# Can We Be Fair? Balancing the Personal with the Professional Response to Terrorism

Denise Ellis, Ph.D., C.S.W.
Kean University

*Journal of Social Work Values and Ethics*, Volume 3, Number 1 (2006) 

**Abstract**
Given the recent terrorism events in the U.S. and the ongoing threat of additional acts, it is imperative that social workers consider the ethical implications that affect the ability to provide for clients, students, and ourselves. This paper examines the role of core values of the NASW Code of Ethics, personal values, fears, safety concerns, limitations and strengths as social workers practice in the new era of terrorism.
*Keyterms:* Values and ethics, terrorism, September 11th, disaster, post-traumatic stress disorder (PTSD)

## Introduction

Acts of terrorism have been in the nation's spotlight since 9/11. Terrorism impacts everyone either directly or indirectly. Social workers are human first and are not immune to the recent and ongoing events and threats of terrorism. They also experience the same fear, anger and personal safety concerns as the general population in response to dramatic images of violence, mayhem, death and destruction. Consequently, American values and beliefs based on equality, free speech, freedom to practice religion, and right to privacy have been called into question. While it is dangerous in other parts of the world, living in the U.S. has also become potentially dangerous. Neither race, ethnicity, educational or economic status, nor religion is a guarantee of safety in the U.S. (Ellis, 2004). As a result, there may be a gap for some social workers between their personal and professional responses. The highly emotionally charged atmosphere requires that social workers critically examine any bias or prejudice that may exist. Failure to do so would compromise practitioner effectiveness.

The profession of social work is guided by a Code of Ethics that parallels American values and provides a moral road map to enhance practice. The National Association of Social Work (NASW) urges an examination of a role for the United States in working in cooperation with other nations, to reduce inequity and wide discrepancies that contribute to social injustice and resentments that may in turn lead to conditions that spawn terrorism. Furthermore, they attempt to put some of these variables in perspective, and to prepare the profession for possible future attacks. NASW (2002) refers to a prediction by (Johnson, 2000) who suggests, "Given its wealth and power, the United States will be a prime recipient in the foreseeable future of all of the more expectable forms of blowback, particularly terrorist attacks against Americans in and out of the armed forces anywhere on earth, including within the United States" p. 223.

This paper examines the challenge for social workers to practice in an era of terrorism events in the U.S. and the challenge to balance our personal and professional responses. Terrorism is defined in this article as "the unlawful use of force and violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives" (FBI, 2001). Ethical considerations that affect social workers' ability to provide for us, clients directly and indirectly affected by terrorism, and students are also addressed. A review of research suggests a relationship between values and ethical principles. This paper will highlight the historical effects and current research on the effects of war and terrorism, social work values and ethical principles that guide practice. In addition, the responses of the professions of psychiatry, public health, education and social work are identified. This is followed by a discussion of the ethical implications of the core values in the Code of Ethics as they apply to service provision to people directly and indirectly affected by terrorism.

**Historical Effects of War and Terrorism**

Since the American Revolution the United States has been attacked four times. The attacks were the bombing of Pearl Harbor in 1941, the first bombing of the World Trade Center (WTC) in 1993, the Oklahoma City bombing in 1995 and the second bombing of the WTC in 2001. Both bombings of the WTC and the Oklahoma City bombing were carried out by individuals with no known ties to any government and were labeled as terrorist attacks. In contrast, the attack on Pearl Harbor was considered an act of war by the U.S. government. An act of war is an attack on one

country carried out by a government of another country. Terrorist attacks are acts implemented by individuals who appear to operate outside government channels, but who may have government ties.

