Psychological Dimensions of Anterior Cruciate Ligament Injury and Rehabilitation: A Continuing Education Manual for Psychologists

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Title Page

Psychological Dimensions of Anterior Cruciate Ligament Injury and Rehabilitation: A Continuing Education Manual for Psychologists

A Continuing Education Reading Manual (1 CE Credit Hour)

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Abstract

Anterior cruciate ligament (ACL) injury is one of the most psychologically demanding orthopedic injuries encountered in athletic and active populations. Although ACL rehabilitation has traditionally been conceptualized as a biomechanical and surgical problem, contemporary

scholarship increasingly recognizes that psychological factors profoundly shape the trajectory of recovery, the likelihood of return to sport, and the long-term mental health of patients. This continuing education manual provides licensed psychologists and graduate-level clinicians with a comprehensive overview of the psychological landscape of ACL injury and rehabilitation. Drawing upon the materials made available for this course, the manual synthesizes historical foundations, contemporary conceptual models, and clinical considerations relevant to psychological practice with this population. Particular attention is given to fear of reinjury, kinesiophobia, identity disruption, depressive and anxious symptomatology, motivational dynamics across rehabilitation phases, and the role of psychologists in interdisciplinary sports medicine teams. The manual emphasizes the integration of cognitive-behavioral, motivational, and acceptance-based frameworks to inform clinical decision-making. Limitations of the existing evidence base are critically examined, and directions for future research and practice are proposed. The intent is to equip psychologists with the conceptual depth and clinical orientation needed to support patients across the continuum of ACL recovery.

Introduction

The anterior cruciate ligament is one of the principal stabilizing structures of the knee, and its rupture represents a watershed moment in the lives of many athletes, active adults, and adolescents. While the surgical and physical rehabilitation aspects of ACL injury have been the subject of decades of orthopedic and physical therapy research, the psychological dimensions of this injury have received comparatively less systematic attention until recently. For psychologists working in sports, health, rehabilitation, or general clinical practice, understanding the unique psychological sequelae of ACL injury is increasingly essential, as patients with this injury are frequently referred for support related to mood disturbance, fear, motivational difficulties, and identity disruption.

This continuing education manual, prepared in accordance with the standards of Webinarceclasses and aligned with the course titled *ACL Injury Rehab Protocols* delivered by Carvajal Icus, is intended to serve as a scholarly reading resource for licensed psychologists and graduate-level clinicians. Rather than focus on surgical technique or physical therapy protocols, the manual situates ACL rehabilitation within a biopsychosocial framework,

emphasizing the cognitive, affective, behavioral, and contextual factors that shape recovery. The manual is written to be accessible to clinicians who may not have specialized training in sports psychology while also offering conceptual depth appropriate for those already working in athletic or rehabilitation settings.

It is important to acknowledge at the outset that the source material provided for this course is limited in scope, consisting primarily of a documentation of completion and identifying course information. Accordingly, this manual draws on widely accepted conceptual frameworks within rehabilitation psychology and sports medicine to expand upon the topic indicated by the course title. Where empirical claims are made, they are framed conceptually and consistent with the orientation of a continuing education reading manual, and the reference list at the end of this document is limited to the source materials that directly support the course identification. Readers seeking primary empirical citations are encouraged to consult the recommended literatures in rehabilitation psychology, sports medicine, and behavioral health.

The structure of the manual proceeds from historical and theoretical foundations through conceptual models, integrated empirical themes, psychological pathways, mental health outcomes, systemic and contextual factors, clinical implications, and future directions. Throughout, the emphasis is on producing a cohesive narrative that supports the psychologist's role in promoting recovery, well-being, and meaningful return to valued activity.

Historical and Theoretical Foundations

The historical evolution of how clinicians have understood ACL injury parallels the broader development of rehabilitation psychology and sports medicine. In the mid-twentieth century, orthopedic care for knee injuries was predominantly mechanical in orientation. The injured ligament was viewed as a structural failure to be addressed through surgical reconstruction and graded physical therapy, with little attention paid to the psychological experience of the patient. Recovery was measured almost exclusively through objective indicators such as range of motion, quadriceps strength, knee laxity, and the ability to perform sport-specific tasks.

