Self-Directed Violence in Psychopathic Personality Disorder: A Scoping Review of Methods and Characteristics

by

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Declaration of Committee

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Abstract

Cleckley (1941) described a paradox wherein individuals with psychopathy frequently engage in non-lethal self-directed violence (SDV) yet rarely die by suicide. This scoping review synthesized 142 publications to evaluate whether the empirical literature has tested this observation. Findings suggest that Cleckley's paradox remains unresolved because studies rarely combined a psychopathy measure capturing the affective, interpersonal, and behavioural features he described with an appropriate psychiatric comparison group. Across studies, frequent and repeated SDV was more consistently related to behavioural dysregulation. Affective-interpersonal symptoms generally showed weaker, null, or inverse associations with SDV, with preliminary evidence suggesting that these symptoms were less characteristic of suicide deaths. However, the evidence was limited by inconsistent SDV definitions and insufficient assessment of suicidal intent, lethality, methods, and function. Future research should prioritize suicide mortality, examine overall psychopathy and its domains, use standardized, intent-based SDV measures, and include appropriate psychiatric comparison groups to directly evaluate Cleckley's paradox.

Keywords: psychopathy, antisocial personality disorder, self-directed violence, suicide

Dedication

To my parents, whose support has made all of this possible.

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Generative artificial intelligence (AI) tools (e.g., Google Gemini, ChatGPT) were used after the completion of initial drafts to assist with editing, organization, and argument refinement. Grammarly was used to improve sentence structure and grammar. No AI tools were used to generate text for data coding and analysis.

Table of Contents

Declaration of Committee ii
Abstract iii
Dedication iv
Acknowledgements v
Table of Contents vi
List of Tables viii
List of Figures ix

Chapter 1. Introduction 1
1.1. Psychopathic Personality Disorder 1
1.2. Self-Directed Violence 3
1.3. The Nexus: SDV and PPD 4

Chapter 2. Methods 8
2.1. Identifying the Research Question 8
2.2. Identifying Relevant Studies 9
2.3. Study Selection 10
2.4. Charting the Data 12
2.5. Collating, Summarizing and Reporting the Results 13

Chapter 3. Results 15
3.1. Study Descriptors 15
3.2. PPD Conceptualization and Measurement 17
3.3. SDV Conceptualization and Measurement 19
3.4. Analytical Approaches and Assessment of SDV Characteristics 21
3.5. The Nexus Between SDV and PPD 22

Chapter 4. Discussion 34
4.1. Suicide Mortality and Cleckley's Paradox 34
4.2. Frequency, Methods, Lethality, and Function 35
4.3. Why Cleckley's Paradox Remains Unresolved 36
4.4. Limitations 37
4.5. Future Directions 38
4.6. Implications 39
4.7. Conclusion 40

References 41

Appendix A. 64
Operational Definitions Used for Screening 64

Appendix B. 67
Abstract and Full-Text Screening Criteria 67

Appendix C. 69
Data Extraction Chart 69

Appendix D. 77
Detailed Coding Protocol for the Nexus Between SDV Characteristics and PPD 77

Appendix E. 85
Full Dataset 85

List of Tables

Table 1. Inclusion and Exclusion Criteria 11
Table 2. Study Settings 16
Table 3. PPD Assessment Methods and Instruments 18
Table 4. Suicidal Intent and SDV Recoding Based on Specified Intent 20
Table 5. Measured Characteristics of SDV 22
Table 6. Characteristics of SDV, by SDV type 22

List of Figures

Figure 1. PRISMA Flow Diagram.....12

Chapter 1.

Introduction

Psychopathy refers to a cluster of personality and behavioural symptoms characterized by affective, interpersonal, lifestyle, and antisocial features. Elevated rates of these traits are observed in forensic populations (e.g., 25–47%; Fazel & Danesh, 2002; Hare, 1991) and are also present in a smaller portion of the general population (approximately 4.5%; Sanz-Garcia et al., 2021). In *The Mask of Sanity*, Hervey Cleckley (1941, 1950, 1955, 1964, 1976, 1988) described a clinical pattern in which individuals with psychopathy appeared to engage in frequent self-destructive and risky behaviours yet were rarely observed to die by suicide. Importantly, Cleckley did not suggest an absence of self-directed violence (SDV). Rather, he described a paradox in which non-lethal forms of SDV appeared relatively common, whereas suicide (i.e., death by suicide) appeared comparatively infrequent.

Over time, this observation has been simplified into a broader claim that individuals with psychopathy are immune to suicide. This interpretation often overlooks Cleckley's distinction between fatal and non-fatal SDV and his interpretation that many non-lethal acts lacked an intent to die – distinctions that are essential to evaluating the paradox. In contemporary research, the association between psychopathy and suicide is complicated by significant variability in how both constructs are defined and operationalized. To understand whether the empirical literature has truly addressed Cleckley's paradox, it is first necessary to examine the competing frameworks used to conceptualize psychopathy and the inconsistent terminology used to categorize SDV.

1.1. Psychopathic Personality Disorder

Research on psychopathy is characterized by a lack of clarity and consensus regarding its conceptualization and terminology. Decades of debate have led to multiple definitions, terms, and assessment procedures. Cleckley's (1950) conceptualization was based on sixteen clinical characteristics spanning interpersonal, affective, and behavioural domains. However, he did not view these characteristics as equally fundamental. He gave greater weight to affective symptoms than to behavioural control

and proposed that emotional responses to reward, punishment, shame, attachment, and consequences influenced how individuals learned from experience and directed their behaviour. Behavioural symptoms were part of the clinical presentation, but he viewed some as secondary to the affective features he emphasized.

To operationalize psychopathy, several dimensional models have been proposed. Although these models differ in their organization of symptoms, they generally agree that psychopathy comprises at least three domains: interpersonal, affective, and behavioural characteristics (Cooke & Michie, 2001; Cooke et al., 2004). The Psychopathy Checklist-Revised (PCL-R) conceptualizes psychopathy using two factors. Factor 1 reflects the interpersonal and affective features (e.g., superficial charm, grandiosity, lack of remorse and empathy), whereas Factor 2 reflects the lifestyle and antisocial components (e.g., juvenile delinquency, impulsivity, lack of long-term goals) (Hare, 2020; Hare et al., 1990). Similarly, the triarchic model conceptualizes psychopathy as three related domains: Boldness (e.g., low anxiety, resilience, social dominance), Disinhibition (e.g., impulsivity, emotion dysregulation), and Meanness (e.g., callousness, lack of empathy, exploitativeness; Patrick et al., 2009). Although these models differ in their organization and terminology, both conceptualize psychopathy as a multidimensional construct encompassing interpersonal, affective, and behavioural characteristics. This distinction between overall psychopathy and its component domains is important for the present review. Total or categorical scores indicate whether SDV is associated with the broader psychopathy profile, whereas factor-level findings show whether that association is concentrated in the affective-interpersonal symptoms Cleckley viewed as fundamental or in behavioural dysregulation.

Despite general agreement regarding the core symptom domains of psychopathy, these domains are not consistently reflected in diagnostic classification systems. The Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.; DSM-5-TR; American Psychiatric Association, 2022) uses the term antisocial personality disorder (ASPD), which emphasizes observable behaviours such as criminal activity, deceitfulness, aggression, and impulsivity. Similarly, the International Classification of Diseases (11th rev.; ICD-11; World Health Organization, 2019) uses the term “dissociality” to describe a similar constellation of symptoms. Cleckley’s description included behavioural and antisocial features, but these alone did not define the psychopathy profile he described. His profile also included affective and interpersonal

features, which are not required for an ASPD diagnosis. Consistent with this distinction, individuals with high PCL-R scores are likely to meet diagnostic criteria for ASPD, but most individuals diagnosed with ASPD do not have high PCL-R scores (Hare, 2020; Ogloff, 2006; Warren & Burnette, 2013). As a result, ASPD identifies a broader group characterized primarily by antisocial behaviour, whereas Cleckley described a narrower profile characterized by the combination of affective, interpersonal, and behavioural symptoms.

For study identification and broad descriptive reporting, this review uses psychopathic personality disorder (PPD) as a practical umbrella label for psychopathy and studies using related antisocial personality terminology, including ASPD, sociopathy, and dissocial personality disorder. This is a reporting convention, not a claim that these terms are synonymous or measure the same construct. Each record was coded according to the specific construct and operational definition used, and findings are interpreted separately by construct. The umbrella label therefore allows the literature to be mapped together without treating the underlying constructs as equivalent.

1.2. Self-Directed Violence

Research on SDV is similarly characterized by variability in terminology, definitions, and measurement approaches. SDV is used here as an umbrella term to describe intentional behaviours directed toward the self that result, or have the potential to result, in injury (Mental Illness Research, Education, and Clinical Center, n.d.). This term encompasses both suicidal and non-suicidal behaviours.

The distinction between suicidal and non-suicidal forms of SDV is determined by suicidal intent (i.e., the desire to end one's life). The following definitions are used throughout this thesis. Suicidal ideation refers to thoughts about ending one’s life. A suicide attempt is a non-fatal act carried out with at least some intent to die, and suicide refers to a fatal act with implicit or explicit intent to die (e.g., O’Carroll et al., 1996; Silverman et al., 2007a). In contrast, non-suicidal self-injury (NSSI) involves deliberate self-injury without intent to die and is typically understood to serve functions related to emotion regulation rather than ending one’s life (Nock & Favazza, 2009; Nock & Prinstein, 2004). Although these behaviours may appear similar, distinguishing them is important because they differ in intent, function, lethality, and clinical implications.

Scholars have proposed several systems to differentiate SDV based on intent (e.g., Mental Illness Research, Education, and Clinical Center, n.d.; O'Carroll et al., 1996; Silverman et al., 2007a, 2007b), with these distinctions reflected in diagnostic manuals (e.g., DSM-5-TR and ICD-11). However, a lack of standardized nomenclature (i.e., logically defined terms that are widely understood and mutually exclusive) and clear operational definitions persists across the literature (e.g., Giner et al., 2016; Goodfellow, 2018; Silverman, 2016). This variability often results in multiple terms being used to describe the same behaviour, or a single term referring to behaviours with different levels of suicidal intent. For example, acts of self-injury without suicidal intent are variously labelled as 'self-harm,' 'self-injury,' or 'non-suicidal self-injury', while the term 'deliberate self-harm' has been used to describe both suicidal and non-suicidal acts (Silverman, 2016).

These conceptual inconsistencies are further compounded by highly variable measurement practices. Assessments in the literature range from a single binary question (e.g., "Have you ever attempted suicide?") to comprehensive tools that evaluate frequency, methods, lethality, and intent. As a result, suicidal intent and function are often unspecified, limiting comparability across studies and making it difficult to determine whether a specific act involved intent to die, served another purpose, or both. Together, these inconsistencies mean that studies of SDV often cannot be assumed to be measuring the same phenomenon. This lack of conceptual clarity complicates comparisons across studies and has important implications for interpreting the literature on psychopathy and SDV.

1.3. The Nexus: SDV and PPD

The intersection of the SDV and PPD literature creates significant challenges for evaluating Cleckley's observations. While Cleckley stated that "suicide [is] rarely carried out" by individuals meeting his narrow conceptualization of psychopathy, he emphasized that this apparent immunity was relative rather than absolute (1950, p. 386):

> Instead of a predilection for ending their own lives, psychopaths, on the contrary, show much more evidence of a specific and characteristic immunity from such an act. This immunity, it must be granted, is, like most other immunities, relative.

Importantly, Cleckley's observations were based on comparisons with other psychiatric patients in secure settings. Therefore, his claim of relative immunity did not imply that individuals with psychopathy rarely died by suicide in absolute terms, but rather that suicide was comparably less common than in other psychiatric populations. To account for this relative immunity, Cleckley distinguished lethal outcomes from other self-destructive behaviour, identifying a qualitative difference in the presentation of non-lethal SDV. He noted that suicidal threats and attempts were frequent but described them as "empty" and "bogus," implying that he did not believe they consistently reflected an intent to die (Cleckley, 1950, p. 386):

> Since suicidal threats, like promises and well-formulated plans to adopt a new course, are so frequently offered by these patients, there is good reason to keep in mind the fact that they are nearly always empty. Many bogus attempts are made, sometimes with remarkable cleverness, premeditation, and histrionics.

Under contemporary terminology, an act without intent to die would be classified as NSSI, whereas an act involving mixed or unclear intent would fall under parasuicide. However, Cleckley's descriptions do not provide enough information to classify these acts retrospectively with confidence.