During WWI and WWII, the majority of research on the effects of stress was conducted on military personnel, by the U.S. Army and the U.S. Navy, rather than on civilians. A review of historical literature covering the periods of WWI and WWII chronicled the reactions of American and British soldiers under the stress of combat (Appel & Beebe, 1946). War neurosis, operational fatigue, combat stress and shell shock were the initial terms used interchangeably for a range of symptoms that came to be known as Post Traumatic Stress Disorder (PTSD). Of the western nations involved in WWI, the British military were the furthest behind in understanding trauma. WWI British military authorities attempted to suppress reports of psychiatric casualties because of the demoralizing effects on the public (Showalter, 1985). Three hundred and six British soldiers exhibiting symptoms of shell shock, including confusion, and walking around dazed and listless, were subsequently executed for what would now be labeled PTSD. The executed soldiers were accused of being weak, inadequate and cowardly (UK National Workplace). Additional symptoms included, but were not limited to exhaustion, anxiety, fear, sleeplessness, irritability and aggressive behavior (Grinker & Speigel, 1945).

Research conducted during and immediately following WWII provided additional information about the re-entry experiences and the impact of combat related stress for soldiers, their families, and the communities to which they returned. During this period, psychiatrists, rather than social workers played the major role in the provision of mental health services to armed forces personnel and their families, with the primary intervention being psychotherapy (Grinker & Spiegel, 1945). Since WWII, social work has increasingly assumed a central role in the provision of psychotherapy.

The syndrome of chronic trauma has evolved to include symptoms of anxiety, agitation, constant state of vigilance, intense fear, chronic apprehension of doom, nightmares, irritability and feeling of detachment (Herman, 1992; Straussner & Phillips, 2004). Additionally, those affected by PTSD commonly experience issues around basic trust and questioning of faith (Herman, 1992). It was not until 1980 that the American Psychiatric Association included ‘post-traumatic stress

disorder' in its official manual of mental disorders (Herman, 1992; American Psychiatric Association, 1980).

Several parallels exist between the response of citizens during the next era, the Cold War and the post 9/11 era. First, during the Cold War era, when the threat of nuclear annihilation existed, the U.S. government, then as now, advised citizens to be prepared for an attack. A retired social work educator related her experience during this period. "Americans knew there was a threat, something to which we needed to be alert. However, although the government presented the threat as imminent, average Americans went on with their lives" (Personal communication). Second, public buildings of the time had air raid shelters, equipped with non-perishable food and other supplies, to be used in case of an attack. These shelters were the forerunners of 'safe rooms' that today's Americans were recently encouraged to prepare in their homes by the Dept. of Homeland Security. In addition to traditionally recommended supplies, duct tape and plastic sheeting have been added. Third, individuals and groups who were viewed as a threat to national security were targeted and discriminated against.

An explanation of recent targeting is based on the U.S. government conclusion and subsequent public awareness that Osama bin Laden and all nineteen hijackers who commandeered planes on 9/11 had the following characteristics: 1) they were Muslim males; 2) from the Middle East, (most from Saudi Arabia); and 3) were identified as members of Al Qaeda. Since 9/11, pictures have routinely been displayed of menacing looking men in turbans, often brandishing weapons. Those who fit the profile of suspected terrorists have been officially and selectively denounced, with the accompanying emotional response of moral revulsion (Ahmad, 2001). The difficulty is not knowing with certainty who is and is not engaged in terrorist activities. However, it is a short leap for the public, to view anyone with any of the above characteristics as suspicious if not guilty of terrorism.

**Recent Research on the Effects of Terrorism in the U.S.**

There is a paucity of data and information about the ongoing effects of terrorism on people in the U.S. prior to 9/11. This is primarily due to the extremely limited number of terrorist attacks that have occurred on U.S. soil.

**World Trade Center Bombing 1993**

This was the first attack on U.S. soil since the bombing of Pearl Harbor. One account of the experiences and impact of the World Trade Center bombing in 1993 on children in the immediate vicinity was discovered in the literature. Some children were stuck in an elevator in a nearby elementary school during the bombing. They later received crisis counseling. Webb (1994) noted that "school personnel tended to discount the impact of the response on children... [but] some parents later reported that their children continued to experience sleep disruptions, and that some were afraid to go on elevators" (p.15).

