integrative cognitive-behavioral therapy
Psychosexual therapy
Sociotherapies
Environmental therapy - adaptation to the environment - sociotherapy
Occupational, working and recreational therapy
Music therapy (therapy with music)
Art therapy
Therapeutic community (Eric, 2006: 13-14).

Following a general approach to psychotherapy so far, we would devote our further exposure to behavioral therapy, primarily because it has found widespread use in the treatment of individuals with developmental disabilities, as well as learning and behavioral problems.

BEHAVIORAL THERAPY AND ITS APPLICATION IN DEFECTOLOGY

Definition

In the literature dealing with the problem of psychotherapy, we can often find a very broad understanding of behavioral therapy as a theory of learning that has been applied in practice. However, such a definition of behavioral therapy would include other psychotherapeutic directions, for example, cognitive therapy (Tadić et al., 2004).

In the *Encyclopedia of Psychiatry*, apart from the general definition of psychotherapy (discussed above), it is not explicitly provided a definition of behavioral therapy but it is indicated that these therapies "start from saying that maladaptive painful responses are, in fact, learned and that by repeated learning they can be replaced by positive anxiety-free practices" (Poro, 1990: 539).

In our background, Starčević provides the following definition: "Behavioral therapy could be more closely defined as the series of techniques and procedures based on the assumption that a psychiatric disorder is the result of a wrongly learned behavior, and because of that the main goal of treatment is to eliminate such behavior. Simply said, behavioral therapy is engaged in changing behavior for better health" (Starčević, 2006: 285).

Theoretical basis

It is safe to say that behavioral therapy is based on the principles of common sense more than it is constituted as a formal form of treatment. Namely, many prominent figures of the seventeenth and eighteenth centuries, including the English philosopher John Locke (1632-1704), the German poet Johan Goethe (1742-1832), intuitively advocated the implementation of behavioral therapy techniques in certain situations. This attitude was also emphasized by Pierre Janet (1859-1947) and Sigmund Freud at the beginning of the twentieth century, but behavioral techniques gained their ground only with the development of experimental psychology. First of all, the experiments of the Russian physiologist Ivan Pavlov (1849-1936), John Watson (1878-1958) and Barshus Skinner (1904-1990) provided solid foundations for behavioral therapy. A significant influence on the emergence of the first behavioral therapy techniques was made by the theory of Mowrer (O.H. Mowrer, 1939), who defined phobia as the fear that is a product of classical conditioning, which is subsequently maintained by the behavior of avoidance. In other words, avoidance reinforces the phobia in a way that reduces the experience of fear. Based on this, it was concluded that phobia cannot be successfully treated without eliminating avoidance.

The aforementioned Mowrer's theory enabled Joseph Wolpe (Josef Wolpe, 1915-1997) to promote the first behavioral therapy in 1958 by introducing systematic desensitization from which the technique of exposure later emerged. The essence of systematic desensitization is reflected in the removal of learned fear by imaginative exposure to objects and situations that cause fear in circumstances in which experiencing fear is not possible (relaxation). The result of repeated "pairing" of

relaxation and exposure to phobic objects and situations is the process of disengagement (desensitization), that is, the appearance of less and less fear as a reaction to a phobic object or situation until the fear disappears, namely until the person learns not to associate the phobic object or situation with fear (Wolpe, 1958).

The aforementioned Wolpe's behavioral therapy technique has been refined and adapted to different patients over time. From the 1960s to the early 1980s, behavioral therapy began to be increasingly applied in the treatment of various phobias and obsessive-compulsive disorders. Significant contributions have been made by some researches that have indicated the success of behavioral techniques in the treatment of these disorders.

The 1980s and 1990s were characterized by the integration of behavioral and cognitive therapy and the development of "hybrid" cognitive-behavioral therapy. This integration is justified and logical for at least two reasons - both are based on the same theories and have the same uses. Although behavioral therapy gives an advantage to the changing of behavior and cognitive therapy advocates changing one's mindset, they do not exclude each other. Besides, it is clear that behavior and the way of thinking go "hand in hand", that is, they influence each other. Also, the practice has shown that in the treatment of many disorders, the cognitive-behavioral approach has had better effects than the "pure" application of one or the other therapy.

