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Therapy with Migrant Farmer Mexican Immigrants: Problems and Possible Solutions from Sociology

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Abstract

Those helping people with mental and emotional problems face a myriad of labels and interventions. In 1952, the American Psychiatric Association developed the *Diagnostic and Statistical Manual of Mental and Emotional Disorders (DSM)* to bring some organization into the chaos, which affected professionals, third-party payers, the client, and her or his family. Today, after several editions, we use a newer version of the *DSM*, which covers many more maladies and helps much better in selecting interventions and recording progress (or lack of it). There always have been problems of reliability with the *DSM*, at least in part because it is patterned after the physicians' International Classification of Diseases (ICD) series of physical disorders, most of which have symptoms that can be determined through direct observation or testing. Recently, the therapeutic community has realized that cultural issues and lifestyles may affect fairly well-adjusted people in ways that confuse therapists. This article argues that many problems faced by one culture, Mexican migrants, may better be addressed with sociological theory and other means than with the *DSM*.

Keywords

culture, community-based research, immigration-migration, mental health, social work, clinical

The purpose of this article is to demonstrate that the parameters of treatment by the professionals in mental and emotional health do not always meet the needs of many clients. The argument will be demonstrated using immigrants from Mexico to the United States as one example. Sociological explanations then are given as evidence that other theory and strategies are needed. While it is not meant to criticize the "helping fields," the article begins with a brief description of these fields, followed by a history of mental health treatment until the present day to show that the scope of their work has not proven effective for a large population of their clients over time, despite stringent efforts and laudable breakthroughs in these fields (i.e., new medications, treatment modalities, and more rights).

For this article, the "helping professions" are specific. They require advanced degrees in preparatory fields, a specified time of closely supervised work, and passing examinations by each state's professional boards. The education is in counseling, marriage and family therapy,

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psychology, social work, and psychiatry. After completing the close supervision and passing the examinations, the first four professions above may then practice and charge fees without supervision and they are recognizable by the "Licensed" in front of the educational field. Some fields have a specified area of practice. For example, in social work, the professional therapist is called a Licensed Clinical Social Worker (LCSW) or something similar in a few states. Psychiatry is different in that it requires a medical degree and expertise in mental and emotional difficulties. It is the only helping profession allowed to prescribe medication. However, any physician may diagnose and give medications for these problems.

The social construction of the reality (Berger and Luckman 1966) about what is seen as acting odd or eccentric differs both among societies and during the historical era, resulting in a wide variance of explanation and treatment. Some societies revered them, others tried to help them, and there have been many societies that killed or tortured them in various ways.

Some statements and other evidence still exist that tell us that even ancient thinkers had a variety of ideas about people whose thoughts and behavior seemed bizarre. Aristotle ([ca. 350 BCE] 1972) discussed psychology in general, relating thinking to sensate understanding and "the soul."

He did not write in depth about psychological problems. However, the Greek goddess, Dionysus, was worshipped as a goddess of "ritual madness" during that time (Taylor-Perry 2003). Archeological evidence from Mesoamerica indicates that at least some of their advanced societies revered Mongoloid people as special, as is demonstrated in museum exhibits throughout Mexico. Writings during the middle ages (see Institoris and Sprenger 1520; Noll 1990) indicate that the religion that dominated European society was active in describing odd behaviors as evil and the interventions generally involved torture, banishment, execution, or even loading as many as possible on old ships and setting the ships to sea without sailors, called "ships of fools."

Foucault ([1961] 1988) follows the history of the treatment of mental health clients through a postmodern view, writing that just before the renaissance, people with emotional or mental disorders frequently were free to do as they wished, so long as nobody was harmed. Later, as cities grew and other institutions gained power, those people were confined because they were viewed as a nuisance. Once that occurred, they were not viewed as being so much a danger as they were viewed as an oddity, which people paid to see, much like we pay to see rare animals in a zoo.

