Public Health, Assimilation, and the Racialization of Science and Religion: Cases from New Mexico in the 1960s

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Public health initiatives are not merely about delivering healthcare; they attempt to change the culture. In the world of public health, medical experts assess the needs of a population, develop plans to treat existing illness, and roll out campaigns of preventative medicine. All of these efforts rely on education, on convincing people to change their habits, their practices—even their beliefs—and to conform themselves to existing science. If comprehensive public health campaigns are about changing a population's culture, then it stands to reason that these campaigns will benefit from trying to understand the culture that they are trying to change. Consequently, historians, anthropologists, and sociologists have all at times collaborated with public health workers to tailor their message for maximum success. The simple idea is that a detailed knowledge of the traditions, values, and norms of the group that needs the public health intervention will help the intervention to be more persuasive and will thus lead to better health outcomes.[1]

In a very real sense, then, public health campaigns promote culture change, even assimilation.[2] If we hold at bay the term's potential negative connotations, we can recognize that public health initiatives desire to "assimilate" whole populations into the most effective and scientifically supported set of health behaviors in order to benefit everyone. For example, vaccination campaigns require a high percentage of public adherence to establish herd immunity and lessen or eliminate the chance of epidemic. Failures to convince everyone to behave in the same way can have dire consequences.

Public health campaigns therefore provide rich insight into the dynamics of assimilative change. Foucault noted in *The Birth of the Clinic* that the practice of modern medicine, particularly in response to epidemics, ineluctably ties public modes of healing to policing.[3] He writes, "Medicine must no longer be confined to a body of techniques

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for curing ills and the knowledge that they require; it will embrace a knowledge of the *healthy man*, that is, a study of *non-sick man* and a definition of the *model man*."[4] The pursuit of public health, then, in a real sense is one avenue for the state to define, create, and control the right kind of citizen, whose health is synonymous with and necessary for the health of the state. Later, Foucault would speak of "biopower," a complex of policies, discourses, and institutions that regulate the bodies that constitute the populace.[5]

Studies of the exercise of biopower through the promotion of public health often focus on minoritized groups whose identities already place them on the edge of, or even outside, policed bodily norms.[6] Fortunately, public health initiatives are typically well documented, which gives the historian a robust archive to consider how these initiatives pursue assimilation while simultaneously marking racial, religious, and other constructions of difference. Indeed, religion often has an outsized role in public health. As the sociologist Ellen Idler has noted, "religion, like public health, has an essentially social character and cannot be understood apart from the groups of people who form themselves into groups for the purpose of practicing their faith."[7] This essay thus turns its attention to the religious impacts of public health initiatives on religio-racial minority communities.[8] Drawing on specific cases, I shed light on the biopolitical effects of public health campaigns through which a minority group's "acceptable" religious practices (as defined by the public health campaigners) are maintained while "unacceptable" practices are eliminated. The unhealthy religious practices, like disease, are to be excised by various means in the well-intentioned—even necessary—pursuit of the public's health.

To better understand this dynamic, this essay explores a cluster of public health campaigns in the early 1960s in Hispano villages in northern New Mexico.[9] Several studies had come out in the decade prior to these campaigns that described and explained Mexican American reluctance to take advantage of modern medical care. For example, an anthropological study in the Southwest in the early 1950s found that Mexican Americans eschewed clinical biomedicine for many reasons: "scientific medicine involves largely impersonal relations, procedures unfamiliar to laymen, a passive role for family members, hospital care, considerable control of the situation by professional healers, and high costs." The study noted that, in contrast, "the folk medicine of Spanish-American villagers" was accessible, accepting of family, happened at home, and was low in cost.[10] A similar study among urban Mexican Americans in the San Francisco Bay area in the late 1950s corroborated these findings and added that this community chafed at the implicit authority that physicians assumed, because "the curer's role in Mexican-American culture is not an authoritarian one.

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Curers may advise, but they may not dictate."[11] The New Mexican campaigns under study in this essay were designed specifically to address this reluctance and to find ways to convince Hispanos to embrace efficacious biomedical healthcare.

I draw particularly on two primary sources related to these campaigns. The first is a 1962 research report by a sociologist, Sam Schulman, and an anthropologist, Anne Smith.[12] The second, which references and expands on the first, is a practical manual written for nurses working in Hispano villages.[13] The authors of the second report were likewise a sociologist and an anthropologist, Robert C. Hanson and Lyle Saunders respectively. Funded by the United States Public Health Service and working in cooperation with the Institute of Behavioral Science at the University of Colorado, these academics and their research team spent a year and a half gathering survey data, doing fieldwork with the aid of bilingual assistants, and coordinating with medical personnel in the region to try to understand why earlier public health initiatives had been mostly unsuccessful. The ultimate objective was to design new, more culturally responsive programs and to increase villager participation. Various reports and journal articles were published in relation to these large-scale studies and supplement the two main reports considered here.[14]

One of the most salient features of these reports is their extensive focus on Nuevomexicano religion as a defining and racializing feature of this population and as the primary barrier to improved health outcomes. My research uses these reports and articles as primary sources and case studies of the complex processes of medical, racial, and religious change, assimilation, and resilience in twentieth-century Latino/a communities. I argue in this essay that these social scientific studies of Spanish-speaking, New Mexican village culture intended to facilitate the "right" kind of assimilation to Anglo cultural norms around health, one that paradoxically aimed to include Hispanos in modern medicine while simultaneously defining essential religio-racial difference. The regulation of Hispano bodies rested on social scientific discourses that racialized religion, science, and health.