In our country, several authors have contributed to the application of behavioral therapy and the education of therapists. Among them are Jezdimir Zdravković (1937-), Slavoljub Radonjić (1932-) and Živorad Kastratović (1941-).

Behavioral therapists have outlined several ways that can lead to fear to be learned: classical (traumatic) conditioning, model learning (imitating or observing others), and transferring information from others.

Classical conditioning was first described by the Russian physiologist Pavlov and is commonly known as a situation in which a certain natural stimulus (food, for example) is followed by a natural, reflexive response (salivation).

The experiment done by Watson and Rayner (Watson & Rayner, 1920) showed that classical conditioning can determine pathological fear and phobia; they provoked fear of white rats in an eleven-month-old baby named Albert, by repeatedly exposing him to a white laboratory rat (conditioned stimulus) simultaneously causing an unpleasant sound (unconditional stimulus) that triggered a fear response (unconditional response). The final consequence was the fear reaction even when the white rat appeared, although the unpleasant sound would be absent. Thus the fear of white rats was learned as their conditional response to the conditional stimulus. In the case presented, the phenomenon of stimulus generalization was also explained because Albert began to fear everything that resembled a white rat (conditional stimulus), such as white rabbits and white fur coats.

Classical conditioning is also called traumatic because a certain traumatic event (as an unconditional stimulus) can be linked to the situation in which it was experienced and which did not cause fear until then.

An occasional reinforcement is required to classical conditioning model which triggered fear in a laboratory to maintain fear, or otherwise, it disappears over time.

Model-based learning involves the emergence of a phobia based on observing or imitating others from one's surroundings. For example, a child may learn to fear an animal or an elevator if the mother is afraid of that.

Also, some fears can be learned through the so-called transfer of information. For example, some children may show fear from some animals if their parents indicate a potential danger from certain animals.

Maintaining phobic fear is explained by operant (instrumental) conditioning. It is directly linked to learning through trial and error. Namely, learning consists of the series of attempts to find a solution to a particular problem or to reach a specific goal. Along the way, mistakes are made, but the behavior that leads to the solution of the problem or the achievement of the goal is reinforced or learned. "Under the operant conditioning model, it is not problematic to support positive and beneficial behavior, but rather to corroborate behavior that only seemingly solves the problem and, in fact, make it even greater. Typical examples of such behavior are avoiding and escaping from phobic situations and performing forced actions. The purpose of these behaviors is to reduce fear, discomfort and / or tension, but such effects maintain fear, discomfort and / or tension at the same time. In this way, the phobia is reinforced, that is, the obsessive-compulsive disorder" (Starčević, 2006: 291).

Objectives

As a primary goal behavioral therapy aims at eliminating symptoms by modifying misconceived behavior. That is why the term behavioral modification is often used. Although behavioral therapy basically do not ignore the other components of symptoms and disorders (cognitive, physical, emotional), it focuses on the behavior that should be changed. Therefore, it is emphasized that: "... the goal of behavioral therapy is to adopt a different, more beneficial behavior as well as to abandon the behavior that characterizes a particular disorder. For example, the first goal of behavioral therapy in the treatment of phobia is to eliminate the fear of certain objects or situations by ceasing to avoid those objects or situations. The next goal is more ambitious because it is about adopting behavior that will protect the person from the patterning of phobia and avoidance" (Starčević, 2006: 292).

Several other goals of behavioral therapy have been rarely highlighted in the literature: to contribute to the responsibility of the patient for his treatment, to allow the patient to rely on himself, and not to make the patient dependent on the therapist.

Indications and contraindications

From the beginning and onwards, behavioral therapy has expanded its indication area, as well as techniques that have been used in almost all forms of psychopathology. Besides, all major achievements in behavioral therapy in working with adults have had relevant impacts on use in working with children and young people.