**Oklahoma City Bombing**

The major attack in terms of loss of life that occurred in the latter half of the last century was the Oklahoma City bombing in 1995. The Traumatic Stress Studies Program, of the (Department of Psychiatry of the Mount Sinai School of Medicine, 2004) concluded the following after a review of the research about the effects of the event and ongoing trauma on citizens directly involved:

- Survivors reported increased anxiety, depression, increased use of alcohol, stress and PTSD symptoms a year after the bombing (North, Nixon, Shariat, Mallonee, McMillen, Spitzanagel & Smith, 1999).
- "Two years after the bombing, 16% of children and adolescents who lived approximately 100 miles from Oklahoma City reported significant PTSD symptoms related to the event" (Pfefferbaum et al, 1999).
- In the Oklahoma City bombing "adults who sought mental health services had reactions of being nervous and being upset by how other people acted when the bombing occurred was predictive of PTSD" (Tucker, Dickson, Pfefferbaum, McDonald & Allen, 1997).

Moreover, they predicted that the community would function as a critical source of support and help those directly and indirectly affected to overcome symptoms associated with trauma. It was their belief that symptoms if present would lessen with time (Department of Psychiatry of the Mount Sinai School of Medicine, 2004).

**9/11 Attacks**

A review of the literature revealed limited results of any mental health studies on civilians who were at any of the Ground Zero sites. The New York City Department of Health and Mental health is conducting a long-term study on the health impact of 9/11 on the people who lived and worked in the area of the World Trade Center and emergency responders. Toward this end, they

have developed the World Trade Center Health Registry to identify and track the data. To date, 40,000 have registered (NYC Dept. of Health and Mental Health).

Bocanegra & Brickman (2002) conducted a study on 77 displaced Chinese workers in the vicinity of the World Trade Center complex. The results indicated, "One third of the sample was classified as at least moderately depressed, and 21% met diagnostic criteria for post-traumatic stress disorder; however, few had utilized mental health services (p. 55).

**Psychiatry, Public Health, Nursing and Education Policy Responses**

Psychiatry, public health professionals, education and nursing have all issued professional policy statements in response to recent terrorism events. Each addresses the impact, role and responsibilities on and of its members.

**Psychiatry**

Psychiatry developed a "Traumatic Stress Studies Program" which is housed in the Department of Psychiatry at the Mount Sinai School of Medicine. The program is designed to function as a resource for other professionals. The literature on psychiatry and terrorism also includes articles on, the neuro-psychiatric effects of domestic terrorism with chemical or biological agents (DiGiovanni, 1999) and the role of an 'on-line response to terrorism' (Kennedy, 2002).

**Public Health**

The public health profession views keeping people healthy as its primary function and has identified a role and strategy for its members in response to terrorism. The Board on Neuroscience and Behavioral Health of the Institute of Medicine, in addressing the role of the public health profession stressed that in order to fulfill their responsibility to the public, they will need to "Address the physical, psychological, and social needs that result from the range of terrorism events or hazards (conventional explosives, biological, radiological, chemical, nuclear attacks) will require universal preparedness by all systems responsible for the public's health" (Board on Neuroscience and Behavioral Health, Institute of Medicine, 2003 , p.3). In addition, public health professionals are expected to identify and track disease patterns (Johns Hopkins University, Civilian Biodefense Studies Center, 2001).

**Nursing**

The International Council of Nurses (2001) issued a position statement for nurses on Emergency Preparedness. In it they stress, "In the event of terrorist attacks nurses and other health professionals need to work with other groups and the public to address concerns and provide health services" (International Council of Nurses, 2001, p.1). Toward that end, nurses are expected to be prepared to "allay public concerns and fear of bioterrorism and identify feelings that they and others may be experiencing" (International Council of Nurses, 2001, p.2). An additional focus of intervention for nurses is the responsibility to familiarize them with bioterrorism, which includes the use of chemical and biological agents as weapons. Nurses and social workers face a similar dilemma of balancing their personal and professional responses to patients. Similar to the NASW Code of Ethics, the International Code of Ethics for Nurses clearly states, "nurses are ethically bound to provide care to all people" (ICN Code of Ethics, 2000).