The Reports: Objectives and Methods

The first report, *Health and Disease in Northern New Mexico*, early on makes its goals explicit:

> Experience has demonstrated that the conventional approach to public health practice is ineffective both in New Mexico and

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> in other parts of the world where sharp cultural differences intervene. The purpose of this project, therefore, is to attempt to learn how to change present approaches and public health practices that are based upon an 'Anglo' culture in order to obtain their acceptance by another cultural group, namely Spanish-Americans. It is hypothesized that such acceptance would result in improved health attitudes and activities.[15]

On its surface, the objective here is to improve health outcomes in the Hispano community by convincing members of that "cultural group" to align their "attitudes and activities" with those being promoted by the Anglo public health workers. While the report's language adopts a positive orientation—"acceptance," "improved health"—the underlying assumption is that "sharp cultural differences" are keeping rural, Spanish-speaking New Mexicans sick. In effect, Hispano culture was pathologized.[16]

Implicit in this objective are at least three assumptions. The first is that acculturation is vital for health. As we will see, this assumption relies heavily on perceived religious and racial otherness. Second, it is suggested in the above quote and throughout the reports that "Anglo" and "scientific" are synonymous when it comes to healthcare. A corollary of this assumption is that Anglos either have no culture when it comes to acceptance of scientific medicine or, if they do, it is utterly congruent with science. The third assumption is that sociologists and anthropologists, through their study of the Hispano population, can discover the rhetorical key to convince the Nuevomexicanos at long last to leave behind their religious and unscientific health traditions and adopt rational and modern medicine. In other words, they believe they can understand Hispano culture well enough to be persuasive within its own idioms and cultural symbols. Using those idioms and symbols will finally break through cultural barriers and spark healthy assimilation.

This flurry of public health research came at what researchers considered an opportune time. Anglo migration to the West and Southwest had lessened Mexican American isolation. Changing economic realities, including a Hispano exodus from long-standing village agricultural life to wage labor in towns and cities, was likewise creating more opportunities for increased Mexican American adoption of Anglo customs and labor patterns.[17] In other words, by the time of these studies, the integration of New Mexico's Spanish-speaking population into broader regional and national cultural and economic conventions was well underway. But, the social scientists employed to guide this process realized that challenges remained. Schulman and Smith noted that "the change is seldom complete, and even in highly acculturated

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persons there are residual health-disease associated habits and ideas stemming directly out of the health-disease complex of the Spanish-speaking village."[18]

Two years after Schulman and Smith's original report was released, another major publication emerged that used and expanded on the first. Entitled *Nurse–Patient Communication: A Manual for Public Health Nurses in Northern New Mexico*, this second report, as the title suggests, focused the findings of the first into a lengthy series of instructions and advice for nurses. This manual, like the Schulman and Smith report, ultimately aimed at creating long-lasting changes in northern New Mexico's way of life. The authors, Hanson and Saunders, explain in the manual's introduction that "Change in one part of a cultural system has consequences for other parts; the nurse who introduces new aspects of health service or health care, whether she intends it or not and wants it or not, is an agent of cultural change."[19] However, the authors show some restraint and insist that wholesale cultural change is not their stated purpose: "Note that it was *not* the intent of this project directly and deliberately to change the beliefs or practices of patients." They explain, rather, that the objective was to "try to understand both public health and patient belief systems and to seek ways to change certain aspects of nurse discourse in order to take advantage of what patients already believe or do."[20]

The approach throughout Hanson and Saunders's manual stays close to the stated focus on "nurse discourse" and communication. The researchers did a discourse analysis of nurse–patient transcripts (using coding and IBM card punching). The results led to extensive advice for enhanced nurse–patient communication and a lengthy list of rules and guidelines related to language use, establishing rapport, and controlling the discourse and outcomes through careful assessment of the patient's "variables" and specific "attributes."[21] The manual concludes with a summary of the "Spanish-American Health Belief System" and reminds the nurse that, due to the considerable cultural gap between the typical public health nurse and her Hispano patient, the nurse must be cognizant and well trained in the proper discourse to bridge this gap.[22]

Efforts to quantify levels of acculturation relied on survey instruments as well as interviews that gauged types of assimilation and grouped categories of more- and less-acculturated patients. The original Schulman and Smith study focused on two villages where graduate-trained, bilingual "resident workers" collected local history, carried out interviews, and observed cases of healing and disease. The period of observation was approximately two months in length, after which the resident workers returned to share and analyze the data they collected with the directors of the project.[23] An anthropologist directed the coding of these data into "some one thousand categories." The

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codes were cross-referenced on paper slips in a code file, which allowed a "highly maneuverable . . . means of making textual or content analysis" and of framing the entire report.[24] After generating various hypotheses from the coded data, the directors of the project convened five panels in "urban centers in the state" to help them test the hypotheses they had formed, based on the resident workers' interviews and observations in the villages. The panelists, though familiar with northern New Mexican village life, were not villagers and "ranged from an unemployed office worker to a university professor."[25] Comparing village field data with presumably acculturated urban Hispanos made it possible for the researchers to draw conclusions about the relationships between acculturation and acceptance of scientific medicine.

Hanson and Saunders's follow-up manual for nurses, with its more specific set of objectives regarding nurse–patient communication, offers several surveys that in-the-field nurses could use to guide their approach to individual patients. For instance, a "Medical Vocabulary Scale" gauged how well patients could understand specific terms such as "respiratory," "isolate," and "germs." Unsurprisingly, results from this scale indicated that patients with higher levels of education as well as English-language usage in the home scored higher than those with less education or who spoke mostly Spanish.[26] Another survey, entitled the "Health Belief Scale," tested patients both on their religious orientation to health and their beliefs about disease causation and treatment. For example, one statement in the scale, which referenced a Hispano village health tradition, was "A cord tied around the waist will help some sicknesses." Another statement asserted "Prayer and faith can cure diseases like cancer." Data gathered using this scale discovered that high scores (more acculturated) corresponded to younger people and those with more than nine grades of school. In contrast, "low scores were associated with the use of Spanish as the primary language in the home, and living alone or in a broken family."[27] This was important, of course, because lower scores indicated more limited access and poorer health outcomes related to the use of scientific medicine. Lack of education and lack of English were symptoms of the larger problem: unhealthy and persistent Hispano cultural and religious norms were related to poor health.