As new thinkers came to power during the enlightenment, some regimes and practitioners tried to treat these unfortunates more humanely, and asylums became more than mere lodgings. At about the same time, under Phillip Pinel, L'hopital General in Paris; under William Tuke, Bethlehem Hospital in London; and under Benjamin Rush, Pennsylvania Hospital were among the first to try to make life more comfortable for those in asylums through a system they labeled "moral treatment." Foucault ([1961] 1988) argues that their change of behavior and treating clients became possible because they were part of a power movement and did not fear backlash. In fact, the royalty of France and Great Britain supported the changes, and Benjamin Rush was not only a friend of George Washington but also the well-respected physician in the United States at the time. With cleaner conditions, better nutrition, better lighting, activities, and so on, there was some improvement, although the statistics are not reliable because anyone who left and returned, then left again, was counted as a second "cure." Also, the seriously ill, poor, some prisoners, and others were sent to the asylums.

By the nineteenth century, conditions at the asylums again became notorious. Crusaders such as Dorothea Dix (Lightner 1999) lobbied the government for change, and practitioners recognized the need for some organization in definitions of mental illness and treatments. In 1844, an attempt was made to organize the various mental and emotional problems that people were presenting to practitioners trying to help them at the time (American Psychiatric Association 2013). Again some progress was made, but people still were labeled as vampires, possessed, outlaws,

and so on. Despite the movement, because of their odd behaviors, many people met with torture or imprisonment instead of treatment or even decent lodging.

By the end of the nineteenth century, those with mental health problems in more advanced societies were being treated using scientific methods. Wundt ([1864] 1963) appears to have coined the word "psychology." Freud ([1901] 2002) founded psychoanalysis, which is a "talk therapy" that minimized the outmoded use of lobotomy and other surgeries at the time. Jung ([1952] 2006) and Adler ([1925] 1979), contemporaries of Freud, among many others, were treating clients using their own theoretical frameworks with some noted success, without medication, although Freud used cocaine and for a time believed it was helpful for clients. The medical field had professionalized as well, and by the twentieth century, psychiatry was an important part of treatment.

Modernity and Mental Health

In 1952, the *Diagnostic and Statistical Manual of Mental and Emotional Disorders of the American Psychiatric Association (DSM)* was developed and since then has undergone many changes, especially increasing the syndromes of concern. Presently, the helping professions use the *Diagnostic and Statistical Manual of the American Psychiatric Association IV-Text Revised (DSM-IV-TR; American Psychiatric Association 2000)* and the *DSM-5* already is out, but will not be used until 2014, providing time for practitioners to be trained in some of the changes. As medical doctors (MDs), the psychiatrists who wrote it used the medical model fashioned after the International Classification of Diseases (ICD) used by physicians for any malady. The medical model approaches symptoms as pathology and seeks to use medical treatments for diagnosed ailments.

Any writing can and should be critically analyzed, and the *DSM* editions are no exceptions. Szasz (1974) began his work in 1954 and argued that mental illness seldom was defined as such by the individual, as it almost always is in physical illness, but by witnesses who sent them to practitioners.

Therefore, the person or team involved in his or her treatment actually is enforcing the morality and politics of the society. Becker (1963) concluded that most deviance is defined by its "etiology" as a "disease." Laing and Esterson (1964) studied schizophrenia and argued that it is not defined well enough to be viewed as something that exists. History apparently has supported them. Once schizophrenia was believed to have been caused by a mother who made her child feel simultaneously rejected and accepted (the "double bind" theory), later it was argued that it was hereditary, but not always so, and now experts are saying it is genetic. Kirk and Kutchins (1992) studied the development of the *DSM* and concluded that it was created by governmental, professional, and corporate (especially insurance companies) interests that severely weakened it as a useful tool for clients. We may conclude that Thomas's ([1923] 1969) "definition of the situation" (as something is defined as real, it will be real in its consequences) applies well to the *DSM*. The manual and users have to define their clients' maladies according to the labels within it, and thus the situation becomes intervening with medications or other therapies already associated with that label. The consequences may be so light as taking a nonaddictive antianxiety pill regularly to entire populations being "euthanized" as the mentally ill were by the Nazis (Friedlander 1995). For practitioners or governments to do this, the person's symptoms are defined as disease, and she or he therefore is viewed as deviant. Note that professionals and governments have joined to take highly different approaches to treatment of the mentally ill.