The emergence of the biopsychosocial model in the late twentieth century, originally articulated for general medicine and subsequently adapted to rehabilitation, marked a turning point. Within this framework, the patient's biology, psychology, and social context were understood as mutually interactive determinants of health outcomes. ACL injury, as a discrete and often dramatic event embedded in the social world of the athlete or active individual, became a natural site for the application of biopsychosocial thinking. Clinicians began to observe that patients with comparable surgical outcomes and physical therapy participation nonetheless varied widely in their psychological recovery and willingness to return to sport.

Theoretical foundations from health psychology, behavioral medicine, and cognitive-behavioral therapy contributed to a more sophisticated understanding of injury response. The stress and coping framework, originally developed by Lazarus and colleagues in the broader field of health psychology, was applied to athletic injury and provided a useful lens for understanding individual differences in adaptation. Fear-avoidance models, initially developed in the context of chronic musculoskeletal pain, were extended to athletic populations and helped clinicians understand the phenomenon of kinesiophobia—the fear of movement or reinjury—that frequently complicates ACL rehabilitation. Self-determination theory, with its emphasis on autonomy, competence, and relatedness, offered an account of motivational processes that proved especially relevant during the prolonged rehabilitation period characteristic of ACL recovery.

Within sports psychology specifically, several integrated models of injury response emerged. These models commonly described psychological responses unfolding over phases, often beginning with shock and denial in the immediate post-injury period, transitioning through frustration and depression in the early rehabilitation period, and ideally culminating in acceptance and proactive engagement with recovery. While such stage-based descriptions have been critiqued for their linearity and lack of empirical specificity, they helped legitimize psychological attention to athletes and shaped the early literature on the psychology of sports injury.

These foundations set the stage for contemporary frameworks that emphasize the dynamic, recursive interplay between cognition, emotion, behavior, and context throughout the recovery trajectory. They also legitimized the role of psychologists as members of sports medicine teams and rehabilitation services, a development that informs the orientation of this manual.

Conceptual Models and Mechanisms

Contemporary conceptual models of psychological response to ACL injury share several common features. They tend to be integrative, drawing on cognitive, affective, behavioral, and contextual variables. They are typically dynamic, recognizing that psychological processes evolve across the long arc of ACL recovery, which commonly spans nine to twelve months or more. They also emphasize bidirectional relationships, in which psychological factors influence physical rehabilitation outcomes and physical recovery experiences in turn shape psychological adaptation.

A useful organizing framework conceptualizes the patient's experience as moving across three broad phases. The first is the acute response phase, encompassing the immediate aftermath of injury and the perioperative period. During this phase, patients commonly experience acute distress, shock, grief over loss of athletic activity, and anticipatory anxiety regarding surgery and recovery. Cognitive appraisals during this phase strongly shape subsequent adaptation; patients who appraise the injury as a manageable challenge tend to fare better than those who appraise it as catastrophic or as a fundamental threat to identity.

The second is the rehabilitation phase, which is typically the longest and is characterized by sustained engagement with physical therapy, gradual restoration of function, and the management of setbacks. Psychological challenges during this phase include adherence difficulties, motivational fluctuations, frustration with slow progress, social isolation from team or activity contexts, and the emergence of depressive or anxious symptomatology. Self-regulatory capacities and social support become particularly important during this extended period.

The third is the return-to-activity phase, in which patients prepare to resume valued activities including sport. This phase is psychologically distinctive because it requires the patient to confront the very movements and contexts associated with the original injury. Fear of reinjury, kinesiophobia, and confidence deficits frequently emerge or intensify during this phase, even when physical readiness has been objectively established. Conceptual figures used in this literature often depict these phases as overlapping rather than discrete, with psychological vulnerabilities and resources fluctuating throughout.

Several mechanisms have been proposed to explain how psychological factors influence rehabilitation outcomes. Cognitive mechanisms include catastrophic thinking, negative outcome expectancies, and attentional biases toward threat-related stimuli such as knee sensations. Affective mechanisms include the impact of depressed mood on motivation and engagement, and the role of anxiety in narrowing attention and disrupting motor performance. Behavioral mechanisms include avoidance of rehabilitative exercises, reduced adherence to home programs, and protective movement patterns that, while initially adaptive, can become maladaptive when they persist beyond the period of tissue vulnerability. Physiological mechanisms include the effects of chronic stress activation on tissue healing, sleep, and pain modulation.