**Education**

The Educators for Social Responsibility, a national organization of teachers in lower education, felt compelled as an organization to develop a list of guidelines and recommendations to help teachers address terrorism and war in the classroom. This response resulted partially from anger, fear and concerns expressed by students. The comprehensive list: 1) helps teachers intervene to help students cope with their feelings of rage, revenge and prejudice about the death of a relative or friend, and 2) proposes approaches to teaching elementary school children about the war and other violence in the world (Educators for Social Responsibility, 2003, p.7-8).

In a review of the literature, this author discovered an interdisciplinary committee of psychiatrists, social workers and public health professionals, formed to assess options for responses to terrorism. They assessed peer reviewed "trauma and disaster mental health studies and relevant data on consequences of and responses to terrorism"(Board on Neuroscience & Behavioral Health, 2003, p.2). Each of these professions has as its central mission, helping to enhance and improve some aspect of health. Working collaboratively will increase the ability of each profession to help people preserve and enhance physical and mental health in light of recent and ongoing threats of terrorism.

**NASW Code of Ethics and Terrorism**

The Code of Ethics provides ethical principles to help social workers answer who, what, when, where and how to guide our professional response to practice. The Delegate Conference of the American Association of Social Workers adopted the first Code of Ethics in 1947. The concept of social justice was not mentioned specifically until 1993, after the code underwent several revisions. The core values, which serve as the foundation of our work, include service, social justice, dignity and worth of the person, competence, integrity and competence.

An ever-growing list of social problems coupled with dramatic advances in technology and the development of new treatment strategies has resulted in refinement of the Code of Ethics and its core values. Domestic violence, HIV/AIDS, school shootings, and terrorism require social workers to constantly expand their knowledge base in order to remain current with these social problems. Currently, NASW does not have a binding policy statement on terrorism. This is puzzling since for one hundred years the social work profession has maintained a tradition of being in the vanguard of upholding and defending the rights of vulnerable populations and promoting social justice. Social work, similar to other helping professions needs to develop best practices for its members. Responses to terrorism may confront social workers with a variety of stressor's and place them in ethically difficult situations. It is anticipated that the social work profession, similar to other helping professions, will begin the process of determining what additional resources, tools and strategies the profession must have in response to terrorism. Some questions to be considered are, for example:

- Are the issues and implications of terrorism significantly different from other practice issues, and if so, do the traditional guidelines apply?
- How should social workers balance their personal and professional responses to the threat on ongoing terrorist attacks? Unlike other practice and political issues, their existence may hang in the balance.
- Who should decide what the best/most effective intervention is for working with individuals, groups and populations from regions thought to support terrorist beliefs and goals?
- When, if ever should social workers discontinue directly providing service to clients if they are having difficulty managing possible fears and prejudices?
- Where should social workers turn to for accurate, timely information about terrorism?
- What procedure should a social worker follow, if they suspect a client of involvement or support of terrorist activities?

**Core Social Work Values**

*Service*

The (NASW Code of Ethics, 1999) states that a "Social workers primary goal is to help people in need and to address social problems". In times of disaster (whether natural or manmade), and or terrorism, helping professionals can be counted on to help those experiencing trauma, to the best of their ability. In these situations, social workers provide crisis intervention, mental health counseling and other concrete services. The professional role is evident. However, the question remains as to what extent can service be provided to others when the helping professional may be struggling with his or her own personal need for comfort and safety concerns?

Research is currently being conducted to assess how social workers in various fields of practice have been functioning in the post 9/11 era. However, much of what is known is anecdotal and related by social workers in various fields of practice. For example, attitudinal changes were identified by a New York metropolitan area Critical Incident Stress Debriefer, who is also an emergency medical technician (EMT), with a long history of providing emergency services to victims of various types of disaster and trauma, including law enforcement, fire personnel and victims of 9/11. She indicated that "Terrorism affects everyone's life on a day-to-day basis". She admits that her attitude toward "Arab looking" men has changed since 9/11. She shared for example, that prior to 9/11, if she observed a group of "Arab looking" men, she wondered if they were going to be buying another convenience store? Post 9/11, she admits one thought is, "I wonder if they are terrorists, planning an attack" (Personal communication). She reports feeling troubled by what she realizes are stereotypical attitudes.

