International Journal of Public Health (2019) 64:1257–1258
https://doi.org/10.1007/s00038-019-01279-0

COMMENTARY

Understanding the etiology and impact of hatred globally in a public health context

Joshua S. Yudkin[1] · Sarah E. Messiah[1]

Received: 24 April 2019 / Accepted: 26 June 2019 / Published online: 5 July 2019

When we think about addictions, we usually think about drugs and alcohol—maybe gambling. Hatred is not only a seductive addiction but also the biggest existential threat to mankind. Its positive feedback loop penetrates family, national and supranational narratives (Maziak 2018). Its viral contagion masterfully oscillates between lysogenic and lytic stages at the will of mankind. It allows children—our collective future—to be hacked to death.

Within the past century, inherently inane hatred has claimed the lives of millions. From failed diplomatic experiments that led to World War I, the systematic genocide of marginalized and subaltern populations during World War II, the ideological clash of communism and the free market backed by the global hegemonic superpowers in developing nations during the Cold War, to the recent genocide against Muslims in Bosnia or Tutsis in Rwanda, humankind self-destructs when our hatred goes lytic. Hatred lowers our collective cognitive defenses of rationality and heightens our desire to blame others, to feel more powerful and find an explanation—regardless of the absurdity or implausibility. Hatred is no different than the same addictive poison that is inhaled when smoking a cigarette—the only difference is that the secondhand smoke of hatred from an individual can affect millions.

There is a famous piece of Persian poetry that describes all of humanity as a one, and when one part hurts, we all hurt: In trying to treat the hate locally with hate, the hatred metastasizes and our chances of survival are very slim. Hatred is a self-perpetuating oncogene that can be found in all of our DNA—both consciously and subconsciously. Our societies have taught us to otherize certain groups due to past trauma and pure prejudice.

This is the 25th anniversary of the Rwandan genocide where Hutu neighbors turned on their Tutsi neighbors with machetes, clubs and their bare hands to inflict a painful and horrific death. Twenty-five years ago in Rwanda, children watched their mothers be raped and fathers be hacked limb by limb to death like a fallen tree branch (Uwizeye et al. 2016). Churches' walls are still stained with blood where toddlers were swung like a baseball bat in batting practice against the wall until skulls cracked and tears dried. Transgenerational consequences—both personal and systemic—continue to plague survivors and their children (Montgomery et al. 2019; Roth et al. 2014; Self-Brown et al. 2014).

But for the first time in history, our immune system was able to defeat this strain of hatred without a different hatred. Our T4 cells were still delayed in identifying and recruiting the T8 cells; however, in Rwanda, a local spontaneous missense genetic mutation arose in our T8 cells where forgiveness was employed to destroy hate.

Where hatred empowered neighbor to hack neighbor to death with machete, forgiveness emboldened the bereaved widows and children to continue to live. Tutsi leadership in Rwanda refused to allow Tutsis to take revenge on their neighbors' barbarism and brutality. Tutsi leadership removed these tribal and charged labels and focused on rebuilding and repairing the Rwandan collective. Regardless of the unique experiences, Rwandan leadership focuses on the pain and loss of the collective. Forgiveness and wholeness immunized against hatred.

But like any vaccine, protection does not last forever. So how do we train ourselves in forgiveness and wholeness? How do we identify hate early and contain it? How do we strengthen ourselves as a collective? As public health professionals, how do we acquire resilience before infection?

For the collective, *Tikun Olam* [repairing or healing the heart] and *Tikun Halev* [repairing the world] may serve

Minor Revision: 27 May 2019.
Major Revision: 24 June 2019.

✉ Joshua S. Yudkin
Joshua.Yudkin@uth.tmc.edu

[1] School of Public Health, University of Texas Health Sciences Center at Houston, Houston, TX, USA

useful. These are the two tenants of the Agahozo-Shalom Youth Village (ASYV) that provide homes and families to the most vulnerable orphans in Rwanda (Schimmel 2011). They are also the tenants of a similar youth village that was created in Israel after the Holocaust for vulnerable orphans (Beker and Magnuson 1996). Just as the Rwandan government created structures and mechanisms such as Gacaca courts (Schabas 2005), infrastructure projects and university scholarships for genocide survivors to both help heal and safeguard against such atrocities, ASYV teaches children to hug and love their friends and family. It teaches DNA—discuss, negotiate and agree—a conflict resolution strategy that the entire village employs when conflict arises. It is living proof that hatred—as an addiction, virus and cancer—can be defeated.

As public health professionals, this is our opportunity to get in front of complicated regression models and engage in truly transdisciplinary work. This is our opportunity to expand our theory and typical teams. As population-level health practitioners, let's build the right inclusive team. Let's not just treat the symptoms—the HIV+ orphans from women who were intentionally raped by HIV+ genocide perpetrators (Ruby Reid-Cunningham 2008) and the hunger and malnutrition of returning refugees (Barber 1997)—but innovate together to identify the etiology of this addictive, contagious and self-inflicted illness of hatred.

Acknowledgements Thank you to the staff and leadership of the Agahozo-Shalom Youth Village and the American Jewish Joint Distribution Committee for their important work in this space.

Compliance with ethical standards

Conflict of interest There are no conflicts of interest to report for all authors.

References

Barber B (1997) Feeding refugees, or war? The dilemma of humanitarian aid. Foreign Aff 76:8–14. https://doi.org/10.2307/20048117

Beker J, Magnuson D (1996) Residential education as an option for at-risk youth. Resid Treatment Children Youth 13:3–48. https://doi.org/10.1300/J007v13n03_02

Maziak W (2018) Syria: public health disasters in the era of no world order. Int J Public Health 63:311–312. https://doi.org/10.1007/s00038-018-1084-8

Montgomery E, Just-Østergaard E, Jervelund S (2019) Transmitting trauma: a systematic review of the risk of child abuse perpetrated by parents exposed to traumatic events. Int J Public Health 64:241–251. https://doi.org/10.1007/s00038-018-1185-4

Roth M, Neuner F, Elbert T (2014) Transgenerational consequences of PTSD: risk factors for the mental health of children whose mothers have been exposed to the Rwandan genocide. Int J Mental Health Syst 8:12. https://doi.org/10.1186/1752-4458-8-12

Ruby Reid-Cunningham A (2008) Rape as a weapon of genocide. Genocide Stud Prev 3:279–296. https://doi.org/10.1353/gsp.2011.0043

Schabas WA (2005) Genocide trials and gacaca courts. J Int Crim Justice 3:879–895. https://doi.org/10.1093/jicj/mqi062

Schimmel N (2011) The Agahozo-Shalom youth village: community development for Rwandan orphans and its impact on orphaned genocide survivors. Prog Dev Stud 11:243–250. https://doi.org/10.1177/146499341001100305

Self-Brown S, Lai BS, Harbin S, Kelley ML (2014) Maternal posttraumatic stress disorder symptom trajectories following Hurricane Katrina: an initial examination of the impact of maternal trajectories on the well-being of disaster-exposed youth. Int J Public Health 59:957–965. https://doi.org/10.1007/s00038-014-0596-0

Uwizeye G, Lee BX, Kroll T (2016) Health system redesign following sexual violence during the genocide in Rwanda. Int J Public Health 61:959–960. https://doi.org/10.1007/s00038-016-0873-1