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Modern society levels of prevention against anti-social and anti-juvenile behaviour in relation to early school leaving: summary of a study

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Abstract
The aim of this paper is to analyse the role of the social worker in mental health, and in particular in Borderline Personality Disorder (BPD). The so-called "mental health" corresponds to the well-being condition in which a person finds himself when he reaches a satisfactory personal psychological balance. Mental health is a subjective condition that depends on different factors (personal, relational, social, economic) and changes as a result of the vicissitudes of life. The subject with mental discomfort lives in a state of suffering: for fear, for loss of confidence in himself or in others, for inability to love, to work, for loneliness. When psychic discomfort persists for a long time it can result in a real mental illness. The most common psychiatric diseases are: depression, anxiety disorder, panic attacks, the large group of psychoses, including schizophrenia. In the past, people with severe mental illness were isolated in asylums, places of segregation rather than places of care. The mentally ill was considered "dangerous to society", so he had to be removed. Today, the Social Worker fits into this delicate context as a professional who contributes to the achievement of the state of health understood by the World Health Organization (WHO), as "complete well-being, physical, mental and social".

Keywords*: Mental health; social service; society, families; borderline.*

Introduction

Today, mental health is recognized as a fundamental factor for people's well-being, greatly affecting everyone's quality of life. The search for individualized and effective interventions aimed at the user, the particular attention to improving the quality of life of people and the respect of their fundamental rights are very recent aspects in the psychiatric

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field. Only since 1978, with the introduction of the Basaglia Law (Italy), the approach to people with mental problems changed. With Law 180/78, in fact, the Parthians of simple care were abandoned and with them the asylums were closed, thus restoring dignity and rights to all people suffering from mental disorders. Until that time, for the latter, the only possible prospect was a long mental institution. By evolving, psychiatry has realized that mental illness, in addition to the physical component, also has a psychosocial character, bringing with it numerous relational and social repercussions. Moreover, very often situations of mental distress are strongly gripped by the stigma, which alters the image of the person suffering from it and, on the other hand, promotes strong discrimination and social exclusion. In order to protect rights and address conditions of weakness and fragility that often unite people with psychiatric disorders, A system of targeted services has been created that guarantee individualized care and encourage the development of user empowerment and a path aimed at recovering responsibility and autonomy. Today, the Department of Mental Health (Italy) and, through the multiplicity of professionals present, involves the person in different rehabilitation activities, supporting and supporting him in his recovery path, acquiring awareness of their potential and the skills to manage their disorder. Among the various interventions should also be highlighted those offered by residential or semi-residential structures, graduated according to their possibilities of assistance, aimed at the recovery of skills of a social and relational nature. Within the Mental Health Center, the Social Worker collaborates with all other professionals present within the Center to achieve the goals set by the entire team. This helps him to consider the user at 360 degrees and to face the need for help expressed by the user in a complete way. Very often, however, the team is not enough to address the social part of the user's needs and the social worker must, therefore, know how to look for the necessary resources offered even within the network of institutional and non institutional services, present in the territory. The latter becomes the space in which the necessary resources can be found and found. It is important, therefore, that the social worker adopts an approach that allows the development of the local community, through their knowledge and methods. Over the years, mental health services have certainly undergone a long process of transformation from institutionalisation to community-based practices.

Mental health and the legislative process in Italy

The history of mental health in Italy is marked by laws rooted in the last century (Tab. 1). The relationship between Mental Health and Social Service is not born in a homogeneous way, but rather, from the set of several elements and events that, at the turn of the sixties and seventies, gave an enormous organizational turn to the phenomenon. Initially, after the Second World War, the social aspects of life of the person were not considered in the field of health, therefore, the Services responded to the problem only through the use of classic therapeutic practices. In fact, because of the Crispi Law, No. 6972 of 1890, social welfare activities were confined to charities, volunteers and municipalities (Rossi, 2014). The approach used was medical, centered on the concepts of body and pathology. At that time, the reference law was No. 36 of 1904, entitled: "Provisions on asylums and alienated. Custody and care of the alienated" which outlined a system based on the social danger of the psychiatric patient and the obligatory treatment (Campanini 2020). The interventions were then carried out through the diagnosis and treatment of the injured parts of the person, in order to normalize the dysfunctional aspects caused by mental illness.