Overall, Cleckley's account outlines a distinct paradox. Among individuals meeting his narrow conceptualization of psychopathy, and relative to other psychiatric patients in institutional settings, the clinical profile is characterized by comparatively low rates of suicide alongside frequent non-lethal SDV that Cleckley interpreted as often lacking a clear intent to die.

Cleckley's observations predate contemporary distinctions between suicidal and non-suicidal behaviours and did not incorporate modern frameworks regarding intent, lethality, or function. As a result, evaluating his observations requires translating his clinical descriptions into testable patterns using contemporary constructs. Specifically, a direct test of Cleckley's observations requires a measure that captures the multidimensional psychopathy profile he described and an appropriate psychiatric comparison group.

These requirements are important because many contemporary studies examine constructs that differ from Cleckley's original description. Because Cleckley described

the paradox among individuals displaying the overall psychopathy profile, total or categorical psychopathy scores can test whether that broader profile is associated with SDV. However, Cleckley's theoretical explanation gave greater weight to affective-interpersonal symptoms than to behavioural symptoms. Factor-level analyses are therefore needed to determine whether that association is more closely related to the affective-interpersonal symptoms Cleckley viewed as fundamental or to behavioural dysregulation.

Studies examining ASPD provide indirect evidence because the diagnosis captures behavioural dysregulation and observable antisocial behaviour without requiring the affective-interpersonal features that distinguished Cleckley's psychopathy from broader antisociality. Elevated SDV risk within these samples may reflect broader externalizing symptoms rather than the specific personality profile Cleckley described. A separate issue concerns the comparison context. Cleckley's observation was based on comparisons with other psychiatric patients in secure institutional settings. An appropriate psychiatric comparison group is therefore required to determine whether people with psychopathy are comparatively less likely to die by suicide.

Beyond construct alignment and comparison context, Cleckley's assertion that suicide is rare implies specific expectations regarding the lethality and methods of SDV. If his observations hold true, SDV in this population should consistently present with low medical severity, a relative predominance of lower-lethality methods, and limited method versatility, consistent with behaviour that is unlikely to result in death. Contemporary models of suicide risk, such as the interpersonal psychological theory of suicide (Joiner, 2005), suggest that engaging in diverse and multiple methods of SDV (i.e., method versatility) habituates individuals to physical pain, thereby increasing their capability for enacting lethal suicide. Accordingly, evidence of frequent use of highly lethal methods, high method versatility, or progression toward increasingly lethal methods over time would be inconsistent with Cleckley's account of relatively non-lethal SDV.

Finally, Cleckley's descriptions suggest expectations regarding both suicidal intent and function. By characterizing these acts as "bogus," he appeared to question whether these acts consistently reflected an intent to die. His references to premeditation and histrionics also suggest that some acts may have served purposes other than death, although he did not clearly identify those purposes. Accordingly,

frequent non-lethal SDV involving absent or limited intent to die would be most consistent with his account. Evidence that some acts served instrumental purposes would also be conceptually compatible with his references to premeditation and histrionics, although he did not directly assess function. However, an instrumental purpose would not by itself establish that suicidal intent or psychological distress was absent. Suicidal intent, instrumental purposes, and psychological distress are not mutually exclusive and may coexist within the same act (e.g., Nock & Prinstein, 2004).

Taken together, evaluating Cleckley's observations requires alignment across four domains: 1) a construct definition consistent with Cleckley's conceptualization of psychopathy; 2) an appropriate comparison group of other mental health patients in secure institutional settings; 3) comparatively lower suicide mortality; and 4) frequent non-lethal SDV assessed in relation to intent, lethality, methods, and function. Studies that use narrower constructs, lack appropriate comparison groups, or rely on ambiguous SDV measures provide only partial evidence regarding his observations. The variability of how PPD and SDV are conceptualized and measured raises a critical question: has the literature actually tested the phenomenon Cleckley described? This scoping review addresses this question by mapping how SDV and PPD are defined and measured, and by examining whether existing evidence can meaningfully confirm or refute Cleckley's observations.

Chapter 2. Methods

Given the heterogeneity in definitions, study designs, and samples in the existing literature, a scoping review was conducted to map the current state of the literature on PPD and SDV. This approach is appropriate when studies employ diverse methodologies and when no prior synthesis has comprehensively examined the topic (Arksey & O'Malley, 2005). This review followed the five-stage framework outlined by Arksey and O'Malley (2005) and Levac and colleagues (2010).

2.1. Identifying the Research Question

Definitions were intentionally broad to capture the full range of studies examining PPD and SDV. The search therefore included psychopathy, ASPD, sociopathy, and dissocial personality disorder, as well as dimensional psychopathy traits assessed in community and subclinical samples. These constructs were grouped under the umbrella term PPD for screening and broad descriptive reporting but were coded and interpreted separately.

During the narrative synthesis, findings were organized according to the construct and measurement approach used. ASPD findings were distinguished from psychopathy findings, and total or categorical psychopathy results were distinguished from factor-level results when this information was reported. This allowed the review to examine both associations with psychopathy overall and differences across its affective-interpersonal and behavioural components.

SDV was defined as any intentional behaviour, communication, or thought directed towards the self that results, or has the potential to result, in injury (Mental Illness Research, Education, and Clinical Center, n.d.). It includes fatal and non-fatal, and both suicidal and non-suicidal behaviours. Although suicidal ideation is not a behaviour, it was included because it is routinely assessed alongside SDV in clinical and research settings. For detailed definitions of PPD and SDV used to screen studies for inclusion, see Appendix A.

This review aimed to address one overarching question: What is the current state of the literature regarding the relationship between SDV and PPD? To answer this, three sub-goals were identified:

1. What are the characteristics of the included studies?
2. How are PPD and SDV conceptualized and measured in the literature?
3. What SDV characteristics are reported in individuals with PPD?

2.2. Identifying Relevant Studies

To conduct a comprehensive scoping review, broad and exhaustive terms were used to search for relevant articles across electronic databases. Keywords were refined using a seed-mining approach (Open Science Framework; see https://osf.io/gjsq3) in which 15 relevant articles (five each from PsycINFO, MEDLINE and Criminal Justice Abstracts) were reviewed to identify commonly used terms. This process identified 7 unique keywords for PPD and 11 for SDV. These terms were combined with additional keywords identified by the author and refined using truncation (e.g., “suicid*”).

The final search string utilized Boolean operators to combine terms related to the two core constructs: (“psychopathy” OR “psychopathic” OR “PCL-R” OR “antisocial personality disorder” OR “ASPD” OR “APD” OR “dissocial” OR “dysocial” OR “sociopath*”) AND (“non-suicidal self-injur*” OR “NSSI” OR “self-harm” OR “self-mutilat*” OR “self-cut*” OR “self-injur*” OR “suicid*” OR “parasuicid*” OR “self-directed violence” OR “self-destructive behav*” OR “suicide-related”).

Seven electronic databases were searched on July 5, 2024. These databases were purposefully selected to facilitate a multidisciplinary identification of relevant studies:

- PsycINFO, PsycTests, and PsycArticles were selected for their focus on psychological research and theory.
- CINAHL was included to capture allied health perspectives, which may address frontline SDV assessment and management.
- ERIC was used to capture literature in education settings and SDV prevention efforts.

- Criminal Justice Abstracts was included because psychopathy and ASPD are especially relevant to justice-involved populations.
- MEDLINE was selected to capture biomedical and psychiatric research.

To ensure the review remained up to date and comprehensive, a second search was conducted on September 22, 2025. This update served three functions: 1) it expanded the search string to include “conduct disorder”, “CD”, and “mortality” for all publication years; 2) it captured any new literature published since the initial search in July 2024; and 3) it incorporated a manual “snowballing” approach. During this phase, the reference lists of relevant review papers and meta-analyses were hand-screened, resulting in additional studies being manually added for screening.

2.3. Study Selection

Search results were imported into Covidence (2025) for screening. Two reviewers (BN and KK) independently screened all titles and abstracts against the inclusion criteria (see Table 1 for Inclusion/Exclusion criteria; Appendix B). The inclusion criteria were based on several considerations:

1. **Language:** Only English-language sources were included. This criterion ensured consistent interpretation of methods across studies by the primary author (BN), who performed the data charting and synthesis.
2. **Publication type:** Journal articles and book chapters were included to maintain consistency in the reporting and scientific rigour of scholarly works. Grey literature was excluded to maintain consistency in reporting standards and accessibility.
3. **Sample:** Participants were required to be primarily adults (≥18 years), consistent with the review’s focus on adult psychopathy and ASPD.
4. **Nexus:** The study must have *intentionally investigated* the relationship between SDV and PPD using narrative, descriptive or statistical techniques.

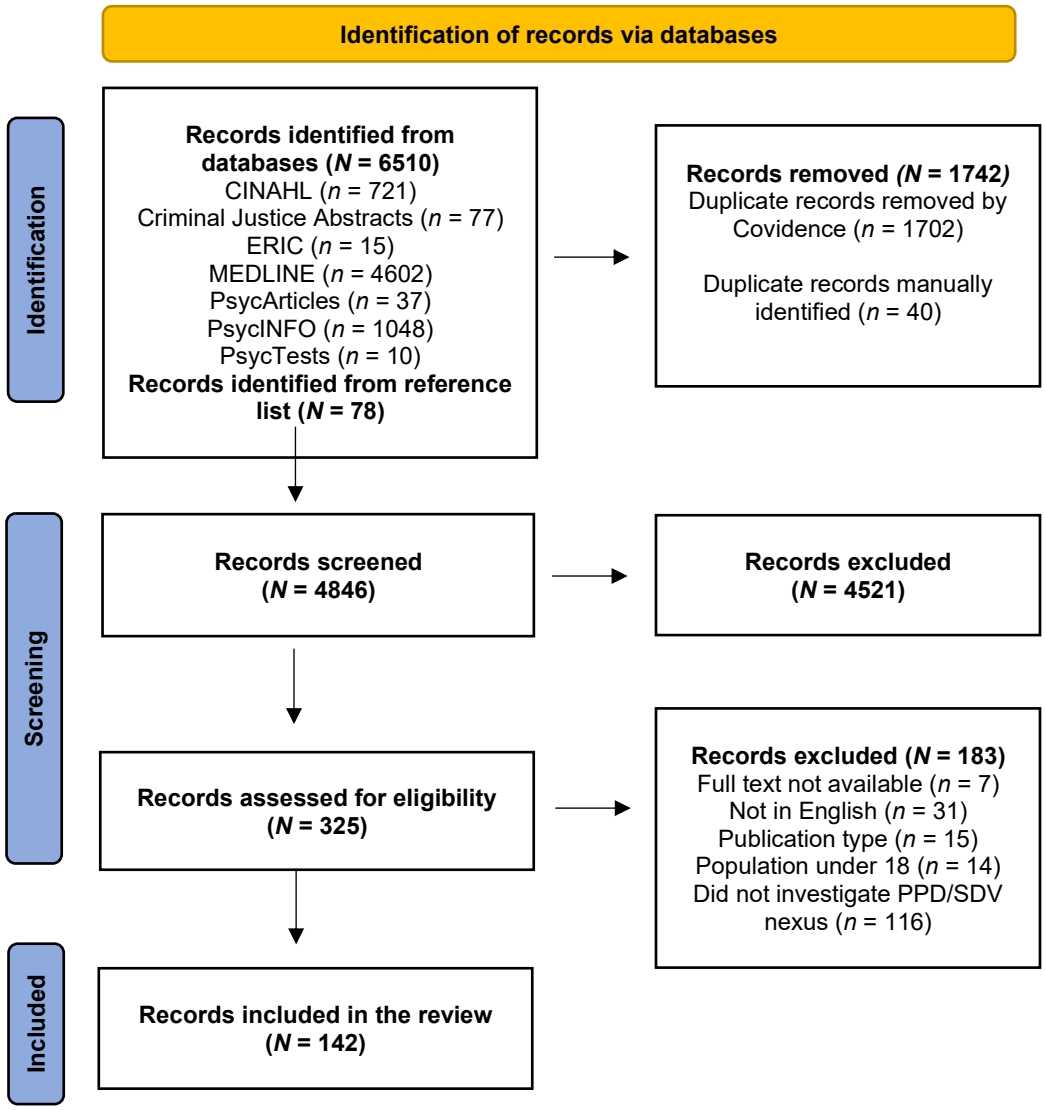
Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
English language	Non-English language
Adult population	Child or youth population
Journal article or book chapter	Books, commentaries, newsletters, conference presentations, theses, grey literature
An intention to examine the nexus between PPD and SDV	Does not intend to examine the nexus between PPD and SDV
Investigation of the SDV and PPD nexus using narrative, descriptive or statistical techniques	Does not investigate the SDV and PPD nexus

Reviewers pilot-screened 50 randomly selected titles and abstracts. This process was iterative; eight pilot rounds were required to refine ambiguous criteria, particularly regarding the definition of the intentional analysis of the PPD-SDV nexus. Once the definitions were refined, a high level of agreement (Cohen's $\kappa = 0.83$) was achieved.