At this point, further attention will be given to the indicative areas of the application of behavioral therapy in defectology, neglecting some indicative areas in the treatment of the population of typical development.

In the 1960s, behavioral therapy took a significant place in the implementation of work with children within the three main areas. The first area concerns the work with children with intellectual disabilities who were hospitalized in specialized institutions. It is within this field of application that the term behavioral modification is used instead of the term behavioral therapy. The programs implemented within this field of application are aimed at building self-care habits and skills (dressing, eating, use of toilets, use of money), as well as developing social skills. Today, it is emphasized that behavioral therapy has revolutionized the field of skills acquisition and learning of children with intellectual disabilities as well as adults.

The need for the use of psychotherapy in oligophrenology is also emphasized due to the higher incidence of disorders and disabilities in people with intellectual disabilities, which may be due to intellectual disability. Thus, for example, Tadić states: "A fundamental intellectual defect, regardless of its causes and peculiarities of relationships and actions between a child, a young person, a family and the wider community, can cause a higher frequency of disabilities and disorders in the emotional and social development of the group of mentally retarded individuals (Tadić, 1988, 1989). But despite the real need, psychotherapy for the mentally retarded population has long and unjustifiably been neglected and little researched" (Tadić, 2004: 395).

Psychotherapy for people with intellectual disabilities must be part of the overall plan for their treatment, rehabilitation, upbringing, and education. To this end, it is necessary to establish appropriate cooperation among experts of different profiles, as well as to familiarize defectologists with theories on personality development, disorders and the basic principles of psychotherapeutic approach because they work in schools and specialized institutions with this population. It is precisely the association of psychotherapy methods and techniques with educational and rehabilitative approaches that could be called a psychotherapy approach in dealing with a population of people with intellectual disabilities.

Bearing in mind the characteristics of people with intellectual disabilities, the goals of psychotherapy with them cannot be far-reaching and deep, primarily because of their inability to fully and consciously control their internal and physical conflicts, to translate their feelings and aspirations into words and opinions. "The goals of psychotherapy for the retarded population are more modest. It aims to alleviate or eliminate devastating emotional suffering and to free up emotional, conscious and social development within existing and objectively diminished opportunities. Psychotherapy cannot be expected to increase the intelligence, although parents often hope for, but it can be expected that by easing emotional suffering and devastating internal conflicts, at least a part of the energy possibilities will be released and invested in better intellectual functioning" (Tadić, 2004: 397). Certainly, psychotherapy is also needed for parents who have a child with an intellectual disability from the very detection of intellectual disability.

Appropriate contraindications to the use of psychotherapy in oligophrenia are also indicated in the Encyclopedia of Psychiatry: "Thus, in cases of psychoses related to the development of a particular organic disorder, such as infection or intoxication, or some deep disturbance of the psychological structure (primary dementia, for example), or those that represent real and incurable psychiatric defects (oligophrenia, senile dementia, constitutional imbalance), psychotherapy has only partial effects" (Poro, 1990: 540).

Another important area of application of behavioral therapy is the area of educational and school problems. These procedures are more often organized in school and family, and rarely in clinical settings. The pre-arranged procedures are conducted daily by teachers, parents, siblings, classmates with the guidance and constant supervision of a behavioral therapist.

Various psychiatric disorders and problems of children and young people represent the third area of application of behavioral therapy. Within this area, the subject of treatment is most commonly behaviors based on anxiety, phobias and fears, attention disorders and behavior in children with hyperactivity, as well as some isolated symptoms (enuresis, encapsulation). Often, all these go with school failure and learning disabilities or specific reading and / or writing difficulties. In all these cases, behavioral procedures are most commonly implemented to improve motivation to learn, improve attention and concentration for learning and teaching, building independence for teaching and learning, and adopting more effective learning methods. Often, while working with children with learning disabilities, the task of therapy can be elimination of the fear of answering or testing.

In clinical settings, behavioral therapy is used in procedures that aim to eliminate or mitigate behavioral disorders, aggressiveness, or delinquent behavior.