Nuevomexicano Religious Healing

Why were these unhealthy norms and behaviors so persistent? In a word: religion. As far as the researchers were concerned, for centuries the religion of the Hispano villagers had been nearly synonymous with healthcare. An earlier study by Lyle Saunders of

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Mexican Americans in the Southwest found that "religion was not a thing apart but an omnipresent component" of all daily activities.[28] This religion was, admittedly, Catholic but different in key ways from the relatively known quantity of white Roman Catholicism. Hanson and Saunders suggest that "Long periods of isolation from the Catholic world produced here a form of folk Catholicism that, while similar to folk Catholicism in other regions, includes traits that are distinctively New Mexican."[29] Key within this folk religion was a kind of resignation to God's will. The Notre Dame sociologist Julian Samora, who was himself a Hispano native of southern Colorado, explained that, in this religious context, God's omnipotence demanded submission: "the secret of making life endurable is one of submission and acceptance" to God's will. Any attempts to change one's fate, including in the area of health, had to navigate what Samora called both a "fatalistic" and a "defeatist" conception of life.[30]

Within these narrow parameters, there was still room for both preventative and diagnostic healthcare as long as God's will, sometimes mediated through specific saints, remained paramount. Schulman and Smith explain, "It is, perhaps, only in the sphere of the religious that the villager may be said to practice a form of general prevention; it is, however, not relegated to disease or injury, but to all evils which may beset men."[31] According to the reports, typical forms of religious preventative medicine were prayer to God and the saints and the avoidance of sinful behavior that might incur punishment in the form of sickness. Sickness, whether caused by sin or other factors, was treated by household remedies—or by religious specialists in more serious cases. These specialists, known as *médicas* or *curanderas*, treated illness with a variety of modalities including prayer, ritual acts, pilgrimage, herbal remedies, and what we might refer to today as bodywork.[32] For example, Hanson and Saunders interviewed a village healer who had expertise in concocting herbal remedies for her patients, which she administered with prayer. The healer noted, "If you have faith you can get well, even with a drink of water."[33] In other cases, healers and villagers relied on the power of Catholic saints. "Each family has its protective saint, as does each village; and the intercession of the saints is often requested for special purposes: a good marriage, successful harvests, recovery from illness, a trouble-free birth or a pain-free death."[34]

By the 1960s, *curanderas* and *curanderos* ("healers") had been treating patients in New Mexico and throughout the Southwest for centuries. While some of their treatments could be biomedically justified, the basis of their care, though certainly empirical, did not result from the scientific method but rather from European and Indigenous religious and medical traditions that predated modern

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science.[35] Moreover, as the historian Jennifer Koshatka Seman has shown in her study of two prominent borderlands *curanderos*, these healers had a wide reach that included "Indigenous peoples, ethnic Mexicans, Tejanos, and even some Anglos with the understanding that they were the conduits through which a larger spiritual force moved." They healed with "the power of God as well as their own curative knowledge of medicinals and therapies," and they also addressed a variety of social ills, often ignored by colonial authorities.[36] In this sense, these local healers had long helped their patients recuperate and cope with suffering, not only as individuals but as communities. Their persistent appeal lay, therefore, both in their efficacious remedies and in the religious and communal legibility of their treatments.

Although not an author or contributor to these studies, William Madsen was an anthropologist working at the same time and in similar contexts. He wrote extensively about the religious bases of Mexican American healing traditions in the area of McAllen, Texas, and his interpretations echo and reinforce those of his peers in New Mexico. For instance, in 1964 he wrote the following:

> The conservative Latin world-view follows the common folk pattern of blending the supernatural and the natural in one integrated system. Although the Anglo may be a devout church member, he usually distinguishes clearly between supernatural and natural phenomena. The scientific isolation of the natural world is incomprehensible to the conservative Mexican-American. Usually a Roman Catholic, he tends to view the Anglo belief as a part of the "Protestant heresy." Even continuous attempts by the Catholic clergy to educate the lower-class Latins to the basic concepts of modern medicine usually fail.[37]

Madsen found that Texan Mexican Americans, like their New Mexican counterparts, often made little sense of the evident Anglo desire to divorce religion from medicine. "While the physician claims to cure merely through acquired knowledge, the curandero operates through the grace of God."[38] Not only was it more rational to rely on an all-powerful God, in contrast to meager "acquired knowledge," but this reliance on God or healing also served as an ongoing ethnic marker of Mexican Americans contra Anglos.

Throughout the New Mexican research reports, there is frequent slippage between assignations of "religion" and "ignorance." Despite the ostensible stance of objective and scholarly agnosticism—and even at times a kind of appreciation for Hispanos' rich cultural traditions—the sociologists and anthropologists leading these studies often indicate in

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their rhetoric that folk traditions and cultural preferences are quaint but will be superseded by information and education. This assumption is underscored by the oft-used phrase "cultural barriers," a phrase which suggests that the purpose of the villagers' culture is to withstand necessary change and movement. In one long section of Hanson and Saunders's nursing manual, transcripts are presented of interviews between local informants and the researchers. Their stated purpose is to share the outlooks of the informants, but it becomes clear that their questions are designed to bait the informants into saying things that highlight their lack of scientific background. For example, in a conversation that was attempting to explore informants' conception of germ theory, the following exchange unfolded:

> Q [researcher]. Awhile [*sic*] ago you spoke to me about this germ. Tell me more about it. Where does it come from?
> A [informant]. Well, I believe that our entire body is all little animals. It appears that we do not have any animals, but we do have. Don't we? And this germ must go way inside, and it must be the one who eats this. Or it comes in the wind or something. Because there is an animal which comes in the wind . . .
> Q. Then you believe this must be the cause of TB or not?
> A. It could be. If it enters inside the body it could be so.[39]