Table no. 1. The most significant laws on mental health, in Italy

1. Law 14 February 1904, n.36, "Dispositions on asylums and alienated persons", known as the Giolitti Law: defines the link between the social factor and psychiatry, to such an extent that not only people with psychopathology are interned, but also anyone who could disturb the balance of society (Ianni 2019).	2. Law 18 March 1968, n.431, "Providence for psychiatric care", known as the Mariotti Law, followed by the d.p.r. n. 128/1969 "Internal order of hospital services". The Mental Health Centres (CIM) are introduced as a community service; a maximum number of beds in each structure is defined; the number of specifically trained professionals is increased and the team working in CIM with psychologists, health assistants and AS is integrated, the latter were introduced in 1972, since previously only present in Psychiatric Hospitals (O.P.); voluntary hospitalization in O.P. is allowed without the loss of civil rights; Art.604 of the Code of Criminal Procedure concerning the registration in the criminal record of measures for admission to the asylum (Melani 2014) is repealed.
3. Law May 13, 1978, n.180, "On voluntary and mandatory medical examinations and treatments", known as Basaglia Law. The aim is to reverse the principle that internment is the appropriate treatment for psychiatric illness (Lentini 2019). The complete closure of the asylums did not end until 1994-1999. The Law 180/78 in fact, lasted only a few months: the 23 December of the same year has merged into art. 33-35 of Law 833/78 establishing the National Health Service (NHS) with which they introduce, at the Local Health Units (USL), departmental services for the protection of mental health with functions of prevention, diagnosis and rehabilitation, equipped with multidisciplinary teams (Marini 2015).	

Psychopathology is "a syndrome characterized by a clinically significant alteration of the cognitive sphere, of the emotional regulation or of the behavior of an individual, which reflects a dysfunction in the psychological, biological or evolutionary processes underlying the mental functioning" (APA 2013). Three basic characteristics have been identified to define the mental disorder: 1. personal distress (deep individual malaise that the person feels as a result of the disorder); 2. violation of social norms and disability (impairment of important areas of the individual's life); 3. dysfunction (alteration of evolutionary, psychological and biological processes) (Kring and Johnson 2023). BPD is one of the Personality Disorders (DDP). "We define "personality traits" as constant patterns of perceiving, relating and thinking about the environment and oneself, which manifest themselves in a wide spectrum of social and personal contexts" (APA 2013). We talk about DDP when such traits become so pronounced and maladaptive as to impair the functioning of a series of areas such as cognitive, affective, social. DDP are ego-tuning disorders, a term that indicates a set of symptoms that the person perceives in tune with his ego and his needs; for this reason, he does not realize the disorder he really suffers from because it is as if it were an integral part of his identity (Hart et al. 2018). Because of this,

unlike what happens for other mental disorders, these people when they ask for help, rarely allude to the manifestations of the real disorder they suffer and therefore, at the beginning of the therapeutic path, professionals must help the person to become aware first of all that it is his personality traits that are dysfunctional and source of malaise (Zimmerman 2021). The DSM-5 identifies ten types of DDP, divided into three clusters:

1. *Cluster A (Odd cluster)*: characterized by eccentric behavior, mistrust and tendency to isolation. It includes personality disorders: paranoid, schizoid, schizotipic.
2. *Cluster B (Dramatic cluster)*: characterized by dramatic behavior and strong emotionality, egocentrism and poor empathy. Includes personality disorders: narcissistic, antisocial, borderline, histrionic.
3. *Cluster C (Anxious cluster)*: characterized by anxious behavior and low self-esteem. Includes personality disorders: avoidant, dependent, obsessive-compulsive (APA, 2013). It highlights how people suffering from certain types of DDP, frequently resort to psychiatric services. People with BPD (cluster B) account for about 10% of outpatient mental health patients and 10% of people with this diagnosis die by suicide (Fonargy 2007). The DSM-5 identifies (Figs. 1,2,3), moreover, nine criteria (it is necessary to respect at least five of them in order to diagnose the psychopathology in question:

Fig.1: Borderline diagnostic criteria

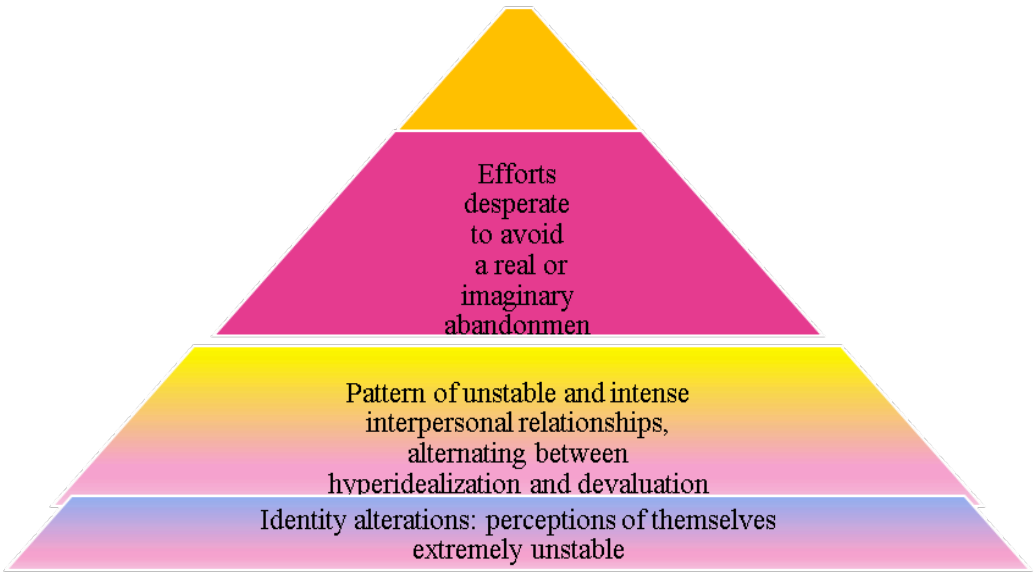


Fig.2: Borderline diagnostic criteria

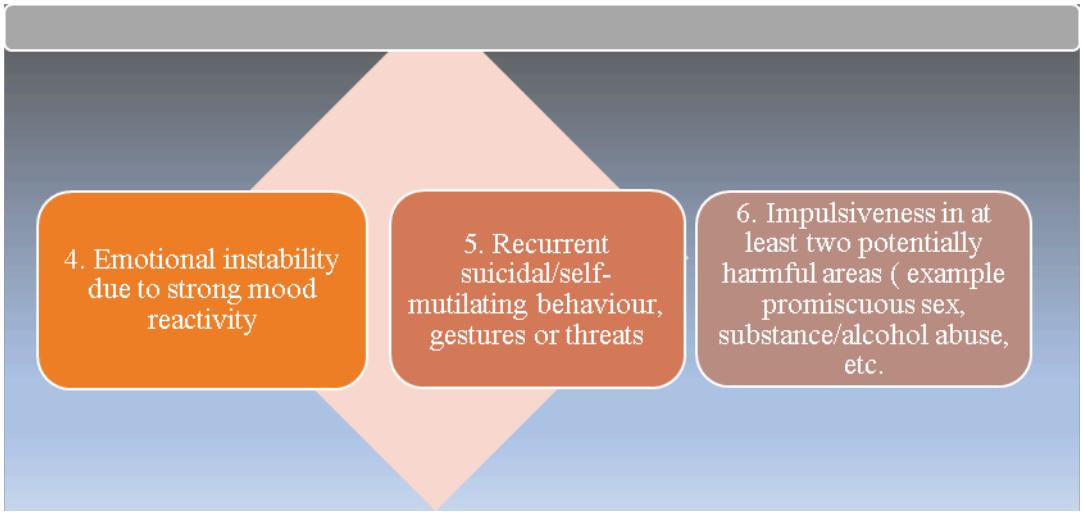
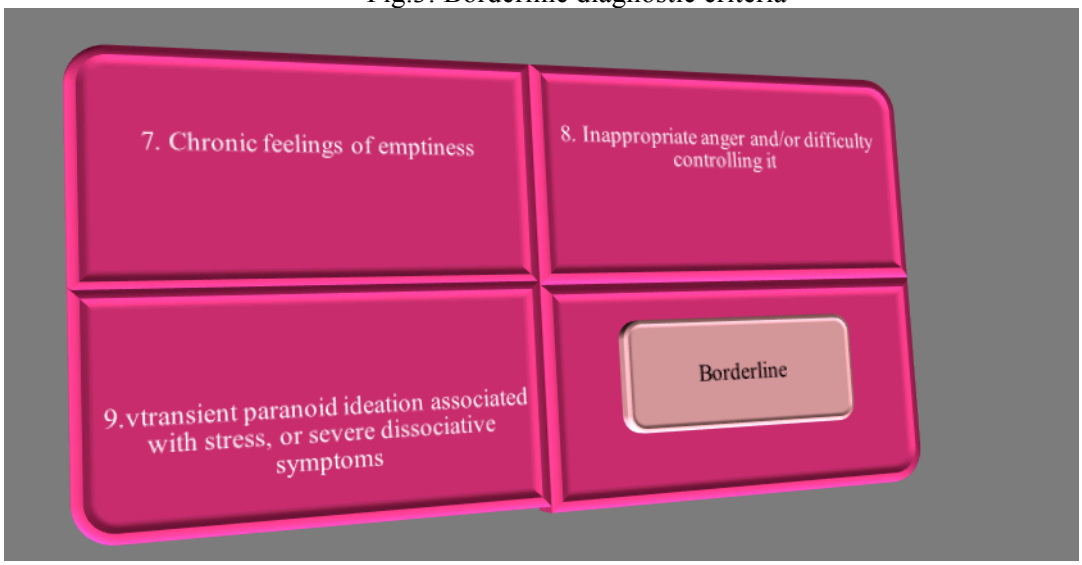


Fig.3: Borderline diagnostic criteria



One of the objectives of the research is to identify, from an early age, the main risk factors for the development of BPD, so as to implement an accurate prevention program (Beeney et al. 2021). These factors include: psychopathology of parents, traumatic events experienced during childhood (e.g. abuse, neglect, caregiver neglect), negative affectivity and impulsiveness of the child (Stepp et al. 2016). In particular, a punitive parenting style, characterized by severe and/or corporal punishments, insults and screams, is strongly associated with the development of BPD, especially if there is already an early emotional regulation deficit in the child (Beeney et al. 2021). People with BPD face emotional suffering through impulsiveness, identifying it as the most appropriate means of self-defense to express anger and frustration. Having suffered significant trauma, can result in

patients with BPD a central nervous system constantly "alert", ready to react immediately and excessive in the face of real or imaginary threats (Manna et al. 2004). In front of people with this disorder, in addition to lightening the severity of the symptoms, it is appropriate to implement a psychosocial intervention that encourages interpersonal relationships, promoting continuity and work success (Giberti and Rossi 2007).