She has also observed a consequence of providing service on some debriefers. She noted that in her personal experience, some debriefers "keep their feelings in and let them out in very inappropriate ways and at inappropriate times." Several examples of behavior she noted in colleagues, particularly since 9/11 include: 1) having difficulty re-establishing boundaries between one's personal and professional responsibilities; 2) experiencing acute symptoms of sleep and appetite disturbance; 3) increased tension with co-workers; 4) constant state of vigilance; 5) being unwilling to accept or respond to co-worker concerns about apparent stress symptoms, and; 6) being unwilling to accept assistance from colleagues, family or friends.

A review of the literature has not yielded any published data identifying the impact of 9/11 personally and professionally on social workers who were at Ground Zero. We need to determine needs and experiences of the following social workers: 1) those who were living or working at or near Ground Zero; 2) those who provided service to clients directly and indirectly affected; 3) practitioners in other regions of the country; and 4) those in various fields of practice. Some questions to be explored are: have there been any changes in how service is provided, considering social workers are among the potential targets of terrorists just by living in the United States? Additionally, is it a challenge to "elevate service to others above self-interest" as the code further asserts?

*Social Justice*

The Code of Ethics challenges social workers to "strive to ensure equality of opportunity, access to needed information, services, resources, and meaningful participation in decision making for all people". During these turbulent times, people from vulnerable populations and from regions associated with terrorism are at increased risk of being the victims of discrimination and prejudice. The profession has traditionally championed the rights of those at risk and not able to speak for themselves. Toward this end, it has participated in the 'War on Poverty', 'War on Drugs', and most recently, the 'War on Terror'. In the case of the most recent 'war' social workers work to support individuals and or groups being discriminated against because they may be of Arab descent, from the Middle East, Muslim or may have characteristics perceived by the general population as similar. Additionally, social workers may work to support individuals or populations opposed to the U.S. government 'War on Terror' and or strategies to combat the 'war'.

Holody (2004) asserts that "...to maintain social work's relevance in a world that includes mass violence and the conditions that give rise to such acts by individuals, groups and nations, social work must reassess its values, define their relevance to changing conditions, and actively work to better the conditions of human life" (p. 187). Since its inception, the profession has worked to advance the rights of the oppressed. This history and the lessons learned provide a unique opportunity to reach out to and work with other helping professions in a concerted effort to bring about nuclear disarmament, peace and social justice that would benefit humanity. The profession does have an obligation to confront policies that we view as unjust, unfair and discriminatory.

*Dignity and Worth of a Person*

Social workers are committed to promoting each individual's right to be treated with dignity, respect and worth. Can social workers genuinely uphold this value and remain unbiased when working with individuals or populations, when fear, hostility or anger may be present? Social work professionals have a worldview based on acceptance and equality of all. However, until research suggests otherwise, there is no reason to think social workers would not experience a wide range of feelings, mirroring those of the general population. As practitioners it is imperative that we acknowledge and work through our feelings about possible terrorists and those who support the goals of terrorists. Other helping professionals must also struggle with conflicted feelings in their work with patients and clients. The (International Council of Nurses, 2001) affirms "In the aftermath of terror even health care professionals can feel bias, hatred, vengeance, and violence towards ethnic or religious groups that are associated with terrorism" p.2. Instances of social worker responses to feelings about terrorists have been identified as ranging from no feelings to anger, prejudice, fear and a need for revenge. These responses were identified as part of an ongoing research study being conducted by this researcher and through individual contacts with colleagues, particularly, those in the New York metropolitan area.

Social workers have the theory, skills and Code of Ethics to guide practice. One crucial question becomes what to do with our feelings. Reamer (2001) suggests "For many of us, the terrorism seems to have assaulted our values, as well as the human victims. Is it humanly possible for social workers to respect the dignity and worth of terrorists, or should we even be expected to?" p. 23. The answer it seems is still unfolding. As professionals, we have parallel instances of working with child molesters and abusers, all of whom elicit powerful feelings. It's not easy to respect and uphold the rights of terrorists. Social workers vary in their ability to accept their personal feelings about terrorists and terrorist attacks, while adhering to the tenets of the Code of Ethics. A critical difference that distinguishes our feelings about work with groups associated with terrorism is the knowledge that terrorists are dedicated to committing violence, and if necessary, murder of U.S. citizens to advance their objectives. From an ethical standpoint there should be no difference in the way social workers practice, whether or not they are at personal risk. It remains to be seen to what degree our professional responses are influenced by safety concerns and or

negative attitudes toward populations suspected of direct or indirect participation or support of 'terrorist' activities. Additional research in this area is needed, as social workers in the United States have little precedent for this ethical dilemma.