A particularly important mechanism is the fear-avoidance cycle, conceptually adapted to ACL rehabilitation from the chronic pain literature. In this model, painful or apprehensive experiences during rehabilitation are appraised catastrophically, leading to fear of movement and avoidance of demanding activities. Avoidance prevents the natural disconfirmation of feared outcomes, maintains physical deconditioning, and ultimately undermines functional recovery. This cycle can persist long after surgical and tissue healing are complete and is one of the principal targets of psychological intervention in this population.

Empirical Findings Across Studies

While the source materials available for this manual do not provide a body of primary empirical studies to integrate, the broader literature on psychological aspects of ACL injury, which is consistent with the orientation of the *ACL Injury Rehab Protocols* course, supports several converging themes that warrant integrated discussion at a conceptual level.

A first theme is that psychological readiness is a robust predictor of return to sport following ACL reconstruction, independent of physical readiness. Patients who demonstrate adequate strength, range of motion, and functional performance but who report low psychological readiness are less likely to return to pre-injury levels of sport and are at elevated risk of dropping out of athletic activity altogether. Conversely, patients with high psychological readiness tend to engage in more confident and complete return-to-sport behaviors.

A second theme is that fear of reinjury, often operationalized through measures of kinesiophobia, is among the most commonly cited reasons for not returning to sport after ACL reconstruction. This finding has emerged across multiple populations, including adolescents, recreational athletes, and elite competitors. Importantly, fear of reinjury is not strongly correlated with objective biomechanical risk, suggesting that it functions as a partially independent psychological variable that requires its own targeted assessment and intervention.

A third theme concerns depressive and anxious symptomatology following ACL injury. A meaningful subset of patients experience clinically significant depressive symptoms in the early post-injury and post-operative periods, with symptoms tending to attenuate over the course of rehabilitation for most but persisting for a substantial minority. Anxiety symptoms often follow a different trajectory, with elevations occurring in the early phase and again as return to sport approaches.

A fourth theme involves the role of social support and contextual factors. Patients with strong social support networks, supportive coaches and teammates, and family environments that promote autonomy tend to demonstrate better rehabilitation adherence and psychological outcomes. Conversely, patients whose identities are heavily centered on athletic participation, particularly when that identity is unidimensional, may experience more severe psychological disruption when injury threatens that identity.

A fifth theme is that psychological interventions, including cognitive-behavioral approaches, imagery, goal-setting, and mindfulness-based strategies, show promise in improving rehabilitation adherence, reducing fear of reinjury, and supporting return to sport. While the evidence base remains heterogeneous and additional rigorous trials are needed, the conceptual case for psychological intervention is strong and converges with the broader literatures on chronic pain, surgical recovery, and athletic performance.

Methodological limitations across this literature warrant acknowledgment. Sample sizes are often modest, follow-up durations vary, measures of psychological readiness and kinesiophobia are heterogeneous, and many studies rely on convenience samples drawn from single clinical settings. The generalizability of findings across age groups, sports, competitive levels, and cultural contexts is sometimes uncertain. These limitations should temper strong causal claims while still supporting the broader proposition that psychological factors are central to ACL recovery.

A synthesis of these themes is presented conceptually in Table 1, which organizes the principal psychological variables, their typical assessment domains, and their relevance across rehabilitation phases.

Table 1. Conceptual Synthesis of Psychological Variables Across ACL Rehabilitation Phases

Psychological Domain	Acute Phase	Rehabilitation Phase	Return-to-Activity Phase
Cognitive appraisal	Threat vs. challenge framing	Outcome expectancies	Confidence in knee
Emotional response	Shock, grief, acute anxiety	Depressive symptoms, frustration	Anticipatory anxiety, fear
Behavioral pattern	Help-seeking, adherence onset	Adherence consistency, pacing	Approach vs. avoidance of sport
Identity	Disruption, loss	Renegotiation	Reintegration
Social context	Initial support mobilization	Sustained support, isolation risk	Reentry to team/community

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Psychological Pathways and Stress Responses

The psychological pathways through which ACL injury exerts its effects are best understood as multilayered. At the most immediate level, the injury event itself can be experienced as traumatic, particularly when it occurs in highly visible or high-stakes contexts, when it involves witnessed or vivid bodily damage, or when it produces an audible or sensory experience that becomes a memorable cue. For some patients, intrusive recollections of the injury event, avoidance of related stimuli, and heightened physiological arousal during reminders meet criteria consistent with acute stress responses or, in a minority of cases, post-traumatic symptomatology. Psychologists should be alert to these presentations, particularly in patients who report distressing replays of the injury or who become emotionally activated when approaching the activity in which the injury occurred.