The *DSM* defines mental illnesses as real. Anything in the *DSM* that does not specify the syndrome as a mental problem is given a "V Code," which is a syndrome that *might* be an issue requiring professional intervention. There also is a very short list of cultural nuances that appear as mental health issues but are merely cultural anomalies.

During the 1960s and 1970s, a new era began in the treatment of mental illness. New medications had shown promise, new treatment modalities proved more effective than psychoanalysis, and professionals were beginning to realize that the environment in asylums frequently encouraged both patients and staff to label behaviors as illnesses (Goffman 1961). Planned in the 1960s and implemented by the 1970s, a large number of "asylums" were closed and the patients were sent to live on their own with the help of Community Mental Health Centers (CMHCs) under the assumption that living near their homes or in smaller group homes was more beneficial. During the 1980s, funding for the CMHCs was cut dramatically, more large institutions were closed, and people suffering from mental or emotional problems often could not find a CMHC, afford one, or even find housing. Many could not find someone who would diagnose and prescribe medication or other treatment, and others used their medication as an economic means of survival by selling it. Many still live as homeless people, and thousands behave in manners that lead them to prisons.

The *DSM* and the helping professionals who use it made strides forward, but, as was the case in ancient Greece, many people suffering from these syndromes receive no treatment, are outcasts, labeled deviant and treated as such. In these ways, help for these people has not advanced much at all.

Mexican Clients and Their Problems

Until now, the discussion of this article has focused on etic behaviors, or, for this article, those characteristics that are viewed more as universal to people cross-culturally. My clientele are Mexican migrants, and many of those who come for "mental health treatment" display symptoms of the syndromes found in the *DSM*. For example, some are depressed, some have problems with alcohol, and some display posttraumatic stress disorder and other disorders listed in the *DSM*. These people I can treat with non-medication interventions or refer them to the resident physician for medication and may therefore be said to be part of the etic population that the *DSM* serves.

Takushi and Uomoto (2001) warned that, while the *DSM* serves an etic purpose, we must identify multicultural issues of concern. These are emic problems. According to these authors, emic problems (when discussing multiculturalism) are those faced by "an ethnic minority or group."

The medical model used by therapists did not address the majority of problems my clients face but several sociological models do. Following their life's history, which I review with them in initial interviews, I found many commonalities.

Alienation

Marx and his contemporary, Engels, wrote of alienation in several works (e.g., Marx [1844] 1964; Marx and Engels [1847] 1978). In brief, alienation occurs when someone loses the subjectivity of his or her work as well as other aspects of his or her life and it becomes objectified, especially in the capitalist mode of production. For Mexican immigrants, this happens as a process. First, they come from very poor backgrounds and are independent small farmers or street vendors from cities. Women occasionally use their knowledge of crafts to supplement their income, but this is very small. Famine and economic recession had made any hope of providing for themselves in these ways minimal. Income does not come from the government, which helps very little, or from large corporations, agencies, and so on. The income source is the family. The family not only provides all of the functions of families in the United States but also is the primary source of protection. Police protection always was weak in Mexico, and corruption remains highly problematic. Since the recent drug wars, law enforcement has become so corrupt that it is

impossible to tell in advance if calling the police will result in resolution of a problem or victimization. There are other differences that make the Mexican family unique. The nuclear family stays together longer. Children frequently live with their parents until the parents' death. One sees few college dormitories or single-occupancy apartments in Mexico. It also differs from that of the United States because the extended family's role is to provide much more support than generally is the case in the United States. The first visit I made to a hospital in Mexico proved this to me. I saw so many people; I believed there may have been some kind of epidemic, but the people with me explained that if someone becomes ill, everyone in the extended family who is free comes with them.