It is unclear whether the informant is trying to tell the researchers what they want to hear or to establish that she—the informant—does, in fact, believe in germs, or if she is perhaps supplying an accurate description of her understanding of illness in the body. The lesson that the researchers take away from such exchanges is that the Nuevomexicanos evince "exposure to the public health *belief system*" but their pre-existing belief systems stymie them in a morass of "considerable confusion."[40]

In another case, the researchers conclude that Hispanos' faith is inscrutable to the point of being practically useless. Hanson and Saunders submit that the people's God is "authoritarian," and therefore must be obeyed. But they lament that "God's will is never clearly revealed," which means that "there is no certain way that an individual can draw upon [God's power] to retain or regain health."[41] Such a conclusion reinforces the ultimate objective of these research projects: to move the Hispano villagers away from their uncertain and unproven religious healing beliefs and acculturate them fully into modern, scientific, and clinical healthcare.

While the religious barriers to medical assimilation were significant, it was also the case that assimilation itself could often

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hold its own dangers. The influential mid-century historian of ethnomedicine Erwin Acknerknecht reminded researchers like Hanson and Saunders that "primitive mentality looks at first glance strange enough to those who are brought up only with the (incomplete) knowledge of the 'white, adult and civilized' man." He added, "The natural is supernatural and the supernatural is quite natural [for the 'primitive']. Perception may not be different, but values are just the reverse of those of our culture."[42] This meant that efforts at assimilation had a two-part danger. First, they could backfire and create new forms of sickness, as well as novel "magico-religious" responses to these new forms of suffering. Ackerknecht found that unhealthy states of mind in acculturating groups were "*typical acculturation phenomena*" that emerged logically in a "*disturbed culture.*" In turn, this produced "*new religion*," or new supernatural explanations and remedies for illness.[43]

The second danger, related to the first, was a dissolution of the religious glue of social cohesion. Ackerknecht surmised that "medical ideologies" could be read as "religious symbolizations of society," which, in turn, guarantee "social cohesion." According to him, this social cohesion, "perhaps more than therapeutic successes, explains the survival of primitive medicine, even when faced by more successful western competitors."[44] If acculturation altered the core medico-religious ideologies of a group, the group's social cohesion would suffer. Margaret Clark, an anthropologist who carried out a health-related study in the late 1950s in a Mexican American neighborhood of San Jose, California, echoed Acknerknecht's analysis. She found that illness was often "a means of dramatizing to others the evil consequences of cultural change and defending the 'old ways'—Mexican customs and traditions which are under constant attack in the United States." As Clark explains, in these cases diseases were attributed to "the demands of Anglo society or the ways of American life which are uncongenial to the patient."[45] The ironic upshot is that promoting assimilation to improve health outcomes could itself cause new or additional malaise.

Non-religious barriers to assimilation to Anglo medicine also existed. For instance, Lyle Saunders, one of the authors of the nursing manual, found in an earlier study that Mexican Americans often avoided Anglo medical treatments and considered them a last resort. Consequently, by the time patients went to the biomedical clinic, they were often quite sick and therefore were less likely to find a cure. This led to "the development of the belief, which could be supported by reference to known cases, that Anglo medical institutions were places where people went to die."[46] Moreover, many Mexican Americans viewed Anglo medicine as impersonal, unfamiliar, passive for family

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members, and costly. In contrast, traditional medicine was personal, familiar, inclusive of family participation, and inexpensive.[47]

Certainty about the positives of biomedical healthcare pervades the New Mexican reports, but, given all the problems related to assimilation, there is far less certainty when it comes to the project of assimilation. To begin with, the researchers were professional social scientists with good intentions. Decades later, we can and should recognize and critique the implicit colonial and racial overtones of their work. At the time, however, they believed they were studying Hispano culture to understand it, contextualize it, and even appreciate and preserve parts of it. The normative impetus of the project—to change healthcare beliefs and practices—lived within an overall project of trying to find the best, most culturally legible ways to communicate the positives of adopting scientific medicine. The desire to communicate in the cultural and religious idioms of the villagers, though sometimes paternalistic and superior, nonetheless recognized the internal importance and durability of Hispano cultural norms.[48]

A danger, then and now, of this assumption is a determinism that is enmeshed in spoken and unspoken conceptions of racial difference. Although the researchers show a degree of sensitivity to the villagers' internal diversity, particularly between different generations, they cannot completely avoid generalizations and stark dichotomies between Anglos and Hispanos. The Nuevomexicano villager, even one who has "progressed" by assimilating many Anglo cultural norms, remains essentially anchored to a clannish and benighted folk Catholicism marked by a persistent commitment to the irrational and to fatalism. The anthropologist Ozzie Simmons, in a 1961 study of Mexican American and Anglos' mutual expectations near McAllen, Texas, wrote that, even when Anglos profess that they want Mexican Americans to adopt Anglo norms, Mexican Americans "do not find that acculturation is rewarded in any clear and regular way by progressive acceptance" into mainstream Anglo society.[49] This effectively meant that the gap between whites and Mexican Americans could never be completely bridged.