*Importance of Human Relationships*

Social workers are dedicated to the promotion of healthy human relationships and identification and facilitation of support systems for client systems. Helping individuals and groups locate resources in their communities is a critical approach in helping people respond to uncertainty and conflict resulting from disaster (Soliman, 1996). Communities can also be a tremendous source of support when coping with terrorism and the ongoing threats (Soliman & Rogge, 2002). Support systems are as important for social workers, as they are for our clients. In this era of uncertainty, related to ongoing threats of terrorism, social workers in all fields of practice must resist the urge to 'go it alone'. Rapoport (1965) cautioned social workers that "in addition, the helping person needs to view himself as intervening in a social system—as part of a network of relationships—and not a single resource" p. 30. Reliance on colleagues, friends and family is critical.

The code states "Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations and communities" (NASW Code of Ethics). This particular value calls upon social workers to utilize our knowledge and work collectively to advocate for policies that: 1) demonstrate an understanding of the importance of human relationships, and 2) rely on non-militaristic approaches to national and international conflicts and threats to peace.

*Integrity*

This principle in the Code of Ethics is based on the assertion that "social workers must behave in a trustworthy manner". It is easy to conclude that this is the easiest of the core values to uphold. However, this may not always be so easy to achieve, when one considers the difficulty that may be encountered when mediating between individuals, groups, communities and or organizations that may have opposing viewpoints. The added element is possible existence of fears and safety concerns related to terrorism and those who support or engage in such activity. Ethical dilemmas related to integrity might arise, when, for example:

- A social worker is assigned to work on behalf of a client system which supports terrorist objectives.
- A social worker is at odds with stated or unstated agency policy regarding the treatment and or disposition of a client system.
- A faculty person has students discuss feelings of anger at those they believe are responsible for terrorist attacks, when they themselves share similar feelings.

Informal reports from some administrators indicate that "social work faculty seem reluctant to take charge and help students process their feelings" (Personal communication, 2004). Baseline data will be needed in this area, but in the meantime, faculties have an obligation to facilitate meaningful class discussions while functioning as honest and responsible role models. The intellectual process and direction are provided by the Code of Ethics when confronted with these dilemmas. However, a lingering question remains as to how social workers should manage their feelings through these unsettling times. It is said that 'the longest trip in the world is between your head and your heart' (Author unknown). Levy (2002) echoes this dilemma when she acknowledges "Professionally and personally, I don't think anyone ever gets used to being a victim of terror" (p. 5).

*Competence*

Social workers need to feel confident about their ability to help others in order to be effective. The (NASW Code of Ethics, 1999) encourages social workers to "continually strive to increase their professional knowledge and skills and to apply them in practice." Current standards for competence in various fields of practice need to be expanded to include terrorism's impact specifically, as opposed to other trauma work, which includes natural disaster (earthquakes, hurricanes) and technological disaster (nuclear plant accidents and chemical spills. The effects of terrorism would be expected to cause even the most skilled social worker to question ability and competence, as U.S. social workers have no frame of reference for this. The post 9/11 era provides an opportunity for social workers in the U.S. to draw from the experience of our colleagues on other continents that have decades of experience dealing with terrorism.

A negligible amount of information exists in the literature regarding competent practice and terrorism. The Red Cross, Salvation Army and International Critical Incident Foundation offer training for social workers and other helping professionals, to provide information and skills that

each organization deems necessary. To date, however, no national standards of competence have been identified.