Once their traditional ways of maintaining themselves became impossible, they turned to other sources. Large corporations hired those that they needed for their workers, so proletarian employment was non-existent for the rest. So many others turned to crime that the U.S. Department of State has a warning about visiting Mexico (U.S. Department of State 2012). The drug wars very quickly became widespread and the violence hideous. Beyond shootings, people are kidnapped and tortured, sold into slavery by human traffickers, beheaded, and harmed in ways that has led to a feeling of terror in the general population. Social control (Hirschi 1969), nearly non-existent in any formal sense, only remained because so many people either did not want to enter into criminal behavior or, even many of those with the worst intentions, were afraid to enter. This left a large population without a source of income, so thousands travel to the United States. This trip begins by breaking what Social Control theorists (Martin 2010) call clan control. The trauma to the family extremely important to Mexicans (Guarnaccia, Martinez, and Acosta 2005) is great and the traveler is "on his or her own."

On a visit to Mexico, I stayed in one village where all of the males between 17 and 64 had gone. All of them had come to the United States hunting work. Their plans were to leave their families, travel to the United States, find work, and support their families with any extra money. For this particular population, I believe the best description of alienation as a problem for Mexican immigrants may be found in *The Grundrisse* (Marx [1923] 1971). Alienation arises from living in a stratified society, where one's labor becomes objectified and directed by another class (the capitalist). Workers who once believed they had control over their futures come to the realization that the system determines it. This affects the workers' relationship to others, how she or he uses the goods produced, and deprives the worker of the full value of their productive activities through surplus labor value. For Mexicans, alienation arises as they lose their own small independent economic entities, learn they have little or no economic worth in their own country, must leave the security of their families, and travel through many perils here to find that the items they help to produce are taken from them, processed, and sold at profit by the large corporate farms. Sometimes, they believe they are buying the very food that they worked to plant and harvest. The farms bring them to grocery stores weekly and they see for themselves that their pay is miniscule compared with the cost of the product. They live in poorly built dormitories, abandoned trailers that the farm dragged into wooded areas near the fields, and similar dwellings. Virtually, the entire small amount of money they make is returned to the family, thereby negating the chance to improve their individual circumstances.

There does not appear to be a major gang or drug problem in the camps. This may be a part of alienation as well. They dread the idea of police taking an interest in the area because so many are illegal immigrants and would be deported. Large gangs, such as the Latin Kings, have no need to intrude into the camps. There is no money to be made by gangs. Very few people in the camps would want to participate in an activity that would draw attention, and even fewer would be interested in a lively night life after 12–15 hours on their knees in the fields, sometimes in temperatures above 95. The system not only controls their legal economic gains but also has an effect on participating in the illegal alternatives as well.

Anomie and Control Theory

A second problem they face is anomie. Durkheim ([1897] 1951:12) proposed that everyone has various expectations and passions that are controlled by the society.

Durkheim clearly states that this control must be “obeyed through respect, not fear.” Part of this control may be governmental or by force, but most of it arises through the collective consciousness. People of particular classes expect certain goals to be obtained and have a realistic idea of what goals will not be obtained. In his discussion, he became almost mystical, writing, “Because the greater, better part of his existence transcends the body, he escapes the body’s yoke, but is subject to that of society.” Durkheim wrote that if a society is struck by chaos or rapid transitions, people lose their connection to the collective consciousness and they “are not adjusted to the conditions forced upon them.” He made some comments about economic disaster, but he meant much more than that. People no longer understand what to expect, but, perhaps worse, what they *should* expect. This is anomie. There is no logical or moral guide to their behavior. They live in conditions that are (using my own term) a-normal.

Now, however, in Mexico, the “moral guide” for the poor is collapsing. They feel compelled to leave their family, which is the primary source of this guide. Throughout Mexico at this time, the migrant travelers face drug lords and their followers, who may kill them accidentally during shoot-outs or for seeing something that threatens the cartel, such as where their plants or processing factories are. Other criminals rob them of everything they have. Human trafficking is rampant. Men are used for slave labor and women for forced prostitution. In fact, one of the last times I was in Mexico, a Mexican professor asked my students and me not to visit a particular area, perhaps as large as 1/10 of Mexico. He called it “muerto de mujeres” (death of women) and said so many women had disappeared in that area, that it is now avoided if at all possible.

At the border, the migrant must find a way past the border guards, both legal and voluntary. They use semiprofessionals called “coyotes” to help in this process (Mindiola 2011), but there is no way to ascertain whether the coyotes is truthful or not. The immigrant is at their mercy and even those who are truthful frequently are discovered and the immigrant is deported to his or her home city only to begin the process again.