Beyond the acute event, the prolonged stress of rehabilitation engages chronic stress response systems. Sustained activation of the hypothalamic-pituitary-adrenal axis and sympathetic nervous system, particularly when combined with poor sleep, pain, and reduced physical activity, can adversely affect mood regulation, cognitive function, and even tissue recovery. The chronic stress of recovery is compounded by the loss of the typical stress-buffering effects that regular athletic participation provides for many active individuals. Patients accustomed to managing stress through vigorous exercise may find themselves without their primary coping resource at the very moment they need it most.

Cognitive pathways are particularly salient. The internal narratives patients construct about their injury shape recovery in powerful ways. Patients who frame the injury as a setback within an ongoing athletic story tend to mobilize resources, maintain hope, and engage actively. Those who frame the injury as a catastrophic disruption of identity or as evidence of personal failure may experience profound demoralization. Catastrophic thinking, in which the worst possible outcomes are anticipated and treated as likely, is associated with greater pain, slower recovery, and elevated fear of reinjury.

Emotional pathways include grief, which can be substantial when injury disrupts cherished activities and identities. Grief in this context resembles other forms of nonbereavement grief, encompassing loss of role, loss of community, loss of physical capacity, and loss of imagined future. The clinical task is not to pathologize this grief but to support its expression, normalize its presence, and facilitate adaptive integration over time.

Behavioral pathways operate through adherence, pacing, and approach-avoidance dynamics. Adherence to home exercise programs, attendance at physical therapy, sleep, nutrition, and gradual return to load all influence physical recovery. Psychological variables including motivation, self-efficacy, mood, and fear influence each of these behaviors, providing multiple points at which psychological intervention can affect physical outcomes.

Social pathways operate through the responses of family members, coaches, teammates, and clinicians. Responses that communicate support without overprotection, that respect the patient's autonomy, and that acknowledge both the seriousness of the injury and the realistic prospects for recovery tend to be most facilitative. Responses that are either dismissive or catastrophizing, that undermine autonomy, or that introduce social comparison with other athletes can be psychologically harmful.

Mental Health Outcomes and Severity Spectrum

The mental health outcomes associated with ACL injury and rehabilitation span a spectrum from transient and adaptive distress to clinically significant disorders. At one end of the spectrum is the normative experience of distress that accompanies any significant injury. Patients commonly report a period of sadness, irritability, sleep disturbance, worry, and reduced enjoyment in the days and weeks following injury and surgery. These experiences typically diminish as functional recovery progresses, social connections are maintained, and a sense of forward momentum is established.

Moving along the spectrum, a substantial minority of patients develop adjustment disorder presentations in which the distress is more pronounced, more persistent, and more functionally impairing than would be expected. These presentations often respond well to short-term, focused psychological intervention and to interdisciplinary supports.

Further along the spectrum, some patients develop major depressive episodes during ACL rehabilitation. The risk factors for depression in this population overlap with general risk factors—personal or family history of depression, limited social support, concurrent life stressors—but also include injury-specific factors such as loss of athletic identity, financial strain related to lost competition or scholarship opportunities, and protracted recovery with setbacks. Recognition is clinically important, as depression undermines adherence and recovery, and as standard treatments are effective.

Anxiety disorders, including generalized anxiety symptoms and specific fears related to movement and reinjury, also occur with notable frequency. Fear of reinjury merits particular attention because it occupies a unique position at the intersection of normative caution and clinically significant impairment. Some degree of caution is adaptive and may protect against reinjury, but when fear is excessive, persistent, and disconnected from objective biomechanical risk, it impairs return to activity and quality of life.

A smaller subset of patients develop trauma-related symptomatology connected to the injury event, and an additional subset experience exacerbations of pre-existing conditions including eating disorders, substance use disorders, or attention-related difficulties that may be

unmasked or worsened by the disruption of routine and the introduction of pain medications.

A particularly important consideration is the long-term mental health trajectory, especially for patients who do not return to their pre-injury level of activity. Permanent or extended cessation of competitive sport, particularly when not freely chosen, is associated with elevated risk for ongoing psychological difficulty. Patients in this situation benefit from sustained attention to identity reconstruction, the development of alternative sources of meaning and physical engagement, and, in some cases, longer-term psychotherapy.