Religious and Scientific Racialization

The primary discursive category used in the public health reports for maintaining this one-way bridge to nowhere is "science." It is an ideal category in this context in that it is, on the one hand, ostensibly universal and universalizable, and, on the other, racialized and, therefore, ultimately unattainable for some and natural for others. The researchers in New Mexico acknowledge and were motivated by

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science's universal nature. In fact, it was their overriding concern and was the ultimate limitation on how far they would extend their commitment to understanding, appreciating, or tolerating Mexican American religious and folk healing traditions. If their dedication to scientific objectivity was clear to the researchers, the racialization of science (and religion) was, however, opaque to them. Khyati Joshi writes, "The *racialization of religion* is a process by which particular religions are associated with certain physical appearances[,] and human differences come to be treated as absolute, fundamental, heritable, like race."[50] Racialization of science is analogous: the process by which adherence to and respect for scientific truth becomes associated with particular racial groups, over and against other groups that, in contrast, are *essentially* unable to apprehend reality based on scientific evidence. Finally, racialization and medicalization of a particular population often go hand in hand. When scientific experts bring new healing modalities to racialized groups, "racial difference acquires the weight of truth through the production of biomedical knowledge and its deployment in therapeutic practice and the public health policy."[51]

Evidence of racialization of science and medicine is embedded in the language of the research reports. Two central dichotomies that recur throughout are "Hispanic/Anglo" and "traditional/scientific." To reiterate, the impetus of the research in New Mexico was the conviction that, if Anglo healthcare providers better understood "Hispanic traditions," they would be more successful at encouraging Hispano acculturation from their ancestral religious and cultural traditions to Anglo scientific norms. This, in turn, would lead to better health outcomes. For instance, fieldworkers noticed that the failure of traditional village medicine opened the door for Hispano experimentation with "Anglo medicine" such as antibiotic injections and surgeries. Some Nuevomexicanos came to trust Anglo medicine even more than their traditional practices, but this is not necessarily evidence of acculturation since "they usually have little or no understanding of *why* it is superior."[52] The nursing study echoes this viewpoint: "Anglo-American medicine is likely to be imperfectly understood by the villager." In the surrounding sentences to this assertion, other adjectives used for "Anglo-American" medicine are "scientific" and "professional" medicine.[53]

These facile equations of "Anglo" with "scientific" and "Hispanic" or "villager" with "traditional" reveal a kind of dramatic irony in that the reports' reader, who is assumed to be Anglo—or, perhaps, a highly acculturated Nuevomexicano—knows something that the objects of the studies do not. Namely, the presumed Anglo reader is tacitly expected to share the conviction that scientific medicine is fact-based and

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consistently effective, which invites the reader into the scientifically (and racially) superior space from which the studies were carried out.

One of the most prominent examples of this rhetorical device, employed repeatedly throughout the studies, is discussion of disease etiology. Etiology—the attributed cause of some phenomenon—functions in these studies as a bright dividing line between Anglo science and Hispano religion and tradition. Schulman and Smith attribute villagers' disease etiology to various sources: "From the Hispanic past comes the notion of imbalance in the hot and cold elements in the body; from the Anglo-American present comes the poorly understood idea that some ideas are 'catching'; from very remote American Indian antiquity is the rare mention of object intrusion as a cause of illness." But above all these sources, however, is "God's will."[54] A similar and contemporaneous anthropological study carried out in the Rio Grande Valley in Texas corroborates the New Mexican studies' findings and elaborates on the source of mental illnesses. Such maladies result from three principal causes: "1) those sent by God or a saint as punishment for misdeeds; 2) those caused by witchcraft or the evil eye; and 3) fright sickness caused by seeing ghosts."[55] In short, both physical and mental afflictions were often judged to have a divine or metaphysical source, whether this be punishment for sin or malevolent curses evoked by one's enemies.

The researchers acknowledge that this conception of health makes room for both prevention and treatment of illness. For example, Hispano disease prevention measures included wearing protective devices such as amulets and taking protective medications such as herbal remedies.[56] Nevertheless, such measures were "alien to the germ-theory oriented medical milieu in which both researchers and sophisticated informants have been socialized."[57] The study in Texas found that some Mexican Americans in the 1950s and '60s actively rejected germ theory and its proponents: "Professional physicians are viewed with suspicion and hostility by conservative members of the lower class who generally regard the germ theory of disease as a fraudulent scheme to help Anglo doctors and nurses extract exorbitant fees from the gullible."[58]

Ignorant of "germ theory," what were the details of villagers' etiology of disease? Schulman and Smith, based on their teams' interviewing, conclude that traditional Nuevomexicanos attribute the cause of illness to "six major areas:"

> (1) Direct punitive action of God; (2) Exposure to "forces" of illness; (3) Adversities of a natural kind; (4) Personal mana; (5) Disturbance or imbalance of external or internal elements; (6) Causal factors alien to the foregoing and assumedly the result of contact between a folk-level Hispanic people on the

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one hand and indigenous and Anglo-American peoples on the other.[59]

Four of the identified six causes of illness, like "germ theory," concern forces outside the body entering it or influencing it in a deleterious way: God's punishment, forces of nature, personal mana, and alien culture. Of these four, two clearly fall in the remit of what researchers considered to be "religious," i.e., God's punishment and mana. (It is important to note that "mana," which here indicates the unique power of certain individuals to bewitch, curse, or enchant others, is certainly not a local term but one imposed by the anthropologists in charge of the study.) But all six, according to the studies, operate in a folk setting that is based on belief and tradition rather than on scientific medical knowledge and evidence. In this sense, an exploration of Nuevomexicano theories of disease etiology serves not as an avenue for finding common ground but rather as a sustained argument for the incommensurability of village healing traditions and Anglo biomedicine. Indeed, one can even get sick from "contact" with Anglos.

This racialization of medical science as Anglo and religion and tradition as Nuevomexicano presents an internal tension in the researchers' studies (and in the entire enterprise of the public health campaigns related to the studies). On the one hand, the reports' and the campaigns' explicit objective is to acculturate Hispano villagers so that they can better access life-saving healthcare. The studies into their culture are meant to open up avenues of understanding. So informed, doctors, nurses, social workers, and other public health professionals are meant to be able to find the right strategies to convince villagers to leave behind the scientifically useless aspects of their healing traditions and to embrace scientifically vetted medicines and practices, including vaccinations, antibiotics, and hospital care when necessary. But, on the other hand, the same studies implicitly insist over and over again that racial differences are essential markers of science and tradition, barriers that, while based on culture and history, are durable. Assimilation in a context of racialization becomes a kind of impossible recursion where every accommodation or adoption of Anglo norms—which in themselves claim to be universal, scientific, and objective—subtly reinforces the essentialist chasm constructed between different racialized groups.