Professional guards take action that is predictable by law, but there is no way to predict what a voluntary border guard may do because he or she has no authority and no supervision. Beyond the guards are Drug Enforcement Administration (DEA) agents, Immigration agents, members of the Federal Bureau of Investigation (FBI), and local law enforcement, all of which pose a risk to successful entry.

If the migrant makes it to the states, she or he then must travel in secret until she or he finds a place that hires migrants. There are many such places. Landscapers, home cleaning agencies, restaurants, and other businesses do so frequently, but the migrants with whom I work are employed on large corporate farms. Their housing in these places tends to be hidden, often behind wooded areas or in back fields, possibly to hide how substandard it is. The workers who live there prevent activity that would draw the attention of authorities. By combining their wages, they are able to drink heavily on weekends, partying and fighting for fun (Borges and Cherpitel 2001). Many have no electricity, so there are no televisions, computers, and so on that may provide entertainment.

They also are lonely. Their original plan usually involves finding a job and paying to have the family come later. Those fortunate enough to succeed face another chaotic and anomic situation. In Mexico, it is not unusual for husbands to have mistresses. Some wives call themselves “cathedrals” and the mistresses “little churches.” Many men have more than one set of children. No doubt it causes friction, but it is a part of their society, and I have known of no families to dissolve because of it. However, once a man brings his wife and children here, that “moral guide” is again broken in two ways.

The first way arises in this manner. Following the norm in Mexico, some men father children here, and by the time the wife arrives, she finds herself a stepmother. The situation is different than in Mexico, where the wife seldom, if ever, sees or knows the mistress. Here, the mistress frequently lives in the camp and the two see each other daily, leading to high levels of jealousy and sometimes violence. The second way is the inverse of the Mexican family system. There are about 10 men to every one woman in the camps. Men find few opportunities or finances to support mistresses, while women constantly are sought after. Many of the women have "novios" or boyfriends. Some husbands try to ignore it just as their wives did in Mexico. Others try to challenge the novio, but even if successful, there are others waiting and they know that a peer already has succeeded with the wife once. Still others try to control the situation with domestic violence. We have no statistics on frequency, but we believe it is rampant for several reasons. First, alcohol is the primary source of entertainment in the camps and is closely related to domestic violence. Second, people would hesitate to report it for fear of deportation, and third, the extended family structure in Mexico, which would have intervened out of a sense of family honor, is not there.

Anomie is one term that describes the situations above, but Control Theory describes the problem in better detail. Hirschi (1969) believed that delinquency is limited by external controls. Martin (2010) conceptualized Control Theory, showing by diagram that "decentralized control" is found through the market. "Centralized control" is found through bureaucracy and both are found through what he labeled "clan control." For the Mexican immigrant, the market decentralized control already has failed, which is what drove him or her here. The Mexican government central control never was effective, and by leaving he or she loses clan control. The moral guide that prevents anomie through the various controls listed above exists here on an extremely weak scale.

Disenchantment

A final sociological problem that Mexican immigrants face is disenchantment. Weber ([1925] 1978:24) noted that as progress continued, "instrumentally rational social action" would become stronger. He defined this as "determined by the expectation of the behavior of objects in the environment and of other human beings; these expectations are used as 'conditions' or 'means' for the actor's own rationally pursued and calculated ends." He found this type of social action in the United States. After his historical, evolutionary descriptions of various Christian sects, he ([1901:] 1958) describes how the modern worker no longer looks to religious support for his or her actions but works toward his or her own goals, most of which are material. This type of social action values rationality as described above and devalues mysticism or magic.

Poor Mexicans are the only group about which I am able to write reliably on this issue. The upper classes may have evolved in their belief system much as the United States has. The rationality of the poor in Mexico is what Weber ([1925] 1978: 25) labeled "value rational," which he defined as "determined by a conscious belief in a value for its own sake of some ethical, aesthetic, religious, or other form of behavior, independently of its prospects of success." They are not irrational people, but their actions are filtered through a value system that guides their behavior.