The recovery path: role, contributions and occupational risks of the social worker

Social service in mental health is defined as "the set of specific professional actions which, within programmes aimed at achieving the objectives of prevention, treatment and rehabilitation of people/groups suffering from mental disorders, contribute to the overall individual and collective health projects, [...] as well as making a significant commitment to the promotion of the culture of inclusion and acceptance of diversity" (Spisni 2013). AS plays a central role in the recovery path. The interventions are addressed to three dimensions: the individual, understood both as an individual and the family; the organization, or the service of belonging to the worker, respecting the institutional mandate; the community (Cellini and Dellavalle 2015). "Effective rehabilitation requires changes in both the individual and the community, which should promote the achievement of rehabilitation objectives by providing support and the necessary resources for users to achieve an independent life" (Carozza 2006). Specifically in the psychiatric field, it is objective the need for multidisciplinary work involving different experts such as the psychologist and the psychiatrist, who, together with the AS, each according to their own skills, provide to develop a Therapeutic Project-Individualized rehabilitation (P.T.I.). The aim is to identify the set of therapeutic-rehabilitation interventions that are best suited to the specific need of the person, helping him to face his discomfort from all points of view and always remembering that even with equal diagnosis, each person is profoundly different (Pacini 2019). To concretize the P.T.I. is approached the instrument of the therapeutic contract (CT); it is a point of reference for the user and his team treating, let alone form of alliance between the contractors and foundations for the relationship of trust that is hoped to be established between these (Cellini and Dellavalle 2015). A research carried out at the CSM of Forlì (Pacetti and Ravani 2013) showed that the drafting of the CT represents a motivational element to therapeutic continuity, discouraging the abandonment of services, frequent choice in people suffering from BPD because of the impulsiveness and relational instability that characterizes them.

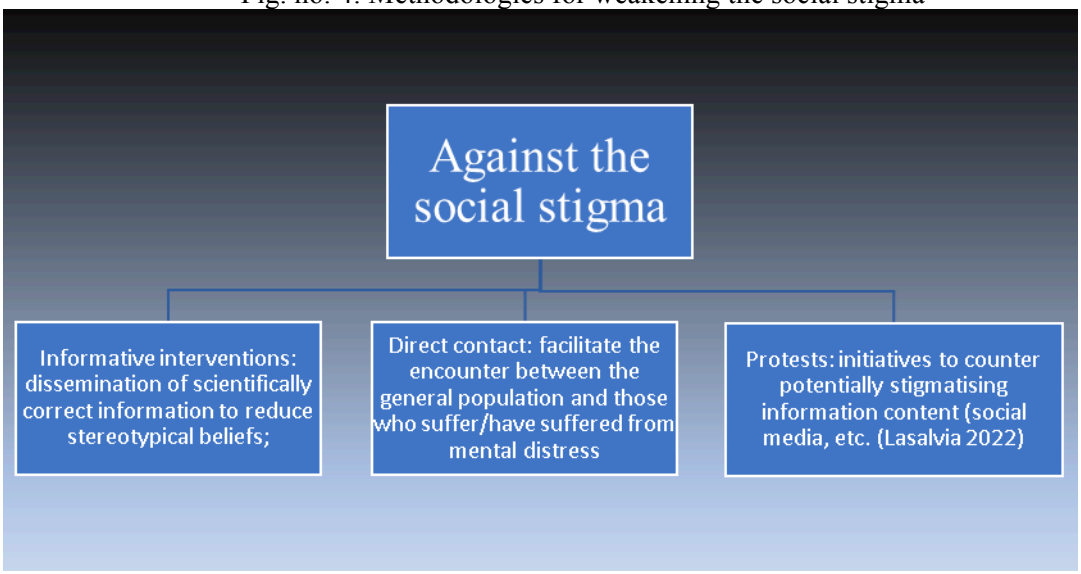
The main role of the AS is to support the person in a path of psychosocial rehabilitation where "rehabilitation means a process that has as its objectives to identify, prevent and reduce the causes of disability and at the same time help the person to develop and use their resources and abilities in order to gain more self-confidence and increase the level of self-esteem, leveraging on what is healthy and not on pathology" (BA 2003). The support in the path of training and work placement is part of the psychosocial rehabilitation that carries out psychiatric AS. It is frequent that a person with severe psychiatric fragility experiences periods of social withdrawal as well as removal from the working environment or difficulties of integration (Rosina 2016). People who suffer from BPD often have an irregular work history characterized by relationship conflicts with colleagues/superiors, procrastination and repeated absenteeism, which leads to job losses as well as frequent changes in work career. In the research carried out by Dahl et al. (2017), the work emerges as a source of personal success, which allows you to feel an active part of the community; it is therefore essential to include work placement among the objectives of the P.T.I. The