Across the spectrum, clinicians should remain attentive to suicidality, particularly in young athletes with strong athletic identity, perfectionistic tendencies, or those facing the end of their competitive careers. Routine and sensitive screening is appropriate when indicated.

System-Level and Contextual Psychological Effects

ACL injury does not occur in isolation; it occurs within systems that shape both the experience and the outcome of recovery. Family systems are often profoundly affected by adolescent and young adult ACL injuries. Parents may experience their own distress, vicarious anxiety, and uncertainty about how to support their child. Family dynamics can become organized around the injury, sometimes in ways that inadvertently increase the patient's distress or undermine autonomy. Psychologists are often well-positioned to support parents and families directly or through psychoeducation, helping them calibrate involvement and communicate supportively.

Team systems, including coaches, athletic trainers, and teammates, exert powerful psychological influence. Coaches who maintain meaningful inclusion of the injured athlete, who communicate confidence in the recovery process, and who avoid implicit pressure for premature return tend to support better outcomes. Teammate relationships can be either sustaining or alienating; injured athletes sometimes describe feeling forgotten or marginalized, especially when they are unable to attend practices and games.

Clinical systems also shape psychological recovery. The communication style of surgeons, physical therapists, and athletic trainers strongly influences patient expectations and emotional responses. Coordinated, consistent messaging across providers reduces patient

confusion and anxiety, while fragmented or contradictory communication can amplify distress. Integrated sports medicine teams that include psychological support as a standard component of care represent an emerging best practice that reflects the biopsychosocial integration discussed earlier in this manual.

Educational and occupational systems are particularly relevant for student-athletes and working adults. Academic accommodations, flexible scheduling for rehabilitation appointments, and recognition of the cognitive impact of pain and stress can support recovery. For working adults, occupational considerations including ability to return to physically demanding jobs, financial implications of extended recovery, and workplace accommodations are central concerns.

Cultural and socioeconomic factors warrant explicit attention. Access to high-quality surgical care and rehabilitation varies substantially across socioeconomic strata and geographic regions. Cultural expectations regarding emotional expression, help-seeking, and the meaning of athletic participation shape how patients experience and present their distress. Psychologists should approach each patient with cultural humility, recognizing that the meaning of ACL injury is constructed within the patient's specific cultural and contextual frame.

Finally, broader systemic factors including the commercialization of youth sports, the early specialization of young athletes, and the cultural valorization of athletic identity create the conditions in which ACL injuries occur and within which their psychological impact is experienced. While these macro-level factors are beyond the scope of individual clinical encounters, awareness of them can inform advocacy and prevention efforts in which psychologists may participate.

Clinical Implications for Psychologists

The clinical implications of the foregoing analysis are substantial and span assessment, intervention, and collaboration. Assessment begins with a careful clinical interview that explores the circumstances of injury, the patient's appraisals and emotional responses, the meaning of athletic activity in the patient's life, the quality of social support, and the presence

of mood, anxiety, or trauma symptoms. Standardized measures of psychological readiness, kinesiophobia, depression, anxiety, and pain catastrophizing can supplement clinical interview when used judiciously and interpreted within context.

Intervention strategies draw on multiple evidence-informed approaches. Psychoeducation about the recovery process, the normalcy of emotional responses to injury, and the role of psychological factors in physical recovery is often a valuable first step. Cognitive-behavioral interventions target catastrophic thinking, fear-avoidance patterns, and adherence difficulties. Goal-setting frameworks help patients establish meaningful short-term and long-term objectives that maintain motivation across the long rehabilitation arc. Imagery and visualization techniques, well-established in sports psychology, can support both rehabilitation engagement and confidence development for return to sport. Mindfulness and acceptance-based approaches help patients tolerate pain, uncertainty, and uncomfortable emotions without resorting to avoidance.

Exposure-based work is particularly important for patients with significant fear of reinjury or kinesiophobia. Graded behavioral approach to feared movements and contexts, ideally coordinated with physical therapy, can be highly effective. Psychologists working with this population benefit from familiarity with the physical rehabilitation timeline and from collaborative relationships with physical therapists and athletic trainers, so that psychological exposure work is calibrated to physical readiness.

Motivational interventions are useful throughout rehabilitation, particularly during plateaus and setbacks. Motivational interviewing techniques, autonomy-supportive communication, and connection to deeply held values can sustain engagement when initial enthusiasm wanes.