Conclusion

What are we to make of public health campaigns and the anthropological studies that justified and informed them? Specifically,

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what did these campaigns and studies do to the intertwined religion and race of Nuevomexicanos? A feature of the reports that stands out with the hindsight of historical research is that the public health officials and the academics on their teams approached their tasks with a sense of righteousness, even justice. They were working to expand the good life to racial minorities in the nation. They wanted to provide access to better, more effective healthcare. They also wanted to make a place of sorts within the US for a greater inclusion of non-white populations. Their assumptions about the value-free world of science as a place of encounter and communication underscore their willingness to find a place where different kinds of people could realistically and beneficially come together. Other than their call for assimilation around health practices, they appear to be unaware, or at least untroubled, that their benevolent impulses could have detrimental effects on Hispano religious traditions. Likewise, they have no obvious anxiety that their efforts could tamper with the boundaries of Nuevomexicano ethnicity. The only caveat is that they recognize that younger Hispanos are already more acculturated to Anglo norms; they situate their campaign as a kind of catalyst for this already ongoing generational change.

A dynamic emerges in which the urge to assimilate Hispano villagers to the universal efficacy of scientific medicine ends up highlighting, and even reifying, their racial and cultural differences. The historian Nayan Shah, in his study of public health, epidemics, and race in San Francisco's Chinatown, wrote that "historians, anthropologists, and political philosophers have demonstrated that ideologies of race are constitutive of modern rationality and its regimes of classification and regulation." He explains further that "modernity, on the one hand, promotes ideas of universality and, on the other hand, obsessively objectifies difference."[60] It follows that difference can only be understood as a deviation from the universal norm.

But the fair-minded and curious public health workers and the anthropologists working on expanding modern healthcare to New Mexican villages did not frame what they were doing as the stamping out of deviance. Instead, they were "studying," "understanding," and even praising the villagers for certain aspects of their traditions and history. My aim here is not to develop an apologetics for the researchers but rather to analyze how their intentions made up part of the outcomes of their work. Their studies occurred in an era prior to the vogue of concepts like "multiculturalism" or "cultural competency," though they certainly understood that other cultures had values and features worthy of their study.

The benevolence of public health research and campaigns, in these cases, rested on at least two basic acknowledgments. First, the impetus behind them was a regard for the health and flourishing of

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Hispano populations. Although other reasons guided their research into Nuevomexicano healing traditions, the most clearly articulated aim was to better integrate scientific medicine into the villages to improve health outcomes. Second, the social scientists producing the reports acknowledged, as a tenet of their disciplines, that cultural differences are resilient even in the face of pressures to acculturate. This very resilience contributed to the scientists' tacit reification of racial difference between "Anglo" science and "Hispano" tradition discussed above.

A qualified binary gets set up between Anglo science and Hispano religious and cultural traditions. It is "qualified" because the social scientists by this point in the twentieth century were not committed to cultural erasure in the name of "civilization." Rather, they desired the health of the people they studied, as well as the health of the nation in general. They had at least some commitment to integration, and they showed moments of sincere appreciation for the traditions of the rural Nuevomexicanos. But, the binary persists with only one acceptable vector: from "tradition" to "science."

However, changing a people's religious behaviors, even if it is "for their own good," is hardly a simple affair. Health researchers and medical practitioners had commented repeatedly about the persistence of certain beliefs and practices among Latin Americans and Latinos/as well into the ostensibly "modern" twentieth century. In a 1948 study of fright-based ailments in Guatemala and elsewhere in Latin America, the psychiatrist John Gillin explained that "magic fright," or *susto*, was a cultural product and that to "persist in this manner, it must be rewarding in certain ways" to those who suffered its effects. He argued that, if psychiatrists and others like himself were to make any headway against these "folk" illnesses, they would need to do a better job of understanding the cultural calculus that made them durable. He wrote, "Therefore, 'superstitions' of this kind cannot be lightly dismissed as a mere body of fantasies which can be legislated out of existence. Modern medicine makes slow headway against them, especially in those conditions in which it takes no account of cultural factors" that sustain them.[61]

If we return to where we started—invoking Foucault's concept of biopower—the cases discussed in this article suggest that governmental medical strategies to control and delimit a population through public health campaigns must ultimately confront certain limitations. Julia Kristeva and her coauthors remind us of "the pathological and healing powers of culture" and that "the human body [is] a complex bio-cultural fact."[62] If we acknowledge these statements as true, then the supremacy of biomedical science over culture breaks down. I assert with these authors that "biomedicine is

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not only culturally produced" but also that "cultures create different kinds of bodies and realities with medical implications."[63] The fact that Mexican American religious and traditional healing practices continue to flourish and evolve, and have even been celebrated as markers of cultural reclamation and pride, further embeds healing in cultural contexts.[64] The irony is that the universalizing objectives of public health campaigns can sharpen the constructed lines of religious and racial difference.

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Notes

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[1]John Hubley and Sylvia Tilford, "Health Promotion," in *Public Health: An Action Guide to Improving Health*, ed. John Walley and John Wright (New York: Oxford University Press, 2010), 115–38.

[2]Scholars have sometimes drawn sharp definitional lines between "assimilation" and "acculturation." See, for example, Israel Cuéllar, Bill Arnold, and Roberto Maldonado, "Acculturation Rating Scale for Mexican Americans-II: A Revision of the Original ARSMA Scale," *Hispanic Journal of Behavioral Sciences* 17, no. 3 (1995): 278–79. This differentiation is useful in certain contexts, but in this article, I use the terms as interchangeable synonyms.