AS can also provide support by taking on the role of mediator to create a profitable working alliance between the person with BPD and those present in the workplace. When a person suffers from a psychopathology, the negative consequences also fall on those around him. For this reason, AS also intervenes on the caregivers of the person, in order to support the primary network in the understanding of mental distress. It may also be necessary to support the family in the search for an appropriate structure in which the person can reside if it is necessary to leave the home, helping to maintain as much as possible family relationships even after the placement (Rosina 2016). It always remains of primary importance to guarantee the emancipation of the person from the assistance received by the services, trying not to make these his only points of reference. It is therefore a matter of identifying the resources not only of the individual but also of the surrounding social fabric, in order to create a varied and constant support network (Sanicola 1997). Numerous evidence shows that people with psychiatric vulnerability suffer not only from psychopathology itself, but also from the social consequences that mental disorder entails and that manifest themselves in the form of discrimination, injury, more generally in the form of stigma (Lasalvia and Tansella 2008). With regard to mental distress, stigmatization has consequences that affect the general well-being of an already fragile individual. The degree of stigma varies according to the type of disorder: a higher level has been noted towards those psychopathologies labeled by society as "dangerous and unpredictable", including BPD (Padovani 2021).

The most serious repercussion of the label is the so-called "label avoidance"1 that generates abstention to care (Lasalvia 2022), followed by "the self-stigma": a set of moods of the person with psychopathology that presents difficulties to admit first of all to itself of having a psychological problem and which can result in self-exclusion from any social environment because it does not consider itself able to live it adequately (Lasalvia and Tansella 2008).

Among the types of “stigma” is also recognized that of socio-health professionals. It refers to the set of stereotypes, negative attitudes and unconscious or conscious behaviors, implemented by aid professionals, who are often victims of stereotypes as much as the general population (Lasalvia 2022). In this regard, research shows that people with BPD are identified among the most difficult patients to treat. This involves the implementation of the process of "malignant alienation" which consists in the interruption of the therapeutic relationship due to the refusal of the user by the professional. This behavior stems from the operator’s fear of manipulative behavior typical of people with BPD. This is experienced by the latter as an expulsion and discriminatory attitude involving a symptomatic worsening. It is a cycle of self-fulfilling prophecies because the professional tends to have preconceptions that affect the interaction with this type of target; In turn, BPD people will respond to the specialist’s actions with behaviors that unknowingly confirm what was previously assumed (Markham 2003; Kealy and Ogrodniczuk 2010). This often leads to an early cessation of treatment and the repeated testing of new carers, drugs and services; this form of constant instability becomes itself a source of stigma (Aviram et al. 2006). To try to break down as much as the public stigma, strategies have been identified including (Fig. 4):

Fig. no. 4: Methodologies for weakening the social stigma



In the fight against stigma, the AS plays an essential role thanks to its formation and awareness of inequalities. The function of advocacy, or giving voice to the rights of the weakest groups, allows you to enter professionally into action to support those who remain aloof in the social fabric. Attention is paid to all health determinants that can affect the worsening of mental ill-health conditions and cross-sectoral projects are implemented, which foster feelings of belonging and interaction in different contexts of daily life (CNOAS 2021). Those who help others professionally create relationships based on emotions and empathy. By empathy, we mean "the ability to understand the state of mind and the emotional situation of another person, [...] immediately understand the psychic processes of the other sometimes without resorting to verbal communication" (Enciclopedia Treccani 1999).