Identity work is often central. Helping patients articulate the multiple dimensions of self beyond athletic performance, expanding sources of meaning, and supporting the integration of injury experience into a broader life narrative can be transformative. This work is especially important for patients with strongly unidimensional athletic identities and for those facing extended or permanent reductions in athletic participation.

Collaboration with interdisciplinary teams is essential. Psychologists working in this area should develop working relationships with orthopedic surgeons, physical therapists, athletic trainers, primary care providers, and, where relevant, coaches and family members. Clear communication, respect for scope of practice, attention to confidentiality and consent, and

shared commitment to patient-centered care are foundational to effective collaboration.

Ethical considerations include attention to informed consent, particularly when working with minors and when collaborating with non-clinical stakeholders such as coaches; careful management of dual relationships in team contexts; and culturally responsive practice that respects diverse meanings of injury, recovery, and athletic participation.

Future Directions and Research Gaps

Several research gaps and future directions warrant attention. Methodologically, the field would benefit from larger, more diverse samples; longer follow-up durations that extend well beyond the typical return-to-sport milestone; standardized measurement of key psychological constructs across studies to facilitate synthesis; and rigorous randomized trials of psychological interventions integrated into standard ACL care.

Conceptually, more sophisticated models of the interaction between psychological and physical recovery processes are needed, including process-oriented research that examines how psychological variables change over time and how those changes relate to physical outcomes. Attention to mechanisms of change in psychological interventions would advance both science and practice.

Populations that remain understudied include adolescents, particularly the rapidly growing population of pediatric and adolescent ACL injuries; women and girls, who face elevated injury rates and may experience the psychological aftermath differently; older recreational athletes; non-athletic patients who sustain ACL injuries in work or accident contexts; and culturally and economically diverse populations.

Implementation research is particularly needed. While the conceptual case for integrating psychological care into ACL rehabilitation is strong, the practical realities of implementation—including reimbursement structures, workforce availability, training pathways, and clinical workflows—remain substantial barriers in many settings. Research that addresses how to deliver psychological care efficiently and equitably across the diverse settings in which ACL patients receive care would have substantial impact.

Technology-enabled interventions, including digital tools for self-monitoring, mobile-delivered cognitive-behavioral content, telehealth-delivered psychological care, and virtual reality applications for graded exposure, represent promising avenues warranting rigorous evaluation. Such tools may be particularly valuable for expanding access in underserved areas.

Finally, prevention-oriented research that examines whether psychological factors and interventions can reduce primary injury risk, and whether psychological care during recovery can reduce reinjury risk, represents a frontier with substantial public health relevance.

Conclusion

ACL injury is a significant event in the lives of athletes, active adults, and adolescents, and its psychological dimensions are integral to the recovery process. From the moment of injury through the long arc of rehabilitation and the eventual return to valued activity, psychological factors shape the patient's experience and influence outcomes in ways that are at least as consequential as physical and surgical variables. For psychologists, the ACL-injured patient represents both a clinical responsibility and an opportunity to contribute meaningfully to interdisciplinary care.

This manual has aimed to provide a coherent narrative grounded in the biopsychosocial tradition, encompassing historical foundations, conceptual models, integrated thematic findings, psychological pathways, mental health outcomes, systemic and contextual considerations, clinical implications, and future directions. The recurring message is that psychological care is not an adjunct to ACL rehabilitation but an integral component of it. Patients who receive thoughtful psychological support are better positioned to recover physically, return to valued activity, manage fear and uncertainty, and integrate the injury into a coherent and meaningful life narrative.

Psychologists who pursue further education in this area, who develop collaborative relationships with sports medicine colleagues, and who approach each patient with the conceptual depth and clinical attentiveness that this work requires will find themselves contributing significantly to a population whose needs are increasingly recognized but still

often underserved. The continuing growth of integrated, evidence-informed psychological care within ACL rehabilitation represents a hopeful direction for the field, and the engagement of psychologists in this work will be central to its continued advancement.

References

Carvajal, F. (2026). *Documentation of completion: ACL injury rehab protocols* [Course completion documentation]. Webinarceclasses. https://www.webinarceclasses.com

Carvajal Icus, D. (2026). *ACL injury rehab protocols* [Continuing education course]. Webinarceclasses.

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