Besides the family, The Roman Catholic Church is a support for the Mexican poor. Roman Catholicism in Mexico hardly resembles the same church in the United States. Sometimes confession lines wrap completely around a cathedral a block wide and a block long. Long lines pray to Saint's statues. Prayer candles all are lit, and rosaries, prayer books, along with other religious items, are in plenty. Sometimes one sees a person crawl to church as a penance or make some other physically painful sacrifice. The sermons tend toward the mystical nature of the sacraments, the saints, miracles, and so on. Holy Day Masses are well attended, and blessings are socially constructed as very important and effective. Lent is a time of real denial of something

otherwise important to them. After Mass, people gather in groups to chat or remain for further prayer.

The mysticism does not stop at the Roman Catholic Church. On one trip to Mexico, I visited a small town in the mountains, hidden from main roads. The people there grew corn as their main subsistence. However, the corn had scorched that summer and they had nothing else. They then took the stalks and covered the Roman Catholic Church building with them in the hope that both the Lady of Guadalupe and the ancient indigenous people's corn god would help them through their plight. While site seeing at some pyramids, I went in the woods behind them and found sacrifices of small animals and fruits to the indigenous people's gods. People have a real fear of "brujeria" (black magic) and sometimes label particular people as witches or witchcraft practitioners, who may conjure spirits, or apply curses for pay. Faith healers, Christian and otherwise, have offices in most cities.

The U.S. Catholic Church is much different. Few people bother with confession and most who do will delay it if the line is more than five to six people long. A few pray briefly to a statue of St. Mary and light a candle for one dollar donation (in many churches in the United States, the "candles" are now electric lights). Sermons are about treating other people better or living good lives and seldom mention miracles. The last time, a sermon was about miracles; the Priest suggested we not expect any. When Mass ends, people leave quickly and go about their business for another week. The last public blessing we had was to bless our pets. There are few social gatherings at Mexican Churches, but many here, provided for many reasons and by the Knights of Columbus Catholic voluntary organization.

New immigrant arrivals, having lost their family, turn to the Church. The new immigrant still has value-rational thought, especially around mystical issues. Many come to me and speak of demons, witchcraft, spirits, duendes (small human-like playful creatures, much like a leprechaun), and other mystical beliefs as possible causes of their emotional problems. The Catholic Church in Mexico does little or nothing to stop such beliefs, and migrants display strong evidence of enchantment in their lives when they arrive in the United States. Even in areas with a large Latino population, the parish generally has a smaller building with a Mexican American Priest, serving his congregation in our instrumental rational manner. Most Protestant Churches believe that the believer is connected to God directly by belief, but the official Roman Catholic Church position is that the believer finds salvation through the Church and the Sacraments. To most citizens in the United States, the difference seems to be one that is a matter of personal belief, but to mystical Catholics (sometimes called "Charismatic Catholics" here), it is very important and gives a hope that pure logic cannot offer. Weber ([1904] 1958) warned that instrumental rational social action would lead to more despair as enchantment is rejected.

Interventions

The reader may note that there are five types of problems in general that immigrants face. First, they all are destitute. Second, many display syndromes that can be found in the *DSM*. Third, we find people alienated from their jobs, families, and even sense of self. Fourth, people have lost their sense of community or collective consciousness, which Durkheim called anomie. Fifth and finally, we must help them adjust to the new form of rational social action they encounter, which lacks the enchantment that comforts them.

Destitution-related problems are handled by the staff at the Migrant Farmworkers Clinic, where people are able to obtain many items necessary for survival and basic expectations. There is free health care, clothing, food, English classes, transportation to appointments, help with organizing economic ideas, and a sense of community. Working with agencies in the area, the clinic has provided free eye examinations and glasses, sunglasses necessary for the health of the

workers, basic legal advice, examinations of sites, condoms and education on venereal diseases, tuberculosis, diabetes, alcoholism, and many other services.