The continuous contact with the suffering of others, can involve in the operator two reactions: identification or identification. The first means the process by which one person ideally moves into the experiences of the other, trying to lend support; the second refers to the assimilation of the state of suffering close to that of the user that causes a dysfunctional alteration of the professional role (Asioli 2022). It is common to think that the "management of emotions" is necessary, which involves a repression and denial of the same; the risk is that the professional, given the lack of emotional processing, is then invaded by their emotions and implements stereotypical or superficial responses. It is therefore necessary the process of "reflection on emotions": listening and self-knowledge, externalization and observation of one's own feelings, are the appropriate behaviors to manage any inner resonances and be able to exploit emotions as a resource in the professional path (Sicora 2010). "For professionals learning the ability to limit (total) mirroring in the pain of the other is as important as being able to identify with his condition and his experience" (Asioli 2022).

Given the continuous exposure of the AS to the vulnerability and suffering of others, it would be desirable, in order to be able to carry out their work, the development of resilience and emotional intelligence. The latter can be defined as the ability to identify,

understand and express one's emotions in a functional way; it involves being able to motivate oneself, persevere in the face of frustrations and prevent anguish from overwhelming the ability to think (Herland 2021). Resilience refers to two key components: the experience of adversity and positive adaptation in response to it. Resilient people are able to tolerate difficult and stressful situations and gain strength from them (Cleveland et al. 2019). Protective factors have been identified for the development of reflexivity; among these is recognized professional supervision, which in the social service can be defined as "process of accompaniment and guidance led by an expert whose objective is to move solicitations of various nature [...] to promote an improvement in the awareness of being and the appropriateness of acting" (Burgalassi and Tilli 2018). Given the complexity of the emotions, the emotional dilemmas that are found in the work, should be the subject of discussion in team meetings and counseling spaces but it is still a highly underestimated reality (Herland 2021). Working in the social sphere often involves work overload, lack of time and a hectic environment, factors that can lead to acute stress and hinder the path of reflection. Burn-out is a particularly severe feature of chronic stress; it is a multifactorial syndrome that has three key dimensions: emotional exhaustion, depersonalization and work inefficiency. It is often associated with psychosomatic symptoms (Lloyd et al. 2002; Kring and Johnson 2023). The authors say that the way others perceive social work is also a source of stress for ASs. In particular, it emerged that ASs working in the field of mental health often feel frustrated because their role is misunderstood, not recognised and not properly evaluated by other colleagues (Lloyd et al. 2002).

Conclusion

Relatively quickly, the evolution of psychiatry has eliminated a strong system of exclusion and institutionalization that marginalized people with mental disorders. Until the introduction of Law 180/78, in Italy, internees were stripped of their rights and dignity, without any hope of readmission within society. With the introduction of the aforementioned Basaglia Law, he changed his gaze towards the sick, whose care and rehabilitation has since been in the hands of a team of professionals belonging to the Departments of Mental Health. Psychic disability is now understood as a disorder in fulfilling those social roles that are normally expected of an individual. In fact, today it is no longer society that must be protected from madness, but it is the sick person who must be protected from the damage that society can transmit to him, even indirectly. This new perspective aims at improving the quality of life through the personalization of interventions, encouraging inclusion in the community by restoring confidence in the performance of daily activities and life. In this reality, there is room for an often underestimated professional: the social worker. The latter, in fact, over the years has seen more and more recognition of its contribution and the affirmation of its role in the world of mental health:

from the performance of very limited bureaucratic tasks or simple social secretariat within the asylums, today holds a pivotal position in the aid process. Through the specific tools of the profession, the social worker works to promote a correct rehabilitation and a correct social reintegration and a possible employment of the user. Moreover, thanks to its ability to network within the services, the social worker is a bridge that allows on the one hand the realization of an individualized project through a global management of services, on the other hand allows to connect the care service with the community service. It is from

the latter, in fact, that the social worker must be able to draw useful resources for the aid project, facilitating and mediating the parties so that the community itself improves the way in which it addresses the problems that involve it.

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