[3]Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1994), 25–26.

[4]Foucault, *Birth of the Clinic*, 34, emphasis in original.

[5]Michel Foucault, *The History of Sexuality, Volume I: An Introduction* (New York: Vintage Books, 1990), 139–45. Vernon W. Cisney and Nicole Morar, "Introduction: Why Biopower? Why Now?," in *Biopower: Foucault and Beyond*, ed. Vernon W. Cisney and Nicole Morar (Chicago: University of Chicago Press, 2016), 1–25.

[6]For instance, see Sylvia Noble Tesh, *Hidden Arguments: Political Ideology and Disease Prevention Policy* (New Brunswick, NJ: Rutgers University Press, 1988); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); John Mckiernan-González, *Fevered Measures: Public Health and Race at the Texas–Mexico Border, 1848–1942* (Durham, NC: Duke University Press, 2012); Catherine Mas, *Culture in the Clinic: Miami and the Making of Modern Medicine* (Chapel Hill: University of North Carolina Press, 2022).

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[7]Ellen L. Idler, *Religion as a Determinant of Public Health* (New York: Oxford University Press, 2014), 3.

[8]For a discussion of the co-construction of religio-racial identities, see Judith Weisenfeld, *New World A-Coming: Black Religion and Racial Identity During the Great Migration* (New York: New York University Press, 2016).

[9]The people of northern New Mexico and southern Colorado who claim colonial Spanish ancestry are often known by the ethnic signifier "Hispano" (in contrast to "Hispanic," "Mexican American," or "Latino/a/x"). In this essay, I use the terms "Hispano" and "Nuevomexicano" interchangeably for this community. I use the term "Latino/a" to refer to all people in the United States with Latin American ancestry. To refer to English-speaking non-Latinos/as, I use the terms "Anglo" and "white." For more on Hispano identity, see John M. Nieto-Phillips, *The Language of Blood: The Making of Spanish-American Identity in New Mexico, 1880s–1930s* (Albuquerque: University of New Mexico Press, 2004).

[10]Lyle Saunders, *Cultural Difference and Medical Care: The Case of the Spanish-Speaking People of the Southwest* (New York: Russell Sage Foundation, 1954), 168.

[11]Margaret Clark, *Health in the Mexican-American Community: A Community Study*, 2nd ed. (Berkeley: University of California Press, 1970 [1959]), 213.

[12]Sam Schulman and Anne M. Smith, *Health and Disease in Northern New Mexico: A Research Report* (Boulder: Institute of Behavioral Science, University of Colorado, 1962).

[13]Robert C. Hanson and Lyle Saunders, *Nurse–Patient Communication: A Manual for Public Health Nurses in Northern New Mexico* (Boulder and Santa Fe: Bureau of Sociological Research, Institute of Behavioral Science, University of Colorado and New Mexico State Department of Public Health, 1964).

[14]Sam Schulman, "Rural Healthways in New Mexico," *Annals of the New York Academy of Sciences* 84, no. 17 (1960): 950–58; Julian Samora, "Conceptions of Health and Disease Among Spanish-Americans," *The American Catholic Sociological Review* 22, no. 4 (1961): 314–23; Sam Schulman and Anne M. Smith, "The Concept of 'Health' among Spanish-Speaking Villagers of New Mexico and Colorado," *Journal of Health and Human Behavior* 4, no. 4 (1963): 226–34.

[15]Schulman and Smith, *Health and Disease in Northern New Mexico*, 2.

[16]Pathologization of non-white people in the West and Southwest was not a new phenomenon. The historian Linda Nash's study of disease and environmental factors in California found that racial ethnic minorities such as Chinese and Mexicans were often

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singled out for their deleterious effects on public health. She wrote that, by 1949, "migrant farmworkers were the most pathologized group in the state." Linda Nash, *Inescapable Ecologies: A History of Environment, Disease, and Knowledge* (Berkeley: University of California Press, 2006), 128. See also Shah, *Contagious Divides.*

[17]Don J. Usner, *Sabino's Map: Life in Chimayó's Old Plaza* (Santa Fe: Museum of New Mexico Press, 1995), 79; Suzanne Forrest, *The Preservation of the Village: New Mexico's Hispanics and the New Deal* (Albuquerque: University of New Mexico Press, 1989), 30.

[18]Schulman and Smith, *Health and Disease in Northern New Mexico*, 35.

[19]Hanson and Saunders, *Nurse–Patient Communication*, 16.

[20]Hanson and Saunders, *Nurse–Patient Communication*, 20–21, emphasis in original.

[21]Hanson and Saunders, *Nurse–Patient Communication*, 105ff, also 126–36.

[22]Hanson and Saunders, *Nurse–Patient Communication*, 152.

[23]Schulman and Smith, *Health and Disease in Northern New Mexico*, 7–8.

[24]Schulman and Smith, *Health and Disease in Northern New Mexico*, 13.

[25]Schulman and Smith, *Health and Disease in Northern New Mexico*, 11.

[26]Hanson and Saunders, *Nurse–Patient Communication*, 88–89.

[27]Hanson and Saunders, *Nurse–Patient Communication*, 87.

[28]Lyle Saunders, *Cultural Difference and Medical Care: The Case of the Spanish-Speaking People of the Southwest* (New York: Russell Sage Foundation, 1954), 49, quoted in Schulman and Smith, *Health and Disease in Northern New Mexico*, 29.

[29]Hanson and Saunders, *Nurse–Patient Communication*, 7. The use of "folk" in terms of religion, a term that I have regrettably employed in previous publications, is problematic and too often signifies a lack of ostensible purity or original authority.

[30]Samora, "Conceptions of Health and Disease among Spanish-Americans," 316.

[31]Schulman and Smith, *Health and Disease in Northern New Mexico*, 87.