Across the original search and the 2025 update, 6,510 records were identified through database searching, and an additional 78 records were identified through citation searching. After 1,742 duplicates were removed, 4,846 records underwent title and abstract screening. Following title and abstract screening ($\kappa = .88$) and full-text review ($\kappa = .83$), a total of 142 studies met all criteria and were included for data extraction (Figure 1).

Figure 1. PRISMA Flow Diagram



2.4. Charting the Data

Data were charted using a coding guide developed *a priori* (Appendix C). To address the specific research questions, the extracted data were organized into three categories:

1. **Study Characteristics (RQ1):** Variables related to study design, sample demographics, and setting.

2. **Measurement and Conceptualization (RQ2):** Variables related to the tools and definitions used to assess PPD and SDV. PPD variables

included the terminology used by the authors and assessment method. SDV variables included the SDV term used by the study, whether suicidal intent was specified, and whether the outcome reflected suicide mortality, suicide attempt, NSSI, parasuicide, or suicidal ideation.

3. **SDV Characteristics (RQ3):** Variables related to the nature of SDV in individuals with PPD, including lethality, frequency, method, and reported reasons or function. Lethality captured medical seriousness, injury severity, or fatal outcome; frequency captured the number or rate of SDV; method referred to the specific means used; and reported reasons or function captured stated reasons, precipitating circumstances, or directly assessed functions.

The primary author (BN) performed data charting for all studies. To ensure accuracy, double extraction was performed on a subset of studies (*n* = 25; 18%) by the second reviewer (KK), achieving 81% agreement across extracted variables.

During the initial synthesis, additional detail regarding SDV characteristics was required to evaluate Cleckley's observations. Therefore, a second extraction form (Appendix D) was developed to capture lethality, method, frequency and function of SDV.

2.5. Collating, Summarizing and Reporting the Results

Data were summarized using descriptive statistics in Microsoft Excel (version 16.100). Consistent with scoping review methodology (Arksey & O'Malley, 2005), the aim was to map the literature rather than evaluate study quality or synthesize effect sizes. Therefore, no formal risk-of-bias assessment was conducted.

For the purposes of data extraction and analysis, a record was defined as a single eligible item identified in the review. Each record represented either a) one unique participant sample from an empirical publication or b) one synthesis publication (e.g., narrative review, book chapter, meta-analysis) that did not contain participant data. Publications reporting multiple independent participant samples contributed one record per eligible sample.

For the narrative synthesis, SDV outcomes were grouped according to suicidal intent and whether the outcome was fatal, because these distinctions were central to evaluating Cleckley's claims regarding suicide mortality and non-lethal SDV. When a

record reported more than one SDV outcome, each outcome was classified separately according to the available information about suicidal intent. A record could contribute findings to the same category or to more than one category.

Chapter 3. Results

3.1. Study Descriptors

There were 142 unique publications included in this scoping review. However, three publications each contained two unique eligible records, and one publication summarized data from nine different eligible samples (Douglas et al., 2006). Therefore, the total number of records was 153.

To ensure methodological rigour and avoid the double-counting of data, the 153 records were classified according to whether they contained original participant data. Of the 153 records, 145 (95%) contained original participant data. The remaining eight (5%) were non-empirical or synthesis publications, including narrative reviews, theoretical book chapters, and meta-analyses, that summarized data already captured in this review. Accordingly, the 153 records were used to describe how SDV and PPD were conceptualized (sections 3.2 and 3.3), whereas all subsequent analyses were based on the 145 empirical records.

Publication Characteristics

The publication dates of the 142 unique publications ranged from 1920 to 2025, with a marked increase in research activity in recent decades. The majority of publications were published between 2000 and 2025 (*n* = 103, 73%), suggesting increased recognition of SDV as a relevant outcome in PPD research.

Geographically, records with participant data (*n* = 145) were conducted across 28 different countries, though the literature was concentrated in Western contexts. The United States contributed the largest number of studies (*n* = 55, 38%), followed by the United Kingdom (*n* = 11, 8%), Turkey (*n* = 9, 6%), and Canada (*n* = 8, 6%). This distribution may shape how PPD and SDV have been conceptualized and measured.

Participant Characteristics

Among the 145 records with participant data, study settings were classified into three primary categories: forensic (*n* = 62, 43%), clinical (*n* = 59, 41%), and community

(*n* = 29, 20%). Within these broad categories, nine studies (6%) were classified specifically as mortality designs. These differed from other study types because they analysed historical data from deceased individuals rather than actively recruiting living participants, and were categorized according to the population to which the decedents originally belonged (e.g., justice-involved individuals versus deaths in clinical populations).

Overall, the literature is concentrated in forensic and clinical settings, particularly prisons and psychiatric facilities, with comparatively fewer studies conducted in community samples. This distribution indicates that research on PPD and SDV has been based largely on high-risk or institutionalized populations. A detailed breakdown of subcategories is provided in Table 2 and Appendix C.

Table 2. Study Settings

	N (%)
Forensic	**62 (43)**
Jail/prison	40 (28)
Forensic hospital	13 (9)
Community forensics/court-mandated treatment	9 (6)
Mortality	7 (5)
Clinical	**59 (41)**
Inpatient	37 (26)
Outpatient	18 (12)
Unspecified	5 (3)
Mortality	1 (1)
Community	**29 (20)**
University	8 (6)
General population	18 (12)
Military	2 (1)
Mortality	1 (1)

Note. N = 145. The setting for each study may have fallen into multiple categories, so the percentages do not add up to 100%.

Demographics

Demographic reporting was incomplete, and samples lacked racial diversity, limiting the generalizability of findings across cultural contexts. Only 44% of studies (*n* = 64) provided racial or ethnic data. Among the studies that reported this information, samples were predominantly White/European, with these participants comprising an average of 65% of the total sample across studies. Representation of other groups was

substantially lower, including Black/African American (*M* = 30%), Latin American (*M* = 11%), Asian (*M* = 9%), Arab (*M* = 7%), and Indigenous participants (*M* = 6%). This pattern indicates that the available evidence is largely based on White-majority samples and that demographic reporting is inconsistent across studies.

Regarding sex and gender, most samples were mixed *(n* = 90, 62%). When single-sex designs were used, studies focused on males (*n* = 39, 27%) more than three times as often as females (*n* = 10, 7%). Six studies (4%) did not report the sex of participants. It is important to note that sources frequently conflated terms regarding biological sex (e.g., "female") and gender (e.g., "women"). As a result, these constructs were treated as equivalent for data extraction.

Study sample sizes varied widely (*n* = 10 to 69,341). The average age of participants was 32.43 (*SD* = 7.33). Age ranges were reported in 47 studies (32%), spanning from 10 to 88 years old.

3.2. PPD Conceptualization and Measurement

The review first examined how studies defined and measured PPD. ASPD and psychopathy were the dominant terms across the 153 records. Over half of the studies used the term antisocial personality disorder (*n* = 85, 56%) and a comparable portion used psychopathy (*n* = 67, 44%). A small minority used alternative terms such as sociopathy (*n* = 7, 5%) or dissocial personality disorder (*n* = 3, 2%). Because records could examine more than one term, these categories were not mutually exclusive. This pattern suggests that many studies relied on diagnostic frameworks that differ from Cleckley’s conceptualization of psychopathy.

Measurement also varied substantially. Across the 145 records with primary empirical data, a wide range of assessment instruments and diagnostic criteria were used. Despite its status as the gold standard for assessing psychopathy, the Psychopathy Checklist–Revised (PCL-R) and its screening version, the Psychopathy Checklist: Screening Version (PCL:SV) were used in only 25% of studies (*n* = 36). Instead, studies more commonly relied on diagnostic interviews (*n* = 59; 41%) and self-report questionnaires (*n* = 40; 28%). Many diagnostic interviews were anchored to ASPD or related criteria emphasizing observable antisocial behaviour. Consequently, much of

the literature assessed behavioural and antisocial symptoms without requiring the affective-interpersonal characteristics that distinguish psychopathy from broader antisociality. A complete breakdown of the specific instruments, organized by assessment method, is presented in Table 3. See Appendix E for the full list of PPD measures used in each study.

Table 3. PPD Assessment Methods and Instruments

Assessment Method	Instrument	Construct	N (%)
Interview	AUDADIS	ASPD	3 (2)
	DIS	ASPD	7 (5)
	IPDE	ASPD	4 (3)
	MINI	ASPD	8 (6)
	SCID	ASPD	22 (15)
	SIDP-IV	ASPD	3 (2)
	Unspecified interview		10 (7)
	Other interview instruments (used in < 3 records)		5 (3)
Self-Report Questionnaire	LSRP	Psychopathy	4 (3)
	MMPI-2-RF Triarchic Scales	Psychopathy	3 (2)
	PAI	Psychopathy	6 (4)
	PDQ	ASPD	7 (5)
	PPI	Psychopathy	8 (6)
	Short Dark Triad	Psychopathy	4 (3)
	SRP	Psychopathy	3 (2)
	TriPM	Psychopathy	4 (3)
	Other self-report instruments (used in < 3 records)		9 (6)
Clinician-Rated Form	PCL-R	Psychopathy	24 (17)
	PCL:SV	Psychopathy	12 (8)
	Other clinician rated instruments (used in < 3 records)		2 (1)

Note. N = 145. Specific instruments are listed individually only if they were used in three or more records. Low-frequency instruments are aggregated into "Other" rows. Instrument counts may exceed category totals because some records used more than one measure. *AUDADIS* = Alcohol Use Disorder and Associated Disabilities Interview Schedule; *DIS* = Diagnostic Interview Schedule; *IPDE* = International Personality Disorders Examination; *LSRP* = Levenson Self-Report Psychopathy Scale; *MINI* = Mini-International Neuropsychiatric Interview; *MMPI-2-RF* = Minnesota Multiphasic Personality Inventory-2-Restructured Form; *PAI* = Personality Assessment Inventory; *PCL-R* = Psychopathy Checklist-Revised; *PCL:SV* = Psychopathy Checklist: Screening Version; *PDQ* = Personality Diagnostic Questionnaire; *PPI* = Psychopathic Personality Inventory; *SCID* = Structured Clinical Interview for DSM; *SIDP-IV* = Structured Interview for DSM-IV Personality; *SRP* = Self-Report Psychopathy Scale; *TriPM* = Triarchic Psychopathy Measure.

3.3. SDV Conceptualization and Measurement

Consistent with the challenges identified in the introduction, the operationalization of SDV varied widely across the literature. Across the 153 records, authors used diverse terms, most commonly suicide attempt (*n* = 75; 49%), suicidal ideation and plans (*n* = 34; 22%), suicide (*n* = 21; 14%), and self-harm (*n* = 18, 12%). Forty studies (26%) examined more than one SDV behaviour, indicating that multiple forms of SDV were often considered within a single study.

A review of definitions revealed substantial variability in how suicidal intent was specified and measured (see Appendix C for definitions of suicidal intent). Because suicidal intent is most relevant for distinguishing between suicide attempts, NSSI, and parasuicide, intent coding was applied to studies examining self-directed acts rather than suicidal ideation, plans, or threats. As shown in Table 4, most act-based SDV outcomes involved mixed, unclear, or unreported intent (*n* = 94, 61%). In comparison, fewer records specified the presence of suicidal intent (*n* = 38, 25%) or absence of suicidal intent (*n* = 20, 13%). For example, many studies assessed suicide attempts using a single item (e.g., “Have you ever attempted suicide?”). Although this implies intent, it does not explicitly address or quantify it. This lack of intent specification complicates distinctions between suicidal and non-suicidal behaviours within the literature.

To address the ambiguity in terminology, act-based SDV variables were recoded based on the presence of reported suicidal intent (Table 4). Outcomes with explicit intent were classified as suicide attempts, outcomes with absent intent were classified as NSSI, and outcomes with mixed, unclear, or unreported intent were classified as parasuicide. Suicide ideation, plans, threats, and suicide deaths were retained as separate categories. Following recoding, parasuicide was the most common SDV classification, indicating that a substantial portion of reported suicide attempts and self-harm in the literature involved unclear or mixed intent. Because Cleckley questioned whether non-lethal acts reflected an intent to die, the predominance of mixed, unclear, or unreported intent is especially important. For most studies, it cannot be determined whether the behaviours align with his description of non-lethal SDV.