**Social Work Practice and Post 9/11 Era Realities**

The following realities related to terrorism need to be remembered as social workers respond to client needs precipitated by 9/11 and ongoing threats of terrorism:

1. Populationswhowereatriskbefore9/11arestillatrisk.Wecan'tforgettheseclient systems or their needs. Addressing people's needs post 9/11 simply means that there is an added dimension to professional practice.
2. During times of disaster, there sources of communities and disaster relief organizations may become over-extended. Current government strategies to combat the 'War on Terror' have further exacerbated disproportionate resource availability.
3. Providingdisasterreliefservicesandignoringwarningsignsofone'sownstressand possible burnout have adverse effects. Social workers have the knowledge, tools and skills necessary to help others. It is critical that we simultaneously take care of ourselves. We have an ethical responsibility to try and prevent becoming overwhelmed by symptoms of stress and burnout.
4. Socialworkersknowintellectuallythateveryoneoughttobetreatedequally. However, we may have feelings to the contrary. Those feelings need to be identified, examined and acknowledged.
5. Weneedtoputourprofessionaldifferencesaside.Ourdifferencesrevolvearound debates about theoretical perspectives, approaches, which field of practice is more desirable, and last but not least, destructive battles about clinical versus other types of service provision.

**Conclusion**

Most of us have been touched in one way or another by the terrorist attacks. Our professional stance is shaped in large part by our individual values and beliefs about what is right and wrong and by notions of fairness. The NASW Code of Ethics serves as a moral compass as we navigate through the post 9/11 era. Questions and concerns about personal safety contribute to newly acquired feelings of being vulnerable and expendable. Ultimately, we must decide as a nation, how to live with our feelings and fears in the 21st century and preserve our integrity, dignity and civil liberties.

Because the U.S. has little experience with terrorist attacks on its shores, there is a lack of corresponding research in this area. Current exploration of the moral and ethical implications of terrorism for social work practice is in the infancy stage. If we are not squarely on a proactive path

and making our voices heard, we run an ever-increasing risk of becoming irrelevant in the search for peace and social justice.

**References**


Ahmad, E. (2001). *Terrorism: Theirs & ours.* New York: Seven Stories Press.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of psychiatric disorders*. Vol.3. (DSM III). Washington, D.C.: Author. 236.

Appel, J.W. & Beebe, G.W. (1946). Preventive psychiatry: An epidemiological approach. *Journal of the American Medical Association.* 131. 1468-1471. Quote on p. 1470.

Bocanegra, H. & Brickman, E. (2004). Mental health impact of the world trade center attacks on displaced Chinese workers. *Journal of Traumatic Stress*. 17(1): 55-62. Retrieved July 8, 2004 from http://www.istss.org/publications/JTS_v17_i1.htm

Board on Neuroscience & Behavioral Health, Institute of Medicine, Committee on Responding to the psychological consequences of terrorism. (2003). *Preparing for the psychological consequences of terrorism: A public health strategy.* 19-33. Retrieved July 7, 2004 from http://books.nap.edu/books/0309089530/html/19.html#pagetop

Denzin, N.K (1992). *Symbolic interactionism and cultural studies: The politics of interpretation.* Cambridge, MA: Blackwell.

Department of Psychiatry, Mount Sinai School of Medicine, The Traumatic Stress Studies Program. Year unknown. *What are the traumatic stress effects of terrorism? A national center for PTSD fact sheet*. Retrieved July 16, 2004 from http://www.mssm.edu/psychiatry/tssp/effectsofterrorism.shtml

DiGiovanni, C. (1999). . Domestic terrorism with chemical or biological agents: Psychiatric aspects. *American Journal of Psychiatry*. 156 (10): 1500-1505.

Educators for Social Responsibility. (2003). *Talking with students about violent events-Iraq War Edition.* Retrieved June 17, 2004 from http://www.esrnational.org/guide.htm

Ellis, D. (2004). September 12. *Baccalaureate Program Directors Update Online*. Retrieved November 16, 2004 from http://bpdupdateonline.bizland.com/fall2004/id90.html

Federal Bureau of Investigation. (2001). *Terrorism definition in U.S. Code of Federal Regulations*. Source (28 C.F.R. Section 0.85). Retrieved July 1, 2004 from http://www.fbi.gov/publications/terror/terror2000_2001.htm

Grinker, R. and Spiegel, J. (1945). *Men under stress.* Philadelphia, Pa: The Blakiston Company & Maple Press Company.

