Introduction

In recent years, our society has witnessed a sharp increase in abusive, violent, and sexually aggressive behavior by our youth. Violent crime by youth decreased for a period in the last few years of 1990s but, once again, is on the upswing. The violent crimes committed by these children and adolescents have been a consistent social problem despite targeted prevention programs and juvenile school-specific interventions becoming increasingly popular around the country. Violent crimes have increased 2.3% from 2004 to 2005 (U.S. Federal Bureau of Investigation, 2006). The Bureau of Justice Statistics (BJS), investigating murders committed during the years 1974 through 2004, found that almost half of the offenders were under the age of 25 years, and 11% were under the age of 18 years. In 1994, FBI national self-report studies indicated that the highest risk for initiation of serious violent behavior occurred between the ages of 15 and 16, and the risk of initiating violent behavior after age 20 was much lower (Elliott, 1994).

Between 8 and 10% of US high school students carried guns to school each day. In a typical middle-size city, 35–50 cases of school violence were reported daily and in half of these cases, guns were involved (Shaffi & Shaffi, 2001).

Everyday in the USA, 12–13 children and adolescents die of violent death, either from homicide or from suicide (Shaffi & Shaffi, 2001). An additional number of physical injuries at schools occur from gunshot wounds. The spread of endemic school violence from urban settings to suburban and smaller communities has brought this major public health problem to national attention. In the decade between 1990 and 2000, the incidence of tragic school shootings increased across the country. There were school shootings in Pearl, Mississippi, Paducah, Kentucky, Springfield, Oregon, Jonesboro, Little Rock, Colorado, Conyers, Georgia, and Fort Gibson, Oklahoma. Other authors have examined the factors contributing to the increase in school violence, described the changed school environment and the contemporary school community, detailed biological and social causes of school violence, and profiled children and adolescents who may be violent offenders in school systems. In this chapter, after presenting a hypothetical case example, we
will discuss the multifaceted role of the emergency room psychiatrist in the aftermath of a school violence incident (Elliott et al., 1998).

**Case Example**

JM, a 14-year-old boy, brought a duffle bag of weapons to a suburban school on a Monday morning. He brought the loaded duffel bag into a school assembly, attended by sixth, seventh, and eighth graders. In a seemingly random fashion, he began shooting. Tragically, he killed four young students and wounded seven others. His actions terrified the adolescents in the suburban high school, their parents, and the community at large.

JM was seized by the school principal and subdued. School administrators called local police, who brought JM to a midsize hospital emergency room in handcuffs. In the days and weeks that followed this tragedy, other adolescents were seen by the emergency room doctor—some physically wounded and others emotionally traumatized. They were followed by a group of concerned parents, administrators, and the media. The emergency room child psychiatrist played an important role in this traumatic situation.

**Evaluation**

**Confidentiality**

In the acute emergency situation, it is important for the emergency room physician to assess the issues of confidentiality which may be confronted in an evaluation of the perpetrator. The emergency room psychiatrist must provide a clear explanation of the purpose of the assessment. Limits of confidentiality need to be discussed before any information is sought from the victim, family members, or other adolescents. Students and their families need to know what information will be disclosed to other interested parties, such as police and media. They need to know about the psychiatrist’s legal obligations under state law and mandatory reporting, such as duty to warn in the event that additional violence is intended (Schetky, 2002).

During the assessment process, the perpetrator may disclose significant information and then ask that it be withheld from the police and other law enforcement officials. Such information may be related to the violence itself, other psychiatric problems of the youth in question, such as substance abuse and prior family violence, or other issues.

Adolescents, their families, child witnesses, and school officials must understand from the onset the limits of confidentiality, which include the duty to warn (Simon, 2001). The emergency room psychiatrist must also recognize that his or