"Psychotherapy as a way of treating children and young people with behavioral disorders is still a subject of discussion among psychiatrists, specialized pedagogues, psychologists, and social workers. Psychoanalysts see this disorder in the light of disturbed objective relations and seek the possibility of successful treatment of such children and young people in the correction of early experiencing of the parent object, which can only be achieved by psychotherapy whose ultimate goal is to enable the child through the introjections of good objects to create a more mature superego and ego-ideals" (Čiček & Nikolić, 2004: 352).

A behavioral model for understanding and eliminating behavioral and experiential disorders emerged in pediatric psychopathology only after many years of domination of the psychodynamic interpretation of these phenomena. There are significant differences between the two models, and they are more reflected in theoretical concepts, while in clinical practice, it is often observed successful completion and collaboration of experts from these two orientations.

When it comes to the use of psychotherapy in typhlology, that is, in people with visual impairments, specific features arise from the peculiarities of their emotional, cognitive and social development, which is described in some works (Lesser, 1979; Popović, 1983; Poznanski, 1979; Tadić & Kraigher, 1980). Due to the disability itself, but also because of inappropriate attitudes of parents, the narrower and wider social environment, the maturity and development of structures and functions of the personality of children and young people with visual impairments are more often endangered and altered compared to children and young people of typical development.

As with persons with intellectual disabilities, psychotherapy must be a part of the overall plan for their treatment, rehabilitation, upbringing, and education, involving parents, the school and the wider community. In this regard, psychotherapy for the visually impaired must have two goals: "preventive (prevention of sensory, cognitive and social disorders of development and promotion of social health) and treatment

of already existing disorders and developmental disabilities (transient reactions and difficulties of adjustment, neurotic reactions, conditions and organized neuroses, character disorders, function organization, and psychoses)" (Tadić, 2004: 399).

The psychotherapeutic relationship with the visually impaired people is established, first of all, by speaking through the color of voice, emphasizing and using words that describe the object and expression of the psychotherapist's face, but also by touch, movement, and play. "One of the first goals of psychotherapy is to make a child or a young person to identify, express, and illuminate, within the framework of a positive psychotherapy relationship, his experience of impairment and painful feelings (sadness, dissatisfaction, anxiety, fear, hostility, jealousy, feeling of inferiority) (Cholden, 1961, Adams 1980), the phantasms, defenses (projections, denials, setbacks, and others) and behaviors and thoughts (withdrawal, rivalry, ferocity, vindictiveness, and others) that accompany it" (Tadić, 2004: 401).

The development of psychotherapy as a method and the knowledge spreading about the psychic and psychiatric consequences of deafness were crucial for the use of psychotherapy in hearing-impaired individuals. Therefore, the use of psychotherapy in hearing-impaired individuals was preceded by appropriate researches on the consequences of deafness in psychological and psychiatric terms. The first research into the mental health of hearing-impaired individuals is related to Edna Levine (1956, 1974), who studied the problem of deafness in the 1950s, followed by F. Kalman (1963) who did extensive researches on deafness that provided a good basis for the application of psychotherapy. However, the very beginning of psychotherapy work with this population is related to rehabilitation and certain assistance to hearing-impaired people in living and working in society during and after formal treatment.

People with hearing impairments exhibit the same types of mental illnesses and emotional disturbances as those with normal hearing, however, due to the dominance of the hearing population, these individuals have additional adaptive demands in the surroundings. Specifically, a key problem in the development of a hearing-impaired child is his limited ability to communicate which, with other limitations, makes mental illnesses in this population more difficult to detect and treat.

