Supplementary Material

PRISMA 2020 Checklist

Note on adaptation. This study is a computational bibliometric review that treats the corpus of publications as its object of study and uses structural topic modeling (STM) to describe thematic structure, rather than a systematic review that synthesizes effect estimates. PRISMA 2020 was therefore followed for the identification, screening, and reporting of records, and items specific to effect synthesis are marked as not applicable to the bibliometric design, with the analogous computational procedure noted where relevant. Page numbers refer to the revised manuscript and are to be finalized.

#	PRISMA 2020 item	Reported?	Location / response
1	Identify the report as a systematic review	Yes (adapted)	Title identifies the study as a mapping/bibliometric review of the personal recovery literature.
2	Structured summary	Yes	Structured Abstract (Objective, Methods, Results, Conclusions and Implications for Practice).
3	Rationale	Yes	Introduction; the gap addressed is the absence of an analysis of the field's overall thematic structure.
4	Objectives and questions	Yes	Introduction, end; three research questions (thematic topics, structural relations, temporal change).
5	Eligibility criteria	Yes	Method, Inclusion and Exclusion Criteria (SMI diagnostic scope; adults; peer-reviewed English-language articles, 1993 to March 2026; exclusions).
6	Information sources	Yes	Method, Search Strategy; six databases (Scopus, Web of Science, PsycINFO, CINAHL, Sociological Abstracts, PubMed); last searched March 2026.
7	Search strategy	Yes	Method and Table 1 (full Boolean strings for both term groups).
8	Selection process	Yes	Method, Study Selection and Screening; Figure 1 (PRISMA flow diagram); deduplication by DOI and normalized title; iterative screening of non-mental-health records.
9	Data collection process	Yes	Method, Analytic Strategy; abstracts and metadata extracted (title, abstract, year, journal, authors, DOI).
10	Data items	Yes	Method; abstract text (STM input), publication year (prevalence covariate), journal, author, and database fields (descriptives). No outcome-effect data were extracted.
11	Study risk-of-bias assessment	Not applicable (bibliometric design)	The unit of analysis is the publication corpus, not effect estimates; interpretive limits are noted in the Limitations.
12	Effect measures	Not	No effect measures were synthesized; analogous

		applicable (bibliometric design)	quantities are topic prevalence and topic correlations.
13	Synthesis methods	Yes (adapted)	Method, Analytic Strategy; STM (stm R package), K = 16 selected via held-out likelihood, semantic coherence, and residuals; topic correlation network; penalized-spline temporal trajectories.
14	Reporting bias assessment	Not applicable (bibliometric design)	No pooled effect was synthesized; publication and indexing bias of the corpus is addressed qualitatively in the Limitations.
15	Certainty assessment	Not applicable (bibliometric design)	Model-selection diagnostics (held-out likelihood, semantic coherence, residuals) are reported instead.
16a	Study selection results	Yes	Figure 1 and Results, Descriptive Statistics: 5,872 identified; 3,150 duplicates removed; 2,722 screened; 18 excluded (no or insufficient abstract); 73 excluded (non-mental-health context or not analyzable); 2,631 analyzed.
16b	Exclusions with reasons	Yes	Figure 1 (duplicates; no or insufficient abstract; non-mental-health context or not analyzable).
17	Study characteristics	Yes	Table 2 (N = 2,631): decade, database, journals, authors.
18	Risk of bias in studies	Not applicable (bibliometric design)	See item 11.
19	Results of individual studies	Not applicable (bibliometric design)	Corpus-level analysis; representative documents per topic are reported in Table 3.
20	Results of syntheses	Yes	Results: thematic structure (Table 3), topic correlation structure (Figure 2; Supplementary Table S1), temporal trends (Figure 3), and supplementary analyses (Supplementary Tables S2 and S3).
21	Reporting biases	Not applicable (bibliometric design)	See item 14.
22	Certainty of evidence	Not applicable (bibliometric design)	See item 15.
23a	Interpretation	Yes	Discussion; two research traditions, the metacognition bridge, and the contribution of each finding.
23b	Limitations of evidence	Yes	Limitations; peer-reviewed articles only, recovery-labeled terminology only, English-language and Global North concentration, abstracts rather than full texts.