Table 4. Suicidal Intent and SDV Recoding Based on Specified Intent

Variable	N (%)
Intent Measured/Specified for Act-Based SDV	
Suicidal intent present	38 (25)
Suicidal intent absent	20 (13)
Mixed, unclear, or not reported	94 (61)
Recoded SDV based on suicidal intent	
Suicide attempt (intent explicit)	17 (11)
Non-suicidal self-injury (intent absent)	20 (13)
Parasuicide (intent not reported/mixed)	94 (61)
Suicidal ideation, plans, threats	34 (22)
Suicide	21 (14)

Note. *N* = 153. Studies may have assessed multiple forms of SDV, so the percentages do not add up to 100%.

Measurement Tools

Among the 145 records with primary data, SDV was assessed using a variety of assessment methods. The most common approach was self-report measures (*n* = 55; 38%), followed by interviews (*n* = 39; 27%), file review (*n* = 22; 15%), and clinician-rated forms (*n* = 19; 13%). In 25 studies (17%), the method used to assess SDV was not specified.

Among studies utilizing interviews, the protocol was often unspecified (i.e., no standardized measure stated; *n* = 23; 16%). Similarly, 13 studies (9%) relied on an unspecified questionnaire. When standardized tools were employed, the Beck Scale for Suicide Ideation (BSS; *n* = 6, 4%) was the most frequently used self-report measure, and the Beck Suicide Intent Scale (SIS; *n* = 10, 7%) was the dominant clinician-rated measure. Notably, the use of unstandardized or unspecified data collection tools introduces substantial methodological variation, making it difficult to directly compare SDV outcomes across different study designs.

Temporal Assessment of SDV

Most SDV data were collected retrospectively (*n* = 131; 90%), most commonly using lifetime reporting periods (*n* = 69; 48%). Retrospective assessment occurred across study designs: cross-sectional studies asked participants to recall past SDV and longitudinal studies asked participants at follow-up to report events that had occurred

since the previous assessment. No studies assessed SDV in real time (i.e., ecological momentary assessments). These retrospective approaches limit precision regarding when SDV occurred and how its frequency or severity changed over time. Although 20 studies (14%) were classified as using a longitudinal design, follow-up periods were brief, most commonly one year or less (*n* = 12; 8%), providing limited evidence regarding longer-term SDV and suicide mortality.

3.4. Analytical Approaches and Assessment of SDV Characteristics

Regarding the analytical methods used to examine the relationship between SDV and PPD, 34% of the studies (*n* = 50) reported both descriptive and statistical analyses. Nearly half of the studies (*n* = 69, 48%) relied solely on statistical models (e.g., regression, t-tests) without reporting descriptive data specific to participants meeting the PPD-related definition used in each study, whereas 19% (*n* = 28) reported descriptive statistics only.

Testing Cleckley's observations requires information beyond the presence or absence of SDV. Specifically, evaluating his paradox requires data on the specific characteristics of the acts, including the lethality, frequency, method, and reported reasons or function. However, of the 145 empirical records analysed, the majority (*n* = 84, 58%) did not assess any of these SDV characteristics, focusing instead on broad prevalence rates. Among the minority of studies that did report specific characteristics, lethality and frequency were the most common variables. Only 18 studies (12%) reported SDV methods and six studies (4%) reported reasons, precipitating circumstances, or functions (see Table 5). This pattern shows that most studies measured whether SDV occurred, but not the features needed to evaluate Cleckley's claims about lethality, intent, or possible instrumental purposes.

Table 5. Measured Characteristics of SDV

Characteristic Measured	*N* (%)
At least one characteristic measured	61 (42)
Type of SDV methods used	18 (12)
Consequences or lethality of SDV	34 (23)
Death	20 (14)
Non-lethal SDV	14 (10)
Reported reasons or function of SDV	6 (4)
Frequency or number of SDV incidents	31 (21)
None measured	84 (58)

Note. N = 145. A study may have measured multiple SDV characteristics, so the percentages do not add up to 100%.

3.5. The Nexus Between SDV and PPD

The narrative synthesis focused on records that reported the frequency, lethality, methods, or reported reasons and functions of SDV. Given the identified gaps in the literature, this synthesis focuses on the nature of SDV to provide a more nuanced context for the available evidence. Table 6 shows how these characteristics were distributed across SDV outcomes. The findings are organized by outcome because suicidal intent and whether the act was fatal are central to evaluating Cleckley's observations. Outcomes are presented from suicide mortality, which provides the most direct test, to parasuicide, in which suicidal intent was mixed, unclear, or not reported.

Table 6. Characteristics of SDV, by SDV type

Characteristic Measured	*Suicide (N = 20, 14%)*	*Suicide Attempt (N = 8, 6%)*	*Suicidal Ideation (N = 2, 1%)*	*NSSI (N = 10, 7%)*	*Parasuicide (N = 29, 20%)*
Reasons or function of SDV	2 (1)	0	0	1 (1)	3 (2)
Lethality of SDV - Death	20 (14)	N/A	N/A	N/A	N/A
Lethality of non-lethal SDV	N/A	6 (4)	0	1 (1)	7 (5)
Frequency or number of SDV	0	2 (1)	2 (1)	9 (6)	21 (15)
Type of SDV methods used	4 (3)	0	0	7 (5)	8 (6)

Note. N = 145 empirical records. Each record was counted once in each applicable cell and could appear in more than one column when it reported more than one SDV type. N/A = not applicable.

3.5.1. Findings for SDV with Suicidal Intent: Suicide Mortality, Attempts, and Ideation

Suicide Mortality

To evaluate Cleckley's core observation that individuals with psychopathy are less likely to die by suicide, data regarding suicide mortality were extracted. The findings differed depending on the specific construct measured. Statistical analyses of suicide mortality using psychopathy measures were rare. One study used the PCL-R in a sample of 76 Spanish men who had committed intimate partner homicide (Halty et al., 2023). The authors conducted two separate analyses comparing individuals who died by suicide with those who did not engage in post-homicide suicidal behaviour and with those who made a non-fatal suicide attempt. In both analyses, significant interactions indicated that the relative pattern of Factor 1 and Factor 2 scores differed across the outcome groups. Those who died by suicide had lower Factor 1 scores than the no-suicide and suicide-attempt groups, while Factor 2 scores were relatively similar across groups. The clearest interpretation is that affective-interpersonal symptoms were less characteristic of those who died by suicide, rather than that behavioural and impulsive symptoms were more characteristic of suicide death. However, the authors did not report between-group comparisons for each factor. In addition, only a small proportion of the sample met categorical criteria for psychopathy, with 3.9% meeting the PCL-R cut-off of 30 and 14.5% meeting the European cut-off of 25.

Broader ASPD findings were less directly relevant to Cleckley's construct. Large cohort and case-control studies generally reported elevated suicide mortality or higher ASPD prevalence among suicide decedents compared with controls (Krasnova et al., 2019; Lesage et al., 1994), although this association was not universal (Black et al., 1996). In addition, one study suggested that ASPD may be more strongly linked to sudden violent death than to suicide (Törnblom et al., 2024). When examined as a comorbid diagnosis, findings were mixed and complicate the interpretation of the unique role of ASPD. Comorbid ASPD was noted among suicide decedents with alcohol use disorder (Chachamovich et al., 2012) and borderline personality disorder features (BPD; Rich & Runeson, 1992). However, because ASPD diagnostic criteria emphasize impulsivity and dysregulation, these findings may reflect broader externalizing symptoms rather than the psychopathy profile Cleckley described.

Many studies reported suicide deaths descriptively without conducting suicide-specific statistical analyses or providing comparison groups that could evaluate relative risk. Descriptive reports of ASPD among suicide decedents were noted across several samples (Apter et al., 1993; Dogan et al., 2010; Flynn et al., 2020; Martin et al., 1985; Stone et al., 1987). Psychopathy, occasionally based on varying or undefined criteria, was similarly identified in other studies (Batchelor & Napier, 1954; Bille-Brahe, 1997; Maddocks, 1970; Vaurio et al., 2018; Vaurio et al., 2022; Viskum, 1975). A smaller subset of studies examined suicide among individuals described as having sociopathy (Buglass & Horton, 1974; Ovenstone & Kreitman, 1974). Although these studies document the presence of PPD among suicide decedents, the absence of suicide-specific statistical analyses and appropriate comparison groups prevents conclusions regarding relative suicide risk or the strength of the association, leaving Cleckley's observations largely untested within this subset.

Few studies provided detailed information on the behavioural characteristics of suicide in individuals with PPD. Three ASPD studies reported suicide methods, including firearms (Black et al., 1996; Dogan et al., 2010) and overdose (Martin et al., 1985). Precipitating circumstances were described in two studies. Dogan and colleagues (2010) identified impending divorce in one ASPD case, whereas Batchelor and Napier (1954) described a psychopathy-focused case involving family estrangement prior to death by potassium cyanide poisoning.

In summary, the literature provides only limited information regarding Cleckley's observations on suicide mortality. Most evidence came from ASPD samples or studies using psychopathy or sociopathy labels without a standardized multidimensional assessment. Only Halty and colleagues (2023) separated affective-interpersonal from behavioural psychopathy symptoms. In that study, affective-interpersonal symptoms were less characteristic of those who died by suicide, a pattern broadly consistent with Cleckley's observation, although relatively few participants met categorical criteria for psychopathy. Of the 20 mortality records, none combined a psychopathy measure capturing the affective-interpersonal and behavioural features Cleckley described with an appropriate psychiatric comparison group. The mortality literature therefore does not directly test his claim of comparatively lower suicide mortality.

Suicide Attempts

Lethality

Among acts classified as suicide attempts, Cleckley's observation would predict comparatively low medical lethality and lower levels of intent to die. However, evidence regarding lethality was mixed. One study of incarcerated individuals found that higher PCL-R total scores were associated with lower suicidal intent and medical lethality (i.e., the objective biological probability of death resulting from the act; Lohner & Konrad, 2006). This association was also evident for Factor 1 scores, whereas Factor 2 scores were not significantly related to seriousness. Notably, these associations did not meet the study's threshold for statistical significance and were interpreted by the authors as trends. When PCL-R scores were examined categorically (≥ 25), psychopathy was not significantly related to lethality.

Findings from ASPD-focused studies were heterogeneous and often challenged the assumption of uniform low lethality. In a sample of female prisoners, ASPD diagnoses were common in both near-lethal suicide attempters and control groups and did not distinguish the groups (Marzano et al., 2010). Similarly, expected lethality scores did not differ between individuals with and without ASPD in an emergency department sample (Blasco-Fontecilla et al., 2009). In contrast, Beautrais and colleagues (1996) reported higher odds of serious suicide attempts among individuals with ASPD. When examined as a comorbidity, the influence of ASPD on lethality was inconsistent. One study of individuals with BPD found that comorbid ASPD was significantly more prevalent among high-lethality attempters compared to low-lethality attempters (Soloff et al., 2005). However, in a separate sample of individuals with BPD, comorbid ASPD showed opposing trend-level associations with higher stated suicidal intent but lower medical lethality, indicating a mismatch between subjective intent and objective severity (Soloff et al., 1994).

Frequency

Cleckley noted that although death by suicide is rare, non-fatal attempts are frequent. Only a small number of studies examined the frequency of suicide attempts in relation to psychopathy traits. In one study of justice-involved individuals using the PCL:SV, behavioural dysregulation (i.e., Factor 2) scores were positively associated with the number of suicide attempts, while interpersonal and affective symptoms (i.e., Factor

1) were unrelated (Verona et al., 2012, Study 2). Similarly, a study of incarcerated men using the Levenson Psychopathy Scale found that behavioural dysregulation symptoms significantly predicted multiple suicide attempts, whereas affective-interpersonal symptoms did not (Smith et al., 2014).

Across the suicide attempt literature, the most relevant lethality evidence came from the only PCL-R study, which found non-significant trends linking higher total and Factor 1 scores to lower suicidal intent and medical lethality. This provides tentative, but insufficient, support for Cleckley's description of comparatively low-lethality attempts. Repeated attempts were more consistently associated with behavioural dysregulation, whereas the affective-interpersonal symptoms Cleckley viewed as fundamental were not associated with repetition. None of the eight records examining suicide attempt characteristics used an appropriate psychiatric comparison group. The available evidence therefore does not establish whether frequent, comparatively low-lethality attempts characterize the psychopathy profile he described.