We must emphasize that there are no specific indications for the use of psychotherapy procedures in children and young people with hearing impairment but that it is the same as for hearing population of the same age, although the hearing impairment itself in certain cases may be an indication for the use of psychotherapy. This is, above all, related to mild hearing impairments, which usually interfere with social contacts and affect the appearance of pronounced adaptive disabilities in these individuals. "However, the position of a deaf child is much different from that of a hearing child. From the moment a hearing impairment is detected, and this is also possible at birth, the deaf child becomes the subject of observation and treatment by a multidisciplinary team in which in most cases everything is focused on the most successful treatment of speech and hearing. Each of these team specialists has his program and the goals he wants to realize. Very often, these professionals act disunited and independently, which seems confusing to the child and creates effects that disrupt the achievement of the goals. The solution is seen in mental hygiene activities whose most effective means is psychotherapy and the type of psychotherapeutic approach should take into account

the child's capabilities. The main goal of these activities is to achieve a more harmonious psychic development. This is where psychotherapy occurs as a preventive measure, it is well developed and is connected to rehabilitation institutions" (Stojnić, 2004: 405).

The specificity of psychotherapy in children and young people (including adults) with motor impairments is also pronounced. Namely, bearing in mind the fact that motor disorders are a consequence of a very wide range of clinical diagnoses, it is not possible to base psychotherapy on a single theoretical approach. The type of motor impairment in a particular person determines the way he reacts in the social field, but at the same time influences the creation of attitudes of the social surroundings concerning his reaction. All this has a dialectical effect on how a person with a motor impairment experiences himself.

In the population of children and young people with motor impairment, we most frequently find those with cerebral paralysis, those who have suffered traumatic head injuries, paraplegics, tetraplegics, children with limb amputations, with congenital physical deformities and neuromuscular diseases. All these diagnostic entities result in the most pronounced changes to the motor system. However, consequences are present not only in the development of practical activities but also in the development of cognitive abilities. Also, in the population of individuals with motor impairments, there are associated disorders or multiple disabilities, for example, varying degrees of intellectual disability, visual impairment, etc. Therefore, different types and degrees of motor impairments can lead to certain disorders and disabilities in the development of personality and cognitive development. All of the above also defines psychotherapy approaches that can and should be used in working with the population of individuals with motor impairments. Bearing in mind the close relationship between a child and his parents, the used psychotherapeutic procedures must target both the child with motor impairments and the parents. In some cases, even the psychotherapy of parents may be sufficient to facilitate the life of a child with motor impairments.

"*Preventive counseling with parents* is of great importance in the psychotherapy of physically disabled children, which, of course, presupposes that parents have the opportunity to become involved in it. This means that the parent must be involved in that work as soon as the child's disorder appears. This should be provided immediately for parents of children with cerebral paralysis... *Counseling with parents is based on psychodynamic grounds*. *It can also grow into some form of group activity for self-help*. First of all, parents should be assisted in establishing cooperation and communication with the child, who is so motor-disabled that this cannot be achieved without difficulties. At the same time, they should be allowed to express their fears, anxiety, sorrows, shaken feelings of their adequacy, frustrating narcissism, feelings of guilt" (Lorenčić, 2004: 409).

Behavioral therapy techniques

Although we have outlined some of the techniques used in behavioral therapy during our review of the selected topic, we have dedicated a special chapter to this problem. At the very beginning, it must be emphasized that the implementation of behavioral therapy must be preceded by a detailed behavioral analysis. The primary goals of the behavioral analysis are for the therapist and the patient to identify and understand the

specific interactions between the factors that lead to the disorder itself and those that sustain it.

A common feature of almost all behavioral techniques is the records keeping of the details of a therapeutic procedure and certain homework that the patient has to do between therapy sessions (Starčević, 2006).

"The American Psychiatrists Association and some other professional associations have classified the following techniques into recognized behavioral therapy techniques:

1. Systematic desensitization.- The essence of the technique is a) a gradual, b) progressive c) exposure d) to the terrifying circumstances with e) an additional stimulus or condition incompatible with fear;
2. Operant principles.- The essence of the method is: a) the planned rewarding of desired behavior b) the planned denial of reward for unwanted behavior;
3. Aversive control. - The essence of the method is to deny the reward and to use the time out method. The term and manner of applying the "time out" procedure is described in the proposed literature (Anić, 1984);
4. Self-affirmation training. - The essence of the method is to teach the person in treatment to express his will and intentions, to counteract in an inoffensive manner, and to achieve more successful relationships with the social environment and to show more security" (Anić, 2004: 102).