23c	Limitations of review processes	Yes	Limitations; abstract-based STM, analyst-guided selection of K, interpretive topic labeling, keyword-based lower-bound estimate of lived-experience involvement.
23d	Implications	Yes	Discussion, Implications for Research, Policy, and Practice.
24a	Registration and protocol	No	The review was not prospectively registered.
24b	Protocol access	Not applicable	No registered protocol.
24c	Amendments	Not applicable	None.
25	Support	See Title Page	Funding information is reported on the Title Page.
26	Competing interests	See Title Page	Declarations of Interest are reported on the Title Page.
27	Availability of data, code, and materials	Yes	Corpus metadata and analysis code are available from the corresponding author upon reasonable request.

Supplementary Methods: Text Preprocessing and Software Details

Abstracts were lemmatized using the spaCy English language model, retaining only nouns, verbs, and adjectives. A custom stopword list was applied to remove methodological and publishing boilerplate, and terms appearing in fewer than 10 documents were excluded from the vocabulary to reduce noise from idiosyncratic terms. Data collection, deduplication, and preprocessing prior to lemmatization were conducted in Python using the pymed, rispy, and pandas libraries.

Supplementary Analysis 1: Lived-Experience Involvement and Coproduction

This supplementary analysis examined the prevalence of lived-experience involvement or coproduction across the corpus (N = 2,631). Because the corpus comprises abstracts and metadata rather than full texts, involvement was identified by a keyword scan of abstracts and author keywords (co-produc*, co-design*, co-creat*, participatory research or participatory action, community-based participatory, service user involvement, patient and public involvement, experts by experience, peer research, peer-led, user-led). This abstract-level approach under-counts involvement that is reported only in the full text and should therefore be read as a lower bound. The keyword list was not validated against full-text coding, so the estimate is best read as the prevalence of explicit involvement language in abstracts.

Explicit reference to involvement or coproduction appeared in 103 of 2,631 articles (3.9%), distributed comparably across the two clusters (experiential 3.6%, clinical/empirical 4.3%). At the topic level, involvement language was most frequent in intervention and tool development topics (Longitudinal Outcomes and Early Psychosis, 12.8%, driven largely by co-designed digital interventions; Family, Caregiving and Implementation, 9.8%; RCTs and Intervention Effectiveness, 8.3%) and least frequent in the conceptual and narrative core (Conceptual Frameworks, 2.4%; Narratives and Lived Experience, 1.3%; Social Inclusion, Employment and Community Integration, 0%). This pattern suggests that, in the published record, coproduction appears predominantly where interventions and instruments are being

built rather than where recovery is conceptualized or narrated. Full results by topic and cluster are presented in Supplementary Table S2.

Supplementary Table S1

Network Centrality Measures for the 16 Structural Topic Modeling Topics

Topic	Label	Degree	Betweenness	Eigenvector	Closeness
14	Cognitive and Psychosocial Interventions	6	59.00	1.000	0.484
4	Personal Versus Clinical Recovery Outcomes	6	27.00	0.952	0.405
9	Metacognition and Psychotherapy	2	54.00	0.244	0.455
6	Conceptual Frameworks of Personal Recovery	4	53.00	0.070	0.405
3	RCTs and Intervention Effectiveness	5	14.00	0.910	0.395
5	Psychiatric Rehabilitation Within Inpatient Care	5	3.00	0.955	0.395
16	Longitudinal Outcomes and Early Psychosis	4	0.00	0.872	0.385
8	Recovery-Oriented Services and Policy	3	19.50	0.019	0.319
11	Social Inclusion, Employment and Community Integration	3	6.50	0.023	0.312
1	Shared Decision-Making and Medication Management	2	0.00	0.446	0.341
10	Narratives and Lived Experience of Recovery	2	0.00	0.021	0.306
13	Workforce Training Regarding Recovery	2	1.00	0.010	0.259
2	Recovery Scale Development and Validation	1	0.00	0.217	0.294
7	Stigma and Psychosocial Processes in Recovery	1	0.00	0.217	0.294
12	Family, Caregiving and Implementation	1	0.00	0.004	0.246
15	Peer Digital Interventions	1	0.00	0.208	0.288

Note. Centrality measures were computed from the positive correlation network produced by the topicCorr function in the stm package. Degree = number of topics directly connected to a given topic; Betweenness = frequency with which a topic lies on the shortest path between other topic pairs; Eigenvector = connectivity to well-connected topics; Closeness = average proximity to all other topics in the network. Topics are sorted by combined structural importance (degree, then betweenness).