Suicidal Ideation

A small number of studies examined the frequency of suicidal ideation in relation to psychopathy traits. In a sample of undergraduate students, frequency of suicidal ideation was negatively correlated with Factor 1 symptoms and positively correlated with Factor 2 symptoms (Verona et al., 2012, Study 1). Similarly, in a forensic sample, behavioural dysregulation symptoms of psychopathy were positively correlated with the frequency of recent suicidal ideation, whereas affective-interpersonal symptoms did not show a significant association (Fadoir et al., 2019).

Across both studies, more frequent suicidal ideation was associated with behavioural dysregulation rather than affective-interpersonal symptoms. Because Cleckley did not explicitly address suicidal thoughts, these findings only provide indirect evidence regarding his broader account of non-lethal SDV and do not test his proposed paradox between frequent non-lethal acts and comparatively infrequent suicide.

3.5.2. Findings for SDV with Absent Suicidal Intent (NSSI)

Reported Reasons and Lethality

Only one study examined both the reported reasons and severity of NSSI in relation to PPD, comparing men diagnosed with ASPD with and without comorbid psychopathy (PCL-R total score ≥ 30; Alpay Ates et al., 2011).

Individuals with comorbid psychopathy more frequently endorsed external stressors as reasons for NSSI, including oppression, familial problems, and economic difficulties. In contrast, emotional motives such as loneliness, grief, or separation did not differ significantly between groups. These findings describe circumstances and reported reasons associated with NSSI, but they do not establish that the behaviour was intended to achieve an external outcome. The presence of external stressors alone therefore does not provide evidence that NSSI served an instrumental function.

In terms of lethality, individuals with comorbid psychopathy were more likely to sustain severe injuries requiring medical intervention or associated with higher physical risk (e.g., requiring stitches, potential disfigurement), whereas those without psychopathy more often engaged in superficial injuries. While Cleckley's observation implies lower lethality rather than injury severity, these findings provide an indirect test of that claim and do not support a simple assumption of uniformly low lethality SDV in people with psychopathy.

Methods

Several community-based studies assessed NSSI using inventories covering multiple behaviours. Greitemeyer and Sagioglou (2021, Study 1) found that psychopathy was positively associated with both source-defined mildly injurious NSSI (e.g., biting one's fingernails until they bled, pulling out large amounts of hair) and moderately injurious NSSI (e.g., intentional burning, non-suicidal strangulation). Other community-based samples similarly found that higher psychopathy scores were positively associated with more frequent endorsement of different NSSI methods (Greitemeyer & Sagioglou, 2021, Study 2; Greitemeyer, 2022, Studies 1 and 2). In a sample of incarcerated individuals, both affective-interpersonal and behavioural dysregulation symptoms of psychopathy were positively associated with the number of NSSI methods used (Fadoir et al., 2019). However, when controlling for overlapping variance, only

behavioural dysregulation symptoms emerged as a unique predictor of NSSI method versatility, whereas the relationship with the affective-interpersonal symptoms was null.

Studies using the triarchic model demonstrated variable findings. Disinhibition was uniquely associated with greater NSSI versatility and emerged as the only significant predictor of engaging in multiple self-harm methods among incarcerated individuals (Brislin et al., 2019; Sica et al., 2021). Boldness and meanness were not significantly related to NSSI versatility.

Frequency

Several studies found positive associations between psychopathy and NSSI frequency across multiple settings. Studies using self-report psychopathy measures in community and forensic samples reported positive associations between total psychopathy scores and the frequency of NSSI behaviours (Greitemeyer & Sagioglou, 2021, Studies 1 and 2; Greitemeyer, 2022, Studies 1 and 2; Gu et al., 2023). Further, in a sample of individuals with ASPD, those who also met the cut-off for psychopathy (PCL-R total score ≥ 30) reported more frequent self-mutilating behaviours than those without psychopathy (Alpay Ates et al., 2011). However, when looking at the total number of episodes, no significant group differences were found. Lastly, when examined at the trait level in a sample with criminal justice involvement, Factor 2 traits were positively associated with NSSI frequency, whereas Factor 1 traits were unrelated (Verona et al., 2012, Study 2).

Studies using the triarchic model of psychopathy demonstrated convergent findings. Disinhibition was positively associated with NSSI frequency and emerged as the only significant predictor in multivariate models (Brislin et al., 2019; Sica et al., 2021). Meanness showed a small positive correlation in one study (Brislin et al., 2019), while boldness was not associated with NSSI frequency (Brislin et al., 2019; Sica et al., 2021).

Across the NSSI literature, several studies found that higher overall psychopathy scores or categorical psychopathy were associated with more frequent NSSI and greater method versatility, although these findings were not entirely consistent. When psychopathy domains were examined separately, frequency and method versatility were more consistently associated with behavioural dysregulation and disinhibition than with affective-interpersonal symptoms. The only study reporting reasons and injury severity

found that participants with comorbid psychopathy more often identified external stressors and sustained greater injury severity, but the reported reasons did not establish function. Frequent NSSI is compatible with one part of Cleckley's account, and the overall psychopathy score findings suggest that it may occur in people displaying the broader psychopathy profile. However, the domain-level results indicate that this pattern may be driven primarily by behavioural dysregulation rather than the affective-interpersonal symptoms Cleckley viewed as fundamental. The findings also did not show a consistent pattern of minor injury or limited method use, suggesting that the evidence does not establish that these non-lethal acts were generally unlikely to result in death. None of the 10 NSSI records combined a psychopathy measure capturing Cleckley's affective-interpersonal and behavioural features with an appropriate psychiatric comparison group.

3.5.3. Findings for SDV with Mixed Suicidal Intent (Parasuicide)

Studies in this section reported outcomes for which suicidal intent was mixed, unclear, or unreported. Source terminology used by the authors (e.g., self-harm, self-injury, suicide attempts) is retained when describing individual outcomes and should not be interpreted as confirmation that suicidal intent was absent or present.

Reported Reasons

Three descriptive studies reported reasons or circumstances associated with parasuicide: one described cases classified as psychopathy, and two examined ASPD samples. In an analysis of 46 individuals hospitalized following a suicide attempt, five were classified as having psychopathy (Lowrey, 1920). Reasons for attempting suicide were interpersonal problems, grief, and depressive episodes. In a clinical sample of individuals with ASPD, crises preceding suicide attempts most commonly involved interpersonal stressors, including relationship conflict and breakups, with fewer reports of legal or financial stressors (Garvey & Spoden, 1980). These two studies primarily describe emotional or situational circumstances preceding SDV rather than what the behaviour was intended to accomplish.

A prison-based study provided more direct information about function. Individuals with ASPD described self-injury as a response to oppressive environments, a means of

diversion, or a strategy to obtain medication or transfer to psychiatric care (Virkkunen, 1976). The latter examples provide the clearest evidence of an instrumental function.

Lethality

To determine if parasuicidal acts in this population consistently present as low-risk behaviour, medical severity was examined. Evidence regarding lethality was limited and inconsistent across study designs. Walsh (1997) assessed the severity of the most serious suicide attempt using the Suicide Risk Rating Scale. Psychopathic (PCL-R total score ≥ 30) and non-psychopathic offenders did not differ in mean risk scores for their most serious attempt. In contrast, in a sample of male offenders receiving psychiatric treatment in prison, those who engaged in self-harm requiring medical intervention were more likely than those who did not self-harm to meet the cut-off for psychopathy (PCL-R total score ≥ 30) and had higher Factor 2 scores (Young et al., 2006). However, Factor 1 scores were not reported, precluding evaluation of the affective-interpersonal features Cleckley viewed as fundamental. Within the triarchic framework, suicide attempt lethality was unrelated to boldness, meanness, or disinhibition (Rufino et al., 2024).

Few ASPD studies examined lethality. The only comparative study found that ASPD diagnoses did not differentiate male offenders who engaged in near-lethal SDV in prison from those who did not (Rivlin et al., 2010). Descriptive studies reported mixed results. For instance, one sample of men with ASPD indicated high levels of clinically significant harm, with 65% of individuals requiring medical treatment for self-inflicted injuries (Semiz et al., 2008). In contrast, another ASPD sample reported that despite frequent attempts, only three suicide attempts required extended hospitalization, suggesting generally low medical seriousness (Garvey & Spoden, 1980). Despite these inconsistencies, the potential for extreme lethality is evidenced by a small study of individuals with self-inflicted, firearm-related facial injuries, where one-third of those requiring extensive reconstructive surgery were diagnosed with ASPD (Öztürk et al., 2006).

Methods

Studies examining methods of SDV in which suicidal intent was not specified were limited and primarily descriptive, with few studies testing whether method choice differed across PPD constructs. When examining psychopathy, one study using a

sample of offenders admitted to a forensic psychiatric unit compared method choice across Factor 1–weighted (i.e., higher Factor 1 scores compared to Factor 2), Factor 2–weighted (i.e., higher Factor 2 scores compared to Factor 1), and non-psychopathic individuals (Carpar et al., 2025). Overdose and cutting were the most frequently reported methods across groups, with Factor 2–weighted individuals showing higher proportions of cutting descriptively. However, statistical analyses indicated that method distributions did not differ significantly between groups.

One study examined method versatility using the triarchic framework in an undergraduate sample. Higher boldness was associated with endorsing fewer types of self-harm behaviours, while meanness and disinhibition were not significantly associated with the number of self-harm methods endorsed (Davis et al., 2024, Study 2). An early psychopathy-focused case also described a low-intent suicide attempt involving a barbiturate overdose (Batchelor & Napier, 1954).

Among ASPD samples, most evidence was descriptive rather than comparative. The only study to test method differences found that the types of self-injurious behaviours did not differ between individuals with ASPD who did and did not have a suicide attempt history (Durmaz, 2017). In a sample of men with ASPD, self-injury methods were most commonly cutting, hitting, burning, and biting, and suicide attempt methods were most commonly overdose and wrist slashing, followed by hanging and weapons (Semiz et al., 2008). Similarly, another ASPD sample reported overdose as the most common method for suicide attempts, with no firearms or knives reported (Garvey & Spoden, 1980). Additional small descriptive studies highlighted severe or atypical methods within ASPD samples. For example, Öztürk and colleagues (2006) identified four individuals with ASPD among patients with self-inflicted firearm injuries, and Virkkunen (1976) described ingestion behaviours, such as swallowing razor blades, among individuals with ASPD who engaged in cutting.

Frequency

Across studies in which suicidal intent was not clearly specified, findings regarding the frequency of SDV varied by PPD framework. Factor-based measures generally implicated behavioural dysregulation in repeated parasuicidal behaviour. Across clinical and forensic samples, higher behavioural dysregulation symptoms were associated with more frequent SDV, whereas affective-interpersonal symptoms showed

inverse or null associations (Carpar et al., 2025; Negredo et al., 2013). Verona and colleagues (2012, Studies 1 and 2) similarly found positive associations between behavioural dysregulation and composite SDV outcomes, which were classified as parasuicide because they combined outcomes with different suicidal intent. Notably, Carpar and colleagues (2025) found that in a forensic psychiatric setting, patients with higher Factor 2 scores (relative to Factor 1) reported more suicide attempts than those with higher Factor 1 scores and non-psychopathic individuals.

Studies using total psychopathy scores or categorical classifications generally did not show an association with SDV frequency. Walsh (1997) found no significant difference between psychopathic and non-psychopathic offenders in the number of serious suicide attempts. Negredo and colleagues (2013) similarly reported null findings. Findings from Semiz and colleagues (2008) were more difficult to interpret. PCL-R total, Factor 1, and Factor 2 scores were not significantly associated with the number of suicide attempts. However, for frequency of self-injurious behaviour, the study reported an inconsistent pattern in which PCL-R total scores were positively associated with frequency, whereas both Factor 1 and Factor 2 scores were negatively associated. Given this unusual pattern, the findings were treated as mixed rather than as clear evidence for either affective-interpersonal or behavioural psychopathy.

Evidence from studies using the triarchic model showed broadly similar patterns. Disinhibition was positively associated with SDV frequency in one study (Tylicki et al., 2021), and with multiple prior suicide attempts among males in another study (Rufino et al., 2024). In contrast, boldness tended to show inverse or null associations (Ricarte et al., 2022; Rufino et al., 2024; Tylicki et al., 2021). Findings for meanness were mixed, with small positive associations in some analyses (Tylicki et al., 2021) and inverse associations in others (Ricarte et al., 2022), suggesting that its relationship to repetition may vary across samples and analytic approaches.