Starčević lists the following behavioral therapy techniques: exposure (exposition), modeling, social skills learning, behavior modification using aversive procedures, stimulus control techniques, chip economics, and other techniques (Starčević, 2006).

Exposure (exposition) is referred to as the most significant, effective, and commonly used behavioral therapy technique, which has already been discussed in the part of the theoretical basics and noted that its theoretical basis is derived from Mowrer's theory according to which the condition for the disappearance of fear is the ending of avoidance. Exposition as a technique is used in many ways, which is conditioned by the form of phobia or fear and the characteristics of the patients. The main differences in the use of exposition relate to whether it is carried out: 1) by imagining or live (in vivo), 2) gradually or abruptly, that is, by flooding, and 3) alone or with the help of a therapist or a partner.

Modeling therapy involves such a behavioral technique in which the patient first observes how the therapist is fearlessly exposed to the phobic object, and, afterward, the patient himself imitates the therapist when ready for it. It is used in the treatment of phobias in children, agoraphobia, less often in obsessive-compulsive disorder.

"Learning social skills involves a variety of techniques aimed at allowing a person to express his feelings freely, to be able to cope with what is important to him, to communicate better and to solve problems more easily, and / or to be able to control his inclination to react impulsively" (Starčević, 2006: 303).

Behavioral modification using aversive procedures is a controversial technique that caused behavioral therapy to be criticized and it is rarely used today. The essence of this technique is to eliminate maladaptive behavior by applying direct or indirect punishment.

Stimuli control as a behavioral technique come down to a series of instructions that are given to influence the change of certain habits. It is most commonly used in the treatment of obesity and insomnia.

"The chip economy was first used as an additional tool in the rehabilitation and re-socialization of chronic, psychotic patients in major mental hospitals. The name of the technique derives from the fact that such patients received chips in exchange for desirable behavior with which they could buy something or use them in another way that suited them" (Starčević, 2006: 305).

Other behavioral techniques include procedures aimed at changing certain actions, habits, and behaviors such as teak, nail-biting, hair pulling, excessive scratching, and thumb sucking in children. All of these actions are based on the replacement of an existing activity or habit with a new one that is incompatible with the previous one and will have an inhibitory effect on it until it is disabled.

Finally, we would emphasize that behavioral therapy techniques are often combined with other procedures (for example, cognitive therapy) and within the indication areas we have discussed.

CONCLUSION

Psychotherapy is an ancient healing skill that took its definitive form in the late nineteenth and early twentieth century when Viennese psychiatrist Sigmund Freud came up with his theory of psychoanalysis, which challenged the exclusive primacy of biological factors in the emergence and treatment of psychological disorders and emphasized the importance of psychological factors. Since its beginning, psychotherapy was exclusively a method of treating neurotic disorders within psychiatry, but over time, its application has become more widespread in all fields of medicine, at all ages, but also in all significant areas of human life: sexuality, marriage, family, academic achievements, work and social success and so on.

The results of numerous studies in the late 20th century confirmed the fact that all mental disorders are a consequence of the interaction of three factors: congenital dispositions, developmental traumas, and social factors and they contributed to the constitution of psychiatry as a scientific discipline.

In addition to the historical approach, the paper discusses the general problems of defining psychotherapy, the theoretical basis and principles of psychotherapy, its goals, indications, and contraindications for its application, classification, and some other general issues. Particular attention in the work is devoted to behavioral therapy and its application in defectology within each of its branches.

It is difficult to predict what further course the application of psychotherapy will have in defectology. Although there are relevant results on the relatively wide use of behavioral-cognitive therapies in working with children and young people (and adults too) with disabilities, the time ahead has to provide more accurate data on their true value, but also about the disadvantages and benefits concerning other approaches. Therefore, it is necessary to build on a more comprehensive theory on the development and elimination of sensory, cognitive and social disabilities based on the results of

appropriate research and further knowledge, as well as the treatment of mental disorders in the population with developmental disabilities.

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