Supplementary Table S2

Lived-Experience Involvement and Coproduction by Topic and Cluster (Keyword-Based Lower-Bound Estimate)

Topic	Label	Cluster	n	%
1	Shared Decision-Making & Medication Management	Clinical/empirical	3	2.6
2	Recovery Scale Development & Validation	Clinical/empirical	2	1.0
3	RCTs & Intervention Effectiveness	Clinical/empirical	21	8.3
4	Personal vs Clinical Recovery Outcomes	Clinical/empirical	4	3.1
5	Psychiatric Rehabilitation Within Inpatient Care	Clinical/empirical	1	1.0
6	Conceptual Frameworks of Personal Recovery	Experiential/social	8	2.4
7	Stigma & Psychosocial Processes in Recovery	Clinical/empirical	2	1.3
8	Recovery-Oriented Services & Policy	Experiential/social	1	0.7
9	Metacognition & Psychotherapy	Bridge	6	3.0
10	Narratives & Lived Experience of Recovery	Experiential/social	1	1.3
11	Social Inclusion, Employment & Community Integration	Experiential/social	0	0.0
12	Family, Caregiving & Implementation	Experiential/social	27	9.8
13	Workforce Training Regarding Recovery	Experiential/social	2	1.9
14	Cognitive & Psychosocial Interventions	Clinical/empirical	5	3.8
15	Peer Digital Interventions	Clinical/empirical	4	2.7
16	Longitudinal Outcomes & Early Psychosis	Clinical/empirical	16	12.8
	By cluster		**n**	**%**
	Experiential/social		39	3.6
	Clinical/empirical		58	4.3
	Bridge (Metacognition)		6	3.0
	Overall		103	3.9

Note. Percentages are the number of articles with explicit involvement or coproduction language (n) divided by the total number of articles in each topic or cluster.

Supplementary Analysis 2: Geographic Representation

This supplementary analysis examined the geographic distribution of the corpus based on the country of first-author affiliation. Records were matched to bibliographic databases (OpenAlex, PubMed/MEDLINE, and Crossref) via DOI, PMID, and title, supplemented by manual verification of records not indexed in those databases. First-author country was resolved for 2,624 of 2,631 records (99.7%). The seven unresolved records included one deliberately anonymized autoethnographic commentary. The distribution was highly stable as coverage increased from an early partial set to near-complete coverage (for example, United States 27.7% at 79.7% coverage vs. 29.2% at 99.7% coverage), confirming the pattern is not an artifact of incomplete coverage.

The corpus was concentrated in a small number of high-income, predominantly English-speaking countries. Among records with a resolved first-author country, 57.3% originated from Anglophone countries (United States 29.2%, United Kingdom 10.6%, Australia 9.4%, Canada 6.4%) and a further 23.6% from non-Anglophone European countries, together 80.9% of the corpus. Scholarship from Asia (11.1%), the Middle East and North Africa (3.8%), Eastern Europe (1.7%), Latin America (1.6%), and sub-Saharan Africa (1.0%) was comparatively sparse, although 76 countries were represented in total. Geographic origin was not strongly associated with cluster membership. The Anglophone share was 59.6% in the experiential cluster and 54.3% in the clinical/empirical cluster, and the bridging metacognition topic was the most Anglophone-concentrated (64.8%). Full results are presented in Supplementary Tables S3 to S5.

Supplementary Table S3

Geographic Distribution of the Corpus by Region (First-Author Affiliation)

Region	n	%
Anglophone	1,503	57.3
Other Europe	620	23.6
Asia	290	11.1
Middle East and North Africa	99	3.8
Eastern Europe	44	1.7
Latin America	42	1.6
Sub-Saharan Africa	25	1.0
Other	1	0.0

Supplementary Table S4

Countries With 40 or More Records (First-Author Affiliation)

Country	n	%
United States	766	29.2
United Kingdom	278	10.6
Australia	247	9.4
Canada	169	6.4
Netherlands	142	5.4
Spain	74	2.8
Sweden	65	2.5
Italy	63	2.4
Israel	62	2.4
Japan	57	2.2
Denmark	57	2.2
Hong Kong	56	2.1
France	55	2.1
Norway	54	2.1
China	46	1.8

Note. Total countries represented = 76.

Supplementary Table S5

Anglophone Share of Records by Cluster

Cluster	Anglophone %	n
Experiential/social	59.6	1,073
Clinical/empirical	54.3	1,355

Metacognition bridge	64.8	196