Findings based on ASPD and related diagnostic categories were heterogeneous. Some samples reported higher rates of SDV among individuals with ASPD compared to those without the disorder (McGonigal et al., 2019), although ASPD subgroup sizes were small in one study (Zlotnick et al., 1999). Other studies found non-significant or inverse associations with repetition (Dirks, 1998; Edwards et al., 2022; Tyrer et al., 2004). Interpretation was further complicated by study designs that lacked non-ASPD

comparison groups, which reported inconsistent results regarding the frequency of parasuicide (Bateman et al., 2016; Durmaz, 2017). Without these control groups, it is difficult to isolate the independent effect of ASPD on parasuicide repetition.

Early studies using the term sociopathy suggested an association with repeated parasuicidal behaviour (Buglass & Horton, 1974; Ovenstone & Kreitman, 1974; Siani et al., 1979), although these findings were based on broad behavioural definitions and lacked standardized diagnostic criteria. Additional descriptive reports using the term “psychopathic state” noted the presence of psychopathy among repeat attempters (Batchelor, 1954; Batchelor & Napier, 1954), but the absence of comparison groups and statistical analyses limits conclusions about relative risk.

Across the parasuicide literature, repetition was more consistently associated with Factor 2 and disinhibition than with affective-interpersonal symptoms. Results for total or categorical psychopathy were generally null or mixed, and did not show a consistent association between repetition and the broader psychopathy profile. Evidence regarding lethality were mixed, no clear differences in method choice emerged across psychopathy groups, and instrumental functions were directly described in only one ASPD study. Only one of the 29 parasuicide records, Carpar and colleagues (2025), combined a PCL-R-based assessment with a comparison group of other patients in a forensic psychiatric setting. However, because parasuicide outcomes involved mixed, unclear, or unreported suicidal intent, the evidence could not determine whether these acts matched Cleckley’s description of frequent non-lethal SDV involving limited intent to die.

Chapter 4. Discussion

This review examined whether the empirical literature has meaningfully tested Cleckley's observation that individuals with psychopathy frequently engage in SDV yet rarely die by suicide. A direct evaluation requires: 1) a psychopathy measure that captures the affective, interpersonal, and behavioural features he described; 2) an appropriate comparison group of other psychiatric patients; 3) evidence of comparatively lower suicide mortality; and 4) evidence of frequent non-lethal SDV assessed in relation to suicidal intent, lethality, methods, and function. Domain-level analyses are also needed to determine whether associations with SDV reflect the affective-interpersonal features Cleckley viewed as fundamental or behavioural dysregulation.

Overall, no study met all four requirements. The current literature therefore neither clearly supports nor refutes Cleckley's observation. Instead, it suggests that the paradox has rarely been examined using constructs and methods aligned with his formulation. Nonetheless, the findings offer some insight into how suicide mortality and non-lethal SDV relate to different features of psychopathy.

4.1. Suicide Mortality and Cleckley's Paradox

Suicide mortality provides the most direct test of Cleckley's paradox. However, this review found that empirical studies examining suicide in relation to psychopathy are rare, and most statistical analyses have instead focused on ASPD or reported descriptive prevalence without comparison groups. One mortality study examined psychopathy at the factor level. Halty and colleagues (2023) found that affective-interpersonal symptoms were less characteristic of those who died by suicide than of those who survived or did not attempt suicide. Although relatively few participants met categorical criteria for psychopathy, this pattern is broadly consistent with the possibility that suicide mortality is less closely associated with the affective-interpersonal symptoms Cleckley viewed as fundamental. However, it does not demonstrate that these features are protective against suicide.

Findings from ASPD studies were mixed, with elevated, null, and comorbidity-dependent associations with suicide mortality. This variation is not necessarily evidence against Cleckley's observation because ASPD primarily captures antisocial behaviour

and behavioural dysregulation and does not require the affective-interpersonal symptoms he viewed as fundamental. The mortality literature therefore points to a possible distinction between affective-interpersonal and behaviourally dysregulated presentations, but it cannot determine whether individuals displaying Cleckley's broader psychopathy profile are comparatively less likely to die by suicide.

4.2. Frequency, Methods, Lethality, and Function

Across non-lethal SDV outcomes, the clearest pattern concerned repetition. Across suicide attempts, NSSI, suicidal ideation, and parasuicide, greater frequency was generally associated with behavioural dysregulation, Factor 2, and disinhibition, whereas affective-interpersonal symptoms showed weaker, null, or inverse associations. This does not show that frequent non-lethal SDV characterizes the full psychopathy profile Cleckley described. Rather, it suggests that repetition may be more closely related to behavioural dysregulation than to the affective-interpersonal symptoms he viewed as fundamental.

Findings regarding methods and lethality were less consistent. Method versatility was more often associated with behavioural dysregulation and disinhibition than with affective-interpersonal symptoms, suggesting that the use of a broader range of methods may be driven primarily by behavioural features. The absence of strong associations with affective-interpersonal symptoms is partly compatible with Cleckley's account, but studies did not identify a distinct lower-risk method pattern among individuals with psychopathy. Across studies, some findings suggested lower medical lethality, others found no difference, and others reported more severe injury or potentially fatal methods. The evidence therefore does not establish that non-lethal SDV in psychopathy is consistently medically minor or unlikely to result in death.

Evidence regarding why non-lethal SDV occurred was particularly limited. Most studies described emotional states, interpersonal conflicts, or other circumstances preceding the behaviour rather than assessing what the act was intended to accomplish. Virkkunen (1976) provided the clearest evidence of instrumental function, but this finding came from one descriptive ASPD study. It therefore cannot establish that instrumental functions characterize the psychopathy profile Cleckley described. Instrumental

purposes also do not imply that an act lacked distress or suicidal intent because these features can coexist.

Overall, the literature does not establish the specific pattern Cleckley described. Frequent or repeated SDV was documented in some psychopathy-related groups, but it was more consistently associated with behavioural dysregulation than with affective-interpersonal symptoms. Evidence was insufficient to show that these acts typically involved low lethality, lower-risk methods, limited intent to die, or instrumental functions.

4.3. Why Cleckley's Paradox Remains Unresolved

The first barrier to evaluating Cleckley's paradox is construct alignment. More than half of the records used ASPD, a diagnosis that emphasizes antisocial behaviour and behavioural dysregulation but does not require the affective-interpersonal features Cleckley viewed as fundamental. These studies were included because the review mapped the broader PPD literature, but their findings provide indirect evidence regarding Cleckley's observation. Studies that used total or categorical psychopathy scores were more closely aligned with his broader profile, although these scores could obscure differences between symptom domains. When domains were separated, behavioural dysregulation was more consistently associated with SDV, whereas affective-interpersonal features generally showed weak, null, or inverse associations. The strongest pattern may therefore reflect behavioural dysregulation rather than the broader psychopathy profile Cleckley described.

The second barrier is the comparison context. Cleckley's observation was relative to other psychiatric patients in secure settings, yet only Carpar and colleagues (2025) combined a PCL-R-based assessment with a comparison group of other forensic psychiatric patients. Most studies used non-psychiatric controls, compared participants according to ASPD, psychopathy, or SDV history, or included no comparison group. These designs can identify associations with SDV but cannot determine whether people with psychopathy are comparatively less likely to die by suicide than other psychiatric patients. The comparison required to test Cleckley's relative claim was therefore almost entirely absent from the literature.

Taken together, Cleckley's paradox remains unresolved primarily because studies have rarely been designed to examine the phenomenon he described. Because studies used different psychopathy constructs, populations, comparison groups, SDV definitions, and outcomes, their findings are difficult to compare and often concern different phenomena. Some results are compatible with individual parts of Cleckley's account, but they generally come from studies that could not test the complete pattern. The apparent conflict therefore reflects differences in what was studied more than contradictory answers from direct tests.

4.4. Limitations

This scoping review should be interpreted in light of several limitations. First, although exhaustive search terms were used across multiple databases, reference-list searching was targeted rather than comprehensive, which may have limited retrieval of older or less-indexed texts. Second, excluding grey literature (e.g., unpublished dissertations and government reports) was necessary to maintain the methodological rigour of the review. However, it may introduce publication bias by underrepresenting null findings. Third, regarding data extraction, this scoping review used a pragmatic strategy. Although screening followed gold-standard procedures (i.e., independent double-screening of all abstracts and full texts), independent double-extraction was conducted on a random subset of the included studies (n = 25). This approach is consistent with methodological guidance for scoping reviews with large datasets (e.g., Pollock et al., 2023; Robson et al., 2019).

Finally, the intentional use of broad definitions for both SDV and PPD increased coverage of the review but also introduced substantial variation in measurement tools and diagnostic criteria. This made direct comparisons between studies difficult. However, this difficulty is also a central finding: the field lacks the conceptual consistency needed to test Cleckley's paradox directly.

4.5. Future Directions

Several changes are needed to test Cleckley's paradox more directly.

1. **Assessing Overall Psychopathy and Its Domains:** Future research should use validated measures that capture the affective, interpersonal, and behavioural features of psychopathy. Overall scores are needed to test whether Cleckley's psychopathy profile is associated with the proposed pattern of SDV, while domain-level analyses are needed to determine whether findings reflect the affective-interpersonal symptoms he viewed as fundamental or behavioural dysregulation.

2. **Using Matched Clinical Comparison Groups:** Cleckley's observation was based on the finding that individuals with psychopathy died by suicide less frequently than other psychiatric patients in secure settings. However, much of the current evidence is purely descriptive or lacks appropriate psychiatric comparison groups. Future research should compare individuals with psychopathy to psychiatric populations consistent with Cleckley's original clinical context. This approach is necessary because findings cannot be directly compared with Cleckley's original observations unless they are evaluated against a similar psychiatric comparison group.

3. **Prioritizing Suicide Mortality:** Cleckley's paradox is primarily concerned with the relative absence of suicide deaths, yet few records in this review examined suicide mortality directly. Future research should prioritize suicide death as a primary outcome rather than relying predominantly on non-lethal SDV. Examining suicide mortality directly is necessary to determine whether individuals with psychopathy are comparatively less likely to die by suicide than similar psychiatric populations.

4. **Standardizing SDV Terminology:** Much of the data is obscured by the use of ambiguous terms (e.g., deliberate self-harm) and undefined suicidal intent. Future studies should adopt clear, intent-based frameworks (e.g., O'Carroll et al., 1996; Silverman et al., 2007a) to distinguish between non-suicidal and suicidal behaviours.

5. **Measurement of SDV Characteristics:** Many studies relied on unstandardized measures that lacked detail on the nature of SDV. To move beyond the mere presence of these behaviours, researchers should incorporate validated assessments of intent to die, objective medical lethality, precipitating circumstances, and the functions of SDV. Functions should be assessed directly rather than inferred from the presence of an external stressor or a possible external benefit.

6. **Employing Longitudinal Designs:** Most studies relied on retrospective reports of past SDV, often over broadly defined or lifetime periods. Future research should assess SDV prospectively

and as close as possible to the time it occurs, using repeated or event-based assessments where feasible. Longer follow-up periods are also needed to examine changes in SDV and suicide mortality over time.

4.6. Implications

The findings of this review have important clinical and forensic implications. Cleckley's assertion that individuals with psychopathy are relatively immune to suicide has sometimes been interpreted to imply that SDV in this population lacks suicidal intent and is not serious. Indeed, research shows that prison staff frequently view SDV as manipulative (Hewson et al., 2022; Sousa et al., 2019). If clinicians or correctional staff assume reduced suicide risk among individuals assessed as having psychopathy or diagnosed with ASPD, they may be less likely to intervene, monitor, or implement prevention tools. This assumption is especially concerning because clinicians may not distinguish Cleckley's narrow conceptualization of psychopathy from broader constructs, such as ASPD or psychopathy measures emphasizing behavioural dysregulation, which have been associated with elevated suicide risk (e.g., Krasnova et al., 2019). These risks are compounded by general narratives that psychopathy is untreatable, a view endorsed by Cleckley, who observed a "lack of response to psychiatric treatment of any kind" (1988, p. 433). Research has documented negative views among clinicians and forensic staff regarding the treatment and prognosis of psychopathy (e.g., Meloy & Yakeley, 2014; Salekin, 2002). However, research challenges this therapeutic nihilism, demonstrating that certain psychopathic traits and associated behaviours can respond to targeted interventions (Salekin, 2002). Together, assumptions that psychopathy is untreatable and that people with psychopathy are unlikely to die by suicide may lead clinicians to underestimate both risk and therapeutic need.