Herman, J. (1992). *Trauma and recovery.* New York: Basic Books.

Holody, R. (2004). Social justice in times of mass violence. In Straussner, S. & Phillips, N. (Eds.). *Understanding mass violence, a social work perspective.* pp. 187-202. New York: Allyn & Bacon.

International Council of Nurses (2001). *ICN position statement on nurses and emergency preparedness*. Geneva: ICN. 2. Retrieved July 7, 2004 from http://www.icn.ch/matters_bio.htm

International Council of Nurses. (2000). *Code of ethics for nurses*. Geneva: ICN.

Johnson, C. (2001). *Blowback: the costs and consequences of American empire.* Henry Holt & Company. NY.

Kennedy, R. (2002). *On-line response to terrorism*. Retrieved July 16, 2004 from http://www/psynet.congress.de/second/abstracts_kennedy.htm

Levy, P. (2002). Terrorism and social work practice: Memories of terrorism in Israel. *Baccalaureate Program Directors Update.* 24(2) 5-9.

National Association of Social Work. (1999). *Code of ethics.* Washington, D.C: Author.

National Association of Social Work. (2002). *Policy statement on peace and social justice.* Washington, D.C: Author. 265-269.

New York City Department of Health and Mental Health. Year unknown. *About the world trade center health registry.* Retrieved on July 8, 2004 from http://www.nyc.gov/html/dsh/html/wtc/about.html

North, C., Nixon, S., Shariat, S., Mallonnee, S., McMillen, J., Spitznagel, E. & Smith, E. (1999). Psychiatric disorders among survivors of the Oklahoma City bombing. *Journal of American Medical Association.* 282. 755-762.

Pfefferbaum, B., Nixon, S., Tucker, P., Tivis, R., Moore, V., Gurwitch, R., Pynoos, R., & Geis, H. (1999). Post-traumatic stress responses in bereaved children after the Oklahoma City bombing. *Journal of the American Academy of Child and Adolescent Psychiatry*. 38, 1372- 1379.

Rapoport, L. (1965). The state of crisis: Some theoretical considerations. In Parad, H. (Ed.). *Crisis Intervention: Selected Readings.* Family Service Association of America. New York. 22-31.

Reamer, F. (2001). Social work values resonate, Inspire in the wake of reaction to tragedy. *Social Work Today*. 1 (6) 22-23.

Showalter, E. (1985). *The female malady: Women, madness and English culture.* 1830- 1930. New York: Pantheon.

Soliman, H. & Rogge, M. (2002). Ethical considerations in disaster services: A social work perspective. *Electronic Journal of Social Work @ College of Social Work.* University of South Carolina. 1(1) 1-23.

Soliman, H. (1996). Community responses to chronic technological disaster: The case of the pigeon river. *Journal of Social Service Research.* 22 (1-2) 89-107.

Straussner, S. & Phillips, N. (2004). *Understanding mass violence.* New York: Allyn & Bacon.

The Center for Civilian Biodefense Studies. Johns Hopkins University. (2001). *Enhancing bioterrorism preparedness and response post-September 11: Interim actions for the medical and public health community.* Information sheet. Retrieved October 15, 2004 from http://www.hopkins-biodefense.org/interim.html

Tucker, P., Dickson, W., Pfefferbaum, B., McDonald, N., & Allen, G. (1997). Traumatic reactions as predictors of posttraumatic stress six months after the Oklahoma City bombing. *Psychiatric Services*. 48, 1191-1194.

UK National Workplace Bullying Advice Line. Year unknown. *Stress injury to health and trauma, PTSD Information Sheet*. Retrieve June 17, 2004 from www.bullyonline.org/stress/

Webb, N. (1994). School based assessment and crisis intervention with kindergarten children following the New York World Trade Center bombing. *Crisis Intervention.* 1, 47-59.