DSM problems are defined in the book, and dozens of intervention theories are available for most of them. The less serious ones, such as depression or anxiety, can be worked with successfully with talk therapies, while others, such as schizophrenia, are treatable with medications. Thus far, we have had no suicides and only two drug abuse clients. One was shopping for medication by going to different doctors, and he was stopped by our physician, refusing him medication. He moved out of state. The other smokes marijuana. It grows naturally in plenty, and I do not know why there are not more users other than they believe it could be reported and bring in the authorities. They also may smoke much more often without us knowing. However, *DSM* problems generally are the easiest to treat.

Disenchantment at first may hurt the new arrivals the most. Their family is gone and now their Church is a stranger. However, some adjust to U.S. Catholicism and are able to be satisfied with it. Others, perhaps the majority, begin to attend Pentecostal-type Churches where the congregations still believe in miracles, the power of prayer, and faith healing. Pentecostal Churches give them back the value-rational mode of thought the U.S. Catholic Church often lacks. Many attend both a Pentecostal Church and attend Mass to obtain the sacraments. Some of them come to me to vent or work through their thoughts and feelings surrounding their own spirituality, and eventually they succeed. The migrants seldom reject their religious beliefs easily and hesitate to attend any church, except the Roman Catholic one. I never suggest either way. Their peers do make suggestions, and they make a decision slowly. It requires a lot of listening and always remembering their cultural differences, but the result of successful intervention is the client becoming involved in a church community, along with many of his or her peers.

Anomie may be the most dangerous. Durkheim wrote about anomie as a cause of suicide. New arrivals have been through many trials and, after arrival, find that the end of their problems is nowhere in sight. The intervention against anomie is based on Control Theory. We try to rebuild external controls by building a community atmosphere among the migrants. Although they are separated from their families, they are not separated from people in the same situation and they soon make strong bonds. Centralized control is maintained by their employers but more in a negative way of controlling their ability to work and earn than in assisting them. I have not seen anyone lose his or her job since I began, and the farm managers search for Latino workers. One told us that he has hired people from other ethnic groups and none has remained more than one day. Migrants work very hard and are serious about doing the job well. Durkheim bespoke of other types of suicide as well. I have never dealt with a suicide among this population, and as I pondered it, I concluded that egoistic suicide would be unlikely because they must work so closely as a team, and altruistic suicide is not conceivable if the person believes his or her death will hurt the community. If we continue to help them adjust to their new harsh environment quickly, we may never see anomic suicide either.

Overcoming alienation is the most difficult problem migrants and the clinic face together. Immigrants have lost their independence in Mexico, only to arrive here and see their small wages turned to large corporate farms' advantage. It has been striking to notice the different attitudes taken between these immigrants and my sociology students. The migrants appear to feel and understand the inequities of the system better. I believe there are several possibilities that explain this. The Mexican migrant never had reached middle-class status even before his situation worsened, so he suffers more discomforts and indignities than he or she would if our economic structure was more level. They had moved from what Marx had labeled the "lumpenproletariat" to a (very low level of) "proletariat" class during their lifetime. My students, however, virtually all come from the middle classes in the United States, which has been among the strongest corporate and service economies in the world since at least the mid-nineteenth century. When I describe inequities and surplus value, the students' reaction is more of boredom than any other emotion.

I suspect that our collective consciousness has accepted advanced capitalism as a social fact. Another factor may be that my students have been raised materialistically and have most of the materials they want. The migrants barely have their needs met.

Working with alienation is similar to working with bereavement. The problem for the therapist is to allow the client to adjust as she or he sees best within acceptable parameters (and thus far, all of the migrants have adjusted within those parameters). As time passes, their creativity and hope begins to work for them. Some are promoted to supervision in the fields or low-level management positions in the factories, which gives them a (low) living wage. Others open small businesses. Near the clinic is one of the camps and beside it are undecorated restaurants, well-staffed by women who have believed cooking to be a Master Status (the one that is strongest in defining a person to herself or himself) all of their lives. There are small grocery stores with products more desirable to Mexicans than other ethnic groups. There is a recreation center with a few games, a pool table, a vending machine, and many chairs where people can gather. A man even cuts hair in a tent he made near the camp.

