

Self-Injury Trauma Scale

Patient: _____

Examiner: _____

Date: _____

Part I. General Description and Summary of Healed Injuries

Check each type of self-injurious behavior exhibited by the patient. Next, note any physical evidence of healed injuries (scars, permanent disfigurement, missing body parts), along with the specific site.

Self-Injurious Behaviors:

- Forceful contact with head or face
- Forceful contact with other body part
- Scratching, picking, rubbing skin
- Biting
- Eye gouging
- Ingestion of inedible materials (pica)
- Vomiting or rumination
- Air swallowing (aerophagia)
- Hair pulling (trichotillomania)
- Other: _____

Healed Injuries:

1. _____
2. _____
3. _____
4. _____
5. _____

Part II. Measurement of Surface Trauma

For each area of the body containing a current (unhealed) injury, identify the location and number of wounds, and note the type and the severity of the worst wound at the particular location.

Number:

- Score:
 - 1) - One wound

- 2) - Two to four wounds
- 3) - Five or more wounds

Type:

- Abrasion or Laceration (AL): A break in the skin, either superficial or deep, caused by tearing, biting, excessive rubbing, or contact with a sharp object.
- Confusion (CT): A distinct area marked by abnormal discoloration or swelling, with or without tissue rupture, caused by forceful contact.

Severity:

- Score AL as:
 - 1) - Area is red or irritated, with only spotted breaks in the skin.
 - 2) - Break in the skin is distinct but superficial; no avulsion.
 - 3) - Break in the skin is deep or extensive, or avulsion is present
- Score CT as:
 - 1) - Local swelling only or discoloration without swelling
 - 2) - Extensive swelling
 - 3) - Disfigurement or tissue rupture

Scoring Section

Head

Location	Number	Type	Severity	Comment
Scalp	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	
Ear L/R	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	
Eye L/R	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	

Eye Area L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Face	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Nose	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Lips/Tongue	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Neck/Throat	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	

Upper Torso

Location	Number	Type	Severity	Comment
Shoulder L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Chest/Stomach	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	

Back	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	

Lower Torso

Location	Number	Type	Severity	Comment
Abdomen/Pelvis	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	
Hips/Buttocks	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	
Rectum	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	

Extremities

Location	Number	Type	Severity	Comment
Upper Arm/Elbow L/R	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	
Lower Arm/Elbow L/R	<input type="checkbox"/> 1	<input type="checkbox"/> AL	<input type="checkbox"/> 1	
	<input type="checkbox"/> 2	<input type="checkbox"/> CT	<input type="checkbox"/> 2	
	<input type="checkbox"/> 3		<input type="checkbox"/> 3	

Hand/Finger L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Upper Leg/Knee L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Lower Leg/Knee L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
Foot/Toe L/R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> AL <input type="checkbox"/> CT	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	

Part III. Scoring Summary

A. Number Index (NI)

From Part II, add all of the scores under the Number column and enter the total here: _____

NI Score	Part II Total
<input type="checkbox"/> 0	No Injuries
<input type="checkbox"/> 1	1-4
<input type="checkbox"/> 2	5-8
<input type="checkbox"/> 3	9-12
<input type="checkbox"/> 4	13-16

<input type="checkbox"/> 5	17 or more
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B. Severity Index (SI)

For Part II, enter the frequency of scores from the Severity Column:

- 1: _____
- 2: _____
- 3: _____

SI Score	Part II Total
<input type="checkbox"/> 0	No Injuries
<input type="checkbox"/> 1	All severity scores are 1's
<input type="checkbox"/> 2	One 2; No 3's
<input type="checkbox"/> 3	Two or more 2's; No 3's
<input type="checkbox"/> 4	No more than one 3
<input type="checkbox"/> 5	Two or more 3's

C. Estimate of Current Risk Based on Location and Severity

- Low: No injuries or, Any AL-1, CT-1, or AL-2 except near eyes
- Moderate: Any AL-2 near eyes, Any CT-2 except on head
- High: Any CT-2 on head, Any AL-3 or CT-3

Source: Iwata, B. A., Pace, G. M., Kissel, R. C., Nau, P. A., & Farber, J. M. (1990). THE SELF-INJURY TRAUMA (SIT) SCALE: A METHOD FOR QUANTIFYING SURFACE TISSUE DAMAGE CAUSED BY SELF-INJURIOUS BEHAVIOR. *Journal of Applied Behavior Analysis*, 23(1), 99–110. [THE SELF-INJURY TRAUMA \(SIT\) SCALE: A METHOD FOR QUANTIFYING SURFACE TISSUE DAMAGE CAUSED BY SELF-INJURIOUS BEHAVIOR](#)