Clinically, these findings underscore the importance of suicide risk assessments rather than assuming reduced risk or inferring a particular function from a psychopathy assessment or ASPD diagnosis. An act may serve an instrumental goal while also occurring in the context of psychological distress or suicidal intent. The presence of a possible external benefit should not be used to dismiss the act or assume that it is low risk. Instead, suicide risk should be evaluated in the context of the individual's current presentation and established risk factors. Assessment should consider behavioural dysregulation and other relevant risk factors rather than rely on a psychopathy label or

assumptions about the function of the act. This is particularly important because the current evidence does not demonstrate that individuals with psychopathy or related diagnoses are inherently immune to suicide or that SDV in this population is necessarily low risk.

4.7. Conclusion

This scoping review found that Cleckley's paradox remains unresolved. No study combined a psychopathy measure capturing his broader profile, an appropriate psychiatric comparison group, suicide mortality, and detailed assessment of non-lethal SDV. Across the literature, repeated SDV was more consistently associated with behavioural dysregulation than with affective-interpersonal symptoms. Cleckley included behavioural symptoms in his description of psychopathy, but he gave greater weight to affective-interpersonal symptoms. The findings therefore suggest that repeated SDV may be associated primarily with the behavioural component of psychopathy rather than with the affective-interpersonal symptoms he emphasized. However, the limited mortality evidence and absence of appropriate comparison groups means that weaker associations involving affective-interpersonal symptoms cannot be interpreted as evidence of suicide immunity. Ultimately, this review suggests that Cleckley's paradox has endured not because it has been confirmed or refuted, but because studies have rarely used measures, comparison groups, and mortality outcomes that match the claim he made.

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Appendix A.

Operational Definitions Used for Screening

Self-Directed Violence (SDV)

Behaviours, communications, or thoughts involving deliberate self-harm, where:

- *Self-harm* means physical harm to one's own body that is something more than trivial (minor) or transient (short-lived) harm, including self-harm that is suicidal or non-suicidal in nature.
- *Deliberate* means with the intent to cause self-harm or with recklessness, ambivalence, or lack of concern as to the likelihood of causing self-harm.
- *Behaviours* are acts or attempts to commit self-harm.
- *Communications* are utterances or gestures that threaten or signal an intent, desire, or compulsion to commit self-harm.
- *Thoughts* are mental experiences or events (including ideas, images, fantasies, obsessions, urges, decisions, and plans) involving an intent, desire, or compulsion to commit self-harm.

Psychopathic Personality Disorder (PPD)

For screening purposes, PPD was used as an umbrella term for studies referring to psychopathy, sociopathy, antisocial personality disorder, dissocial personality disorder, or dissociality in personality disorder. The following operational definition was used to identify potentially eligible studies:

- *Personality* means a person's usual or characteristic style of organizing their own psychological functions and relating to self and others that is chronic (emerges in childhood or adolescence and persists into adulthood), reflects personal rather than social deviance (does not reflect cultural beliefs or practices), and is not the result of some other somatic or mental disturbance.

- *Personality traits* are specific aspects of personality.

- *Extreme* means the personality traits under consideration are elevated (obvious or prominent) and rigid (fixed or inflexible) relative to the person's other personality traits as well as relative to the same personality traits of most other people.

- *Maladaptive* means the personality traits under consideration cause a chronic impairment of the person's psychological and social functions.

- *Specific cluster* means the personality traits under consideration include those related to: a detached, uncommitted, and unempathic style of attachment relations; an impetuous, disruptive, and aggressive behavioural style; an intolerant, inflexible, and suspicious cognitive style; an antagonistic, domineering, deceitful, manipulative, insincere style of dominance relations; a shallow and labile emotional style; and an egotistical, conceited, and defensive style of self-presentation.

SDV and PPD Nexus

Intentionally investigates the nexus between SDV and PPD, where:

- *Intentionally* means purposeful, planned, deliberate, and goal-directed actions. This may be illustrated using a priori hypotheses, planned methodology and experimental design, or deliberate analytical techniques.

- *Investigate* means to understand, explore, or characterize the relationship using methods that are systematic, detailed, or formal. These may include quantitative (statistical) research methods (e.g., descriptive statistics [means, standard deviations, frequency], inferential statistics [ANOVA, regression, chi-square]), qualitative (non-statistical) research methods (e.g., grounded theory), or theoretical analysis applying an established framework (e.g., Interpersonal Theory of Suicide, Three-Step Theory) to the PPD-SDV relationship.

- *Nexus* means the relation, co-occurrence, or connection, whether observed, inferred, or theoretical in nature.

Appendix B.

Abstract and Full-Text Screening Criteria

IDENTIFIER: _____

UNIQUE: Is the item a duplicate or original?

☐ Duplicate ➔ END

☐ Original ➔ CONTINUE

LANGUAGE: Are both the title and abstract in English?

☐ No ➔ END

☐ Yes ➔ CONTINUE

FULL TEXT: Is the full text of the item available in English?

☐ No ➔ END

☐ Yes ➔ CONTINUE

PUBLICATION TYPE: Is the full text of the item the correct publication type?

☐ No, dissertation, book, book review, or commentary ➔ END

☐ Yes ➔ CONTINUE

TARGET POPULATION: Does the item focus primarily on the association between SDV and PPD in adults?

☐ No, unclear ➔ END

☐ No, focuses primarily on children (age < 12) ➔ END

☐ No, focuses primarily on adolescents (age 12 to 17) ➔ END

☐ Yes, focuses primarily on adults (likely more than 90% age ≥ 18) ➔ CONTINUE

PURPOSE: Is the purpose or intent of the item, as stated in the hypothesis, purpose, methods, or analytical design, to examine the nexus between PPD and SDV?

☐ No ➔ END

☐ Yes ➔ CONTINUE

RELEVANCE: Does the item examine the association between SDV and PPD?

☐ No ➔ END

☐ Yes ➔ CONTINUE

Appendix C.

Data Extraction Chart

RQ 1. What are the characteristics of the included studies?

Section 1: Study Descriptors

1.1. Name of Publication: _____

1.2. 1st author last name: _____

1.3. 2nd author last name: _____

1.4. 3rd author last name: _____

1.5. Year of publication: _____

1.6. Format type:

1 = journal article (review or research report)

2 = book chapter

3 = Other _____

1.7. Journal name: _____

Study Descriptors and Sample

2.1 Country

1 = Canada

2 = United States of America

3 = United Kingdom

4 = Australia

5 = Other _____

2.2 Type of Study

1 = Quantitative synthesis (e.g., meta-analysis ➔ combines/analyses results from many studies)

2 = Qualitative synthesis (e.g., scoping review, systematic review ➔ searches for research on topic and draws findings from individual studies together, methodology outlined)

3 = Quantitative research report (gathers and analyses numerical data)

4 = Qualitative research report (non-numerical data)

5 = Theoretical report/discussion (e.g., no systematic process for finding studies)

6 = Other (specify) _____

2.3 Study Design (if research report)

1 = Cross-sectional

2 = Retrospective

3 = Prospective

2.4 Setting/Recruitment Setting

1 = Forensic settings: participants recruited from within the criminal justice system and forensic psychiatric system.

- Prison/Jail: participants incarcerated at time of recruitment.
- Forensic hospital: participants detained in forensic psychiatric facility, often under legal/court order or for evaluation.
- Probation/court-mandated treatment: Participants living in community but under legal supervision or court order to attend treatment.
- Forensic (mortality): Participants identified post-mortem through legal sources, such as Coroner or Medical Examiner.

2 = Clinical settings: participants recruited from the civil healthcare system (voluntary or involuntary).

- Inpatient: Participants admitted to hospital.
- Outpatient: Participants recruited from clinics, private practice or hospital departments that did not involve overnight stay.
- Mixed: participants recruited from both inpatient and outpatient settings.

3 = Community settings: participants recruited from the general population or non-medical/non-forensic institutions.

- General population: Participants drawn from census data, national registries or epidemiological surveys.
- Military: Participants active-service members at time of recruitment.
- University: Participants are students at a university.

2.5 Number of Participants: _____

2.6 Mean age of participants: ____

2.7 SD age of participants: ____

2.8 Minimum age of participants: ____

2.9 Maximum age of participants: ____

2.10 Ethnicity reported:

1 = Yes

2 = No

2.11 Reported ethnicities in sample (verbatim from study): _____

2.12 Ethnicity recoded into groups n(%):

1 = Arab/Middle Eastern/West Asian

2 = Asian

3 = Black

4 = Indigenous/Native American

5 = Latin American/Hispanic

6 = White/European

7 = Other: _____

2.13 Sex/Gender of Participants

1 = Male (men)

2 = Female (women)

3 = Both

2.14 Total number of studies included for review (for synthesis studies) _____

Research Question 2a: How is PPD conceptualized and measured in the literature?

3.1 Measurement/Operationalization of Psychopathic Personality Disorder

1 = Hare's Psychopathy Checklist Revised (PCL-R)

2 = Psychopathy Checklist: Screening-Version (PCL:SV)

3 = Levenson's Self-Report Psychopathy Scales (LSRP)

4 = Triarchic Psychopathy Measure (TriPM)

5 = Structured Clinical Interview for DSM (SCID)

6 = Mini International Neuropsychiatric Interview (MINI)

7 = Diagnostic Interview Schedule (DIS)

8 = Personality Assessment Inventory (PAI)

9 = Minnesota Multiphasic Personality Inventory (MMPI)

10 = Millon Clinical Multiaxial Inventory (MCMI)

11 = Personality Diagnostic Questionnaire (PDQ)

12 = Psychopathic Personality Inventory (PPI)

13 = Self-Report psychopathy scale (SRP)

14 = Short Dark Triad

15 = Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS)

16 = Structured Interview for DSM–IV Personality Disorders (SIDP-IV)

17 = Semi-Structured Interview for the Assessment of the Genetics of Alcoholism (SSAGA)

18 = Psychological autopsy

19 = File review

20 = Unspecified (semi-structured) interview

21 = Unspecified questionnaire (e.g., form, checklist, questionnaire created for study)

22 = Diagnostic and Statistical Manual of Mental Disorders (DSM)

23 = International Classification of Diseases (ICD)

24 = Other

25 = Not reported

3.2 PPD Term/Disorder examined, verbatim from study

1 = Psychopathy

2 = Antisocial Personality Disorder (ASPD/APD)

3 = Dissocial Personality Disorder

4 = Psychopathic Personality Disorder (PPD)

5 = Sociopathy

3.3 PPD Outcomes/Variables of Interest (for synthesis studies): _____

Research question 2b: How is SDV conceptualized and measured in the literature?