[32]Samora, "Conceptions of Health and Disease among Spanish-Americans," 321.

[33]Hanson and Saunders, *Nurse–Patient Communication*, 60.

[34]Schulman and Smith, *Health and Disease in Northern New Mexico*, 26.

[35]Brett Hendrickson, *Border Medicine: A Transcultural History of Mexican American Curanderismo* (New York: New York University

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Press, 2014), 19–36; Robert T. Trotter and Juan Antonio Chavira, *Curanderismo: Mexican American Folk Healing*, 2nd ed. (Athens, GA: University of Georgia Press, 1997), 25–40.

[36]Jennifer Koshatka Seman, *Borderlands Curanderos: The Worlds of Santa Teresa Urrea and Don Pedrito Jaramillo* (Austin: University of Texas Press, 2021), 134.

[37]William Madsen, "Value Conflicts and Folk Psychotherapy in South Texas," in *Magic, Faith, and Healing: Studies in Primitive Psychiatry Today*, ed. Ari Kiev (New York: Free Press of Glencoe, 1964), 422–23.

[38]Madsen, "Value Conflicts and Folk Psychotherapy in South Texas," 429.

[39]Hanson and Saunders, *Nurse–Patient Communication*, 50–51.

[40]Hanson and Saunders, *Nurse–Patient Communication*, 51, emphasis added.

[41]Hanson and Saunders, *Nurse–Patient Communication*, 175.

[42]Erwin H. Ackerknecht, "Psychopathology, Primitive Medicine and Primitive Culture," *Bulletin of the History of Medicine* 14, no. 1 (1943): 53–54.

[43]Ackerknecht, "Psychopathology, Primitive Medicine and Primitive Culture," 64, emphasis in original.

[44]Erwin H. Ackerknecht, "Primitive Medicine's Social Function," *Miscellanea Paul Rivet, Octogenario Dicata* (1958): 7.

[45]Clark, *Health in the Mexican-American Community*, 201.

[46]Saunders, *Cultural Difference and Medical Care*, 159.

[47]Saunders, *Cultural Difference and Medical Care*, 168.

[48]More than thirty years before these researchers were active, the pioneering anthropologist Ruth Benedict cautioned against assuming that the anthropologist's own culture was the teleological norm of all cultures: "In the higher cultures the standardization of custom and belief over a couple of continents has given a false sense of inevitability of the particular forms that have gained currency, and we need to turn to a wider survey in order to check the conclusions we hastily base upon this near-universality of familiar customs. . . . Modern civilization, from this point of view, becomes not a necessary pinnacle of human achievement but one entry in a long series of possible adjustments." Ruth Benedict, "Anthropology and the Abnormal," *Journal of General Psychology* 10 (1934): 59.

[49]Ozzie G. Simmons, "The Mutual Images and Expectations of Anglo-Americans and Mexican-Americans," *Daedalus* 90, no. 2 (1961): 296–97.

[50]Khyati Y. Joshi, *White Christian Privilege: The Illusion of Religious Equality in America* (New York: New York University Press, 2020), 46, emphasis in original.

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[51]Laurie B. Green, John McKiernan-González, and Martin Summers, "Introduction: Making Race, Making Health," in *Precarious Prescriptions: Contested Histories of Race and Health in North America*, ed. Laurie B. Green, John McKiernan-González, and Martin Summers (Minneapolis: University of Minnesota Press, 2014), x.

[52]Schulman and Smith, *Health and Disease in Northern New Mexico*, 174–75, emphasis in original.

[53]Hanson and Saunders, *Nurse–Patient Communication*, 68.

[54]Schulman and Smith, *Health and Disease in Northern New Mexico*, 105.

[55]William Madsen, *Society and Health in the Lower Rio Grande Valley* (Austin: University of Texas, Hogg Foundation for Mental Health, 1961), 20–21.

[56]Schulman and Smith, *Health and Disease in Northern New Mexico*, 77.

[57]Schulman and Smith, *Health and Disease in Northern New Mexico*, 61.

[58]Madsen, *Society and Health in the Lower Rio Grande Valley*, 20–21.

[59]Schulman and Smith, *Health and Disease in Northern New Mexico*, 107.

[60]Shah, *Contagious Divides*, 5.

[61]John Gillin, "Magical Fright," *Psychiatry* 11 (1948): 400.

[62]Julia Kristeva, Marie Rose Moro, John Ødemark, and Eivind Engebretsen, "The Cultural Crossings of Care: A Call for Translational Medical Humanities," in *Routledge Handbook of the Medical Humanities*, ed. Alan Bleakley (London: Routledge, 2020), 34.

[63]Kristeva et al., "The Cultural Crossings of Care," 37.

[64]See, for example, Brett Hendrickson, "Restoring the People: Reclaiming Indigenous Spirituality in Contemporary Curanderismo," *Spiritus: A Journal of Christian Spirituality* 14, no. 1 (2014): 76–83.

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ABSTRACT *Public health campaigns among Catholic Mexican American populations in New Mexico in the mid-twentieth century often relied on the expertise of anthropologists and sociologists to help tailor the campaigns to Mexican American culture. Social scientists produced several reports based on fieldwork that suggested that New Mexican village religious practices and beliefs, often referred to as "folk Catholicism," were durable barriers to embracing scientific healthcare standards. This article uses those reports to reveal and analyze the role that public health campaigns and social science researchers played in defining and challenging Hispano religious healing traditions. It likewise examines the various intersections of science and racializing discourse in the reports. I argue that these social scientific studies of Spanish-speaking, New Mexican village culture were intended to facilitate the "right" kind of assimilation to Anglo cultural norms around health, one that paradoxically aimed to include Hispanos in modern medicine while simultaneously defining essential religio-racial difference. The regulation of Hispano bodies rested on social scientific discourses that racialized religion, science, and health.*

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