The general population continues to look suspiciously and negatively toward the migrants, but they continue to learn English, many times from their own children, learn American history, and work toward citizenship. The waiting time is long, the study is difficult, and the cost is high, but many succeed eventually and they are very patient. If they obtain citizenship, many open well-decorated Mexican food restaurants in the area work toward management positions in other corporations or agencies and begin "the American dream." Once they reach that middle-class status, the population appears to accept them.

Another process lessens alienation. A large portion of workers never intended to remain here. They work very hard, save money, and return home with an amount that makes them appear well-to-do in their hometowns. Small businesses in Mexico are more the norm than are large corporate businesses and I believe many return to make a living for their families.

Summary

This article has two major sections. The first explains the myriad of difficulties, both historically and contemporary, surrounding people suffering mental and emotional problems and why the *DSM* is not sufficient to successfully treat the emotional and mental problems of everyone. That section of the article more or less begins with Aristotle's confusion about some bizarre behaviors and the ineffective manner in which Greeks responded through one of their Gods. After briefly following the historical gains of mental health, and critiquing some of its major works, that section ended with people having emotional and mental problems largely left on their own, many homeless, more not treated at all, and others imprisoned, due to inadequate funding and unrealistic expectations of those in power.

The second part of the article focused on Mexican migrant clientele to demonstrate that there are sociological theories that may be used alongside of the system above, both to explain causality and suggest ways to respond to their problems. That section began with Mexicans being made destitute in a dangerous environment that encourages many of them to challenge the dangers and come to the United States. Once here, they face four problems that sociology addresses and many have *DSM*-related problems as well that may be addressed.

There is nothing in the *DSM* that indicates that a poverty-stricken person needs assistance. Furthermore, while many sociologists address poverty and stratification as basic problems, few sociologists or activists have answers to eliminate it. In fact, we may look to Marx when he writes that the lumpenproletariat can never be the revolutionary class, and to Christ telling us, "The poor you have with you always." Macro-level change (Bell 1978) may or may not be at the heart of the matter.

The migrant clinic works with the poor on an individual basis until the client feels able to move forward independently using basic case management and interacting with agencies in the area. They did not read theory. They developed the program on their own before I arrived and it works well enough for that population. This work, at least in this particular case, is a-theoretical from either a psychological or sociological perspective.

The article then addressed "The Holy Trinity" of sociology and there is an extra intervention for this group among the ideas of Marx, Weber, and Durkheim. Marx proposed that alienation is a continuing problem and it is evident in the camps. Our intervention is to allow those feeling it to use that energy and work their way into another circumstance. Alienation is not likely to disappear from a worker who has it as part of his or her awareness, but once the migrants obtain somewhat stable status, it weakens.

Durkheim's concept of anomie may be more descriptive of this population than of the population he studied. The massive negative changes that have nearly destroyed Mexico have led to this mass migration, and when these people arrive, they find little to guide them. Using Control Theory, we encourage a sense of community through camp visits, migrant clinic programs, and support their businesses. Until it is possible for the migrant to have his or her family with them again, we seek to replace it with a social bond among people in the same situation. That helps with both centralized and decentralized control. The hierarchy of the corporate farms provides a negative form of centralized control, but we still must contend with the disorganization that arises from a lack of decentralized control by market forces. The migrants are so poor that they barely are on the fringes of the market, and it therefore exerts little control.

Weber's concept of disenchantment is used to help clients review their own identity and to provide them with a second community. Religion and the Church are very important to most migrants and they tend to be much more actively involved than their American counterparts. The enchantment of the churches provides the hope that they were given in their host society as well.

The general population of people suffering mental and emotional problems is a concern because no matter how much we advance in medicine, intervention, or societal attitudes, after thousands of years, their plight and outlook is poor. For the migrant population, I remain optimistic a bit more optimistic. As Mexicans arrive, they have a passion to adjust to the culture. I see fewer and fewer single language clients. I see more and more who escape the painful work on the farms and set up their own businesses. Their crime rate is low. As they move toward acculturation, I move toward a better understanding of their needs and culture, and we appear to be on the same path of eventual success. While I, and any other therapist, will be able to help the vast majority with psychological problems found in the *DSM*, these people's entire worldview can be changed by addressing these sociological issues.

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