4.1 Measurement of SDV

1 = Beck Scale for Suicide Ideation (BSS)

2 = Beck Suicide Intent Scale (SIS)

3 = Columbia Suicide Severity Rating Scale (C-SSRS)

4 = Hare's Psychopathy Checklist Revised (PCL-R)

5 = Structured Clinical Interview for DSM (SCID)

6 = Mini International Neuropsychiatric Interview (MINI)

7 = Diagnostic Interview Schedule (DIS)

8 = Personality Assessment Inventory (PAI)

9 = Minnesota Multiphasic Personality Inventory (MMPI)

10 = Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS)

11 = Structured Interview for DSM–IV Personality Disorders (SIDP-IV)

12 = Semi-Structured Interview for the Assessment of the Genetics of Alcoholism (SSAGA)

13 = Psychological autopsy

14 = Physical examination

15 = Acquired Capability for Suicide Scale - Fearlessness About Death (ACSS-FAD)

16 = Lifetime History of Aggression questionnaire (LHA)

17 = Self-Injurious Thoughts and Behaviour Interview (SITBI)

18 = Deliberate Self-Harm Inventory (DSHI)

19 = Suicidal Behaviors Questionnaire (SBQ)

20 = Oxford Monitoring System for Attempted Suicide

21 = Self-Harm Inventory (SHI)

22 = File review

23 = Unspecified (semi-structured) interview

24 = Unspecified questionnaire (e.g., form, checklist, questionnaire created for study, unspecified items)

4.2 SDV Outcomes/Variables of Interest (for synthesis studies): _____

4.3 Type of SDV Measured, as stated by authors in their wording

1 = Suicide ideation/thoughts (SI)

2 = Non-suicidal self-injury

3 = Suicide attempt (SA)

4 = Death by suicide

5 = Self-mutilation

6 = Self-harm

7 = Parasuicide

8 = Other

4.4 Suicidal Intent Measured/Specified in Definition or Measure used

1 = Yes, intent to die is explicitly specified as part of definition or measured/reported in results

Includes:

- Suicide attempt defined as involving at least some intent to die
- Suicide attempt measured with a suicide intent scale, interview, or clinician/professional rating
- Suicide death
- Nonfatal self-injurious behaviour where intent to die is explicitly reported

2 = Yes, no intent to die is explicitly specified as part of definition or measured/reported in results

- SDV behaviours defined without suicidal intent, such as non-suicidal self-injury

3 = Intent mixed, unclear, unspecified intent, not measured or not reported

Includes:

- Self-harm, self-injury, self-mutilation, self-destructive behaviour, parasuicide, or SDV when intent is not defined
- Studies that combine suicide attempts and NSSI without separating them
- Authors state intent was not assessed
- Authors explicitly exclude intent from the definition
- Studies that do not define or discuss suicidal intent

4.5 Recode of SDV Measured

1 = Suicidal ideation (SI), plans, or threats

2 = Non-suicidal self-injury (NSSI) ➔ injuring oneself with **no intent to die**

3 = Suicide attempt (SA) ➔ injuring oneself with at least **some intent** to die, non-fatal

4 = Suicide ➔ injuring oneself with at least some **intent to die, fatal**

5 = Parasuicide ➔ injuring oneself, intent not specified or measured, non-fatal

4.6 SDV Study Design

1 = Retrospective (e.g., past month, lifetime, most recent suicide attempt)

2 = Longitudinal (e.g., follow-up time points)

3 = Cross-sectional (e.g., current/in this moment suicidal ideation)

4.7 Retrospective time period

1 = Lifetime

2 = 12 months

3 = 1 month

4 = 1 week

5 = Current SDV (e.g., reporting retrospectively on index SDV behaviour, like patients admitted to hospital for SA)

6 = File data collection dates (e.g., suicide death certificates from 2000-2005 examined = 2000-2005)

7 = Other

4.8 Longitudinal time period

1 = 1 week

2 = 1 month

3 = 6 months

4 = 12 months

5 = Other

Research Question 3: What are the characteristics of SDV in individuals with PPD?

5.1 Methods used to assess PPD and SDV nexus

1 = Statistical analysis

2 = Narrative (e.g., chapter in a book describing it, review paper, theoretical paper with no analyses conducted)

3 = Descriptive statistics (mean, SD, variance – no further statistical analyses conducted)

5.2 Examination (i.e., measured and reported in results) of SDV Methods (i.e., overdose, cutting) and PPD

1 = Yes, SDV methods were examined in relation to PPD using statistical, descriptive, or narrative methods, with results reported.

2 = No

5.3 Examination (i.e., measured and reported in results) of Consequences or Lethality of SDV and PPD

1 = Yes, the lethality or consequences of SDV were examined in relation to PPD using statistical, descriptive, or narrative methods.

- For hospital-based samples, code "yes" only if hospitalization is discussed as a consequence or proxy for lethality
- Study operationalizes SDV that includes a consequence/lethality

2 = No

3 = Death – by definition lethal

5.4 Examination (i.e., measured and reported in results) of reported reasons or function of SDV

1 = Yes, reported reasons, precipitating circumstances, or directly assessed functions of SDV were examined in relation to PPD using statistical, descriptive, or narrative methods.

2 = No

5.5 Examination (i.e., measured and reported in results) of the frequency or number of SDV

1 = Yes, the frequency or number of SDV incidents was examined in relation to PPD using statistical, descriptive, or narrative methods.

- Includes *number* of SDV episodes and *frequency* of engaging in SDV

2 = No

Appendix D.

Detailed Coding Protocol for the Nexus Between SDV Characteristics and PPD

Definitions:

- Not reported ➔ The study did not report this information
- Reported for the whole sample ➔ Data is reported for the whole sample rather than the population of interest (i.e., PPD). When information was reported only for the whole sample and no PPD-specific result or breakdown was available, the characteristic was coded as not relevant to testing Cleckley's observation.
- Results:
    - Positive results ➔ Consistently significant in a positive direction across statistical models
    - Negative results ➔ Consistently significant in a negative direction across statistical models
    - Non-significant results ➔ Null results across all statistical models tested
    - Mixed results ➔ results differ by model (e.g., after controlling for covariates, multiple tests performed)
    - N/A ➔ The construct or domain was not assessed or the result was not applicable.
- Relevance to a component of Cleckley's observation:
    - Directly relevant to the mortality component ➔ Examines suicide death using a multidimensional psychopathy measure and reports a statistical association or comparison involving psychopathy overall or its domains.
    - Indirectly relevant ➔ Provides PPD-specific descriptive or statistical evidence about one part of Cleckley's observation. This includes:
        - Suicide mortality assessed using ASPD, sociopathy, or an unclear psychopathy classification
        - The frequency or repetition of non-lethal SDV
        - Suicidal intent
        - Medical lethality and injury severity
        - SDV methods or method variety

        - Reported reasons, precipitating circumstances, or functions
- Not relevant ➔ Does not provide a finding specific to PPD or does not address any part of Cleckley's observation. This includes information reported only for the full sample without a PPD-specific breakdown or association, and characteristics that do not inform either relative suicide mortality or Cleckley's description of non-lethal SDV.

Study number: _____

SDV measured (recoded):

1 = Suicidal ideation

2 = NSSI

3 = Parasuicide

4 = Suicide attempt

5 = Suicide

Source terminology was retained in the detailed description, but the recoded SDV category was used for synthesis.

Comparison group for statistical analysis: _____

Methods of SDV:

1.1 Measurement type

1 = Continuous (e.g., number of SDV methods used)

2 = Categorical (e.g., specific methods reported)

1.2 Measurement tool (e.g., DSHI): _____

1.3 Measure details and description (verbatim from study): ____

1.4 Mean (SD) number of methods (for continuous variables): _

1.5 Range in the number of methods used (for continuous variables): _

1.6 Prevalence of SDV methods (for categorical variables, n/%):

1 = Poisoning: _____

2 = Cutting: _____

3 = Jumping: _____

4 = Hanging: _____

5 = Overdose: _____

6 = Firearm: _____
7 = Hitting: _____
8 = Burning: _____
9 = Biting: _____
10 = Other: _____

1.7 Type of analysis:
1 = Descriptive statistics only
2 = Inferential statistics

1.8 Type of inferential statistic:
1 = Group comparisons (e.g., t-test, ANOVA)

2 = Correlation

3 = Regression or multivariate test

1.9 Type of PPD examined:

1 = Psychopathy

2 = ASPD

3 = Sociopathy

4 = Dissocial PD

1.10 Results (list if positive, negative, mixed, non-significant, N/A):

PCL-R or derivative measures, Factor 1: _____

PCL-R or derivative measures, Factor 2: _____

Psychopathy diagnosis or total PCL-R score: _____

ASPD diagnosis: _____

Dissocial personality diagnosis: _____

Sociopathy diagnosis: _____

Triarchic model of psychopathy, Meanness: _____

Triarchic model of psychopathy, Boldness: _____

Triarchic model of psychopathy, Disinhibition: _____

1.11 Results summary: _____

1.12 Relevance to testing Cleckley's observations:

1 = Directly relevant to the mortality component

2 = Indirectly relevant

3 = Not relevant

Reported Reasons or Function of SDV:

2.1 Measurement type

1 = Continuous (e.g., number of reported reasons or functions)
2 = Categorical (e.g., specific reasons or functions reported)

2.2 Measurement tool (e.g., FASM): _____

2.3 Measure details and description (verbatim from study): ____

2.4 Mean (SD) number of reported reasons or functions (for continuous variables):

___

2.5 Type of analysis:

1 = Descriptive statistics only

2 = Inferential statistics

2.6 Type of inferential statistic:

1 = Group comparisons (e.g., t-test, ANOVA)

2 = Correlation

3 = Regression or multivariate test

2.7 Type of PPD examined:

1 = Psychopathy

2 = ASPD

3 = Sociopathy

4 = Dissocial PD

2.8 Results (list if positive, negative, mixed, non-significant, N/A):

PCL-R or derivative measures, Factor 1: _____

PCL-R or derivative measures, Factor 2: _____

Psychopathy diagnosis or total PCL-R score: _____

ASPD diagnosis: _____

Dissocial personality diagnosis: _____

Sociopathy diagnosis: _____

Triarchic model of psychopathy, Meanness: _____

Triarchic model of psychopathy, Boldness: _____

Triarchic model of psychopathy, Disinhibition: _____

2.9 Results summary: _____

2.10 Relevance to testing Cleckley's observations:

1 = Directly relevant to the mortality component

2 = Indirectly relevant

3 = Not relevant

Frequency of SDV:

3.1 Measurement type

1 = Continuous (e.g., number of lifetime suicide attempts)
2 = Categorical (e.g., single attempter vs. multiple attempter)
3 = Likert scale (e.g., scale of 1 = never to 5 = daily)

3.2 Measurement tool (e.g., DSHI): _____

3.3 Measure details and description (verbatim from study): ____

3.4 Mean (SD) frequency/number (for continuous variables): ___

3.5 Range of reported frequencies/numbers (for continuous variables):_____

3.6 Prevalence of SDV frequency (for categorical variables): _____

3.7 Type of analysis:

1 = Descriptive statistics only

2 = Inferential statistics

3.8 Type of inferential statistic:

1 = Group comparisons (e.g., t-test, ANOVA)

2 = Correlation

3 = Regression or multivariate test

3.9 Type of PPD examined:

1 = Psychopathy

2 = ASPD

3 = Sociopathy

4 = Dissocial PD

3.10 Results (list if positive, negative, mixed, non-significant, N/A):

PCL-R or derivative measures, Factor 1: _____

PCL-R or derivative measures, Factor 2: _____

Psychopathy diagnosis or total PCL-R score: _____

ASPD diagnosis: _____

Dissocial personality diagnosis: _____

Sociopathy diagnosis: _____

Triarchic model of psychopathy, Meanness: _____

Triarchic model of psychopathy, Boldness: _____

Triarchic model of psychopathy, Disinhibition: _____

3.11 Results summary: _____

3.12 Relevance to testing Cleckley's observations:

1 = Directly relevant to the mortality component

2 = Indirectly relevant

3 = Not relevant

Lethality or Injury Severity of SDV

4.1 Severity measure

1 = Lethality (non-lethal SDV; e.g., how likely the behaviour was to result in serious harm/death, such as medical lethality, lethality rating scales)

2 = Physical consequences (non-lethal SDV; e.g., actual medical outcomes)

3 = Clinical intervention (non-lethal SDV; e.g., the event required hospitalization or medical care)

4 = Subjective seriousness (non-lethal SDV; e.g., self-reported seriousness or intent to die)

5 = Death (lethal SDV)

4.2 Measurement type:

1 = Continuous

2 = Categorical

4.3 Measurement tool (e.g., DSHI): _____

4.4 Measure details and description (verbatim from study): ____

4.5 Mean (SD) severity/lethality (for continuous variables): ___

4.6 Range of severity/lethality reported (for continuous variables):_____

4.7 Prevalence of SDV severity/lethality outcomes (for categorical variables, non-lethal SDV, e.g., %): _____

4.8 Prevalence of suicide death (lethal SDV, %):_____

4.9 Type of analysis:

1 = Descriptive statistics only

2 = Inferential statistics

4.10 Type of inferential statistic:

1 = Group comparisons (e.g., t-test, ANOVA)

2 = Correlation

3 = Regression or multivariate test

4.11 Type of PPD examined:

1 = Psychopathy

2 = ASPD

3 = Sociopathy

4 = Dissocial PD

4.12 Results (list if positive, negative, mixed, non-significant, N/A):

PCL-R or derivative measures, Factor 1: _____

PCL-R or derivative measures, Factor 2: _____

Psychopathy diagnosis or total PCL-R score: _____

ASPD diagnosis: _____

Dissocial personality diagnosis: _____

Sociopathy diagnosis: _____

Triarchic model of psychopathy, Meanness: _____

Triarchic model of psychopathy, Boldness: _____

Triarchic model of psychopathy, Disinhibition: _____

4.13 Results summary: _____

4.14 Relevance to testing Cleckley's observations:

1 = Directly relevant to the mortality component

2 = Indirectly relevant

3 = Not relevant

Appendix E.

Full Dataset

See the supplementary Excel file for the full dataset at https://summit.sfu.ca/item/40943.